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Submission of the National Association for Home Care & Hospice (NAHC) in response to the Rural and Underserved Communities Health Task Force Request for Information (RFI)

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INFORMATION REQUESTS (Limit each response to 250 words - Total submissions should not exceed 10 pages, 12 pt font):

1. **What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?**

Delivery of effective community-based care, including home health and hospice services, in rural and underserved areas is heavily dependent on the availability of a sufficient cadre of skilled health care personnel.

Following are recommendations that we suggest for consideration by the Task Force to address this important area:

- Enact PCHETA (HR 647/S 2080) to expand the supply of palliative and hospice-trained care disciplines to address the overall growing societal need
- Create and enhance grant and loan forgiveness programs to encourage newly trained personnel to provide community-based care in rural and underserved areas
- Allow RHCs and FQHCs to bill for center-employed PA, NP and physicians hospice attending services (HR 2594/S 1190)
- Allow hospices additional time to perform the face-to-face encounter (up to 7 days following the start of the benefit period) to ease scheduling difficulties

- Reinstate the home health “3% rural add-on” as adequate reimbursement is a key factor in securing a sufficient workforce in rural areas that is needed to attain positive patient outcomes
- Enact the Home Health Care Planning Improvement Act of 2019, H.R. 2150, which would permit certain non-physician practitioners to certify Medicare eligibility for home health services

2. **What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?**

Technologies for use in the delivery of home health and hospice care are increasingly recognized as essential for an industry challenged by exponential growth in the number of patients with chronic disease, a shortage of skilled professionals to meet care demands, and by diminished reimbursement. Through the effective use of such technologies the overarching goals of keeping patients safely at home and reducing emergent and acute care spending can be realized.

Congress should:

- Establish telehomecare services as distinct benefits within Medicare and Medicaid coverage to include all present forms of telehealth services. As part of these benefits, Congress should allow sufficient flexibility to adopt coverage of emerging technologies, and allow costs associated with them for cost reporting purposes;
- Clarify that telehomecare qualifies as a Medicare covered service and permit visit equivalency under the home health and hospice benefits;
- Authorize the home as an originating site for telehealth services by physicians under section §1834(m)(3)(C) and provide greater flexibility for the use of remote patient monitoring services;
- Ensure that all health care providers and their patients, including HHAs and hospices, especially those in rural areas, have access to appropriate bandwidth so that they may take full advantage of technology appropriate for the care of homebound patients;
- Hold cellular carriers accountable to incentives provided by states to expand broadband to rural regions; and
- Direct CMMI to study the impact that early adoption of technology has had on access to care and reductions in overall health care costs.

3. **What should the Committee consider with respect to patient volume adequacy in rural areas?**

A key concern of community-based providers in rural and underserved areas is financial stability. This can be particularly problematic because these providers generally are smaller in size and have a lower volume of patients, and therefore have higher overhead costs per patient. These providers also may be more dramatically impacted by admission of high-cost patients, as they are less able to balance the costs against lower cost patients.

NAHC recommends that the Task Force consider the following reforms to maximize financial stability for home health and hospice organizations in rural and underserved areas:

- Reinstate a 3% rural add-on for home health services as home health care in rural areas is often more costly due to travel costs and the absence of economies of scale to absorb the costs of minimum standards of quality in Medicare/Medicaid Conditions of Participation;
- Examine the adequacy of hospice payments in rural and underserved areas and consider legislation to provide an add-on targeted to these areas; and
- Reform wage index policies to ensure that all providers in a service area can compete for the same types of health care staff; consider addressing the negative impact of year-to-year wage index value "swings" by limiting any wage index drop to a specified percentage to limit dramatic losses that strain providers' financial stability

8. **The availability of post-acute care and long-term services and supports is limited across the nation, but can be particularly challenging in rural and underserved areas facing disproportionately large burdens of chronic and disabling conditions. What approaches have communities taken to address these gaps in care delivery and the associated challenges of social isolation?**

With the many limitations and obstacles present in rural health care, resources must be maximized to their fullest potential to bridge the gap in care delivery not experienced in a more urban setting. Empowering clinicians to practice up to their full scope of practice is an important step toward more efficient care delivery. Modernizing our approach to the use of telehealth services will also help to increase the efficiency and effectiveness of care delivery in rural areas and underserved areas. Specifically, NAHC recommends that Congress authorize:

- The use of telehealth services and remote monitoring in hospice care, including allowing its use in fulfilling hospice face-to-face encounter requirements (as proposed in the CONNECT Act);

- PAs to perform the hospice face-to-face encounter requirement -- this change will make the hospice face-to-face requirement more comparable to the home health requirement and ease scheduling burdens, as well as allow for more effective use of hospice physicians and NPs;
- Non-physician practitioners to certify eligibility for the home health benefit. (H.R. 2150) This will reduce an unnecessary burden for patients and enable them to receive care from their desired provider, while also enabling non-physician practitioners to practice care within their scope of capabilities; and
- Permit an expanded scope of services for home health aides and personal care attendant services in Medicare and Medicaid to the extent of scope of practice and nurse delegation authority under state law.

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In closing, the following resources provide additional insights into some of the challenges that are inherent in providing effective hospice and palliative services to hard-to-reach populations:

Quality of Hospice Care: Comparison between Rural and Urban Residents
Rural Implications of Changes to the Medicare Hospice Benefit
Rural Hospice and Palliative Care