Restructuring Rural Health Care: Expanding the PACE for Rural Elders

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Abstract

The Balanced Budget Act (BBA) of 1997 created an opportunity for improving long-term care for the rural frail elderly by granting permanent provider status to the Program of All-Inclusive Care for Elders (PACE) under Medicare. PACE is a unique managed care model that provides comprehensive, integrated acute and long-term services for frail elders and program providers assume full financial risk. However, all existing PACE sites are currently located in urban settings. This article reviews the PACE provisions in the BBA legislation and describes the current PACE model. Two possible adaptations of the model are discussed for expanding PACE into rural areas.

Keywords: Balanced Budget Act of 1997, long-term care, rural, frail elders, family caregivers, Program of All-Inclusive Care (PACE), Medicare restructuring

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Comprehensive long-term care includes the sum of health, social, housing, transportation, and other supportive services needed by people with physical, mental, or cognitive limitations that compromise independent living (Binstock, Cluff, & vonMering, 1996). Currently, long-term care in the U.S. is a costly, fragmented non-system that emphasizes sickness care rather than a comprehensive, integrated package of health, rehabilitation, and social services (Evashwick, 1996). Many rural elders would be able to remain at home if support services were available, such as meal preparation, housekeeping chores, medication management, and personal care.

This article examines the provisions of the Balanced Budget Act (BBA) of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 related to the Program of All-Inclusive Care for Elders (PACE). PACE is a unique managed care model that currently provides comprehensive, integrated acute and long-term care services for frail elders in urban settings. This article reviews the PACE provisions in the recent legislation and describes the current PACE model. Two possible adaptations of the model are also discussed for expanding PACE into rural areas.

The Growing Need for Rural Elder Care

In rural areas, persons aged 65 and older make up a larger proportion of the population than is found in urban areas, 18% as compared with 15% (Rogers, 1999). The number of rural elders varies from region to region, with the largest percentage concentrated in the South and Midwest portions of the United States (Ricketts, 1999). Smaller, rural communities with less than 2,500 residents consistently have the highest proportion of older persons across all age categories. Because older persons are at greater risk for disability and chronic illness, they are substantial users of medical and social services. The projected increase in the proportion of

elderly in the population will have a tremendous impact on future long-term care delivery systems, especially in rural communities. In many rural communities, health care services for the elderly are less accessible and more costly to deliver than in urban areas (Bull, Howard, & Bane, 1991; Liken & King, 1995; Ricketts, 1999). The larger proportion of low-income individuals, especially elders, in rural areas also leads to a smaller tax base to support local social and health services (Rogers, 1999). Between 1980 and 1990, the poverty rate for older persons living in rural counties increased. The poverty rate ranges from 12.8% for elders living in counties with populations of 20,000 adjacent to a metro area to 20.6% for those in rural, nonadjacent counties. Older women are also more apt to be poor than are older men (Rogers, 1999). Rural elders receive a higher proportion of their income from Social Security, but they receive lower average monthly benefits than those living in urban areas and are more apt to be classified as "poor" or "low" income (Ricketts, 1999). The most economically vulnerable cohort is the rural population over the age of 85 (Rogers, 1999).

Currently, there is no reimbursement under Medicare for non-skilled eldercare in any setting, such as personal care services and/or supervision for those with cognitive impairment. Medicare home health benefits are limited to skilled services related to an acute illness or exacerbation of a chronic illness and only for homebound elders. Moreover, family members who provide home care for their rural elders who have chronic illnesses and dementia must also pay out-of-pocket for any respite services. Additionally, Medicare Part B provides no coverage for prescription medications.

The elderly who reside in rural areas—and their caregivers—are forced to deal with additional difficulties that may not impact those living in urban areas. In rural areas, there is limited availability of local health and social service providers, lack of transportation, and

frequently vast distances for elders and their families to travel to obtain needed services. In addition, elderly poor have limited access to support services, often have inadequate nutrition and sub-standard housing, and are less apt to be healthy (Rogers, 1999).

Clearly, better models are needed for delivering comprehensive long-term care in rural communities where many vulnerable elders reside and disparities exist between health needs and resources. According to Aaronson (1996), health services organizations are products of the way in which the services they deliver are financed. A major impediment to the development of a continuum of long-term care, especially for rural community-based elders is the lack of a system of financing services for individuals with complex and, frequently, chronic care needs.

How the BBA and BBRA Increased Provisions for PACE

One of the most promising provisions for restructuring the current system of eldercare in the U.S. was included under Subtitle I of the BBA of 1997 (U.S. Congress, 1997). This legislation granted permanent provider status to the Program of All-inclusive Care for Elders (PACE) under Medicare. State Medicaid agencies were also given the option to include PACE as a Medicaid benefit. The BBA of 1997 granted the 23 existing PACE sites, serving approximately 7,000 enrollees, permanent status as Medicare providers. The legislation raised the cap on the number of programs to forty in 1998, with a provision for 20 new programs each year thereafter. The opportunity for 10 for-profit organizations to become new demonstration sites was also included in the legislation (Hansen, 1999; RUPRI, 1999). In the BBRA of 1999, there was only one provision that specifically addressed PACE. Subtitle C- Demonstration Projects and Special Medicare Populations, Section 536 extended the Medigap "guaranteed issue" protections for Medicare+Choice plan enrollees to all PACE participants (U.S. Congress, 1999).

PACE provides for comprehensive, multi-disciplinary acute and long-term care services to frail elders who are certified eligible for nursing home placement. Objectives for the program are fourfold: (1) enhancing the quality of life and autonomy for frail, older adults; (2) maximizing the dignity of, and respect for older adults; (3) enabling frail older adults to live in the community as long as medically and socially feasible; and (4) preserving and supporting the older adult's family unit (National PACE Association, 2001). The Health Care Financing Administration's goal vis-a-vis PACE is to reduce the fragmentation of services and effectively integrate acute and long-term care services and financing into a single seamless system (Vladeck, 1996).

The PACE model of care began in 1973 in San Francisco as a community-based, adult day health center named On Lok ("peaceful happy abode" in Cantonese). In 1975, On Lok added in-home support services and in 1978, HCFA provided a 4-year demonstration grant to include primary medical services. In 1983, On Lok obtained waivers from both Medicare and Medicaid to test a new financing method for long-term care. Capitated monthly payments were received from Medicare and Medicaid for each participant and On Lok delivered the full range of services, including hospital care. In 1986, with additional grant support from several foundations, On Lok began replication of the innovative service delivery and financing method in six additional public and nonprofit sites. At that point, the new program was renamed the Program for All-inclusive Care for Elders (PACE) (Bodenheimer, 1999; Eng, Pedulla, Eleazer, McCann, & Fox, 1997; Lee, Eng, Fox, & Etienne, 1998).

PACE is the only program that integrates acute and long-term care service delivery and financing (Lee, Eng. Fox, & Etienne, 1999). The underlying philosophy of the program is that provision of intensive medical and supportive outpatient and home care services for frail elders

will save money by reducing rates of hospital and nursing home care. The two cornerstones of PACE are (1) a multidisciplinary team approach and (2) the PACE center. The PACE center is an adult day health center attached to a full service medical clinic. The multi-disciplinary team includes primary care physicians, nurse practitioners, clinical nurses, home health nurses, social workers, occupational and physical therapists, dietitians, aides, recreational therapists, and transportation workers. Typically, PACE sites function as staff model organizations for primary care, with all clinicians employed by the site and salaried (Bodenheimer, 1999). The entire team serves as care manager for each participant, without going through third-party payers. Services may be provided at the PACE center, in homes, or at inpatient facilities (see Figure 1).

Center-based services include visits with the health care provider—physician, nurse practitioner, and/or social worker—meals, exercise, recreational activities, and educational sessions. Other medical services can include visits with medical specialists, prescription drugs, x-rays and laboratory tests, and receipt of durable medical equipment and supplies. Home care services include visits from the home health nurse, personal care, and chore services. Other elder care services under PACE include: case management; dental and vision care; nutritional counseling; physical, occupational and speech therapy; companion services; home-delivered meals; transportation; caregiver training; and respite for informal caregivers (Eng, Pedulla, Eleazer, McCann, & Fox, 1997).

A PACE provider must make available all items and services under Title XVIII (Medicare) and Title XIX (Medicaid) without limitations on amount, duration or scope, and without application of deductibles, co-payments, or other cost sharing. Older adults who are financially ineligible for Medicaid must pay out-of-pocket for the Medicaid portion of the PACE capitation. However, participants who are eligible for Medicare only and who need fewer hours

of care services per week may be allowed to purchase a reduced or lower cost eldercare program (Bodenheimer, 1999). According to the National PACE Association, certain organizations may have alternative tiered payments that complement their PACE Program. In 1998, the Medicaid monthly capitation rate among all PACE sites ranged from $1,750 to $4,301. Once enrolled, a participant must receive services only from PACE staff or contract providers authorized by PACE staff (Eng, Pedulla, Eleazer, McCann, & Fox, 1997).

Expanding PACE for Rural Elders

How can we take the best aspects of PACE and adapt the program for implementation in a rural setting? Hansen (1999) states, "there is no one answer to caring for frail elderly, PACE must fit into a variety of approaches that will be different in each state" (p.6). PACE is primarily a program for low income, frail elders with eligibility in both Medicare and Medicaid. Expanding PACE into rural areas can create a lower cost package similar to the one currently available at On Lok in San Francisco. Currently only about 5% of elders nationwide are certified eligible for nursing home placement, thus limiting the number of elders eligible for PACE participation. In 1995, there were approximately 8.2 million persons over the age of 65 residing in rural places (Ricketts, 1999). Therefore, if 5% of the rural elders nationally are eligible for nursing home placement, then approximately 410,000 will qualify for enrollment in PACE under current policies. This estimate of the potential beneficiaries for a rural PACE initiative is conservative. It does not take into account either the growing number or the generally poorer health of rural elders (Rogers, 1999), nor does it account for potential easing of eligibility policies for rural PACE enrollees.

What Have We Learned from PACE?

Coordination and support are necessary for success. During the early years, several hospitals that sponsored the programs found themselves in the unfortunate position of having to absorb PACE program losses. Therefore, it is important that the rural hospital or community health center sponsoring the PACE is financially stable and has sufficient resources to assist in program development. Furthermore, since reimbursement depends on enrollment, rural providers may need to assist with educating the community on the benefits of this program. During the early years of PACE, several sites experienced problems with enrollment, which had a negative impact on program profitability (Branch, Coulam, & Zimmerman, 1995).

Depending on client characteristics, not all clients may be appropriate candidates for PACE programs. Branch, Coulam, and Zimmerman (1995) compared seven PACE programs with the On Lok program and found that clients who exhibit disruptive behaviors, cognitive deficiencies, and substance abuse problems are less likely to be admitted into a program. Therefore, for PACE to be successful in rural areas, these programs need to provide mental health and other cognitive services for even the most difficult of clients if they are in the catchment area. Although costly, these services may be necessary to attract a sizable client base to ensure program success (Branch, Coulam, & Zimmerman, 1995).

Staffing issues present a major obstacle to the success of rural PACE programs. Although the use of contract staff may offer a temporary solution, it may be too costly for long-term use. However, in terms of recruiting certain staff, one study found that nursing assistants who worked in five PACE programs reported greater job satisfaction than those who worked in traditional nursing homes (Friedman, Daub, Cresci, & Keyser, 1999). Two other staffing options might also be considered:

- Local community residents who are employed or retired can be hired and trained as PACE personal care workers. They will receive the national standardized nursing assistant program and upon graduation, be certified by the PACE program. These local workers will be assigned to provide all unskilled home care services to a limited number of frail elders. These workers will build a trusting relationship with the elders—and their caregivers—and spend as much time as required to meet each elder's needs.
- If family members are available, capable, and willing to receive the nursing assistant training, they can be "certified" as personal care workers and receive some payment for provision of eldercare services. Family caregivers can also negotiate for relief from eldercare by requesting respite services from one of the local, trained personal care workers.

Two Possible Models

The two cornerstones of current PACE initiatives are (1) the PACE center and (2) the multi-disciplinary team. On one hand, replicating this center-based, multidisciplinary model in a rural setting is possible. On the other hand, a home-based, multidisciplinary model might also be needed. Under either model, the multidisciplinary team can consist of employees from the local hospital, plus contractual arrangements with others. In rural settings, there are limited numbers of primary care physicians, and elders may be reluctant to leave their physician. The rural PACE site can make contractual arrangements with participants' private physicians to continue as their primary care providers. Contracts can be negotiated with specialty physicians, dentists, optometrists, and podiatrists from both rural and urban locations. All of these contracted personnel will receive payments from the PACE site. Master's prepared nurse practitioners and/or nurse case managers will serve as coordinators for the multidisciplinary team. Other

members of the team will be the hospital-based nutritionist, social worker, nursing aides, x-ray and laboratory personnel, and rehabilitation therapists.

Well elders who are able to live independently, and want to receive some of the PACE center services, can be allowed to purchase a lower cost or partial program. Enrollment strategies, similar to those used by the Child Health Insurance Program (CHIP), can be used to locate eligible elders and enroll them in the rural PACE initiatives. Personnel from the local Area Agency on Aging (AAA) and the states' Department of Human Resources (DHR) can assist with the enrollment process.

A Center-Based PACE Model for Rural Elders.

Probably the best site for the rural PACE center is the local community hospital with an adjoining or nearby health clinic. Alternatively, a community health center (CHC) might serve as a suitable site. The hospital or CHC can also consider the feasibility of constructing an adult day care center because these services are needed and PACE capitated funds can be used to pay for day care services. A suitable building can be leased and renovated to forego the larger capital outlay for new construction. The number of frail elders in need of day care due to physical or cognitive impairment will probably support the center. Provision of adult daycare will allow family caregivers to work outside the home and receive income and also some respite. Many rural elders are dependent on home care provided by family members who may be unable or unwilling to be full-time caregivers, thus increasing the risk of elder abuse and neglect. The PACE participants can be transported to the center by family members or receive transportation from vans provided by the hospital-based PACE site or the Area Agency on Aging (AAA).

If a local hospital also operated a home health agency, those personnel can provide assistance for homebound elders as needed. Hospital maintenance personnel can be used to

assess the appropriateness of housing for PACE participants and make needed repairs and disability accommodations, such as constructing wheel-chair ramps. Durable medical equipment for use by PACE participants can be obtained through local providers. The hospital cafeteria can furnish meals for participants attending the PACE site and meals for homebound participants can be obtained from the local AAA nutrition site.

A Home-Based PACE Model for Rural Elders.

Some frail elders in rural settings will be unable to travel to the PACE center due to physical or cognitive impairments. They may also require more supervision, meal preparation, and medication administration than is provided under the Medicare visits from the home health agency.

The nurse practitioner or nurse case manager overseeing the PACE team will provide supervision for personal care workers. Interdisciplinary team meetings will be held periodically to discuss each PACE participant's plan of care. All members of the team, including the elder and participating family members, will make decisions about changes in the participant's plan of care. When a PACE participant requires more care than can feasibly be provided in the home setting, alternative arrangements can be made. These arrangements can include admission to the local hospital-based PACE center and/or to a community boarding home, assisted-living facility, or skilled nursing facility. Of course, when facilities are used for eldercare that are not owned or operated by the hospital-based PACE center, then contractual arrangements must be made for payment for participants' care.

Implications and Conclusion

The Balanced Budget Act of 1997 began the process of restructuring Medicare and provided a mechanism for extending and improving care for frail rural elders. PACE provides a

unique managed care model for delivering and financing long-term care services to low-income, frail elderly 55 years old and older. Commercial managed care plans have been reluctant to enter rural markets (Mueller, 2001). PACE sites, unlike commercial HMO's, have actually reduced costs for both the Medicare and Medicaid programs (Bodenheimer, 1999). We discussed two different, but complementary models, for adapting PACE to rural settings and providing comprehensive, integrated long-term care services that can be cost-efficient and acceptable for all elders.

Quality is a necessary and important component of health services delivery. In urban areas, there are many providers from which to choose; however, rural areas have disproportionately fewer providers. Therefore, the likelihood that a chosen provider will offer substandard care may be greater in rural areas. The sponsoring hospital, community health center, or other institution will have to maintain strict oversight to ensure that providers meet appropriate standards and employ measures to correct any quality problems as quickly as possible. This may be a costly but necessary process, requiring additional staff. Certainly, further research may be necessary to determine which quality measures and approaches are suitable for rural PACE initiatives.

For rural communities affiliated with academic health centers and related institutions, quality of care issues may be less prominent. Indeed, university-sponsored health profession training programs should be encouraged to participate in rural PACE initiatives. Excellent opportunities for interdisciplinary training in rural elder care for students in medicine, nursing, social work, nutrition, and health care management will be available. Faculty and students can also engage in empirical research, increasing the number of published studies on rural health services.

Future research should focus on ways to solve the obstacles highlighted in this paper. While early reports suggest PACE programs are successful in meeting the needs of the frail elderly, all of the programs studied are in urban areas. We suggested two methods for implementing PACE in rural settings, but the implementation of these models will not be without some level of difficulty, given the nature of rural health care delivery. Existing rural health providers will need to commit both financial and organizational resources to allow for innovations, restructuring, and fine-tuning. In other words, action-oriented research is needed to determine what modifications in the PACE model may be necessary to ensure program success in rural settings.

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