Rural Health Reform Policy
RESEARCH CENTER

POLICY BRIEF

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Home is Where the Heart Is: Insights on the Coordination and Delivery of Home Health Services in Rural America

Introduction

Access to home health in rural areas is an important public policy concern because the rural elderly population is growing faster than its urban counterpart –there is an increasing need for health services in rural communities (Berry and Glasgow 2013). In addition, rural residents tend to be poorer (United States Department of Agriculture, 2015) and suffer from more chronic disease (Meit, et al., 2014). To address concerns about access to home health in this aging population, this study seeks to better understand how home health services are provided in rural areas through interviews with home health providers and discharge planners. Phone and in-person interviews were conducted over a ten-month period in 2015-2016. Findings identify facilitators and barriers to providing home health services in rural areas, as well as stakeholders' thoughts about the provision of home health services in the future.

Key Findings

- Strong relationships between rural home health agencies and local hospitals facilitate the provision of home health services to rural beneficiaries.
- Financial support from local governments, grants, or other organizations is essential for some rural home health agencies to maintain their current coverage area.
- Electronic health records (EHRs) are viewed as facilitators when hospital systems and agencies have integrated systems that facilitate smooth patient transitions; however, EHRs are viewed as a barrier when costs of implementing and maintaining EHR systems are too great.
- Most home health agency administrators reported that Medicare's current reimbursement does not cover the costs to deliver care to some rural beneficiaries, and that further reductions to reimbursement rates or the rural add-on (which is currently an additional 3% payment on claims that originate in a rural area) would result in reducing their coverage area.
- Medicare's requirement that a physician must certify an in-person visit, called the face-to-face requirement, can cause delays in service and reimbursement challenges.
- The requirement that a beneficiary be homebound in order to qualify for home health services can be restrictive and difficult to interpret.
- Transitioning rural home health services to a value-based payment system that is integrated with other care providers may result in additional resources and financial support in rural communities. A shared savings model was described as a path forward to sustain and potentially expand access to home health services for rural Medicare beneficiaries.

A Consortium of

University of North Dakota Center for Rural Health
&
NORC Walsh Center for Rural Health Analysis

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Background

Home health services are medical services provided in the home by a skilled licensed provider. These services, which are provided through for-profit or non-profit agencies, include intermittent skilled nursing, physical therapy, occupational therapy, speech therapy, medication management, and medical social services.[1] Patients may be referred to home health services for post-acute care when they are discharged from the hospital or by their physician. To assist with post-acute care planning, case managers and discharge planners are responsible for identifying and connecting home health agencies to coordinate services.

Medicare is the largest payer of home health services (Centers for Medicare and Medicaid Services 2014). In 1998, Medicare adopted the interim payment system (IPS) in order to contain the increasing home health costs under the fee-for-service system. After the implementation of the IPS, home health services utilization rates were reduced, particularly among rural beneficiaries (Sutton 2005). Nationally, between 1997 and 2000, beneficiaries using home health services dropped by about one million patients. In addition, the number of total visits fell from 258 million to 90 million, and the number of home health agencies decreased by 31% (Medicare Payment Advisory Commission 2016).

In 2000, Medicare implemented the current home health prospective payment system (PPS) (Centers for Medicare and Medicaid Services 2015b). Under the PPS, Medicare-certified home health agencies who provide services to eligible beneficiaries are paid a fixed rate for an “episode of care” lasting 60 days, independent of the volume of services provided. Medicare beneficiaries do not have a co-pay associated with utilizing these services.

Congress enacted a 10 percent add-on for home health services that originate in a rural area through the Benefits Improvement and Protection Act (BIPA). The add-on has gradually been reduced 3 percent over the past 15 years and is expected to expire at the end of 2017 (The SGR Repeal and Medicare Provider Payment Modernization Act of 2015 (H.R.2; Pub Law No: 114-10)). Rural home health agencies became more financially vulnerable after the implementation of the PPS due to the legislation’s mandated financial cuts and restrictions on reimbursement. These cuts contributed to some rural home health agencies’ closures, while other agencies reduced their service areas (Lin et al. 2005). As of 2008, 33 U.S. counties were not served by a Medicare-certified home health agency, and rural counties were more likely to be served by a single agency or no agency as compared to urban counties. Furthermore, while geographic coverage of home health services was based on the counties in which home health agencies were licensed to provide services, agencies may only serve a small portion of these counties(Probst et al. 2014). A CMS report presented to Congress showed that home health agencies in rural areas were twice as likely as agencies in urban areas to report that they are not able to admit patients who live in “hard to reach” areas (Centers for Medicare and Medicaid Services 2015c). In addition, this report, along with other studies, has shown that rural residents were less likely to be referred to, or use, home health services than urban residents. (Centers for Medicare and Medicaid Services 2015c, Probst et al. 2014)

The Patient Protection and Affordable Care Act (ACA) of 2010 clarified the definition of homebound services and revised the face-to-face encounter requirements. These changes were, in part, a response to a growing number of individuals being referred to home health services directly from the community, rather after a hospital discharge. In 2001 about an equal number of patients were admitted to home health through the community as they were through the hospital. However, in 2008, two-thirds of patients were admitted from the community. The growth in admissions from the community over this timeframe was greater than the growth of admissions from the hospital (48% increase from community vs. 12% increase from hospital) (Goldberg Dey et al., 2011). For-profit home health agencies also had a higher percentage of patients admitted directly from the community (Murtaugh, Peng, Moore, & Maduro, 2008).

The definition of “homebound” for the purposes of receiving Medicare reimbursement for home health services was refined in 2015. To be certified as “confined to the home,” the individuals must be unable to leave the home without assistance or that leaving the home is contraindicated. In addition, individuals must also be unable to leave the home or leaving the home must require a considerable effort (Medicare Benefit Policy Manual, 2015).

This study is focused solely on home health and does not include home care services. Unlike home health services which provide medical services, home care provides support services, such as assistance with activities of daily life, like bathing, cooking, cleaning, and shopping for groceries. Home care is not prescribed by a physician and is typically paid by individuals or provided as part of services under a Medicaid community-based waiver.

A patient's homebound status and his/her need for skilled services must be certified by a physician in a face-to-face encounter before a home health agency can receive Medicare reimbursement for any home health services provided to a patient. The face-to-face can occur remotely via telehealth. Non-physician providers, such as nurse practitioners (NPs) and physician assistants (PAs) may conduct the face-to-face encounter, but a physician is required to document it in the order for a home health service agency to be reimbursed. Arranging approval of the face-to-face can be difficult in many rural areas where much of the primary care is provided by nurse practitioners and physicians assistants. In some states NPs have a wide scope of practice and there are no physician providers in close proximity. It is difficult for these NPs to find a physician in a timely manner to review the face-to-face documentation and approve.

The Balanced Budget Act of 1997 (BBA) permits reimbursement for telehealth services for a limited number of Part B services through the Medicare Fee-for-Service Program. However, Medicare is not authorized to reimburse telehealth as a covered service under the home health benefit.

Methods

Phone interviews were conducted with home health agency administrators, hospital discharge planners or case managers, and rural health innovators. Rural health innovators were identified as national leaders who were implementing new integrated rural health delivery and payment models that included home health services, such as accountable care organizations. Home health agency administrator and hospital discharge planner interviews were conducted in eight states representing each of the four major census regions including, Maine, Pennsylvania, Georgia, Texas, Iowa, Nebraska, Montana, and Oregon. Innovative rural hospital administrators from Pennsylvania, Indiana, and Minnesota were also interviewed. The rural health innovators were identified by national rural health experts. A total of 51 interviews were conducted. See Table 1. Interviews were recorded, transcribed, and then reviewed by the research team. The team identified key themes and the transcribed interviews were coded for each theme. Data analysis was conducted with QSR NVivo v10 software.

Table 1. Number of Interviews by Type of Interviewee and State

	PA	ME	OR	MT	TX	GA	NE	IA	Other	Total
Home Health Agency Administrator	3	2	7	2	2	3	4	5	0	28
Discharge Planner	5	4	2	2	1	1	2	0	0	17
Rural Health Innovators	1	0	0	0	0	0	0	0	5	6
Total	**9**	**6**	**9**	**4**	**3**	**4**	**6**	**5**	**5**	**51**

Findings

Interviewees identified facilitators, barriers and challenges, and shared their thoughts about the delivery of rural home health services in the years ahead. The most prevalent and pertinent themes from home health agency administrators, discharge planners, and rural health innovators are highlighted in the following sections.

Facilitators for Rural Home Health Agencies

External Financial Support

Financial support from external sources has become necessary for some home health agencies to remain financially solvent. Five of the 28 home health agency administrators reported relying on support from local entities to remain in operation including a county-wide health district fund, mill levies, a county general fund, and local foundations grants. These home health agencies emphasized that their financial supporters viewed their agency as an essential community resource that provided an overall benefit to the community.

Hospital Affiliation

Over half of the home health agencies were directly affiliated with or owned by a hospital, of which most received direct funding from their partner hospital. Hospital-affiliated agencies reported that their relationship with a hospital was essential for remaining financially viable as well as providing a consistent patient volume. Only two of the 28 home health agencies were part of an alternative payment model, such as an Accountable Care Organization (ACO).

"I feel solid knowing that I always have the hospital to use as a buffer, we're a tax write-off. However, those stand-alone agencies—they're not going to make it, they're just not going to, and these people aren't going to have access to care." – Home Health Agency Administrator

Integrated EHR Systems

The few agencies who have bidirectional communication with hospital systems through their EHR said that

this communication facilitated referral and tracking of patients between the hospitals and home health care. For example, home health agency staff members were able to view all necessary patient documentation, reducing delays with obtaining the face-to-face documentation from the providers.

Collaboration with Providers

Half of the home health agency administrators reported having close collaborations with local providers, and having these relationships facilitated the provision of home health services by improving communication between the care delivery teams. Many home health agencies reported that these trusting relationships were attributed to working in rural settings in which people knew each other.

Home Health Agency's Educational Efforts

Home health agencies have found that taking the time to educate physicians regarding the face-to-face documentation requirements has helped to improve the referral process. Home health agency administrators also reported that they educate physicians about the availability of home health services.

Barriers and Challenges for Rural Home Health Agencies

Reimbursement and Insurance Coverage

> *"We're having to do more in less visits, you just have to do more in less time… and that makes it tough. Especially with the elderly, perhaps you can only teach so much at one time and then they can't retain it." – Hospital Case Manager*

Home health agency administrators reported that the current Medicare reimbursement level does not adequately reimburse them for the added travel costs and staff time required to provide services to beneficiaries who live in remote rural areas. Additional staff time to serve rural beneficiaries included significant time traveling in the car. The rates of reimbursement are not enough to cover this additional time. The agencies reported that reimbursement in some rural areas was inadequate to support their financial viability and that continually decreasing reimbursement would have a negative effect on access to home health services in rural areas. Financial difficulties negatively affect home health agencies' abilities to provide services, recruit and retain their workforce, and obtain or maintain technologies.

Limitations in insurance coverage also affect service provision to rural residents. Three home health agencies described how they assess the services they provide to patients based on the patients' insurance coverage (e.g. PPS Medicare versus Medicare Advantage). Home health agency administrators also reported that some Medicare Advantage plans could be restrictive, did not reimburse well, or required copays. In addition, a few discharge planners and home health agency administrators were frustrated that intravenous (IV) antibiotics were not covered by traditional PPS Medicare reimbursement (Paladino and Poretz 2010).

Face-to-face Requirement

> *"Nurse practitioners and physicians assistants are not allowed to sign orders for home care. We do have a shortage of physicians, so sometimes it is three weeks before you can get a doctor to sign orders." – Home Health Agency Administrator*

Nearly all of the home health agencies (25 agencies) described difficulties receiving complete face-to-face documentation in a timely manner from hospitals. This documentation is especially difficult in many of the rural areas that experience physician shortages – in which case it is difficult to get physicians' time to complete the face-to-face and/or review and approve documentation of the face-to-face visit. Some agencies would admit a patient before receiving finalized face-to-face visit documentation in order to provide the necessary services. Physicians and hospital discharge planners provide the agencies with the face-to-face documentation, however, it is the agencies that submit the forms for reimbursement and are not reimbursed if the documentation is incomplete. If hospitals do not provide proper documentation, the agencies will not be reimbursed for the services they provided. One agency reported that they had $300,000 worth of claims under review pending face-to-face documentation approval.

Homebound Status Requirement

Nearly all of the home health agencies and discharge planners mentioned Medicare's homebound status requirement as a barrier or challenge. Physicians and home health agencies may interpret Medicare's definition of homebound differently, which can interfere with beneficiaries receiving timely care. As one interviewee stated, "the homebound status has never been black or white, it is very grey". Over two-thirds of the interviewees reported there were rural patients who could benefit from

home health services but did not meet the homebound criteria. One-third of the home health agencies reported that it may be inconvenient or even dangerous for some elderly patients to be driving; however, because they did drive they did not qualify for home health services.

Substitutions for Home Health

Nearly all the home health agencies (25 of the 28) explained that one of the primary "substitutions" for home health services was family and/or patient education to care for themselves. While this alternative may work for some patients, many families are not able to take time away from their jobs and their own children to care for aging parents. This is prevalent in rural areas, where many adult children have moved out of the rural community for career opportunities. As a result, if home health services are not available, there may be no viable alternative. Most home health agencies interviewed (95 percent) explained that in these cases patients often go home without any real care, fending for themselves. Substitutions are not implicitly barriers to receiving home health services, but are indicative of the issues that arise when home health services are not available to patients. One-third of home health agencies reported that when there was no coverage in a patient's area, some patients received these post-acute services in outpatient, skilled nursing, or swing bed.

Changing Policies

Over one-third of all administrators expressed frustration over frequent changes and increasing complexity in Medicare's policies affecting home health services. Agencies not only had to educate themselves about changing rules and regulations, but they also had to educate the providers. This education process results in extra work for the agencies each time rules and regulations change.

Access & Service Area Coverage

Home health agencies in seven of the eight states were aware of areas in their state that were not covered by any agency. Furthermore, nearly half of the 28 home health administrators reported that they covered partial counties, meaning that while they were licensed by Medicare to serve the whole county, they only had the resources, staff, and capacity to cover part of the county. Two agencies also reported that they often receive referrals for patients who live across state lines, but they do not have state verification to provide care in across state lines. Gaps in coverage areas result in some rural Medicare beneficiaries not having any access to home health services.

Nearly all of the 28 home health agency administrators described travel distance and "windshield time" as major barriers to providing home health services in rural areas. Agency administrators noted that bad weather and poor road conditions, which were common in their rural areas, increased the time staff spent traveling between visits. One agency reported that they lose money providing a visit to any patient that lives more than 30 miles from their office. Overall, agencies reported maximum distances traveled to patients varied between 30 and 80 miles.

Workforce

Rural home health agencies experienced workforce challenges that impacted their ability to provide access to home health services, including difficulties hiring therapists because they were unable to offer full-time employment due to small caseloads. They also had difficulties hiring nursing staff because they were unable to pay competitive wages. Seventeen of the 28 home health agencies reported difficulties staffing at least one of the therapy services. Several home health agency administrators reported that at times they were unable to accept referrals because they did not have a therapist available to provide the needed care.

Over half of the rural home health agencies reported that they used contracted therapy staff. Small agencies were often unable to support full-time therapists due to their small caseloads so they contracted with therapists from their local hospitals or other organizations. Utilizing contracted therapists allowed small, rural home health agencies to provide patients with access to in-home therapy. Contracted staff could also expand access by serving as back-up during high census periods. However, interviewees pointed out that when a rural home health agency relies solely on contracted staff, access to therapy services may be limited because contracted therapists may already have full case-loads. In addition, home health agency administrators noted that because contracted staff did not often live in the rural communities, reimbursement rates typically did not cover the additional mileage costs for visits.

Half of the agencies also reported challenges with recruiting nursing staff. Agencies cited their inability to offer full-time positions and to provide a competitive wage as major barriers to recruiting nurses. It was also difficult to find candidates in some rural areas who had the experience needed to handle the range of tasks that home health nurses encounter in patients' homes.

Discharge & Referral

Half of the discharge planners reported challenges with the discharge and referral process, and often these challenges were in line with home health agencies feedback. Discharge planners reported that home health agencies refused referrals if the patient did not live in an area they covered, if the rural agency did not have adequate staff coverage, or did not offer specific therapy services. Discharge planners reported that even if a home health agency accepted a patient, some were too overburdened to make an initial visit within 24 to 72 hours, leaving the patient without the needed services. Once a patient is discharged, many discharge planners explained that they have "no way of tracking whether [patients] get seen or whether home health calls them." These challenges may delay service delivery, which increases the likelihood of hospital readmissions or emergency department visits.

Obtaining and Maintaining Electronic Health Records

A total of 21 of the 27 agencies indicated that they have electronic health records. Five of the home health agencies that had electronic health records had the same system as their affiliated hospital; however, three of the five still received referrals from fax and/or had limited communication with the hospital.

Agency administrators commented that the large upfront cost of implementing an EHR is often prohibitive for small home health agencies. For example, one home health agency administrator explained that with a yearly census of 40 patients, they could not afford an EHR system with a base cost of $40,000.

Once an EHR system has been implemented, administrators said that additional investments are necessary to keep the system software updated, and to integrate EHRs with hospitals and providers to improve care coordination and enhance quality. Even when home health agencies have implemented EHR systems, agency administers noted that nurses often encounter problems with charting at the patients' home due to poor internet access in remote areas.

Future Considerations for Rural Home Health Agencies

The future of rural home health services was explored during the interviews with home health administrators and rural health innovators. The discussions focused primarily on the roles that integrated health systems and telehealth technologies may play in the delivery of rural home health services.

Integrated Health Systems

All of the rural health innovators and most of the home health administrators commented that the current reimbursement structure was problematic for many rural home health agencies. Yet, they noted that rural home health services are valuable to hospital systems and rural communities because they address important post-acute care needs and reduce emergency department and hospital readmissions. One rural health innovator suggested that if home health agencies were included in ACOs, they could improve linkages to social and health resources in the community because they would be integrated with a larger network of health providers. Another rural health innovator stressed that for both physicians and home health agencies, it is important to look at the integration of health care and social services to understand what resources are available in the community, so that each can be leveraged to best meet the patients' needs. These resources may include non-health related services, such as carpenters to work with patients to make their homes safer by installing hand rails or wheelchair ramps or providing transportation to seniors who really shouldn't be driving.

Rural health innovators also pointed out that distributing fixed costs, such as personnel, across a larger system would help to reduce the fiscal burden for the home health agency. As such, three of the rural health innovators advocated for a per-member, per-month arrangement to guarantee home health providers a set revenue that they could direct to covering operations and personnel costs. Home health agency administrators also expressed preference to be integrated into an ACO or shared-savings model.

Telehealth

Providers were interested in exploring technological solutions to reduce visits and travel costs. One home health administrator had implemented telehealth visits to help monitor patients. Even though Medicare does not reimburse for these telehealth visits, the agency staff believed it improved patient outcomes by helping the agency to respond quickly when there was a change in a patient's condition. They also calculated that if they can

"save one nursing visit a month, the equipment has paid for itself" in comparison with the travel costs to go into the home.

Discussion and Policy Considerations

Rural home health agency administrators and discharge planners reported a variety of challenges with providing home health services to rural Medicare beneficiaries, including insufficient reimbursement, Medicare requirements, and recruiting and retaining an adequate workforce. External financial support, affiliation with a hospital, integrated EHR systems, and strong relationships with hospitals may help address these challenges; however, problems still remain for many agencies. Looking to the future, these facilitators can be augmented and leveraged to integrate home health into health systems, prioritizing value-based care, and exploring the benefits of telehealth in the delivery of home health and post-acute care.

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act, H.R. 4994) aims to improve Medicare's post-acute care (PAC) services, such as home health, and develop a new reporting system and a value-based payment system(Centers for Medicare and Medicaid Services 2015a). The IMPACT Act includes developing a standard set of quality metrics for all post-acute settings (skilled nursing facilities, rehab facilities, home health, and long term care facilities). It is expected that a unified value-based payment system would encourage improvement in quality of care through promoting patient-centeredness while reducing overall healthcare costs (Centers for Medicare and Medicaid Services 2015). Other proposed changes include rebasing home health payments and requiring beneficiaries to contribute a co-pay.

As new quality metrics and a unified payment system are developed through the IMPACT Act, the unique challenges faced by rural home health providers that are presented here and in other reports need to be considered in order for home health agencies to remain financially viable. If reimbursement incentives for home health services are changed and there is an increased demand for services, it will be important to consider the personnel costs for long travel distances or "windshield time." In addition, increased demand for home health services may also help to offset some of the challenges of recruiting and retaining the home health workforce by providing a consistent source of revenue to cover personnel costs. Likewise, improvements in home health agencies' financial viability will position them to make important EHR investments to help track and improve quality while ensuring access to home health services for rural Medicare beneficiaries.

To support home health agencies' transition to value-based payment systems, it may be helpful to offer technical assistance through State Offices of Rural Health to navigate new contracting mechanisms under ACOs and global budgets. Likewise, new partnership arrangements under value-based payment systems, such as home health agencies integrating services with community-based care providers to address the full continuum of health needs for rural Medicare beneficiaries to safely age in place, may result in new post-acute business models. Results from CMS's home health value-based purchasing demonstration will also provide insights regarding how agencies transition.

The facilitators and challenges identified in this study offer insights about the delivery of home health services in rural communities that should be considered by policy makers, innovators, and providers as rural health care evolves. Our key findings and their relevance to policy are summarized below:

Access: Rural home health agency administrators in all but one of the eight states indicated that there are rural areas in their states that are not served by a home health agency. Policy makers should consider how to expand access to home health services to serve more rural Medicare beneficiaries.

Reimbursement: Reimbursement is a significant barrier that affects almost all aspects of home health agencies' work. Rural home health agencies are more likely than urban home health agencies to report that "timing, frequency, or duration of services" created issues in access to care (Centers for Medicare and Medicaid Services 2015c). Many rural home health agency staff members travel great distances to serve patients, which limits the number of visits that can be made in a day, thereby lowering their margins. Home health reimbursement policy directly impacts rural Medicare beneficiaries' access to home health services.

Workforce: Rural home health agencies struggle to recruit and retain nurses and therapists. Training programs for

students and mentoring programs for newly licensed nurses may enhance skills to meet the unique experiences of home health service provision in rural areas. In addition, policies that address the financial challenges that agencies experience would support agencies in offering more competitive wages may improve workforce recruitment and retention.

Homebound Status and Face-to-Face Requirements: Interviewees reported challenges with securing the documentation to satisfy the homebound and face-to-face requirements due to ambiguous definitions and limited access to physician providers. Policy changes that allow advanced practice nurses and physician assistants to certify patients' eligibility could alleviate some of these challenges. Agencies will need to continue to adapt their practices as reimbursement models continue to evolve. The pre-claim review process demonstration for home health services is testing new ways to prevent fraud without delaying care by requesting provisional affirmation of coverage before the claim is submitted.

Electronic Health Records: EHRs are often too expensive for small rural home health agencies to implement and maintain, however, once they are implemented, EHRs can facilitate communication between the hospital and the home health agency, which streamlines the referral and tracking of patients between the hospitals and home health agencies. Financial incentives for rural home health agencies to implement EHRs may help to improve health outcomes, especially for rural patients who may receive their health care from urban tertiary providers and rural primary care providers in which care coordination is paramount.

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Additional Information

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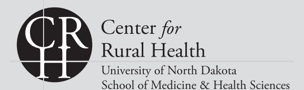
Authors

Alana Knudson, PhD;
Britta Anderson, PhD;
Kellie Schueler, BA;
Emily Arsen, BA.

Center Contact



Center for Rural Health
University of North Dakota
School of Medicine
& Health Sciences

1301 North Columbia Road
Stop 9037
Grand Forks, ND
58202-9037
701.777.3848
ruralhealth.und.edu

Director
Gary Hart, PhD
gary.hart@med.und.edu

The Walsh Center
for Rural Health Analysis
NORC AT THE UNVERSITY OF CHICAGO

NORC Walsh Center for Rural Health Analysis
4350 East West Highway,
Suite 800
Bethesda, Maryland 20814
301.634.9300
walshcenter.norc.org

Deputy Director
Alana Knudson, PhD
knudson-alana@norc.org
301.634.9326