# PRESERVE ACCESS TO RURAL HOME HEALTH SERVICES

**ISSUE:** In late 2000, as part of the Benefits Improvement and Protection Act (BIPA), Congress enacted a 10 percent add-on for home health services delivered in rural areas between April 2001 and April 2003. On April 1, 2003, the payment add-on expired. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 reinstated the rural payment improvement at 5 percent for a period of one year (April 1, 2004, through March 31, 2005). In February 2006, as part of S. 1932, the Deficit Reduction Act of 2005 (PL 109 - 171), a one-year (calendar year 2006) 5 percent rural add-on for home health services delivered in rural areas was signed into law. The rural add-on expired on December 31, 2006.

In 2010 the Patient Protection and Affordable Care Act (H.R. 3590; P.L. 111-148) reinstated a 3 percent payment add on for home health services delivered to residents of rural areas. Under the legislation the rural add-on payment became effective for visits ending on or after April 1, 2010, and before January 1, 2016. The SGR Repeal and Medicare Provider Payment Modernization Act of 2015 (H.R.2; Pub Law No: 114-10) included a provision extending the rural add on through the end of 2017. The Preserve Access to Medicare Rural Home Health Services Act of 2017 (S.353) would make permanent the rural add on.

**RECOMMENDATION:** Congress should permanently extend the 3 percent payment differential for home health services delivered in rural areas.

**RATIONALE:**

**Cut in Reimbursement Will Result in Service Area Reductions**

• The loss of the rural add-on will likely result in reductions in service areas and some agencies may have to turn away high resource use patients in rural areas. Access to care is a critical issue in rural America. Before the rural add on was reinstated in 2010, some agencies reported that they had to eliminate delivery of services to remote areas. For example, some agencies in Maine had to eliminate delivery of services to outlying islands.

**Workforce Shortages and Competitive Wages**

• Rural agencies have greater difficulty hiring or contracting with therapists, and frequently must use nurses instead of therapists to provide rehabilitative services, which could affect a patient's rehabilitation progress. Additionally, when an agency does not use a physical therapist for therapy services, it cannot qualify for the higher therapy rates allowed by the prospective payment system (PPS).

• Home health agencies have difficulty competing with hospitals to hire staff because they are unable to afford the wages, benefits, and large signing bonuses that hospitals offer. Further, home health agencies are not eligible for reclassification of their wage index – an option available only to hospitals. This problem can be even greater for rural agencies in cases where their rural hospital counterparts are eligible to become critical access hospitals or sole community providers, which afford them the opportunity for

greater reimbursement. Despite this, rural home health agencies must offer competitive wages for care workers that are comparable to wages paid in urban areas because of the nationwide nursing and staffing shortages. In certain frontier states, graduating nurses leave the state seeking better wages, thus compounding the workforce shortage.

**Costs Often Higher Than for Their Urban Counterparts**

• Agencies in rural areas frequently are smaller than their urban counterparts, which means that costs are higher due to smaller scale operations. Smaller agencies with fewer patients and fewer visits means that fixed costs, particularly those associated with meeting regulatory requirements, are spread over a smaller number of patients and visits, increasing overall per-patient and per-visit costs. Smaller agencies have less likelihood of maintaining a high patient volume –which means they have less access to a varied case-mix. There are not always enough marginally profitable cases to offset the resource-intensive, expensive cases. Outlier payments are not sufficient to cover these costs. A small agency's census of patients is often inconsistent, which makes it difficult to retain consistent full-time staff.

• In many rural areas, home health agencies can be the primary caregivers for homebound beneficiaries with limited access to transportation. This means that rural patients often require more resources than their urban counterparts, and are more expensive for agencies to serve. The cost of a nursing visit is considerably higher in rural areas than in urban areas. In the rural areas of Maine, for example, nursing visits are 37 percent more costly than in urban areas. Before the rural add on was reinstated, agencies often had to make decisions to not accept certain patients because of limited resources, and access suffered.

**Very Limited or No Access to Capital Resulting In Inability to Purchase Time-Saving Technology**

• Rural home health agencies often lack access to the capital needed to take advantage of time-saving technological advances that could increase efficiency, such as home monitoring devices. This problem is compounded by the fact that Medicare payment policy does not allow for reimbursement of such devices.

**Rural Agencies Generally Have Lower Margins**

• Since MedPAC has been studying Medicare home health margins, it has consistently found that the profit margins of rural agencies were below those of urban agencies.

• To analyze the financial impact of the home health PPS, NAHC secured nationwide data contained in the annual Medicare cost reports filed by freestanding and hospital-based home health agencies.