National Advisory Committee
On Rural Health and Human Services

Affordable Care Act Provisions Affecting the Rural Elderly

Policy Brief December 2011

Editorial Note: *In 2011, the National Advisory Committee on Rural Health and Human Services will focus on the rural implications of key provisions from the Patient Protection and Affordable Care Act through a series of policy briefs with policy recommendations that will be sent to the Secretary of the U.S. Department of Health and Human Services.*

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) includes a number of programs that focus on elderly health and human service needs. These include the following:

- The Community First Choice Option (Section 2401)
- The Removal of Barriers to Providing Home and Community-Based Services (Section 2402)
- The Money Follows the Person Rebalancing Demonstration (Section 2403)
- The Funding to Expand State Aging and Disability Resource Centers (Section 2405)
- The Community-Based Care Transitions Program (Section 3026)
- Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes (Section 10202)
- Payment Adjustment for Conditions Acquired in Hospitals (Section 3008)
- Hospital Readmissions Reduction Program (Section 3025)

Recommendations

1. The Secretary should require training for ADRCs on key aspects of the rural health care delivery system through the HHS Office of Rural Health Policy to better understand the unique challenges faced by rural seniors.
2. The Secretary should promote regional applications that include rural providers for the Community-Based Care Transitions grant program.
3. The Secretary should ensure that any evaluation of Section 3026 includes an analysis of the number of rural beneficiaries served and the number of awards that include rural providers.
4. The Secretary should allow CAHs to report hospice-related costs at the skilled nursing service rate on the Medicare cost report in order to ensure that the payment of these services is consistent with the overall cost-based reimbursement methodology as outlined in Section 1820 of the Social Security Act.

BACKGROUND

These provisions represent important potential resources for addressing the needs of the rural elderly. For this policy brief, the National Advisory Committee on Rural Health and Human Services (Committee) examined and offers recommendations on Sections 2405 and 3026 in some detail while providing general considerations on the remaining provisions, Sections 2401, 2402, 2403, 10202, 3008 and 3025, which have already been implemented by the Department of Health and Human Services (HHS).

The Committee seeks to focus on Sections 2405 and 3026 because they are still being implemented and speak to particular challenges facing rural seniors. The first is helping rural seniors understand what services are available and how to take advantage of them and the ADRCs are an important tool in that regard. The second is the need to revisit some past work by the Committee on the Community-Based Care Transitions grant program in order to ensure rural participation in the program. To gather information on these issues, the Committee held a rural roundtable during its field meeting in Hattiesburg, MS on September 27th with caseworkers for the elderly and health and human service administrators from across the region.

Approximately 7.5 million of the 50 million people who lived in rural America in 2005 were over age 65. Although the difference in percentage of the elderly between rural and urban areas is not dramatic (15 percent versus 12 percent), the rural elderly population is growing at a faster rate.[1]

The rural elderly are more likely to have limitations in activities of daily living and suffer from higher rates of chronic disease.[2] Rural elderly are also more likely to be poor with 10.3 percent of the non-metro elderly population living in poverty compared to 8.7 percent for the metro elderly population based on 2011 data from the Current Population Survey.[3]

Rural Medicare beneficiaries are more likely to be white, (87 percent vs. 76 percent) and to report being in poor health (12 percent vs. 9 percent).[4] While rural residents make up approximately a quarter of the Medicare population, 30 percent of Medicare's beneficiaries who also qualify for Medicaid (dual-eligibles) live in rural America.[5] This presents some significant challenges given the limited rural health care infrastructure.

The Medicare Payment Advisory Commission reports that the dual-eligible population accounts for 31 percent of aggregate Medicare spending in fee for service despite making up only 18 percent of the total beneficiary population.[6]

Rural elderly are also affected by geographic isolation and a limited patchwork of health and human services available to them.

Given the demographic, geographic, and financial challenges facing the rural elderly, these ACA provisions are key tools to help support the rural elderly safety net.

DISCUSSION AND RECOMMENDATIONS

Funding to expand State Aging and Disability Resource Centers – ACA Section 2405

The Aging and Disability Resource Centers (ADRCs) are a collaborative effort of the Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS). ADRCs serve as single points

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[1] Jones, C.A., Kandel, W., and Parker, T. "Population Dynamics Are Changing the Profile of Rural Areas." *Amber Waves.* Washington: U.S. Department of Agriculture, Economic Research Service, April 2007. Web. 22 Dec. 2011. <http://www.ers.usda.gov/AmberWaves/April07/Features/Population.htm>

[2] National Center for Health Statistics. Health, United States, 2010: With Special Feature on Death and Dying. Hyattsville, MD. 2011

[3] Farrigan , T. "Rural Income, Poverty, and Welfare: Poverty Demographics." Updated date: September 17, 2011. Economic Research Service, U.S. Department of Agriculture. Web. October 31, 2011. <http://www.ers.usda.gov/Briefing/IncomePovertyWelfare/PovertyDemographics.htm>

[4] The Medicare Payment Advisory Commission. A Data Book: Health Care Spending and the Medicare Program. (June, 2011). Web. 22 Dec. 2011 <http://www.medpac.gov/documents/Jun11DataBookEntireReport.pdf>

[5] Ibid.

[6] Ibid.

of entry into the long-term supports and services system for older adults and people with disabilities. Sometimes referred to as "one-stop shops" for information, ADRCs address many of the frustrations consumers and their families experience when trying to find needed information, services, and supports. The core functions of an ADRC include information, referral and awareness, options counseling, advice and assistance, streamlined eligibility determination for public programs, and person-centered transitions.

The ACA appropriated to the Secretary of Health and Human Services, acting through the Assistant Secretary for Aging, $10,000,000 for each of fiscal years 2010 through 2014 for the ADRCs. As one of its first actions, AoA drafted National Standards to guide this work. To date, 19 of the original states which received an Option Counseling Grant and an additional 7 non-grant States have adopted the draft national standards as the core of their State-specific work. Another 21 States are in the beginning stages of developing standards based on the draft national standards. AoA has also used program funding to enhance Person-Centered Hospital Discharge Planning, which is one of the core functions of a fully functioning ADRC. As a result, States have made significant progress in establishing partnerships with critical pathway providers such as hospitals, hospital associations, and quality improvement organizations (QIOs).

The Committee believes the ADRCs can play an important role in connecting rural seniors, particularly isolated rural seniors and their caregivers, with the range of resources that may be available. The challenge for the ADRCs will be in understanding the unique challenges that may face a rural senior, such as the lack of transportation and lack of direct health services. In addition, due to the fact that ADRCs serving rural communities also may be required to coordinate access to elderly support programs such as congregate and home-delivered meal programs that are financially limited given higher per-unit service costs reflecting the need to deliver services to smaller populations spread over large geographic areas. Specifically, ADRCs will need to tailor their services to the geographic reality of the senior. For example, some rural areas lack access to local hospice services, particularly those areas which are served by Critical Access Hospitals (CAHs), as the provision of these services results in lower overall payment for the CAH under Medicare due to cost-reporting regulations. In addition, some areas may not have access to home health care services. The Secretary should require training for ADRCs on key aspects of the rural health care delivery system through the HHS Office of Rural Health Policy to better understand the unique challenges faced by rural seniors.

Community-based Care Transitions Program – ACA Section 3026

The Community-based Care Transitions Program (CCTP) is designed to improve the quality of care transitions, reduce readmissions for high risk Medicare beneficiaries, and document measureable savings to the Medicare program by reducing unnecessary readmissions.

The Committee issued a White Paper on this program to the Secretary in early 2011 recommending that CMS give careful attention to rural-based models and ensure that rural providers are part of the overall award pool. Though the statutory language excluded Critical Access Hospitals (CAHs) from applying for the grants, they may still play a role in grant projects. The Committee strongly recommended that funded projects include Rural Health Clinics, principal rural or urban referral center(s), PPS hospitals, CAHs, ADRCs, Area Agencies on Aging (AAA), home health agencies, and skilled nursing facilities. To date, the deadline for this program has been extended. This creates an opportunity for CMS to provide more flexibility in the review of proposals to ensure that rural Medicare beneficiaries are able to benefit from this investment. There is also an opportunity for HHS to promote the program to rural AAAs and eligible rural hospitals. The Committee continues to be concerned that the entities funded under this program will be primarily urban. There are a variety of reasons why this program could be critically important in serving rural beneficiaries. Many rural seniors, who tend to have higher rates of

chronic disease, must travel long distances during care transitions, which presents a unique set of challenges as a patient is handed off from an urban tertiary care center back to a rural community. Exclusion of significant rural providers of care, such as CAHs, would reduce the effectiveness of care transitions.

During its time in Hattiesburg, the Committee was impressed by the efforts of Forrest General Hospital in this area. The hospital is working with the surrounding rural communities and their hospitals and caregivers to provide smooth care transitions. This sort of regional approach may offer a model for HHS to consider and ensure better opportunities for rural participation given the statutory limitations. The Secretary should promote regional applications that include rural providers for the Community-Based Care Transitions grant program. The Secretary should ensure that any evaluation of Section 3026 includes an analysis of the number of rural beneficiaries served and the number of awards that include rural providers.

Remaining ACA Aging Provisions: Ensuring a Range of Services for the Rural Elderly

Many of these provisions (Section 2401, Section 2402, Section 2403 and Section 10202) are designed to provide HHS and the States with added flexibility to allow independent living by the elderly. Section 3008 and 3025 provide financial incentives to reduce Healthcare Acquired Conditions in the hospital setting and to reduce readmissions of Medicare patients to hospitals after discharge. Frequently this could mean providing needed care to the elderly in their homes rather than in the hospital or nursing home setting. Section 2405 holds the potential for connecting seniors to the needed services while Section 3026 may be critical in helping to reduce re-admissions and improving outcomes for seniors.

Taken together, these provisions represent important potential tools for rural seniors but many challenges remain as the Committee learned during two panel discussions with rural health and human service providers in Mississippi. Reiterating concerns that the Committee has heard in other meetings, two caseworkers from the AAA talked about the difficulty of coordinating services as the elderly move from one benefit program to another. A senior can be discharged from a Medicare service in a hospital and into an AoA Older Americans Act, Title III Case management program. Although a patient leaving the hospital may eligible for Medicaid in-home services, the transition of services from Medicare to Medicaid is cumbersome. This transition disrupts care services and is confusing to the patient and their family. Additionally, the case manager must then attempt to fill the "gap" between the eligibility for Medicare and Medicaid services.

During the site visit, a rural primary care physician noted that seniors are often discharged in a vulnerable state. But even though they are still at risk they may not be eligible for either home health or skilled nursing facilities. This risk is often compounded by the inability to have a timely follow up visit with a primary care provider due to the realities of working in a Health Professional Shortage Area (HPSA) where a shortage of providers means heavy patient loads which can make it difficult to quickly schedule a post-admission follow up appointment. Scheduling can be made even more difficult for rural elderly patients given the lack of transportation options in these communities. Seniors are at risk for re-admission and rural hospital administrators felt these were factors that were beyond the hospital's control. The CAH administrators and physicians collectively felt that factors such as being in a HPSA and lacking transportation were factors that were beyond their control in terms of re-admission.

There is a need to offer a broad range of services for the elderly, including hospice care services. A CAH administrator noted the challenges CAHs face in providing hospice services in how costs are allocated through the Medicare cost report. CAHs are paid on a cost-basis under Medicare and tend to provide hospice services via a contract with a hospice provider. There is not clear guidance on how to account for these costs on the cost report and some CAHs have been required to report the costs

differently. This has resulted in variance in how the costs are calculated with some CAHs with differing levels of hospice associated costs carved out of the cost report, resulting in lower overall payments for some CAHs. The Secretary should allow CAHs to report hospice-related costs at the skilled nursing service rate on the Medicare cost report in order to ensure that the payment of these services is consistent with the overall cost-based reimbursement methodology as outlined in Section 1820 of the Social Security Act.

CONCLUSION

The Committee recognizes that HHS alone cannot address all of the challenges and that States and communities also have a role to play in developing innovative solutions to serving this population. The challenge of coordinating services across the various Federal and State programs is not unique to rural areas but can be more daunting in isolated communities that lack basic health care infrastructure. The Committee believes the ADRCs can play a key role in helping to promote coordination and encourage collaborative links between the hospitals and clinics and the elderly support programs offered through AAAs or other entities including the faith and community-based sector.

There may also be better ways to assist rural care coordinators with understanding the range of programs that cut across HHS programs. In recent years, CMS has expanded the Program of All-Inclusive Care for the Elderly into some rural communities but there is a need to broaden this program to additional rural communities. For all of the ACA provisions that serve the elderly, HHS needs to better understand the impact of these programs on rural communities. Currently, HHS has little data on how many seniors take advantage of programs such as Money Follows the Person or Community First Choice Option. HHS should consider expanding its current evaluation of its aging programs to better understand the impact in rural communities. While there are a range of potential programs and benefits to assist rural seniors, the needs and geographic challenges are many.

In each of its field meetings, the Committee continues to hear about the challenges of finding transportation for the rural elderly in rural communities and Mississippi was no exception. HHS may want to consider expanding the work of the United We Ride program it currently operates with the Department of Transportation given the lack of transportation options in rural communities.