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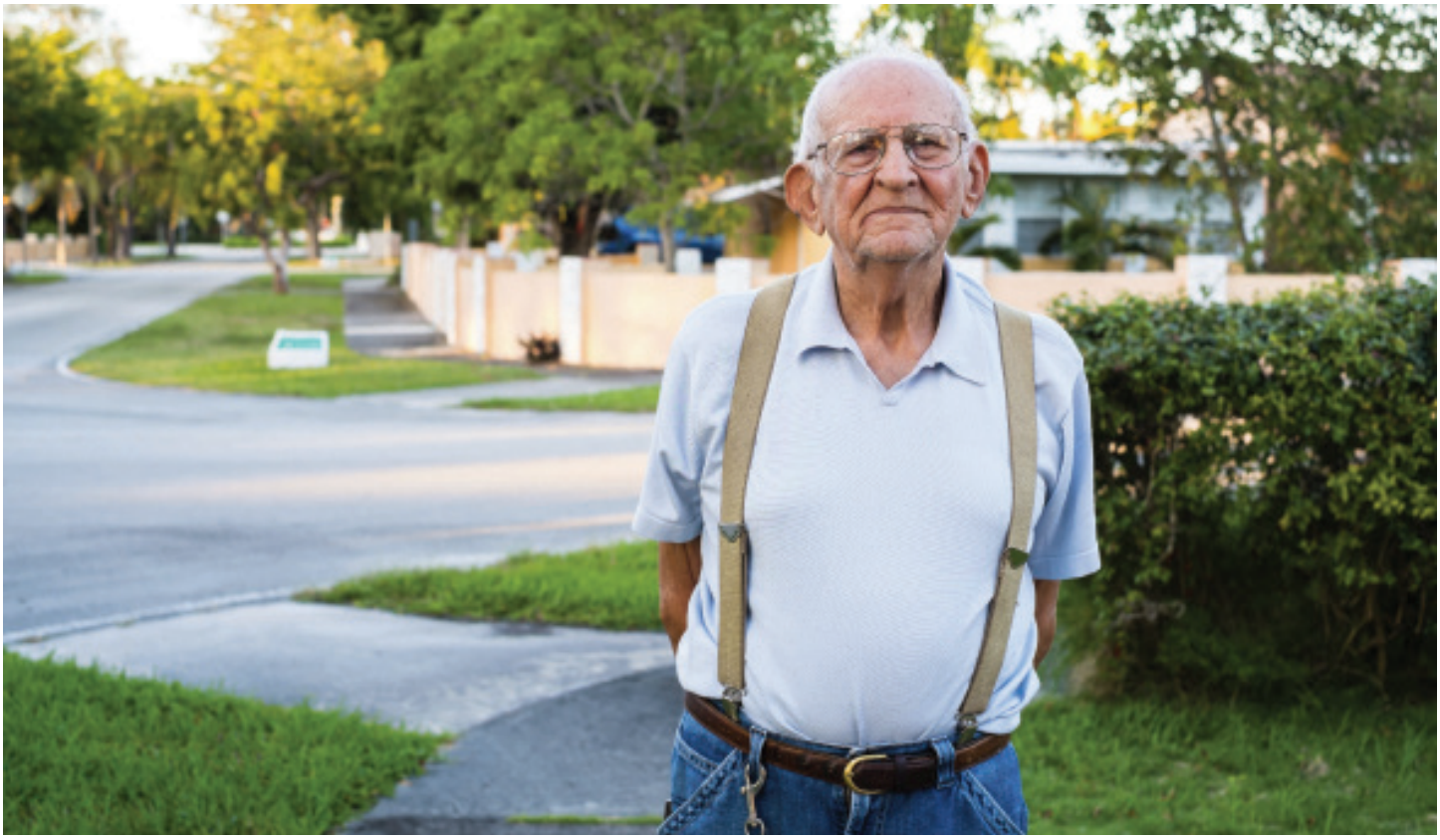

Helping Rural Seniors Age In Place

BY JOSHUA EWING

Introduction

The overall rural population has been declining in recent years;[1] however, those living in and moving to rural areas are most commonly older Americans.[2] This older rural population creates a growing need for services, which will increase as more and more baby boomers reach retirement age.

In recent years, states have taken a number of steps to shift eligible seniors from institutions to home and community-based care settings and to prevent premature placement for others. However, institutional care still accounts for the majority of state spending on long-term services and supports (LTSS). Studies show that care provided in home and community-based settings is less costly and that most seniors would prefer to remain at home or in their community. Many of the issues facing rural seniors are the same ones facing rural America generally: long distances, provider shortages, and limited access to recent technological advances and broadband. However, many states are taking steps to address these challenges, the results of which are helping seniors live independently much longer in rural America. This brief provides a number of strategies states may want to consider that will help rural seniors age in place and live with dignity, including the following:

- Home and Community-Based Services
- Coordinating Care for Seniors Eligible for both Medicare and Medicaid
- Rural PACE Programs
- Family Caregivers
- Telehealth

Background

When Medicare and Medicaid were created by the Social Security Amendments of 1965, the average life expectancy for a man in the United States was approximately 67 years and 73 years for a woman. Today, it is 76 for men and 82 for women.[3] This may not seem like a large difference, but the longer people live, the more health-related services they require. In fact, the growing elderly population and those set to reach retirement age in the next decade will have a significant impact on health care in Amer-

ica, because nearly 70 percent of people over age 65 will need some form of LTSS in their lives.[4]

In the 2010 census, the population aged 65 and older[5] increased to more than 40 million people; one in every eight people is now 65 or older. Further, while the elderly population grew a modest 15.4 percent between 2000-2010, those ages 45-64, who will reach 65 in the next two decades, grew by 31 percent.[6] The number of Americans age 65 and older is expected to double between 2000 and 2030 as the baby boomers reach retirement age.[7]

For many years, the majority of LTSS have been provided in an institutional setting. This is often a nursing home where residents are monitored around the clock by licensed medical professionals. Today, institutional care accounts for around 43 percent of LTSS spending nationally.[8] Individuals residing in these facilities often need higher levels of assistance, medical care and monitoring. For this reason, institutional care is significantly more expensive than that which is provided in home and community-based settings. However, individuals residing in nursing facilities do not always need this level of care, and would be sufficiently served by minimal periodic assistance.

States have a vested interest in how and where LTSS are delivered, as Medicaid accounts for the largest percentage of all LTSS spending in the United States. Providing high quality, appropriate LTSS is expensive. In 2007, the average annual spending per Medicaid beneficiary using long-term services and supports was $43,296, while the average was only $3,694 for Medicaid beneficiaries not utilizing long-term care services.[9]

Home and Community-Based Services

Over the past couple of decades, the quality and availability of LTSS that are delivered in the home or in small community-based facilities such as adult day centers has increased. These services can include a wide variety of services— ranging from help from a home health aide with grocery shopping or bathing to more intensive services provided by nursing professionals such as ensuring adherence to medication regimens. Studies show that individuals receiving LTSS at home or in community-based settings report a higher quality of life—because most people prefer to live at home and maintain their independence. In addition to being generally happier, there is a cost difference for services provided at home and in community-based settings. The average annual cost of a nursing home room in the United States is $81,030. The average cost for an assisted living facility is $39,600 annually, $15,860 for a community-based setting, and $43,472 for a home health aide.[10]

- State policymakers may want to evaluate existing polices and reimbursement procedures to align with a shift to more home and community-based services (HCBS) as existing policies may have been written at a time when institutional care settings were the dominant option.
- Another issue state policymakers may want to consider when looking to grow HCBS is the number of qualified providers working in rural areas of their state. One issue that states are finding as they move to more HCBS services is that seniors cannot always get the necessary care to remain at home. Policymakers may want to consider student loan reimbursement or scholarship programs in order to bolster their workforce. Some states, such as New Mexico and Georgia, have also enacted rural provider tax credits for primary care, behavioral health and dental providers. States could consider extending these to HCBS providers.

Cost of Care

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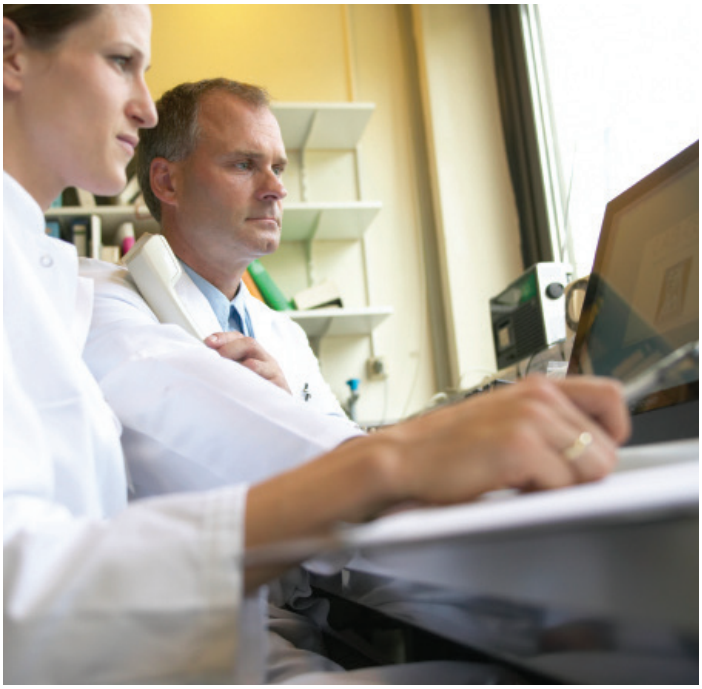
(Genworth Financial, Inc., 2012)

Family Caregivers

The majority of LTSS in America are provided by unpaid family and friends. Traditionally, such help includes activities of daily living such as bathing, dressing, cooking, cleaning and grocery shopping. However, studies now show that family caregivers are increasingly responsible for more complex activities as well, such as medication management, wound care and operating complex medical equipment. According to AARP, this amounted to 61.6 million unpaid caregivers providing approximately $450 billion worth of care nationally during 2009. In rural areas, where access to providers may be limited, the importance of family or other informal caregivers to seniors living independently is even greater.[11]

- States have several options to support family caregivers, thereby enabling more seniors to live at home rather than in costly institutions. For instance, states may want to consider



allowing family and friends serving as caregivers to be paid for their services in rural areas. If the difference between a rural senior living at home or in a costly nursing facility is a part-time caregiver, and there are no paid caregivers available in their area, states may see a benefit to reimbursing the family member. Federal Medicaid policy allows such payments, but states must opt-in to this additional benefit. States may also offer cash and counseling programs—also known as consumer-directed, participant-directed and self-directed care programs—which allow recipients to choose their own home health agency. Under this program, family members can also serve as the home health agency and receive reimbursement. At least 43 states have some form of cash and counseling program.[12]

- Another option states may want to consider in order to ease the burden on family caregivers is paid workplace leave policies. Family caregivers often must choose between work and caring for an aging family member. By providing more workplace flexibility for family caregivers, rural seniors can rely more upon their greatest source of care without jeopardizing the employment of a loved one. A 2012 AARP study found that one in five female and about one in six male workers in the United States serve as family caregivers.[13]
- Most workers may take up to 12 weeks of unpaid leave annually to care for an elderly relative under the Family and Medical Leave Act (FMLA). However, not all workers are eligible for FMLA, and the time may be used to care only for immediate family members (child, spouse or parent). It may also not be financially feasible for a working caregiver to take up to three months off work without pay—especially if they are trying to help an aging parent or family member pay expensive medical bills. Two states–California and New Jersey–have enacted paid leave insurance programs to care for an immediate family member. These two programs are funded through payroll deductions that provide partial wage replacement for eligible beneficiaries.[14]

Telehealth

The scope and availability of technology is changing the way health care is delivered in rural America and making distance less of a barrier for rural seniors. For instance, rather than having rural seniors travel long distances for routine visits, primary care providers now have the ability to check vital signs or prescription drug adherence, and meet with patients remotely in the comfort of their homes. Telehealth technologies also are giving rural providers the opportunity to consult on difficult cases with specialists who typically are located in large urban centers and at universities.

As is the case with any technology, a learning curve exists for both patient and provider when first using telehealth technologies. Individuals must also have the necessary equipment, which can be costly. However, the potential for seniors to conduct more health care interactions through technology reduces the need for traveling great distances and expensive transportation services.

- In order for telehealth technologies to grow while maintaining patient privacy and safety, states may want to look at existing laws and policies for establishing the provider-patient relationship, as many were written before the advent of telehealth technologies.
- States may also want to consider licensure options and reimbursement policies for telehealth providers so that providers can practice and be paid in the same way they would for in-person visits.
- Finally, policymakers may also want to look into existing broadband internet capacity in rural areas and the costs for equipment, both for the patients and providers who wish to use telehealth as a means to conduct health care interactions. Both have significant up-front cost in many cases; however, studies show that these investments can lead to reduced costs in the future.[15]

Coordinating Care for the Dually Eligible

The daily lives of some older individuals consist of travelling from one doctor appointment to another. And, as they continue to age, many seniors will also have to deal with transitions between levels of care, such as from hospitalizations to rehab or skilled nursing to home and community-based care. If these transitions aren't difficult enough, individuals and their families must also navigate the muddy waters of where Medicare ends and private insurance or Medicaid begins. Because Medicare generally pays only for medical care related to acute conditions or hospitalizations and follow-up care for a short amount of time, many seniors find themselves in a position where they qualify for both Medicare and Medicaid. These dually eligible people rely on Medicare for acute services and Medicaid for LTSS.

States and the federal government have taken a number of steps in recent years to coordinate care transitions for seniors. For example, the Centers for Medicare & Medicaid Services' (CMS) Medicare-Medicaid Coordination Office (MMCO) was established by the Affordable Care Act with the goal of improving care transitions and simplifying the process for the dually eligible. To accomplish this, MMCO initiatives eliminate cost-shifting between programs, eliminate regulatory conflicts for individuals transitioning between Medicare and Medicaid, among other things.[16] More details on these initiatives are listed below.

- **Financial Alignment Initiative**: One of the most challenging issues facing the dually-eligible population has been the financial misalignment between Medicare and Medicaid. In the past, states undertaking efforts to coordinate care for dually-eligible individuals that resulted in a cost-savings to Medicare saw no return on their investment. This initiative created an avenue for states to recoup a portion of their costs when Medicare saw a cost-savings. Interested states were asked to submit a proposal describing their plan using one of the two models below:
  - **Capitated Model**: Under this model, a state, CMS, and a health plan enter into a three-way contract. The health plan is paid a set rate per dually eligible beneficiary with funds from both Medicare and Medicaid. In exchange, the health plan is responsible for ensuring that the beneficiary receives care and meets standards and quality measures set forth in the contract. Because the health plan assumes the risk of costs above and beyond the capitated rate, it is incentivized to ensure that individuals maintain maximum health.
  - **Managed Fee-for-Service (FFS) Model**: Under this model, states that improve quality and reduce costs for the dually eligible population will receive performance payments from CMS based on a portion of the savings. Examples could include incentive payments for providers, increased provider-payer collaboration and payment reforms.[17]
- **Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents**: According to CMS, 45 percent of hospital admissions in 2005 were preventable among Medicare skilled nursing patients and Medicaid nursing facility service patients. This amounted to 314,000 hospitalizations and approximately $2.6 billion in Medicare expenditures. Under this initiative, seven organizations were selected to partner with states and nursing facilities to implement evidence-based interventions in at least 15 sites across a state in order to reduce unnecessary hospitalizations.[18]
- **Alignment Initiative**: Realizing that Medicare and Medicaid program rules, requirements, and policies were often the latent cause for duplication of services, waste, and inefficiencies, CMS sought to align policies in order to streamline care for the dually eligible population. The alignment initiative was launched in 2011 and identified 29 areas to better align policies and procedures across Medicare and Medicaid. CMS has been working with states to address these 29 issue areas and streamline care for dually eligible seniors.[19]

Many states are participating in the demonstrations listed above; however, states don't necessarily have to participate to benefit from the programs. Data are beginning to be released for early adopters of the programs, allowing other states to benefit from promising results and identify what needs to be evaluated further.

Rural PACE Programs

Pace (Program of All-inclusive Care for the Elderly) is a program that integrates care for individuals age 55 and older who are dually eligible for both Medicare and Medicaid. PACE programs generally operate a PACE Center that houses multiple services under one roof, including: primary care, social work, personal care services, occupational and physical therapy, and meals. Each PACE program receives monthly capitated payments from Medicare and Medicaid rather than fee-for-service reimbursement.

Traditionally operated in urban areas, Congress created a pilot project in 2006 that expanded PACE to rural areas. Fourteen rural PACE sites were created across the country. According to a 2011 evaluation by CMS, the potential exists for other rural PACE programs to succeed. However, the author states that creating a PACE program from scratch requires a large amount of start-up capital and that seed money in the form of a grant from CMS was essential to the success of the pilot programs.[20]

- As of 2014, 104 PACE programs were operating in 31 states. Interested states could look at working with CMS and providers in their states to establish PACE programs in rural areas. For example, in the 2011 report to Congress evaluating the rural pilot programs, the state of Pennsylvania is mentioned as wanting to establish a PACE program in every county. As of 2013, Pennsylvania had 17 PACE program providers operating 30 centers in 18 counties (roughly 25 percent) across the state.[21]
- Rural PACE programs face hurdles to start-up, including limited resources of nonprofit providers, transportation barriers for seniors trying to get to adult day centers, and Medicaid budget shortfalls which have led to caps in some states. However, the PACE integrated care model, once established, can help provide seniors the help they need to remain independent.[22]

Conclusion

As the baby boomer generation continues to reach retirement age and the number of Americans age 65 and older doubles in the coming decades, states will continue to struggle with how to meet the needs of this population. For rural seniors, the challenges are magnified by distance, culture and an overall lack of health care services and providers, making this group some of the highest cost, highest need individuals. By improving care coordination, aligning reimbursement, and helping rural seniors stay at home longer, states can reduce costs and make a significant impact in the lives of these individuals.

Other State Strategies to Help Rural Seniors Age in Place

In addition to the strategies listed in this brief, state policymakers may also want to consider issues such as: building healthy communities, chronic disease prevention and management, promoting exercise, healthy eating and preventing elderly falls.

NCSL has a wide range of information on these topics and more at www.ncsl.org/research/health.

Endnotes

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