May 17, 2012

The Honorable Kathleen Sebelius  
Secretary  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201  

Dear Secretary Sebelius:

Thank you for providing the Visiting Nurse Associations of America (VNAA) with the opportunity to participate in the Rural Health Stakeholder event on May 1, 2012 with the White House Rural Council. Margaret Franckhauser RN, MS, MPH, CEO of Central New Hampshire VNA and Hospice represented our concerns relative to rural and frontier home health and hospice agencies. VNAA represents only mission-driven home health and hospice agencies that provide care to all patients regardless of their ability to pay and the nature of their illness.

Experts know that a majority of rural and frontier counties are considered primary care health professional shortage areas. In addition, populations in these communities suffer from chronic disease (such as diabetes, heart disease, high blood pressure, and obesity) at rates much higher than urban populations.

**Home health and hospice providers are unique because they travel to assist patients who are too sick to leave their homes.** While in the home setting, healthcare professionals conduct patient assessments, provide high quality healthcare or therapy, manage medications, educate patients and provide comprehensive care management. As a result, both initial and repeat hospitalizations can be prevented.

While you have asked us to limit our recommendations to rural/frontier communities, it is important to state that many of our recommendations are important for all mission-driven home health and hospice agencies that serve vulnerable patients in any geographic area. While many patients may be challenged in rural/frontier communities, there are other patients who reside in inner cities who are equally as challenged. For that reason, I ask that you carefully consider the 13 recommendations included in 2012 VNAA Public Policy Priorities for initiatives that may help the Department of Health and Human Services (DHHS) to achieve its goals throughout the country.
The list below and the attached chart do narrowly focus on recommendations that will better deliver home health and hospice in rural/frontier communities. In addition, VNAA would like to make several over-arching points.

First, the Medicare rural add-on for home health is critical to access because it provides the funding for transportation and other expenses that are incurred by mission-driven home health providers to serve patients in rural/frontier communities.

Second, while VNAA strongly opposes co-payments for all home health patients, co-payments would be especially devastating in rural/frontier communities where waste, fraud and abuse are not prevalent and poverty rates are greater.

Third, as an innovative idea, we recommend that the Administration consider how nonprofit home health and hospice providers could become “Community Health Centers on Wheels.” The unique funding provided in legislation to CHCs (and similar providers) that serve low income populations should be extended to home health and hospice providers with the same mission. This concept, which would require new legislation, could greatly transform access to care in rural/frontier areas.

Fourth, as the Administration considers many state proposals on how to provide care for patients who are eligible for both Medicare and Medicaid, we ask that you look carefully to be sure that adequate resources are provided for home health and hospice and that no incentives for stinting are established inadvertently.

This letter and the attached charts identify issues and provide recommendations for DHHS, the Centers for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA) to consider improving quality, access and affordability of care in rural/frontier communities.

**Regulatory/Legislative Recommendations**

1. **Medicare Home Health Ordering/Certification:** With a lack of primary care physicians in rural/frontier communities, mission-driven home health agencies are essential providers. Medicare beneficiaries can receive home health if 1) a doctor orders home health, 2) the patient requires at least one of the following services: part-time or intermittent skilled nursing care or physical therapy, speech-language services, and 3) the patient is homebound such that leaving home requires considerable and taxing effort.

   **Recommendation:** Nurse practitioners, clinical nurse specialists, nurse midwives and physicians assistants should be allowed to order home health as outlined in the Home Health Planning Improvement Act (S. 227). These important changes would improve patients’ access to necessary care, particularly in communities that are experiencing physician shortages or generally lack consistent access to a physician.
2. **Face-to-Face Encounter for Home Health and Hospice:** Medicare regulations require that a face-to-face encounter between a physician (or certain providers under a physician’s direction) and a patient must be achieved for home health and hospice within strict timeframes in order to qualify for Medicare payment.

**Provider Designation:** The face-to-face encounter must be performed by the certifying physician or by the nurse practitioner, a clinical nurse specialist who is working in collaboration with the physician, or a physician assistant under the supervision of the physician, including a physician who cared for the patient in the hospital or skilled nursing facility. The documentation of the face-to-face patient encounter can only be signed by the certifying physician.

**Recommendation:** Nurse practitioners, clinical nurse specialists, nurse midwives and physicians assistants should be allowed to independently complete the face-to-face encounter form. This is especially true given the critical shortage of physicians in rural/frontier areas.

**Location:** Regulations provide that a face-to-face encounter can be achieved by telehealth as provided in §1834(m) of the Social Security Act only at specific “originating sites.”

**Recommendation:** In rural/frontier communities, the home should be designated an authorized “originating site” so that telehealth can be used to complete the face-to-face encounter for rural/frontier communities.

3. **Wage Index for Home Health Agencies:** Home health agencies (HHAs) are not able to seek reclassification as can hospitals for purposes of the wage index adjustment. Home health agencies also do not qualify for the hospital “rural floor” policy. Because HHAs inherit the “pre-floor, pre-reclassified” hospital wage data, their wage index is consequently set at a lower level than hospitals, which makes it extremely difficult for HHAs to compete with hospitals in the same area for nurses, therapists and other clinicians.

**Recommendations:** A mission-driven home health agency that operates in the same area as a hospital should be entitled to the same wage index as the local hospital with regard to classification and the “rural floors.”

4. **Critical Access Hospital (CAH) Cost Reimbursement:** CAH rules were modified several years ago to disallow the costs of home health and hospice. In some rural areas, this caused financially fragile CAHs to divest their home health and hospice programs, thus reducing access to community care in these rural areas and, in some instances, eliminating the only providers of those services in the area.

**Recommendation:** Revise cost reimbursement rules to allow CAH in rural areas to include home health and hospice as allowable costs.
5. **Home Health Advance Beneficiary Notice (HHABN):** CMS requires that a HHABN be signed by the patient. If the patient is unable to sign but is their own healthcare agent, the document must be annotated by the provider - with a witness's signature - in advance of the service change.

While the HHABN does not technically require hand delivery, the requirement for a patient signature or annotation (with witness signatures) implies that hand delivery is the only method likely to result in meeting all the requirements in a timely fashion. In rural/frontier areas, hand delivery is difficult and extremely costly across long distances and constitutes a considerable burden for providers.

**Recommendation:** In rural/frontier communities, flexibility should be granted to alleviate the burden on small agencies that do not have the capacity to hand deliver each HHABN. Options might include a phone discussion accompanied by a notice that is mailed or emailed.

**Innovation Recommendations**

1. **Quality for Home Health and Hospice:** Consideration should be given to how quality measurement might be adjusted for rural/frontier communities for home health and hospice that provide care in a patient’s home as opposed to an institutional setting.

   **Recommendation:** CMS and HRSA should convene a working group including VNAA and other national organizations to consider health care quality measurements for home health and hospice in rural/frontier communities.

2. **Workforce for Home Health and Hospice:** There are serious problems with the recruitment and retention of primary care providers in rural communities. This is particularly important for home health and hospice which require a workforce with the advanced training and/or experience to work directly with patients in home settings. If changes are not made, then access to home health and hospice will be needed.

   **Recommendation:** HRSA should devote resources to train, recruit and retain the mission-driven home health and hospice workforce in rural/frontier settings.

3. **Telehealth for Home Health and Hospice:** Technology has helped to improve quality and decrease hospitalizations when used with home health and hospice. It is an innovation that has been proven very valuable in rural areas where travel is prohibitive.

   **Recommendations:** 1) Medicare should pay an increased amount for episodes where telehealth is used in rural/frontier settings, 2) CMS should use the Center for Medicare and Medicaid Innovation (CMMI) to test out programs
outlined in the Fostering Innovation Through Technology Act or FITT Act (S. 501).

7. **CMMI Grants for Home Health and Hospice**: Rural/frontier providers often lack the capacity and the expertise to submit competitive applications for CMMI grants and demonstrations. Many rural/frontier communities and providers lack a skilled grant writer and do not have enough staff to devote to grant writing and project/demonstration applications.

**Recommendations**: CMMI should seek to attain a goal that rural/frontier providers receive fair consideration for each grant proposal including 1) targeting grants, 2) conducting outreach to encourage rural/frontier providers to apply and 3) providing appropriate technical assistance to rural/frontier providers that have indicated an interest in applying for grants.

With support from the Department of Health and Human Services (DHHS), the Centers for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA), mission-driven home health and hospice could become a key tool in the federal effort to improve access to high quality care in rural and frontier communities while also being cost effective.

Sincerely,

[Signature]

Andy Carter  
President and CEO

Cc:  
Marilyn Tavenner, Acting Administrator, Centers for Medicare and Medicaid Services  
Mary Wakefield, Administrator, Health Resources and Services Administration  
Mark Miller, Executive Director, Medicare Payment Advisory Commission  
Jonathon Blum, Deputy Administrator and Director, Center for Medicare