PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY IN RURAL AMERICA

POLICY BRIEF AND RECOMMENDATIONS TO THE SECRETARY

MARCH 2023

NACRHHS

National Advisory Committee on Rural Health and Human Services

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EDITORIAL NOTE

In September 2022, The National Advisory Committee on Rural Health and Human Services (hereinafter referred to as "the Committee") convened for its 91st[th] meeting in Lawrence, Kansas to examine the use of the Programs of All Inclusive Care for the Elderly (PACE) in rural areas. Throughout the course of the meeting, the Committee heard from subject matter experts on PACE, aging, and long-term care issues. As part of the meeting, Committee members participated in site visits to Midland Care Connection, Inc.'s headquarters in Topeka and a rural PACE site in Emporia, Kansas. This policy brief presents the benefits and challenges of PACE in rural areas that were conveyed during the meeting, as well as the Committee's policy recommendations and considerations to better utilize PACE in rural America.

ACKNOWLEDGEMENTS

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The Committee also extends its appreciation to the staff at the Federal Office of Rural Health Policy (FORHP) for coordinating the meeting and to Meredith Anderson for drafting this policy brief.

POLICY RECOMMENDATIONS

Recommendation 1: The Committee recommends the Secretary support a PACE pilot focused on Medicare only beneficiaries, including Part D coverage challenges, to assess viability in rural areas, and determine start-up capital needed for sustainability.

Recommendation 2: The Committee recommends the Secretary consider how best to extend telehealth coverage to PACE organizations in light of the Consolidated Appropriations Act of 2023, to the extent it has the authority to do so.

Recommendation 3: The Committee recommends the Secretary support the development of a rural PACE resource guide to promote the model to rural and tribal communities and provide technical assistance and case studies from successful rural and tribal programs.

Recommendation 4: The Committee recommends the Secretary support guidance to clarify the range of allowable shared space arrangements for Critical Access Hospitals (CAHs) and encourage partnerships between CAHs and PACE organizations, including considerations for cost reporting that support these partnerships without excessively reducing CAHs' cost-based reimbursement.

Recommendation 5: The Committee recommends the Secretary allow PACE sites to be eligible for loan repayment under the National Health Service Corps and the Nurse Corps.

Recommendation 6: The Committee recommends the Secretary encourage students trained through HRSA Health Profession and IHS training programs to rotate to rural PACE service sites.

Recommendation 7: The Committee recommends the Secretary allow PACE organizations to submit multiple applications simultaneously.

Recommendation 8: The Committee recommends the Secretary allow existing PACE sites to have an expedited approval process for expanding to new service area populations on a rolling basis.

INTRODUCTION

Although 1 in 5 older adults (65 and over) in the United States live in rural areas,[1] there is inadequate access to long-term services and supports (LTSS)[1], particularly home and community-based services (HCBS), to meet the complex needs of the population.[2] Expansion of the Programs of All-Inclusive Care for the Elderly (PACE) in rural areas may help ameliorate this problem. The Committee selected PACE as a topic because of the model's unique integration of health and human services and the program's potential for serving rural elderly.

PACE is a Medicare program and Medicaid state option.[3] It is part of a group of care delivery approaches focused on preserving seniors' ability to live at home that includes Medicare Advantage and Medicaid HCBS. However, PACE is a unique, integrated care model that provides comprehensive health care and human services to frail older adults with chronic care needs. To be eligible for PACE, an individual must be 55 or older, live in the service area of a PACE organization, need a nursing home-level of care (as certified by their state), and be able to live safely in the community with assistance from PACE.[4]

Individuals enrolled in PACE continue to live in their community for as long as they are able due to the program's coordination of preventive, primary, acute care, and LTSS.[5] Because PACE is the sole source of services, there is a substantial decrease in administrative burden for PACE clinicians, participants, and caregivers. Clinicians are empowered to focus on patient-centered care, and participants and caregivers on better quality of life.

Evidence indicating cost savings and improved health outcomes for PACE participants, particularly for individuals who are dual-eligible for Medicare and Medicaid, continues to grow.[6] After learning about PACE from experts and site visit stakeholders during the September meeting, the Committee believes that the model has great potential for rural areas. They were impressed with how the model addresses social determinants of health by focusing on high-quality medical care, access to community services, socialization, and safe and comfortable housing.

However, awareness of PACE as a viable option remains low in rural areas. Not all states have PACE organizations or approve PACE as a Medicaid option. The significant start-up funding and application process needed to establish PACE organizations are barriers to initial implementation as well as expansion. PACE organizations that successfully serve rural populations maximize existing partnerships and resources, but the Committee realizes that may not be feasible in under-resourced rural communities.

Based on their background work and presentations from experts and stakeholders, the Committee focused on several issues that potentially affect broad expansion of PACE in rural areas. This includes low patient volume, broadband and telehealth, limited awareness of the model, the rural hospital landscape, workforce shortages, and transportation challenges. They also focused on application, administrative, and start-up funding issues that influence the viability of PACE in all areas but pose greater challenges for

[1] Long-term services and supports (LTSS) covers a wide range of health and social services that assist individuals with functional limitations due to aging, chronic conditions, and disabilities. LTSS provide assistance with activities of daily living (including eating, bathing, and dressing) and instrumental activities of daily living (including medication management, housekeeping, and money management). They are delivered in institutional and home and community-based settings. Examples of LTSS include nursing facility care, caregiver support, adult daycare programs, home health aide services, and transportation (Kaiser Family Foundation, 2015).

the model in rural communities. Despite the barriers, the Committee believes PACE is an important option in long-term care and that expansion of the model in rural America is a worthwhile endeavor.

BACKGROUND

Rural Demographics and Health Disparities

In rural America, an older population, persistent health and economic disparities, combined with fragmented access to health and human services results in limited options for healthy aging. From 2012 to 2016, 17.5 percent of Americans living in rural areas were 65 and older, compared to 14.5 percent among the total population and 13.8 percent in urban areas.[7] Additionally, in comparison to urban areas, rural areas have:

- A higher poverty rate (15.3% vs. 11.9%) and lower per capita income ($42,993 vs. $59,693),[8]
- A higher prevalence of adults with multiple chronic health conditions (cancer, arthritis, diabetes, hypertension, etc.) (34.8% vs. 26.1%),[9] and,
- a higher percentage of people with a disability (approximately 17.1% vs. 11.7%).[10]

Rural communities are also increasingly diverse. Ten million rural residents identify as Black, Hispanic, American Indian/Alaska Native, Asian American/Pacific Islander, or mixed race. One in five rural residents belongs to one or more of these groups.[11] Compared with White residents, racial and ethnic minorities who live in rural areas (except for Asian and Native Hawaiian and other Pacific Islander residents) more often report their health as fair or poor and are more likely to report being unable to see a physician in the past 12 months because of cost.[12] As the more diverse rural population ages, distinctive LTSS concerns may emerge.

These demographics and disparities result in a high need for LTSS and HCBS in rural areas, which is not being met. According to research conducted by the University of Minnesota, the majority (62.5 percent) of rural Medicare beneficiaries report a preference for receiving LTSS in their home versus an institution.[13] Despite this preference, a study by the Maine Rural Health Research Center found that fewer rural Medicaid LTSS users received at least one HCBS than urban LTSS users (75 percent vs. 81 percent) and more rural LTSS users received nursing facility services than in urban areas (48 percent vs. 38 percent).[14] Even when facility-based care is the preference or best option, access is limited due to persistent nursing home closures in rural areas.[15]

PACE Description and Payment System

PACE is a comprehensive health plan for adults ages 55 and older – who require a nursing home-level of care. The model was developed in the early 1970's by staff at On Lok Senior Services (a nonprofit corporation) in San Francisco to meet the LTSS needs of older adults who immigrated from Italy, China, and the Philippines.[16] The goal of PACE is to keep participants living in their communities and out of the hospital and nursing home facilities for as long as possible. Ninety five percent of PACE participants live in community settings.[17] To achieve this, an interdisciplinary team (IDT) provides all Medicaid and Medicare covered services, as well as any other services determined necessary by the IDT to improve and maintain the participant's overall health status. The IDT members include physicians, nurses, physical therapists, social workers, dietitians, and transportation drivers.[18, 19]

Examples of health care services provided by PACE include:

- Primary care

- Nursing care
- Medication management and prescription drugs
- Physical/occupational therapy
- Coordination of all specialty care and care provided outside the PACE center (cardiology, dental, audiology, etc.)

Examples of human services provided by PACE include:

- Meals
- Transportation
- Home repairs (carpentry, air conditioning and heat repairs, etc.) and modifications (ramps, grab bars, etc.)
- Case management/social work
- Caregiver support

PACE organizations contract with hospitals, skilled nursing facilities, and community-based specialists for any additional health care needs. They are responsible for providing or arranging care to meet participants needs 24/7 and 365 days a year.[20]

The PACE program operates through a unique, 3-way relationship between the Centers for Medicaid & Medicare Services (CMS), individual states, and PACE organizations. As of November 2022, there are 149 PACE programs operating in 32 states[2] and a number of pending PACE applications across the country. Seventeen of the operational organizations are in areas designated as rural.[21] There are also PACE programs located in urban areas that include some rural participants, provided they reside in the approved service area.

PACE uses a capitated payment system, funded by four sources: Medicare Parts A & B, Medicare Part D, Medicaid, and private pay (depending on the programs for which each participant is eligible).[22] This pooling of funds allows PACE organizations to provide their participants with a full spectrum of health care and services. It also places the full financial risk of enrollees' care on PACE organizations, so there is strong incentive to keep participants healthy and avoid expensive hospital stays and nursing home care. PACE organizations function as both a provider and a health plan.[23, 24]

Legislative History and Statutory Authority
Congress established PACE as a permanent Medicare program and a Medicaid state option in the Balanced Budget Act of 1997 (Sections 4801 and 4802, Pub. L. 105-33) by adding Sections 1894 (42 U.S.C. 1395eee)[25] and 1934 (42 U.S.C. 1396u-4)[26] to the Social Security Act. Section 1894 addresses Medicare payments and coverage and Section 4802 addresses Medicaid. CMS regulates the implementation of PACE statutory requirements.[27] The CMS regulations are detailed in Part 460 of the Code of Federal Regulations (42 CFR § 460).[28]

[2] States and jurisdictions without a PACE program as of November 2022: Alaska, Arizona, Connecticut, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Maine, Minnesota, Mississippi, Montana, Nevada, New Hampshire, South Dakota, Utah, Vermont, West Virginia, and Wyoming

Dual-Eligible Population

Approximately 87 percent of PACE participants are dual-eligible for Medicare and Medicaid, 13 percent are Medicaid only, and .5 percent are Medicare-only or not eligible for Medicare or Medicaid.[29] Twenty one percent of people who are dual-eligible (approximately 2.6 million people) live in rural areas.[30, 31] However, challenges with eligibility exist. Rural residents are more likely to transition in and out of Medicaid income eligibility thresholds because they are more likely to be poor or near poor and experience more frequent income shifts than urban residents.[32]

Health disparities exist among urban and rural dual-eligible beneficiaries. A 2021 study assessing differences in all-cause mortality found higher mortality rates among rural dual-eligible beneficiaries. While all-cause mortality declined for both groups, the rates remained higher for rural dual-eligible beneficiaries and the gap in the rates increased over time.[33]

Due to complex health problems and disability, dual-eligible beneficiaries are a high cost and high health care and LTSS utilization segment of Medicare and Medicaid users. In 2019, dual-eligible beneficiaries made up 19 percent of the Medicare population but accounted for 34 percent of Medicare spending. For Medicaid in 2019, they made up 14 percent of the population and accounted for 30 percent of the spending.[34]

A 2021 study conducted by the Assistant Secretary for Planning and Evaluation (ASPE), within the Department of Health and Human Services (HHS), found that dual-eligible beneficiaries in PACE are significantly less likely to be hospitalized, to visit the ED, or be institutionalized, compared to dual eligible beneficiaries enrolled in a regular Medicare Advantage plan.[6]

Further Evidence of Better Health Outcomes and Cost Savings

Evidence suggesting cost savings and better health outcomes linked to PACE continues to grow. The National PACE Association (NPA) reports that the model costs states 13 percent less per month than other Medicaid services.[35] For Medicaid savings, the Bipartisan Policy Center estimates that PACE Medicaid per capita expenditures are about $6,000 less, on average, compared to those for nursing facility services.[36]

Due to the capitated payment system, PACE organizations were able to maintain a high level of care during the COVID-19 pandemic and pivot to a fully home-based model of care. Because PACE organizations are not part of a fee-for-service dynamic, they were not subject to lost revenue and could increase their use of telehealth and home monitoring services throughout the pandemic.[36] The focus on preventive care, HCBS, and the ability to adapt appear to have made PACE a safer option than nursing homes throughout the pandemic. As of February 2021, NPA reports that PACE enrollees have contracted COVID at one-third the rate of nursing home residents.[37]

Clinician and Caregiver Satisfaction

At the September meeting, PACE clinicians described their work as highly rewarding due to the model's focus on prevention, robust care coordination, and flexibility. With PACE, clinicians are empowered to focus on lifestyle changes for their patients that have long-term benefits, rather than the "revolving door" they experienced while working at hospitals. Because PACE is the payer and preauthorization from other insurers is not needed, clinicians and staff experience reduced administrative burden.

While there is limited information on PACE caregivers available in the health services literature, a 2018 NPA study suggests that caregivers experience high levels satisfaction and reduced burden with PACE. ninety six percent of the survey respondents indicated that they were "very satisfied or satisfied" with PACE and 97 percent would recommend PACE. Over 58 percent of the survey respondents who indicated a moderate to high level of caregiver burden at initial PACE enrollment, reported a lower level of burden after their loved one was enrolled.[38]

Transportation and Distance

Long distances to healthcare sites and inadequate transportation options pose major challenges for aging in place and accessing LTSS in rural areas. Based on analysis of the 2017 National Household Travel Survey, the Southwest Rural Health Research Center found that rural residents travel nearly double the distance to medical or dental care than urban residents (8.10 vs. 17.8 miles).[39] A 2021 study conducted by the University of Minnesota found that State Offices of Rural Health (SORHs) cited transportation as the greatest barrier to older adults successfully aging in place in rural areas.[40]

Transportation is a service PACE programs must provide if it is indicated in a participant's plan of care as determined by the IDT.[41] Therefore, PACE programs can help fill transportation gaps for rural elders. While PACE does provide transportation, during the September site visits, clinicians and staff explained that tolerating long rides can be a challenge for frail older adults. Thorough assessment of the challenges associated with transportation in rural areas is an important consideration and potential inhibitor for prospective rural PACE organizations. In order to better manage the geographic variability of rural areas, the Committee suggests exploring the use of mobile units as PACE alternative care settings.

Role of the U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Within the U.S. Department of Health and Human Services (department or HHS), CMS regulates, monitors, and supports PACE. CMS manages the application process for potential PACE organizations, along with quality data reporting, audits of existing PACE programs, and the implementation of PACE statutory requirements.

Per the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, (BIPA) CMS has the authority to modify or waive certain PACE regulatory provisions.[42] With this authority, CMS has made important modifications that allow for provider flexibilities. For example, in CMS' 2019 PACE Final Rule, PACE organizations no longer need a waiver to allow individuals to receive care from community-based physicians.[43]

In terms of a specific focus on PACE in rural areas, CMS administered the Rural PACE Pilot Grant Program, which was authorized under the Deficit Reduction Act in 2005.[44] The program awarded $7.5 million in start-up funding to 15 providers in rural areas in 13 states to establish PACE programs. Of the 15 initially funded programs, 11 are still operating.

In 2011, CMS conducted an evaluation of the 2006 Rural Pace Pilot Grant Program. The evaluation assessed the start-up, enrollment, and implementation of rural PACE sites and the impact of the grant on these activities. The importance of leveraging partnerships and existing resources in rural areas emerged as a theme from the evaluation and was emphasized at the September Committee meeting. The evaluation found that successful rural PACE organizations used positive relationships with established

organizations, such as the Area Agencies on Aging, to help market and boost initial enrollment. Another successful approach described in the evaluation was the "hub and spoke" model This model connects the operations of a rural site with a pre-existing non-rural site within driving distance.[45] Midland Care Connection, Inc. (the host for the Committee's September site visits) utilizes this type of approach.

The Committee believes that greater flexibility is needed for rural PACE organizations to maximize partnerships and resources. Additionally, the Committee thinks that there is potential for more partnership with existing safety net providers including Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), Community Health Centers (CHCs, and Local Health Departments (LHDs). Flexibilities might include allowing PACE organizations to contract with community-based organizations (CBOs), which could lead to exploration of the use of alternative care settings supplied by CBOs.

DISCUSSION AND POLICY RECOMMENDATIONS

Although PACE has clear benefits, it is a model that is not yet well-known in many rural communities. Successful expansion of PACE will require careful consideration of barriers specific to rural areas, as well as the significant costs and labor needed to stand-up new PACE organizations. The Committee thoroughly assessed these challenges, which informed the policy recommendations and considerations.

While the Committee believes PACE has potential to improve aging in rural communities, they also acknowledge that there are complex challenges to expanding the model. The Committee's policy recommendations focus on mitigating the rural access issues and broader challenges with the application process discussed in this brief, which may impede expansion and implementation of PACE in rural areas. These recommendations were informed by subject matter experts and stakeholders during the Committee's September 2022 meeting in Lawrence, Kansas and site visits to Midland Care Connection, Inc.'s rural PACE sites in Topeka and Emporia, Kansas

Rural Access Barriers

Low Patient Volume and Medicare-Only Challenges

Low patient volume is a persistent challenge for the viability of health care facilities in rural areas. The low volume in rural areas leads to limited numbers of patients from which to spread costs.[46] PACE organizations raised this volume issue at the September meeting and suggested expanding the participant population to include more Medicare-only beneficiaries. The ability to expand PACE to more Medicare beneficiaries may also help enhance access to and viability of LTSS in rural areas.

However, high costs of the Part D prescription drug plan are a serious barrier for Medicare-only beneficiaries interested in PACE. Based on national averages, Medicare-only PACE participants pay a monthly premium of approximately $1,000 while, in comparison, the average monthly premium for stand-alone Part D plans that are not part of PACE is approximately $43.[47] This discrepancy is due to several complex factors, which are described below.

The Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108-173) requires that PACE organizations operate Part D plans.[48] Statutorily, PACE organizations are required to cover all Medicare and Medicaid-covered services, including prescription drug coverage for their enrollees.[49] Regulations prohibit PACE organizations from charging deductibles or copays and prohibit PACE participants from concurrent enrollment in any other Medicare Prescription Drug plan.[50, 51]

Therefore, Medicare-only PACE participants must enroll in the Part D benefit and pay for the full price of it. Stand-alone Part D plans have a larger and broader population to spread risk and can offer more affordable rates.[52] Given the growing population of older adults in rural areas and greater challenges with Medicaid eligibility among rural residents, improving access to PACE among Medicare-only beneficiaries is an important consideration for PACE in rural areas.

> **Recommendation 1**: The Committee recommends the Secretary support a PACE pilot focused on Medicare only beneficiaries, including Part D coverage challenges, to assess viability in rural areas, and determine start-up capital needed for sustainability.

Broadband and Telehealth

Telehealth popularity and viability continues to grow, however challenges with access to reliable broadband internet persist in rural areas. According to a 2021 survey conducted by the Pew Research Center, 72 percent of rural Americans say they have a broadband internet connection at home, compared to 77 percent of urban Americans and 79 percent of suburban Americans.[53] Additionally, the cost of reliable broadband in rural areas can be three times higher than in urban areas due to the lower housing density.[54]

While PACE programs traditionally focus on in-person care, the COVID-19 pandemic forced a shift to care delivered via telehealth. In March 2020, to minimize the spread of COVID-19, CMS granted temporary flexibilities, or enforcement discretions, to PACE Organizations that allowed for use of telehealth to conduct participant assessments, care planning, monitoring, communication, and other activities that are usually done in person.[55] During the September meeting, PACE experts and site visit stakeholders stressed the benefits of these telehealth flexibilities, which they hope will be made permanent. They explained that expanded telehealth allows rural PACE organizations to maximize their staff and resources to better serve their participants.

The Consolidated Appropriations Act of 2023 extended certain Medicare Fee-For-Service (FFS) telehealth flexibilities granted during the COVID-19 Public Health Emergency (PHE) until December 31, 2024.[56] At the time of publication of this report, it is unclear whether the PACE PHE telehealth flexibilities, which were granted via CMS administrative authority,[57] will be extended. Telehealth is an important aspect of PACE organizations' ability to serve and protect frail elders from the ongoing threat of COVID-19 in rural areas.

> **Recommendation 2:** The Committee recommends the Secretary consider how best to extend telehealth coverage to PACE organizations in light of the Consolidated Appropriations Act of 2023, to the extent it has the authority to do so.

Limited Awareness

Although PACE is an established model, consumer and provider awareness remains low. The Bipartisan Policy Center included raising consumer awareness as one of four areas of interventions in their October 2022 report, "Improving Access to and Enrollment in Programs of All-Inclusive Care for the Elderly (PACE)".[36] Prior to the September meeting, the Committee had limited knowledge about PACE. After learning about the benefits of PACE, many noted their communities would benefit from offering PACE and that there was limited awareness of this Medicare and Medicaid benefit for rural beneficiaries and the providers who serve them.

Recommendation 3: The Committee recommends the Secretary support the development of a rural PACE resource guide to promote the model to rural and tribal communities and provide technical assistance and case studies from successful rural and tribal programs.

Rural Hospital Landscape

From January 1, 2010, to January 31, 2023, 143 rural hospitals have closed.[3,58] Because PACE organizations contract with hospitals, the availability of operational rural hospitals is an important factor for PACE organizations serving rural areas. A related and ongoing concern is the financial viability of the remaining facilities. There were 196 rural hospitals predicted to be at high risk of financial distress in 2019 based on the Federal Office of Rural Health Policy-funded financial distress index.[59]

Nearly 60 percent of the hospitals in rural areas are Critical Access Hospitals (CAHs).[60] Sharing resources is one way for rural health care facilities to address viability challenges and find efficiencies. However, current guidance on co-location of services and cost reporting rules create confusion about and disincentives for CAHS to partner and share space with PACE organizations. Many rural communities have few available buildings with appropriate construction and road access for PACE service delivery. The local hospital building generally has health care-appropriate construction and may have underutilized space.

While CMS issued guidance to hospitals in 2021 on co-location with other hospitals or health care facilities, this guidance did not include CAHs.[61] Another issue related to shared space stems from Medicare policies prohibiting commingling to ensure that Medicare does not pay twice for the same service. These policies require CAHs to carve-out the proportion of the rented space in the cost report (including a portion of physical plant costs attributed to the space such as utilities and maintenance) and carve out building and operations costs that Medicare might otherwise allow CAHs to factor into their cost-based reimbursement. Due to the complexities of cost report calculations, these exclusions can inadvertently reduce the CAH's Medicare reimbursement by more than they are paid in fair market rent for the space rented to a PACE organization or other third party. This financial impact can be a barrier to partnerships between CAHs and PACE organizations seeking to leverage proximity and shared space.

The Committee believes that partnerships between CAHs and PACE organizations should be explored and promoted to increase PACE access for rural beneficiaries. Clarification of Medicare policies on CAH shared space arrangements and reporting of related costs is needed.

Recommendation 4: The Committee recommends the Secretary support guidance to clarify the range of allowable shared space arrangements for Critical Access Hospitals (CAHs) and encourage partnerships between CAHs and PACE organizations, including considerations for cost reporting that support these partnerships without excessively reducing CAHs' cost-based reimbursement.

Workforce Shortages

Workforce shortages in rural areas are an important consideration for PACE organizations. Rural areas make up over 65 percent of HRSA-designated health professional shortage areas (HPSAs).[62] The per capita rate of physicians per 10,000 people in rural areas is 10.8 vs. 30.8 in urban areas. For registered nurses, it is 65.3 per 10,000 people in rural vs. 93.6 in urban.[63] The PACE IDT staffing requirements

[3] A "closed hospital" means that it stopped providing short-term, general, acute inpatient care. A hospital closure could be either classified as: (1) a complete closure with no healthcare services available at the former hospital site, or (2) a converted closure that provides services other than inpatient care (e.g., outpatient, emergency, urgent care, skilled nursing, or rehabilitation services).

include a primary care provider, registered nurse, master's level social worker, physical therapist, occupational therapist, and a dietitian, professionals that are not abundant in most rural communities.[64]

Additionally, recent research conducted by the University of Minnesota reports disparities in the direct care workforce for rural older adults. The findings indicate that the supply of home health aides relative to the older adult population is nearly 35 percent greater in urban areas than rural and that the supply of nursing assistants is 17 percent greater in urban areas than rural.[65] While home health aides and nursing assistants are not required staff for the IDT, they are key components of the care needed to help PACE participants safely live in their homes, the primary tenant of PACE.

The National Health Service Corps (NHSC) and Nurse Corps are critical for the recruitment and retention of health care workers in rural areas. As of 2022, over 7,400 NHSC participants serve in rural areas.[66] However, PACE sites are not currently eligible for loan repayment under these programs.[67]

> **Recommendation 5**: The Committee recommends the Secretary allow PACE sites to be eligible for loan repayment under the National Health Service Corps and the Nurse Corps.
>
> **Recommendation 6:** The Committee recommends the Secretary encourage students trained through HRSA Health Profession and IHS training programs to rotate to rural PACE service sites.

Start-up and Application Challenges

Throughout the September meeting and site visits, the Committee heard that the time and labor-intensive application process to establish or expand PACE in rural communities are daunting. These challenges were also reflected in the 2011 CMS evaluation of the 2006 pilot program (described on page 8). PACE programs must be fully operational (including the hiring of a care team and establishment of an adult day center) while waiting for approval from the state and CMS, which can take up to a year.

They also cannot market the program before obtaining CMS approval of the application. The marketing efforts and associated costs needed to raise awareness about a new PACE program in rural areas and attract participants can be significant. Delays in marketing can lead to delayed program enrollment.[36] Given the challenges with lower patient volumes in rural areas, delays in marketing may jeopardize the solvency of a new PACE organization.

Currently, organizations can only submit one application for a new PACE site per quarterly application cycle. This pertains to both organizations without an existing PACE site and long-standing programs that want to open a new PACE site. It also applies to established PACE organizations that want to expand their geographic reach to a new service area. Existing PACE organizations may not submit a service area expansion (SAE) application if one is currently pending. [68]

While CMS acknowledges the application concerns, there are challenges with the current application system. With their current system, CMS cannot accommodate simultaneous review of multiple applications for both operational and policy reasons. The automated application process only accommodates the review of one complete application at a time, enabling CMS to consider the applicant's current service area and the proposed expansion as part of its review.[69]

The start-up and application process may be especially challenging in rural areas where there are typically fewer available resources and less familiarity with the PACE model. A key takeaway from the 2011 CMS evaluation was that the pilot grant funds were indispensable for the launch of rural PACE programs.

Similarly, PACE staff and experts stressed the importance of seed funding to establish and maintain PACE in rural areas. However, the pilot grant was a one-time appropriation from Congress and CMS does not have the capital to provide such funding. Therefore, the Committee believes that access to start-up funding is needed to expand PACE in rural areas.

> **Recommendation 7**: The Committee recommends the Secretary allow PACE organizations to submit multiple applications simultaneously.
>
> **Recommendation 8**: The Committee recommends the Secretary allow existing PACE sites to have an expedited approval process for expanding to new service area populations on a rolling basis.

Other Policy Considerations

In addition to the policy recommendations listed above, the Committee also sets forth policy considerations to address the utilization of PACE in rural America. Policy considerations consist of actions the Committee thinks should be taken that may involve work across multiple departments or to be outside the jurisdiction of HHS and may require action by lawmakers at the Federal and state level. These considerations also address the rural access issues and PACE application and start-up challenges discussed in the brief. They were also informed by subject matter experts and site visit stakeholders.

- The Federal Communications Commission (FCC) should consider allowing PACE sites to be an eligible site for broadband and telecommunication program resource allocations.
- Congress and the Administration should make PACE sites eligible for an automatic HPSA designation.
- Congress and the Administration should provide start-up capital grants for new rural PACE sites and cost-overrun protection for three years (repeating the 2006 initiative).
- Congress and the Administration should amend the PACE regulations to create a travel distance adjustment to the payment methodology to account for the higher transportation costs in rural areas.
- HHS should consider public-private partnerships to address the high start-up costs of starting rural PACE organizations.
- State Medicaid Directors should consider sending a letter to long term care providers in their state to improve awareness of the PACE program.

CONCLUSION

Healthy aging that includes aging in place is not currently a feasible option in many rural communities. The Committee believes that PACE exemplifies integrated care and that expansion of the model in rural America would improve the fragmented state of LTSS. A holistic approach that truly connects health and human services is unique and an integral aspect of PACE that improves the health and quality of life of rural elders and caregivers.

The Committee sees PACE as a value-based model. However, CMS does not currently include PACE as one of its value-based models.[70] PACE preceded value-based models, which were first implemented in 2012.[71]

The Committee believes that PACE embodies key principles of value-based care including improved outcomes, cost-savings, and a focus on quality over quantity of care.

Due to the capitated payment system, patient-centered approach, and focus on the social determinants of health, PACE meets the five areas identified by the quintuple aim for healthcare improvement (an evolving framework developed by experts to address the healthcare landscape and increasing disparities that emerged during the COVID-19 pandemic). The five areas are: Improved patient experience, better outcomes, lower costs, clinician well-being, and health equity.[72] PACE is uniquely situated to adapt and meet the complex needs of rural older adults. Through its policy recommendations and considerations, the Committee hopes that barriers can be better addressed to expand access to PACE in rural communities.

APPENDIX A – SITE VISIT PROFILE

Midland Care Connection, Inc. is a nonprofit home health care organization that was founded in 1978 and began offering PACE in 2007. Midland Care PACE serves over 500 older adults with complex health care needs across 12 Kansas counties, both urban and rural, and is expanding. Midland Care PACE provides integrated care through an agreement with CMS, the Kansas Department of Aging and Disability Services (KDADS), and the Kansas Department of Health and Environment (KDHE). The Committee split into two subcommittees and participated in site visits to Midland Care's headquarters in Topeka and a rural PACE site in Emporia, Kansas. During the site visits, the Committee also participated in virtual meetings with staff from the following PACE organizations that serve rural populations:

- Cherokee Elder Care, Tahlequah, Oklahoma
- Humboldt Senior Resource Center, Eureka, California
- Bluestem PACE, McPherson, Kansas
- Appalachian Agency for Senior Citizens, Cedar Bluff, Virginia

Midland Care Connection, Inc., Topeka, Kansas

This subcommittee, chaired by Committee Member Patricia Schou, visited Midland's headquarters in Topeka. The Committee members held a discussion with Midland's President and CEO, Shawn Sullivan and virtually with Melissa Hooven, the CEO of the Humboldt Senior Resource Center in Humboldt County, California and with Connie Davis, Executive Program Director and Dr. John Galdamez, Medical Director, both from the Cherokee Elder Care in Tahlequah, Oklahoma. The Committee also had the pleasure to visit with one of Midland's PACE program's participants.

The Humboldt Senior Resource Center opened the first rural PACE program in California in 2014 and now operates in two communities. They provide services to approximately 250 eligible seniors and the program continues to increase enrollment due to a growing qualified population. Ms. Hooven discussed their successful partnerships with local hospitals and community organizations but mentioned the challenges of lack of affordable access to PACE for the Medicare only population and the lack of flexibility to meet the specific needs of PACE programs that serve rural areas, including distance and the need to create a service area that is viable over a large geographic area.

Cherokee Elder Care opened in 2008 and provides services to approximately 205 eligible seniors. It was the first PACE to open in Oklahoma and is the only tribally operated PACE program in the country. The PACE program is sponsored by the Cherokee Nation but is available to all residents in the service area.

Approximately 50% of their beneficiaries are Native American and they serve couples that are both native and non-native. Dr. Galdamez was a Critical Access Hospital (CAH) physician prior to joining Cherokee Elder Care as the Medical Director. He describes PACE as the type of medical care that medical students envision in their minds when they enter the medical profession. The combined disciplines of PACE allow the whole care team to focus on the well-being of the patient, both during medical services and post-services. Dr. Galdamez mentioned that the COVID Public Health Emergency opened their eyes to the enormous potential of telemedicine to support in-person care. Ms. Davis indicated that the application process for expansion of their program creates hurdles to needed expansion in the area, however.

Midland Care Connection worked with the State of Kansas to offer PACE as one of the insurance options when the state created their Medicaid Managed Care Program, during Committee Chair Governor Colyer's term as Lieutenant Governor. Mr. Sullivan believes that there are few other systems that are aligned like PACE, where financial incentives are in line with clinical and quality of life outcomes. He discussed their interest in continuing to expand Midland's service area, as several local rural communities are requesting coverage, but creating a rural service area that is viable is challenging due to population density. Midland has determined that a PACE program needs to serve 100 people to be a viable program while factoring in population density.

Finally, the Committee concluded their day with a conversation with one of Midland's participants. The participant has accessed Midland's services for both her deceased husband while he was undergoing treatment for cancer, and now has returned for care for herself. Between her time at Midland with her husband and her return to Midland's program, she experienced social isolation that took a toll on her mental and physical health. She mentioned that Midland kept in regular contact with her until she was able to rejoin as a beneficiary and has offered her the social interaction and medical care that she sorely needed.

Midland Care PACE, Emporia, Kansas

The other subcommittee, chaired by Committee Member Michelle Mills, visited Midland Care's PACE Center in Emporia, Kansas. During the site visit, the Committee met with staff involved in the provision of integrated care. The Midland staff included:

- Mark Wiles – MD, Chief Medical Officer
- Adrianne Meyer – Senior Care Consultant

The staff described the wide range of health and human services they provide to help keep their participants healthy and in their homes. For example, if a participant's air conditioner breaks, the program pays for a new AC, arranges the installation, and will even pay for a hotel. They do this to avoid heat-related illness and emergency room visits that can occur among frail, elderly adults.

They also expressed a thorough understanding of each participant's needs. All staff are engaged in and monitor the participant's health, from the drivers to the physicians. They communicate frequently and work together to coordinate care needs, which allows for in-depth knowledge of critical factors like participant's fall risks.

After visiting Midland Care's PACE Center in Emporia, the Committee traveled to Emporia State University where they heard from two of Midland's PACE participants, as well as staff at other, rural, PACE organizations. The panelists included:

- Justin Loewen – Executive Director, Bluestem PACE, McPherson, Kansas
- Dr. Jenifer Heidmann – Medical Director, Humboldt Senior Resource Center, Eureka, California
- Regina Sayers – Executive Director, Appalachian Agency for Senior Citizens, Cedar Bluff, Virginia
- Dr. John Galdamez – Medical Director, Cherokee Elder Care, Tahlequah, OK
- Connie Davis Executive – Program Director, Cherokee Elder Care, Tahlequah, OK

The panelists emphasized the importance of strong partnerships and utilizing existing resources in rural areas. For example, the Humboldt Senior Resource Center gets consistent referrals through their long-standing relationships with the hospitals and community organizations in their area. The panelists conveyed that greater flexibilities to contract with community-based organizations and to use alternative care sites would maximize partnerships. They also discussed how the telehealth flexibilities granted during the pandemic revealed the significant potential of telehealth to augment their programs and better serve their participants. Overall, the panelists are passionate about the PACE model and its potential to improve long-term care in rural areas.

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