SUPPORTIVE SERVICES AND CAREGIVING FOR OLDER RURAL ADULTS

POLICY BRIEF AND RECOMMENDATIONS TO THE SECRETARY

AUGUST 2019

NACRHHS

National Advisory Committee on Rural Health and Human Services

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EDITORIAL NOTE

In April 2019, the National Advisory Committee on Rural Health and Human Services (hereinafter referred to as "the Committee") convened its 85th meeting in Sacramento, California, to examine supportive services and caregiving for older rural Americans as one of two topics. Throughout the meeting, the Committee covered a variety of programs and activities across all components of the elderly care continuum. While in Sacramento, the Committee heard from national- and state-level experts on the issue. The Supportive Services and Caregiving for Older Rural Adults subcommittee then visited with local community organizations and stakeholders in Grass Valley, California (see Appendix A).

ACKNOWLEDGEMENTS

The Committee would like to acknowledge all those whose participation helped make the April 2019 meet in Sacramento, the adjoining site visit in Grass Valley, and this policy brief possible.

The Committee would like to thank all the presenters for their expertise. These individuals are: Emily Allen (AARP Foundation); Terry Fulmer, PhD, RN, FAAN (the John A. Hartford Foundation); Jedd Hampton, MPA (LeadingAge California); Sarah S. Steenhausen, MS (The SCAN Foundation); and Craig Thomas, PhD, MS (National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention).

The Committee thanks the California Area Agency on Aging (Planning and Service Area 4) and the FREED Center for Independent Living for identifying organizations to come and share local perspectives on the issue during the site visit. In addition, the Committee expresses its appreciation to the Sierra Nevada Memorial Hospital for hosting the site visit.

Finally, the Committee extends its gratitude and appreciation to Taylor Zabel for coordinating the activities of this meeting, summarizing the Committee's findings, and contributing to this policy brief.

POLICY RECOMMENDATIONS

Recommendation 1: The Committee recommends the Secretary create a comprehensive resource on the aging and long-term services and supports available to older adults in rural areas.

Recommendation 2: The Committee recommends the Secretary continue to expand flexibility in Medicare telehealth billing and provide a comprehensive resource of telehealth offerings in rural areas.

Recommendation 3: The Committee recommends the Secretary ensure the promotion and encouragement of age-friendly concepts within rural health grant programs.

Recommendation 4: The Committee recommends the Secretary explore the entry of Medicare Advantage Dual-Eligible Special Needs Plans into rural areas, identify potential barriers, and work with states to adopt policies that encourage or expand the reach of these plans to rural beneficiaries.

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INTRODUCTION

Historically, the Committee has placed an emphasis on older individuals living in rural areas and those who provide their care. "Serving the Rural Elderly" was the first human services topic discussed after the Secretary expanded the Committee's charter to include human services issues in 2004.[1] Life expectancy in the United States has risen since the 2004 report was sent to the Secretary, bringing with it new challenges in providing both short- and long-term care for an aging nation. The effects of these challenges are especially pronounced in rural America where the proportion of older adults—those ages 65 years and older—has been steadily increasing and outpacing the proportion living in urban areas.[2] The aging of rural America has been well documented, including the fact that rural areas have higher rates of poverty, multiple chronic conditions, and age-adjusted mortality for all causes.[2] As the U.S. Department of Health and Human Services (HHS) grapples with issues related to the costs and challenges of providing care for older Americans, an understanding of the current supportive service and caregiving policies affecting the care of rural older adults will be helpful to the Secretary.

Note: As the Committee distilled the findings from its 85th convening into this policy brief, three broad themes were identified: availability, accessibility, and acceptability of services. The sections below provides background information on each key theme as pertaining to the Committee's policy recommendations and considerations.

BACKGROUND

Availability

Information about the availability of supportive services offered in rural communities is limited. Yet, as the average age of rural populations continues to increase, there will be an increasing demand for care across the service spectrum. Long-term services and supports and telehealth services were identified as particularly important components of care for rural older adults.

Long-Term Services and Supports (LTSS)

Many older Americans living with disabling or chronic conditions need attention and care for the long-term. LTSS refers to assistance with activities of daily living such as bathing, dressing, meal preparation, medication administration, and transportation. LTSS can be provided in a variety of settings, such as the individual's home, nursing homes, or assisted living facilities, depending on the personal preferences and financial constraints of those receiving care. Roughly half of older adults will be reliant upon LTSS at some point in their lifetimes and, in the near future, demand for LTSS systems is expected to reach unprecedented levels.[3]

Because long-term care and nursing facilities are mandatory Medicaid benefits offered to recipients who require that level of care, federal spending has historically gone to institutional settings. Within the past few decades, however, federal and state policies, as well as consumer preferences, have shifted in favor of home and community-based services (HCBS). To be eligible for Medicaid funding, HCBS must:

1. Be integrated with and support full access of individuals to the greater community;
2. Be selected by the individual from among setting options including non-disability specific settings such as their private residence;

3. Ensure an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint;
4. Optimize individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact; and
5. Facilitate individual choice regarding services and supports, and who provides them.[i]

Rural areas appear to lag behind this national trend toward Medicaid-funded HCBS. Spending on HCBS for rural enrollees comprised a significantly smaller proportion of overall LTSS spending compared to urban enrollees.[4] However, rural-urban differences in HCBS spending cannot be explained by beneficiary characteristics alone. Contributors to spending difference may include state-by-state policies on HCBS and the supply of nursing facilities compared to HCBS in rural areas. There is some data available on home health, a component of HCBS, at the county level. However, data comparing rural and urban availability of other HCBS services, such as personal care, adult day care, or rehabilitation, is limited. According to a study conducted by the South Carolina Rural Health Research Center, using Medicare Compare Home Health Agency Data, nearly all U.S. counties (99 percent) had access to home health services, but those counties that did not have a home health provider or who only had a single agency providing services were almost exclusively located in a rural area.[5] In counties where home health is available, rural counties were more likely than urban counties to be served by a single agency. Conclusions from the study suggest this could create circumstances where smaller communities that lack sufficient home health or other long-term care services would be forced to send those in need of long-term care services to facilities far from their friends and family.[5]

Telehealth

Telehealth services allow for the exchange of medical information through electronic communication, (e.g. two-way videos, smart phones, or other specialized internet-enabled devices) with the goal of improving a patient's health status. It can be used for primary care, specialty care, patient education, and case management, among other options. Historically, telehealth services reimbursed through Medicare have been limited to specific services at originating sites in rural settings, (e.g. Critical Access Hospitals (CAHs) or Rural Health Clinics (RHCs)), where the patient interacts with a certified distant site provider.[ii] Advocates for telehealth argue that these services expand access to care, increase convenience for patients, improve overall quality of care, and reduce the cost of similar care services offered in-person. Critics warn about supply-induced demand driving up costs through unnecessary services and caution that commercial health plans have not found strong evidence of telehealth reducing costs or improving health outcomes.[6]

Medicare telehealth utilization is small but growing. In 2016, 0.3 percent of Medicare Part B beneficiaries had a telehealth visit, a 79 percent increase from 2014. Beneficiaries who utilized these services were mostly rural, eligible for both Medicare and Medicaid, and chronically ill.[6] While rural-urban data is available on the types of telehealth services provided through the Health Services and Resources Administration's Health Center Program, efforts to gather information on telehealth service providers nationally have posed a greater challenge.[iii] Currently, there is no complete geographic inventory of the

[i] Obtained from CMS's Regulatory Requirements for Home and Community-Based Settings: https://www.medicaid.gov/medicaid/hcbs/downloads/requirements-for-home-and-community-settings.pdf

[ii] Recent expansions of telehealth reimbursement eligibility are discussed further in the "Policy Recommendations" section of this brief.

[iii] Retrieved from a presentation on telehealth from HRSA's Bureau of Primary Health Care: https://bphc.hrsa.gov/sites/default/files/bphc/nachc/bphc-telehealth.pdf

telehealth services available across the country, rural or urban. Registries such as "Telehealth Connect" and the "Telehealth Service Provider Directory" do exist, but are not comprehensive and rely on voluntary reporting and registration by providers.

Accessibility

Older adults in rural settings need access to a variety of affordable care options to keep them in their communities and financially sound. Care coordination and navigation, transportation to and from care, loneliness and social isolation, and the importance of unpaid caregivers for older adults were the issues of highest concern for the Committee.

Care Coordination and Navigation

Care coordination has received considerable attention within the health care sector as payment and delivery options shift to achieve the triple aim of better patient care, improved population health, and lower per capita cost. These goals are met by integrating medical services, human services, wellness programs, and recognizing the individual preferences of the patients into a single care continuum. Ideally, rural care providers would deliver these services in a coordinated manner, however, services are often fragmented across multiple entities, each with its own organizational priorities, regulations, and funding sources. This fragmentation make it difficult for those seeking post-acute services and LTSS to navigating their options, especially older adults and their caregivers. Care coordination in rural settings is also difficult due to increasing emphasis on the use of electronic health records (EHRs) across the care continuum. EHRs can be too costly for smaller, rural supportive service organizations (i.e. home health) to install and maintain.

Transportation

In rural communities, the travel necessary to and from medical services is a persistent barrier to accessing care and supportive services. Older adults who do not have the ability or means to drive themselves must find alternative options to keep their appointments. These options typically involve getting a ride from a friend or family member as public transportation is limited or non-existent. When reliable transportation to a health care provider is not available, it can cause delayed or missed health appointments, treatment disruption for chronic patients, physical and financial stress relating to traveling greater distances, and a decline in medication usage associated with living farther from the care provider.[7]

Loneliness and Social Isolation

A growing topic of discussion among health policy experts is the connection between social relationships and health status. While there is common understanding regarding the importance of social relationships for emotional well-being, their effect on physical well-being has only been recognized recently. Loneliness—the subjective condition of feeling alone—has been correlated with an increased mortality risk and a host of costly and preventable conditions for older adults. Social isolation, or the "objective lack of social networks and access to information and resources,"[8] has also been found to have a significant impact on mortality. In fact, mortality risks from loneliness and social isolation exceed the mortality risk associated with obesity. Even more alarming, the negative health outcomes of social isolation have been compared to smoking 15 cigarettes daily.[8] In a 2010 National Institutes of Aging study on adults between 62 and 91 years of age (n=3,240), nearly 1 in 5 suffered from loneliness.[8] Along with human suffering, economic impact to society should not be ignored as recent estimates state that social isolation alone contributes an additional $6.7 billion in Medicare spending annually.[9]

Research on rural-urban differences in loneliness and social isolation is limited. Available research suggests that a lack of social contact is prevalent among older rural residents—over 25 percent of men and almost 20 percent of women reported socializing with others less than once per month.[10] Although rural residents describe less social isolation and more social relationships when compared to urban residents, there are marked differences in perceived loneliness by race and ethnicity in rural areas.[11] Efforts to address social isolation and loneliness in rural communities should be tailored by geography and account for the uniquely rural risk factors.

Unpaid Caregivers

Informal caregivers, the nearly 44 million family and friends who provide the vast majority of supportive services and long-term care in the United States, provide nearly $500 billion annually[12] in unpaid care for an older adult or individual who is disabled. Unlike many urban areas, rural lack the resources for training informal caregivers, and characteristic in the rural culture, caregivers are reluctance to ask for help, and less access to respite services.[12] This creates conditions where the caregiver may be unable or unwilling to access help beyond their scope of care when it is necessary, and isolates them from their own social connections because they cannot leave the care recipient on their own.

Acceptability

Stigma and a lack of understanding of the care required for older adults are potential barriers that rural communities must confront. Recent literature on stigma relating to public assistance for older adults grouped its negative associations under two categories: internal stigma and external stigma.[13] Internal stigma can arise within an older adult who feels shame or personal blame due to their inability to care for them self. External stigma can occur based on negative experiences with the agencies who administer public assistance. Both forms of stigma can result in reduced utilization of public assistance programs. In an attempt to combat this stigma and make services more amenable to the needs of older adults, organizations have promoted the adoption of "age-friendly communities" and "age-friendly health systems" into their program framework.

Age-Friendly Communities and Health Systems

Older Americans living in rural areas generally have fewer financial resources, business opportunities, health and social services, and transportation options. Rural suburban, or urban, all need strong and responsive community infrastructure to accommodate an aging populace. Age-friendly communities encourage active aging by optimizing opportunities for health, participation, and security in order to preserve quality of life. In an age-friendly community, individuals of all ages should be able to safely and easily travel to key community locations without a car.[iv]

As the Committee heard, age-friendly health systems for older adults in should be constructed in a way that provides the best care possible and satisfies the health goals and preferences of the individual. The four essential elements of an age-friendly health system include: 1) knowing what matters to the patient, 2) medication, 3) mentation, and 4) mobility.[v] Known as the *4M Framework*, these elements support the idea that each older adult should have care aligned with their health outcome goals and preferences,

[iv] Age-friendly concepts can be further explored on the World Health Organization's website on "Ageing and Life-Course: https://www.who.int/ageing/age-friendly-world/en/

[v] Information on Age-Friendly Health Systems and the 4M Framework can be found on the John A. Hartford Foundation website: https://www.johnahartford.org/grants-strategy/current-strategies/age-friendly/age-friendly-health-systems-initiative/

including end-of-life care, across all settings. For example, prescribing should be age-friendly, meaning that medicine should be prescribed with the recognition that side effects and drug interactions may be different in an older person than a younger person and should be adjusted accordingly. In addition, illnesses such as dementia, depression, and delirium should be prevented, identified, treated, and managed across care settings. Finally, older adults in an age-friendly health system should be able to move safely every day in order to maintain mobility, balance, and function.

FEDERAL PROGRAMS

HHS funds a variety of grants, workforce programs, research and data efforts, technical assistance, and direct provision of services related to supportive services and caregiving for older adults. The Committee highlights those efforts with the most direct relevance to rural communities:

- The Older Americans Act
- Administration for Community Living (ACL)
- Centers for Disease Control and Prevention (CDC)
- Center for Medicare & Medicaid Services (CMS)
- Health Resources and Services Administration (HRSA)

The Older Americans Act (OAA)

The OAA, first enacted by Congress in 1965, established much of the federal infrastructure for supportive services for older adults in the United States. OAA programs are primarily overseen by the Administration on Aging (AoA) in the ACL.[vi] Since 1980, OAA funding has dropped 34% when adjusted for inflation.[14] Over the same period, the segment of the population 65 years of age and older has grown by 60%.[14] In fiscal year 2015, roughly two cents in federal funding was spent on OAA-funded supportive services for every dollar of acute-care Medicare spending on older adults in the United States.[14]

ACL Programs

Within the ACL, the AoA delegates funds and responsibilities to the entities that comprise the National Aging Network, including State Units on Aging (SUAs), Area Agencies on Aging (AAAs), and certain tribal or Native Hawaiian organizations. SUAs serve as the state-level agency for planning and policy development for OAA activities. AAAs operate within a local Planning and Service Area. All AAAs offer five core services, as mandated by the OAA: elder rights, options for caregivers, nutrition (including Meals on Wheels), health & wellness, and supportive services. AAAs directly provide these services or contract with local service providers to assess community needs, educate the public on available resources, and serve as access points to care. Across the country, there are 56 SUAs, 622 AAAs, and over 250 tribal and Native Hawaiian organizations that fall under AoA authority.

Although the ACL offers several online and physical resources related to the care of older adults, specific programs worth noting for the purpose of this brief are Aging and Disability Resource Centers (ADRCs),

[vi] A comprehensive description of OAA programs and statutory authority can be found in the Congressional Research Service's Report. "Older Americans Act: Overview and Funding." Updated November 14, 2018. https://fas.org/sgp/crs/misc/R43414.pdf

the National Family Caregiver Support Program (NFCS), and the Lifespan Respite Care Program.[vii] ADRCs were created to serve as a local access point for information on OAA and LTSS programs and recently, information on accessing Medicare, Medicaid, and Veterans Affairs programs. ADRCs also offer services such as options counseling and discharge planning. There are over 500 ADRCs in 50 states, two territories, and the District of Columbia. The NFCS Program ensures caregivers have the assistance and support they need to provide care successfully. The program also offers individual counseling, group counseling, and training for caregivers and respite care. The Lifespan Respite Care Program supports community-based efforts that provide respite for caregivers of individuals who have special needs. Recent NFCS grantees have emphasized integrating with their state's LTSS programs and filling service gaps for family caregiver respite services.[vii]

CDC Programs

The CDC, in part, contributes to the country's efforts to help older adults through a variety of programs. One example that the Committee heard about during its meeting was the Alzheimer's Disease and Healthy Aging Program for those experiencing cognitive decline. *Healthy People 2020* reports that primary care providers do not routinely test for Alzheimer's disease or related dementias, thus, people with the disorder may be undiagnosed.[viii] Moreover, the disease and other dementias are more often undiagnosed in rural and minority populations than in urban or white populations. The Alzheimer's Disease and Healthy Aging Program leads efforts to help those with Alzheimer's or other forms of dementia remain active, independent, and involved in their communities. The program helps promote awareness and the importance of early diagnosis of the disease and other dementias; supports the study of the societal and economic burden of dementias in states and communities; fosters data collection on cognitive decline and caregiving; and works to ensure that caregivers have the resources needed to provide quality care to people with dementia.

The CDC's Healthy Brain Initiative developed the *Road Map for State and Local Public Health Partnerships to Address Dementia*. This effort is framed by four essential services of public health: to ensure a competent workforce, monitor and evaluate the population, develop effective policies and mobilize partnerships, and educate and empower the nation. Activities under this effort are guided by three core principles: to ensure health equity, collaborate across multiple sectors, and leverage resources for sustained effect. There is also special emphasis on rural and American Indian/Alaska Native populations.[ix]

CMS Programs

CMS provides financing services across the spectrum of care for older adults, with Medicare covering acute and post-acute care and Medicaid covering LTSS. During the Committee meeting, the members expressed particular interest in the integration of services for rural older adults who qualify for both Medicare and Medicaid in their state of residence. These individuals, known as "dual-eligible," have the challenge of navigating two distinct and complex programs, each with their own eligibility requirements and service offerings. As a result, care can be fragmented or poorly coordinated. Attempts have been made to remedy this issue through the creation of managed care plans, with varying degrees of Medicare-

[vii] Retrieved from an ACL factsheet on the Lifespan Respite Care Program: https://acl.gov/sites/default/files/programs/2018-05/Fact%20Sheet_Lifespan_Respite_Care_2018.pdf

[viii] Retrieved from the *Healthy People 2020's* webpage on "Dementias, Including Alzheimer's Disease": https://www.healthypeople.gov/2020/topics-objectives/topic/dementias-including-alzheimers-disease

[ix] For more resources on CDC's work in Indian Country, see https://www.cdc.gov/aging/healthybrain/Indian-Country-resources.html.

Medicaid integration. These range from Medicare Advantage dual-eligible special needs plans (D-SNPs), with minimal integration, to the Program for All-Inclusive Care for the Elderly (PACE), which fully integrates benefits.

D-SNPs, a 2006 pilot program, was permanently authorized in the Bipartisan Budget Act of 2018. All D-SNPs contract with state Medicaid agencies to coordinate the integration of Medicare and Medicaid benefits. At a minimum, D-SNPs must offer assistance to enrollees seeking Medicaid covered services, authorizations, or appeals regardless of how the enrollee receives their benefits (e.g. fee-for-service or managed care). Fully Integrated Dual-Eligible Special Needs Plans (FIDE-SNPs) are a sub-category of D-SNPs designed to coordinate Medicare and Medicare benefits for dual eligible beneficiaries under a single managed care organization and provide coverage of primary, acute, and LTSS benefits consistent with state policy. According to the MedPAC June 2019 Report to Congress, approximately 400 D-SNPs are available in 40 states and 40 FIDE plans are available in 10 states. Despite the legislative authority allowing D-SNPs to be offered, MedPAC points out that there are great differences in the levels and types of Medicare and Medicaid integration across D-SNPs. To remedy this disparity, the Bipartisan Budget Act of 2018 specified that starting in 2021 D–SNPs must meet additional standards for integration.

The Program of All-Inclusive Care for the Elderly, or PACE, is the most integrated benefit plan offered by CMS for frail older adults who wish to remain in their community and delay or avoid placement in a nursing facility. PACE participants receive comprehensive and integrated preventive, acute, and supportive services. Providers who offer this level of care are financed through a capitated payment system to encourage providers to coordinate their services as an interdisciplinary team and promote value-based care. Approximately 16 percent of the 122 PACE programs across the nation operate in rural areas, according to the most recent data, and 95 percent of PACE participants were able to remain in a community setting despite being eligible for care in a nursing home.[x]

HRSA Programs

HRSA provides access to health care and other services for the 54 million individuals residing in rural communities across the nation. The Federal Office of Rural Health Policy (FORHP), which operates within HRSA, support efforts to improve access to care for rural populations. In addition to advising the Secretary on the rural implications of federal health policy, FORHP also administers grants to local and state entities for the purposes of expanding rural health care services, outreach, and research, with the goal of improving overall population health.[xi]

POLICY RECOMMENDATIONS

Over the course of the meeting and site visit, the Committee developed a sense of the importance of a complete care continuum focused on improved health outcomes for older adults living in rural areas. Although traditional definitions of "supportive services and caregiving" generally fall under the human services category of LTSS programs, the Committee recognized that both health services and human services have an interconnected role in the provision of care for older Americans. This idea is reflected in the following recommendations to the Secretary. The Committee chose to limit the scope of its

[x] Information obtained from the Rural Health Information Hub's "Rural Aging in Place Toolkit:" https://www.ruralhealthinfo.org/toolkits/aging/3/pace

[xi] A complete list of past and current rural health funding opportunities offered through FORHP can be found here: https://www.hrsa.gov/ruralhealth/programopportunities/fundingopportunities/default.aspx

recommendations to the Secretary based on issues that were specifically actionable within HHS and unique to rural communities. Issues that the Committee felt were more general or were not rural-specific have been included within the "Policy Considerations" portion of the brief.

The national and state policy experts that presented to the Committee emphasized the difficulties caused by fragmentation of care across multiple funding streams and programs. Disjointed care systems for older Americans places the burden of navigating the options on the individual and their family and limits the possibility of optimizing resources. On the final day of the meeting, the Committee concluded that health and human service programs should be designed to allow rural older adults to age in place in a manner that is accessible, available, and acceptable to the needs of each individual. These themes laid the framework for the Committee's first three recommendations on providing access to OAA resources, expanding telehealth services, and promoting age-friendly communities and health systems in rural health initiatives at the federal level.

Providing Greater Access to OAA Resources

The AoA offers information on LTSS programs through its approximately 30 national resource centers; however, a recent GAO report on rural service providers noted that these resources are dispersed across many platforms and could be difficult to locate for service administrators, caregivers, or those receiving care.[xii] This was evident during the Committee's site visit in rural Northern California, where local health service providers expressed that community members did not know what services are available, so they are not getting the assistance they need to plan for aging in their community. Additionally, the GAO reported that ACL does not currently offer a resource specifically for older adults in rural areas, nor is the ability to search for rural caregiving options across existing programs and resources. The Committee agrees with the GAO analysis, as it aligns with their observations during its meeting, and suggests that information barriers could be addressed by synthesizing the ACL program offerings into a coordinated and more accessible resource tailored to the unique needs of rural older adults.

> **Recommendation 1:** The Committee recommends the Secretary create a comprehensive resource on the aging and LTSS available to older adults in rural areas.

Expanding Telehealth Services

The Committee recognized that telehealth services can be an effective tool in providing access to routine and specialty care, but also understands that regulations and financing restrictions limit the availability of telehealth offerings. Such barriers to access can lead to postponement of seeking care until the condition has become acute, causing more discomfort for the patient and requiring more resources to treat.

The Committee was also concerned with the inability of a patient's place of residence to be billed as originating site for telehealth. Inconsistencies in the telehealth reimbursement policy compared to other rural-based reimbursement methods and the extended time required for health plans to credential new specialists affect the provision of telehealth services.

There have been few successful federal efforts to change Medicare telehealth reimbursements. For example, the Next Generation Accountable Care Organizations (ACO) Telehealth Expansion Waiver was

[xii] Further information on OAA resources and rural service providers can be found on the US Government Accountability Office's (GAO) 2019 report on the Older Americans Act: https://www.gao.gov/products/GAO-19-330

put in place through the Center for Medicare & Medicaid Innovation, allowing a patient's place of residence to be an originating site for telehealth services. This waiver was also extended for Medicare Shared Savings Program ACOs participating in the "Pathways to Success" program.[xiii] Additionally, the Bipartisan Budget Act (BBA) of 2018 removed the restrictions on monthly assessments and at-home dialysis through telehealth for individuals with end-stage renal disease.

However, Medicare reimbursement for telehealth services remains a barrier in rural settings, particularly the fixed-rate facility fee paid to originating site providers. For CY 2019, the payment amount for the telehealth originating site facility fee is 80 percent of the lesser of the actual charge, or $26.15).[15] The Committee believes the Secretary should consider cost-based reimbursement, which would align with the payment model for rural facilities such as CAHs. There is precedent for providing cost-based reimbursement for telehealth in the Frontier Community Health Integration Project (FCHIP) Demonstration, where participating CAHs received a reimbursement through Medicare at 101 percent of the cost of the telehealth services provided. The 2018 interim report to Congress on FCHIP noted a 70 percent increase in telehealth for distant site providers across multiple specialties only one year after this reimbursement change. FCHIP participants did note, however, that the greatest implementation challenges were due to credentialing specialists, pointing up another barrier the Secretary should address to improve access to rural telehealth services.

Navigating and accessing telehealth options in rural settings is difficult due to the lack of a complete geographic inventory of telehealth services offered. Registries such as "Telehealth Connect" and the "Telehealth Service Provider Directory" do exist, but they are not comprehensive and rely on voluntary reporting and registration, and require provider consent. In order for these services to be effective, rural older adults and patients must know where to find them.

> **Recommendation 2:** The Committee recommends the Secretary continue to expand flexibility in Medicare telehealth billing and provide a comprehensive resource of telehealth offerings in rural areas.

Promoting Age-Friendly Communities

The Committee heard from experts on national aging policy who stressed that age-friendly care results in concordant care, improved health, and cost-effective services. Health and human service systems should align care with the health goals and preferences of the older adult, including whether or not they wish to age in place and receive care in their community. The Committee learned of two frameworks that could be used for age-friendly capacity building in rural settings: (1) the 4M framework of Mobility, Medication, Mentation, and What Matters; and (2) the CDC's Healthy Brain Initiative created by its Alzheimer's disease and Healthy Aging program.[xiv] The Committee is of the opinion that the principles of these frameworks should be incorporated into federal rural health grant funding initiatives and notes that HHS has precedence for including age-friendly concepts into its Notice of Funding Opportunities within HRSA programs.[xv]

[xiii] More information on the Pathways to Success program can be found on the Medicare Shared Savings Program website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html

[xiv] Further information on these programs is provided in the "Acceptability" and "Federal Programs" section of this brief.

[xv] The Geriatrics Workforce Enhancement Program, offered through HRSA's Bureau of Healthcare Workforce, incorporated age-friendly health system concepts into a fiscal year 2019 Notice of Funding Opportunity: https://www.hrsa.gov/grants/fundingopportunities/default.aspx?id=4c8ee9ff-617a-495e-ae78-917847db86a9

Recommendation 3: The Committee recommends the Secretary ensure the promotion and encouragement of age-friendly concepts within rural health grant programs.

Supporting Integrated Service Delivery Models in Rural Communities

Currently, delivery of health care and supportive services in rural communities is a fragmented system spread across multiple organizations and funding streams. Because federal- and state-level programs are often not person-centered and because Medicare does not cover LTSS, people have difficulty navigating and financing services on their own.

The traditional fee-for-service model is shifting to promote better organization and care navigation through integrated managed care-based programs. However, the shift is primarily occurring in urban areas where insurance and service options are more readily available. Dual-eligible individuals living in rural areas are the most affected by the urban-rural discrepancy, as they are often the sickest and most vulnerable individuals in the population.

D-SNPs were created as a Medicare Advantage option to integrate Medicare and Medicaid for dual-eligible enrollees. Despite the fact that D-SNPs are the most common form of integrated plan for dual-eligible,[16] there is a lack of published research on the availability of D-SNPs in rural areas and Medicare Advantage enrollment as a whole has lagged in rural areas compared to urban.[17] The Committee believes further research is needed on the role of D-SNPs and integrating care for rural enrollees. The Committee also believes that adjustments to federal and state policies regarding D-SNPs could promote expansion into rural settings.

Recommendation 4: The Committee recommends the Secretary explore the entry of Medicare Advantage Dual-Eligible Special Needs Plans into rural areas, identify potential barriers, and work with states to adopt policies that encourage or expand the reach of these plans to rural beneficiaries.

POLICY CONSIDERATIONS

In addition to the specific recommendations above, the Committee offers the Secretary the following policy considerations.

Collaborating and Integrating Strategic Efforts across Federal Agencies

The Committee notes that with the number of federal departments with programs that support older adults in rural communities, there is the potential for duplication. The Committee urges HHS to emphasize collaborative efforts with other federal partners such as the U.S. Department of Housing and Urban Development (HUD), the U.S. Department of Transportation (DOT), and the U.S. Department of Agriculture (USDA) by fostering intergovernmental strategic planning which focuses on the unique needs of rural older adults. The Committee also recognizes the importance of coordinated local leadership and suggests that the Secretary consider developing programs that encourage and foster participation of local leaders.

Emphasizing the Importance of Non-Emergency Medical Transportation

Under current regulations, states are required to provide Non-Emergency Medical Transportation (NEMT) to all Medicaid beneficiaries. The administration's current budget proposal commits to using regulatory authority to change provision of this benefit from mandatory to optional.[xvi] In rural communities, where transportation options are already scarce or non-existent, the Committee believes this proposal would negatively impact rural Medicaid beneficiaries' health outcomes and create additional barriers to care. The Committee urges the Secretary to reconsider this proposal and maintain NEMT services as a mandatory service for states to provide to their Medicaid beneficiaries.

Supporting the Reauthorization of the OAA

As outlined in the "Federal Programs" section of the brief, programs funded through the OAA provide important services for older adults residing in rural communities. The current authorization of the OAA expires at the end of September 2019. The Committee expresses its support for the prompt reauthorization of the OAA and suggests that the Secretary work with Congress on the reauthorization of the OAA.

Including Social Isolation within the *Health People 2030* Framework

Social determinants of health are an established priority within the HHS *Healthy People* framework, yet current guidelines within the *Healthy People 2020* goals do not include addressing social isolation or loneliness as contributors to poor health outcomes.[xvii] According to a report by the National Rural Aging Advisory Council and others, there is mounting evidence about the health risks associated with social isolation as an independent risk factor for coronary heart disease, stroke, and all-cause mortality.[18] Public education and action related to these risks should be a strategic priority for HHS, especially for rural populations who are older and display higher rates of multiple chronic conditions. Therefore, the Committee urges the Secretary to consider social isolation and loneliness as a component of the *Healthy People 2030* objectives on "Social Determinants of Health."

Valuing the Need for Peer Navigators in the Care Delivery Process

The complex and fragmented care system places a strain on rural older adults and their caregivers as they attempt to navigate options to meet their care requirements. After the meeting and site visit discussions, the Committee concluded that improved efforts are needed to match older adults and their caregivers with peers who have gone through similar challenges and who understand the current care system. This is a necessary priority for the Secretary and other HHS leadership to consider as the population of older Americans continues to increase. Community health workers (CHWs) have been utilized as a local, peer option to connect people to the resources and services available in their community, but there is currently no permanent paraprofessional training program for CHWs offered by HHS agencies such as HRSA.[xviii] The Committee believes the Secretary consider a training program for CHWs which incorporates peer support

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[xvi] Retrieved from the Department of Health and Human Services' FY2020 Budget in Brief https://www.hhs.gov/sites/default/files/fy-2020-budget-in-brief.pdf

[xvii] Retrieved from the *Healthy People 2020* Social Determinants of Health objectives: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health/objectives

[xviii] HRSA provided funding for CHW training through the Frontier Community Health Care Network Coordination Pilot Grant Program from 2011-2014. However, this was only awarded to one grantee, the Montana Department of Public Health and Human Services, and the program was terminated after the 3-year grant period concluded.

for older adults and family caregivers to improve health outcomes, reduce stigma associated with accessing resources, and to make rural communities more age-friendly.

Promoting and Expanding Unpaid Caregiver Support Programs

Unpaid caregivers of older adults, who are usually family members, provide an estimated $500 billion in long-term care services annually, but programs to support these caregivers are lacking in rural areas compared to urban areas.[12] Research on unpaid rural caregivers noted a lack of access to resources as one of the greatest challenges to overcome, as rural areas had "fewer formal support programs, more restricted access to healthcare, workforce shortages, and less access to home care and respite services."[12] Federal initiatives through the AoA—such as the National Family Caregiver Support Program or the Lifespan Respite Care Program—are available, but the Committee believes more public education and financial investment in rural caregiver support programs is needed from federal sources.[xix]

CONCLUSION

Rural older adults living in the United States face unique and persistent challenges—such as transportation, fragmented delivery and financing of care, and social isolation—which affect their ability to receive necessary supportive services and caregiving. The Committee believes HHS can make progress to combat these challenges by consolidating resources and adopting age-friendly principles in federal programs, expanding telehealth knowledge and availability, and researching the delivery of public insurance for the most vulnerable residents.

[xix] The Committee has studied caregiver-related issues over the years, results in at least eleven specific recommendations to the Secretary.

APPENDIX A – SITE VISIT PROFILE

Grass Valley is a rural community in Nevada County, California, located in Gold Country in the Sierra Nevada Mountain Range. Grass Valley has a population of approximately 13,000 residents according to U.S. Census data. It is designated as a Medically Underserved Population, a Primary Care Health Professional Shortage Area (HPSA), and a High Needs Geographic Mental Health HPSA.[xx]

The Committee's site visit to Grass Valley was hosted by Sierra Nevada Memorial Hospital, which has operated in Nevada County since 1958. Services provided by the hospital range from family medicine to cancer care and emergency services, but they also provide outreach programs on Alzheimer's disease and caregiver support. The California Area Agency on Aging (Planning and Service Area 4) as well as the FREED Center for Independent Living were also instrumental in recruiting service providers and consumers to attend the site visit, including Gold Country Community Services; Helping Hands Adult Day Program; Chapa De Indian Health; Hospitality House; Hospice of the Foothills; Elder-Care Providers' Coalition of Nevada County; Falls Prevention Coalition of Nevada County; and Partners in Care.

Local Perspectives

- Stakeholders from the California Area Agency on Aging, Gold Country Community Services, Chapa De Indian Health, Partners in Care, and Hospice of the Foothills all expressed transportation as a significant barrier for older adults who wish to receive their services. A lack of transportation was also noted as a limitation on senior's food and nutritional choices, and social isolation forced some older adults to walk significant distances to receive certain services.
- Representatives from Hospitality House and the Helping Hands Adult Day Program said the community used to have a centralized senior center, but it closed years ago and hindered the ability to provide services from a well-accessed and centralized location. They noted the uptick in people who are homeless as a growing issue in the community, as over thirty percent of the homeless population are 55 years of age or older.
- Attendees representing Chapa De and Hospice of the Foothills noted that primary care, dental, behavioral health, and nutrition assistance were some of the most utilized care offerings in the area, but other important services (e.g. case management, patient navigation) were provided without reimbursement.
- Individuals who worked for the FREED Center for Independent Living discussed the effects of recent wildfires in the region as particularly detrimental to older adults and those living with disabilities. Those who were affected that lost their homes had no other options other than going to an assisted living facility.
- The Elder-Care Providers' and Falls Prevention Coalitions of Nevada County mentioned that the area has still not recovered from the economic effects of the 2008 recession, particularly, a resource center dedicated to providing training and respite care services for caregivers was forced close. They noted stigma in accessing services as a great barrier to care for their older adults. Person-centered planning programs for those aging in their area have been introduced to combat stigma and improve participation in local aging services, but they are understaffed and require additional resources to be more effective.

[xx] Information on HPSA status was obtained from the Health Resources and Services Administration's "HPSA Find" tool. Available from: https://data.hrsa.gov/tools/shortage-area/hpsa-find

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