Written Testimony of
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Hearing on:
Aging in Place: The Vital Role of Home Health in Access to Care
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Good morning, Chairman Cardin, Ranking Member Daines, and distinguished Members of the Committee. My name is Tracy Mroz and I am an Associate Professor in the Department of Rehabilitation Medicine at the University of Washington. Thank you for the opportunity to provide testimony about opportunities and challenges for home health in supporting Americans' ability to age in place, particularly in rural America.

My expertise in this area comes from my experience as a health services researcher and an occupational therapist. I have studied access to and quality of home health care with an emphasis on care provided in rural communities for over a decade as an Investigator with the WWAMI Rural Health Research Center, funded by the Health Resources and Services Administration (HRSA) – Federal Office of Rural Health Policy, as well as through grants funded by the Agency for Healthcare Research and Quality, National Institutes of Health, and the National Institute on Disability, Independent Living, and Rehabilitation Research. I am also an Investigator with the HRSA-funded Center for Health Workforce Studies which focuses on research to inform health workforce planning and policy. My clinical background as an occupational therapist has given me frontline experience working with older adults to optimize their ability to participate in the activities they find most meaningful, from self-care and home management to work and leisure.

Based on my expertise, I will focus my comments on three main topics:

1. The role of home health in supporting aging in place for Medicare beneficiaries
2. Disparities in access to home health in rural communities
3. Drivers of access to care, including resource constraints, benefit requirements, and workforce challenges

The Role of Home Health in Supporting Aging in Place

The majority of American prefer to age in place in their own homes.[1-3] Medicare's home health benefit provides an opportunity to support aging in place for the approximately 3 million fee-for-service beneficiaries who receive home health care annually.[4] The home health benefit covers skilled nursing, rehabilitation (physical therapy, occupational therapy, and speech

language pathology), medical social work, and home health aide services. These services can help facilitate beneficiaries' ability to remain in the community. For example, beneficiaries can utilize home health to receive skilled nursing services to provide medications, monitor health status, and learn about self-management of their condition. Beneficiaries can receive rehabilitation services to facilitate performance of daily activities, increase strength and balance, assess safety at home, and make recommendations for assistive devices, home modifications, and adaptive strategies to maximize function. Home health aides can provide temporary assistance with self-care and home management during the home health stay, and medical social workers can help beneficiaries coordinate resources needed to manage their care at home. Home health staff may also provide training for family caregivers so that the caregivers can better support the beneficiary and reduce unmet care needs.

The home health benefit allows for direct referral from the community (community-entry home health) in addition to referral following hospitalization (post-acute home health). Regardless of entry-point into home health, home health services can support aging in place.

Post-acute home health:
Home health can help bridge the transition from an acute care hospital stay back to the community for a beneficiary who has been hospitalized. For example, beneficiaries may need care at home after being hospitalized following an emergent event, such as a stroke, heart attack, or fall that causes major injury. Beneficiaries may also receive home health following a planned hospitalization for a procedure, such as a total knee replacement or cancer treatment.

Community-entry home health:
Home health can support beneficiaries with chronic conditions who experience a change in health or functional status that does not necessitate hospitalization, but does require skilled services for recovery, stabilization, or to help the beneficiary stay safe at home. For example, beneficiaries may experience a decline in health or functional status due to an exacerbation of chronic obstructive pulmonary disease or heart failure, a flare up of multiple sclerosis symptoms, worsening arthritis, or a fall causing minor injury. Beneficiaries referred to home health from the community are more likely to be older, be dually eligible for Medicaid, have more cognitive impairment, lower functional status, and a higher need for caregiver assistance compared to beneficiaries referred to home health following hospitalization.[5-6]

Both post-acute and community-entry home health can provide valuable supports for beneficiaries who wish to remain in their homes. Home health to support aging in place may be particularly important for Medicare beneficiaries living in rural communities because these beneficiaries tend to be older, have poorer health, and have fewer financial resources compared to their urban counterparts.[7] However, the promise of the home health benefit as a means to support aging in place relies on the ability of beneficiaries to access home health care.

Access to Home Health in Rural Communities

While the most recent MedPAC Report to Congress on Medicare Payment Policy notes that over 98% of Medicare beneficiaries live in a ZIP code served by at least two home health agencies, and nearly 88% live in a ZIP code served by five or more home health agencies,[4] the reality of access to care for rural beneficiaries is more nuanced. The number of home health agencies serving a community represents supply, which is a necessary but not sufficient measure of access to home health. Even when a home health agency is ostensibly serving a rural community, the agency may not always have the capacity to admit new patients, provide services in a timely fashion, or provide all types of services the beneficiary needs.[8-9] Indeed, some rural home health agencies report capacity constraints that result in only being able to cover part of their licensed service areas and they may refuse new admissions if they do not have adequate staffing to provide care at the time of referral.[8] For beneficiaries that are admitted to home health, the number of visits they receive may be limited due to the amount of "windshield time" (i.e., travel time) required by home health care staff when driving long distances to visit patients dispersed widely across rural areas.[8-9]

So, despite reports that most rural beneficiaries are served by at least one home health agency, there is a growing body of evidence on disparities in access to home health based on rural-urban status.[10] Rural beneficiaries who are hospitalized are less likely to be discharged to home health compared to their urban counterparts, and this gap is wider for beneficiaries living in non-urban-adjacent rural counties compared to urban-adjacent rural counties.[11-12] Furthermore, when rural beneficiaries have a planned discharge to home health following hospitalization, fewer than 60% of them are admitted to a home health agency to receive this planned care following hospital discharge.[13] When considering both post-acute and community-entry home health, an increasingly smaller percent of Medicare beneficiaries use home health care as rurality increases, with beneficiaries in the most remote rural communities at highest risk for unmet need, though geographic region also drives variation in utilization.[14] Rural beneficiaries may also have trouble accessing high-quality home health care because a greater percentage of rural home health agencies in small rural and isolated small rural communities are considered low-quality based on Medicare's 5-star quality of care rating and perform worse on individual quality measures like hospital readmissions and emergency department visits.[15-16] Of note, rural home health agencies are more likely to have high-quality 5-star ratings for patients' experience of care,[16] recognizing that quality of care and the experience of care are separate domains.[17]

Disparities in access to rehabilitation services are also evident for specific patient populations receiving home health. Rural beneficiaries who experience a stroke are less likely to receive rehabilitation services than urban beneficiaries, which is concerning because rehabilitation is a critical component of post-stroke care.[18] Rural beneficiaries receive fewer physical therapy visits following total knee replacement compared to urban beneficiaries, despite physical therapy's essential role in recovery following lower extremity joint replacement.[19] Beneficiaries

recovering from critical illnesses that necessitate intensive care unit stays during hospitalization also receive fewer rehabilitation visits during home health if they lived in rural versus urban communities.[20] These findings of fewer visits of rehabilitation services may stem in part to due to specialized services being less widely available in rural counties, particularly remote rural counties.[21]

Drivers of Access to Home Health

Resource Constraints:
Even though historically high average Medicare margins for home health agencies, including rural home health agencies, have received much attention,[4] it is important to know that averages can mask the reality that while some home health agencies are very profitable, others are less so. To fully understand the resources of rural home health agencies, the wider context of the rural home health market must be considered. Compared to urban home health agencies, a significantly higher percentage of rural agencies are non-profit or governmental versus for-profit and hospital-based versus freestanding.[15-16] These distinctions are important because margins tend to be lower in non-profit and governmental agencies and margins are only reported for freestanding.[4] Half of Critical Access Hospitals and three-fifths of other rural hospitals offer home health care services either on their own or as part of a health system or joint venture, in order to increase access to care in rural communities.[22] Furthermore, hospital-based agencies often rely on their relationship with the hospital to remain financially viable.[8] Some rural home health agencies also rely on local foundations, county general funds, levies, and county-wide health district funds to bolster their financial resources and maintain their current coverage areas.[8]

In recognition of the extra costs often required to serve rural beneficiaries, Medicare has intermittently provided a percentage increase in payments to home health agencies for care provided to rural beneficiaries. When active, the rural add-on payment has varied over the past decade and has been as high as 10% when initially implemented to as low as 1%, the current rural add-on percentage. Rural add-on payments are in the process of being sunsetted following a phaseout process in which rural add-on payment percentages were changed from a single percentage for caring for all rural beneficiaries to targeted amounts based on the utilization and population density of the community in which the rural beneficiary lived due to the Bipartisan Budget Act of 2018.[23] Concerns have been raised about the impact of targeting, reduced amounts, and eventual sunset of rural add-on payments on access to care for rural beneficiaries. While research supports targeting of the rural add-on payment in terms of its effect on home health agency supply, only higher rural add-on payments (e.g., 5%, 10%) have historically led to supply changes in non-urban-adjacent rural communities that have kept pace urban communities.[24] However, even a lower 3% rural add-on payment resulted in reductions in rehospitalizations for rural beneficiaries receiving post-acute home health.[25] Together these findings suggest a reconsideration of the sunset of rural add-on payments, with the caveat that

the appropriate number of home health agencies serving a community depends both on capacity of the home health agencies and the outcomes achieved by providing services.

Moreover, the impact of decreasing rural add-on payments and their eventual sunset are unclear in part due to the overlapping implementation of a new payment system, the Patient Driven Groupings Model (PDGM), in January 2020 and the emergence of the COVID-19 pandemic shortly thereafter. PDGM represents a massive shift in reimbursement for home health agencies, the intent of which is to base payments on patient characteristics at admission and remove the prior incentive for rehabilitation services under which higher volumes of rehabilitation visits resulted in higher payments. PDGM also introduces admission source into payment calculations for the first time such that post-acute home health is incentivized over community-entry home health and multi-episode home health stays (e.g., longer than the initial 30-day payment episode of care) are paid less after the first 30 days of care. Thus, PDGM may result in decreases in rehabilitation services, fewer beneficiaries accessing home health via community-entry, and shorter stays, but the impact is not yet known.

Additional research is also needed on the impact of the COVID-19 pandemic on home health agencies, staff, and patients, both to understand short- and long-term consequences and opportunities of the public health emergency as well as to better prepare for future disasters by learning from the responses to the pandemic.[26-30] Much of the home health evidence base relies on studies performed with data prior to implementation of PDGM, the emergence of the COVID-19 pandemic, and changes to rural add-on payments. Therefore, studies using the most current data are urgently needed to understand the impact of these overlapping events as well as payer mix on the stability of rural home health agencies and their ability to provide needed care for rural beneficiaries.

To be clear, not all rural home health agencies are facing resource constraints and struggling to remain operational to serve their communities. Many are profitable. Rather, the financial constraints of rural home health agencies that are struggling deserve further attention with respect to how resource availability impacts access to and quality of care for rural beneficiaries. Payment policies should be monitored for unintended consequences and revised to ensure that rural home health agencies that admit less profitable patients and face increased costs to deliver care have the resources to serve rural beneficiaries in their communities and support their ability to remain at home.

Benefit requirements:
Beneficiaries are required to be “homebound” in order to be eligible for the home health benefit. To be considered homebound, the beneficiary must need the aid of supportive devices (e.g., wheelchair, walker) or the help of another person to leave their home or leaving home is medically contraindicated, and the beneficiary must be unable to leave the home or leaving home requires considerable and taxing effort. While the homebound requirement does allow

for short, infrequent trips outside the home, this allowance may not be sufficient for rural beneficiaries to maintain their homebound status when resources to meet their basic needs require long travel times and may even lead some beneficiaries to be unwilling to agree to the homebound requirement even if advisable.[9] Rural home health agencies have also reported challenges in interpretation of the homebound requirement, which may also reduce access for rural beneficiaries.[8]

Recent changes to other home health requirements may mitigate some of the challenges that rural beneficiaries face in accessing care. The original face-to-face requirement for physicians to certify a beneficiary for home health is burdensome in some rural communities due to the more limited physician supply and travel distances.[8-9] However, during the COVID-19 pandemic the practitioners permitted to certify a beneficiary for home health was expanded to non-physician practitioners, including nurse practitioners, clinical nurse specialists, and physician assistants.[31-32] In addition, the use of telehealth services was permitted for the face-to-face encounter with a beneficiary's home allowed as a originating site of care (versus a provider's office); this allowance will continue through December 2024.[31-32] Whether these changes will increase or help maintain access to home health care in rural communities longer-term remains to be seen; nevertheless, these changes were welcomed by rural home health agencies as they decreased barriers for certification of home health.

Workforce challenges:
Access to home health is dependent on the ability of home health agencies to recruit and retain qualified workers. Rural home health agencies have cited multiple barriers to recruiting and retaining home health staff, including geographic isolation, workers' desire to spend more time caring for patients versus driving to their homes, and lack of competitive wages compared to other types of rural care settings like hospitals and similar jobs in urban areas.[8-9] In addition, small volume home health agencies may not have enough patients to support full-time staff.[8-9] Needing to contract with local hospitals to fill vacancies for therapists due to the inability to hire for full-time status can be more expensive for home health agencies and lead to delays in care when therapists' caseloads are already full or they need to prioritize hospital patients over home health patients.[8-9] Even when nurses and therapists are available to work in a rural community, home health requires a level of experience and independence for providers such that newer graduates may be underqualified or unwilling to take available positions.[8-9]

The home health aide workforce is particularly fragile. Wages for home health aides are usually low and hours may be unpredictable or insufficient, leading to economic precarity for these workers.[9,33] The additional barrier of unreliable transportation for low income workers may be especially challenging for home health aides in rural communities.[9] Also, home health aides are often managing their own chronic conditions while working and many express an intent to leave the profession after experiencing on-the-job injuries.[33-35] The emotion demands of their work may also impact their well-being, further leading to challenges with retention.[36-37] The

fragility of the home health aide workforce is concerning for rural home health agencies as there is a significantly lower home health aide workforce in rural areas, with only 32.9 home health aides per 1,000 older adults, as compared with urban areas where there are 50.4 home health aides per 1,000 older adults.[38]

Other considerations:
While outside the primary focus of my comments, it is worth briefly noting several other considerations for home health policy. First, I have emphasized home health for rural beneficiaries in my comments, but there are other inequities in home health that must be highlighted. Research has shown disparities in home health utilization, timeliness of care, patient outcomes, and admission to high-quality home health agencies based on race, ethnicity, and socioeconomic status of beneficiaries.[39-45] It is critical that these inequities are addressed to ensure all Medicare beneficiaries have the ability to benefit from home health.

Second, the impact of value-based care models, including accountable care organizations, bundled payment models, and the newly expanded Home Health Value-Based Purchasing (HHVBP) program, needs to be considered in conjunction with other policies. The final evaluation of the nine-state demonstration of the HHVBP does not suggest HHVBP had a differential impact on access to care for rural beneficiaries;[46] however, given regional variation in home health, it will be important to monitor the impact of the nationwide expansion of HHVBP on access to home health for rural beneficiaries. Also, since rural home health agencies have lower performance on certain quality measures included in total performance scores for HHVBP compared to urban home health agencies and a higher percentage of rural home health agencies have lower overall quality of care ratings, particularly agencies in small rural and isolated small rural communities,[10,15-16,47] there will be rural home health agencies at risk for penalties under HHVBP. While the threat of penalties is meant to incentivize home health agencies to improve quality, penalties imposed on lower resourced home health agencies may actually decrease their ability to improve quality. For rural communities that are served by only one or two home health agencies, loss of one agency may drastically reduce access to home health care within that community. So, careful monitoring is warranted to ensure payment adjustments do not diminish opportunities to implement quality improvement initiatives in these lower performing agencies and do not hasten closures in underserved communities where low-quality home health agencies are the only option for care.

Third, continued growth in enrollment in Medicare Advantage plans may have ramifications for home health care. Much of the research thus far on home health utilization comparing beneficiaries enrolled in Medicare Advantage to fee-for-service Medicare has found lower utilization among Medicare Advantage beneficiaries, particularly when plans include cost-sharing,[48-49] but regional variation exists in these differences.[50] In addition, Medicare Advantage beneficiaries are more likely to receive care from lower quality home health agencies.[51] Even though the rate of growth in enrollment in Medicare Advantage plans is increasing more rapidly

in rural counties, enrollment in Medicare Advantage is still lower for rural versus urban beneficiaries and distribution of plan types (e.g., HMO, PPO) differ by rural-urban status.[52-53] Continued research on Medicare Advantage's impact on access to home health and specific services as well as patient outcomes by rural-urban status is needed.

Fourth, research is needed to understand how dually eligible beneficiaries utilize Medicare's home health benefit and Medicaid's home and community-based services, whether there is substitution or duplication of services, and whether there are opportunities for integration of services. Since Medicaid's home and community-based services vary by state and may be subject to waiting lists, it is possible that Medicare's home health benefit may provide dually eligible beneficiaries with key supports to remain at home. There may also be opportunities to learn from innovative programs available to some Medicaid beneficiaries, such as the Community Aging in Place- Advancing Better Living for Elders (CAPABALE) program, an interdisciplinary short-term intervention to address difficulty performing activities of daily living through nursing, occupational therapy, and handyman services, that has been successful in helping older adults remain in their homes.[54]

Finally, while spending on home health is expected to grow year-over-year by an average of nearly 8% annually from 2022-2031, it remains a relatively small percentage of overall health care expenditures.[55] Post-acute care costs are higher for beneficiaries who could be served by a home health agency but instead receive care in a skilled nursing facility due to lack of access to home health.[56] Emerging research on small populations also suggests that increased spending on home health may be associated with reduced overall health care spending due to reductions in expensive hospital admissions.[57-59] While research on a national scale that uses current data on home health agencies operating under PDGM is needed, there may be a tradeoff between increased spending on home health and potential cost savings elsewhere for Medicare.

Conclusions

The Medicare home health benefit is currently supporting beneficiaries' ability to age in place, but the full potential of home health may not be realized, particularly for rural beneficiaries. Research on home health suggests the need for targeted solutions that incentivize service provision to beneficiaries at risk for reduced access and poorer outcomes, including rural beneficiaries, and do not create or exacerbate challenges for home health agencies that disproportionately serve the most vulnerable patients. As home health agencies continue to adapt to multiple policy changes and emerge from the public health emergency, it remains essential to monitor access to and outcomes of home health services and "apply a rural lens to programs and policies" in alignment with the CMS Rural Health Strategy.[7]

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