PACE in Rural Areas: Financing and Risk Management Challenges and Strategies

America is aging. In response, governments, health care providers and citizens across the country are seeking ways to better serve the growing number of elderly persons, particularly persons at risk for permanent nursing home placement. The search for solutions in rural areas, however, often is complicated by a relative lack of health care providers and facilities, long distances between patients and services, and lower population densities. Fortunately, help could be on the way.

PACE: A Rural Possibility

Since 1983, Programs of All-inclusive Care for the Elderly (PACE) have been serving frail senior citizens in ways that enable them to live as independently as possible, keeping them in their own homes and communities. The model began in San Francisco as an effort to help Chinese-American families keep their elders with their families and in their communities. It accomplished this goal by offering a comprehensive set of services including medical care, physical and occupational therapy, nutrition, transportation, respite care, and socialization that kept people happier and healthier. It also created a way to pay for this care using federal, state and private funds that can be pooled at the program level, allowing maximum flexibility, effectiveness and even cost-savings.

PACE serves persons who are:

55 or over

Certified to meet the state's criteria for nursing home level of care

Living in a designated PACE service area

Able to live safely in the community, with the help of PACE services, at the time of enrollment

The success the PACE model has demonstrated in keeping people out of hospitals and nursing homes has inspired providers around the country to adopt this model of care. Today, there are 32 PACE programs operating in 18 states. All of these programs, however, serve predominantly urban settings. That need not be the case. Rural communities and rural elders can and should benefit from PACE programs.

The need for PACE in rural communities is in some ways greater than in urban America. Compared to their urban counterparts, the rural elderly:

- report worse health status;
- are generally older;
- have more functional limitations;
- are more likely to live alone at age 75 and older;
- are more likely to be poor or near poor; and
- are at greater risk of being placed in a nursing home.

Although one-fifth of the nation's elderly live in them, many rural areas lack the full range of long term care services that rural elders need. PACE can help meet some of this need.

A Flexible Blueprint

Undoubtedly, bringing PACE to rural America will require creativity and flexibility on the part of providers, regulators and policymakers. Because rural communities differ from urban areas in some very important aspects, rural PACE programs will likewise differ from urban programs. One size will not fit all. Successful PACE programs are tailored to meet individual community needs rather than being pulled from a rack, ready to wear.

PACE programs are able to effectively serve elders in the community by being flexible and bridging the gaps that often exist in today's health care. PACE programs have several basic features that enable them to tailor their care and services to the needs and situation of each individual.

- A focus on empowering individuals to live in the least restrictive and most pleasing setting possible.
- Interdisciplinary teams composed of persons who are both providers and decision-makers for the health care and supportive services each PACE participant receives
- A capitated payment that pools financial resources from government and private payers so that providers have the freedom to provide preventive and holistic care and support that can often postpone or avoid the need for more intense acute or long term care
- A responsibility to provide or pay for the provision of all needed preventive, acute and long term care services so the organization has a financial incentive to provide the best and most effective care possible

Rural Challenges and Emerging Strategies

In September 2002, PACE providers and rural health experts, along with state and federal policy makers from across the country, gathered in Roanoke, VA, to explore the possibilities for PACE in rural communities. This "Rural PACE Summit" was sponsored by the National PACE Association (NPA) and the National Rural Health Association. Its findings are captured in a report entitled "Setting the PACE for Rural Elder Care: A Framework for Action." Participants at the Summit identified some of the critical issues and challenges that rural organizations will face in adapting the PACE model:

- Staffing
- Financing and Risk Management
- Developing the Necessary Infrastructure
- Using Information Technologies

As part of the Rural PACE Technical Assistance Program, funded by the Health Resources and Services Administration, NPA convened workgroups of rural health and PACE providers to further discuss these issues. The following issue brief on financing and risk management is part of a series summarizing the workgroups' discussions on each of the topics listed above. Collectively, the issue briefs are designed to help rural organizations identify and meet the challenges they will face in bringing the PACE model to their service areas.

Rural PACE Issue Brief #2: Financing and Risk Management

In addition to the liability risks faced by all health care providers, PACE programs also face financial risk because they receive a fixed, prospective payment on a monthly basis. Because payment is not based on the PACE program's costs, the PACE provider is at financial risk for managing the costs of the care it provides within the limits of the payments it receives.

Rural PACE programs' ability to manage financial and liability risks may be further challenged by several characteristics of rural areas, including dispersed populations and a scarcity of health care services. Fortunately, a number of strategies drawn from rural health care suggest how the PACE model might be adapted to meet these challenges.

Challenges and Strategies

Challenge 1: Achieving Adequate Enrollment

When it comes to financial risk, size matters. As enrollment increases, the average fixed costs of operation decrease. When that happens, revenues are more likely to cover costs. Revenues over and above those needed to cover costs can be used to establish a risk reserve with which to cover outlier expenses that exceed the monthly payments received for any individual. Unfortunately, enrollment may grow slowly in rural PACE programs. As a result, it may take longer to reach "break-even" enrollment and establish a risk-reserve fund, leaving the programs more exposed to risk.

Strategy 1a: Serve a larger area. Rural PACE programs can meet the challenge of sufficient enrollment by modifying the delivery of care to extend services over a larger geographic area. The larger geographic area can offset the lower population density and enable the PACE program to establish higher levels of enrollment.

Strategy 1b: Work with trusted sponsors. Rural PACE programs can ally themselves with rural health care providers already known and trusted within the community. This can help enrollment by, among other things, reducing concerns that the PACE program will disappear as managed care companies may have done in the past when faced with financial difficulties.

Strategy 1c: Link with other PACE programs. Rural PACE providers can link with urban PACE providers or other nearby rural providers to share fixed costs and facilitate access to required health professions and services. This strategy has been applied in South Carolina to extend services from an urban center into an adjacent rural area. Similarly, a program in Wisconsin has used an outreach location linked to its central site to serve a more rural population.

Strategy 1d: Tap into a wide range of payer types. Because of their history of providing care to all members of a community, rural PACE providers may be able to

attract private-pay individuals—increasing enrollment and diversifying the payer mix. Private payments supported by individuals' long term care insurance benefits also may have the potential to increase enrollment opportunities for rural PACE programs. Rural PACE programs also may have opportunities to serve veterans and receive payment from the Veterans Administration.

Challenge 2: Ensuring Adequate Operating Revenues

The lower Medicare and Medicaid reimbursement rates for rural areas upon which PACE capitation rates are based, in combination with higher per-unit costs of service, challenge rural PACE providers' ability to obtain adequate operating revenues.

Strategy 2a: Contain costs of inpatient care. In establishing hospital contracts, rural PACE providers may be able to set a per-diem rate with a provision that total costs of an episode of care not exceed the Diagnostic Related Groups (DRGs) payment, thus helping to contain hospital costs. For hospitals not under contract to the PACE organization, charges are limited by federal statute to what Medicare or Medicaid would pay.

Strategy 2b: Contain costs of outpatient care. Rural PACE providers can ask health professionals to accept a per-enrollee, per-month fee. In exchange for this fee, the health professional would be available to provide services to a PACE enrollee as needed. This arrangement can be used to reduce the costs of specialist care, primary care and therapy until enrollment levels support a salary for these professionals.

Strategy 2c: Utilize enhanced state/federal payments during start-up. States can pay PACE programs a higher Medicaid capitation rate during start-up phase (e.g., 100 percent of upper payment limit). These enhanced payments can help offset initial operating losses of the PACE program while it grows its enrollment. State incentive payments for taking people out of nursing homes and returning them to a community setting also can provide additional revenues to a rural PACE program.

Strategy 2d: Ensure that full costs of comparable care are considered in setting the PACE rate. Rural PACE programs will need to work with state Medicaid agencies to establish a PACE rate that captures the full costs of providing comparable care to a comparable population. Notably, transportation costs will be high for rural PACE. State rates for PACE should consider the comparable transportation costs of existing programs.

Challenge 3: Gaining State Commitment to Funding

Funding for rural programs by states varies but tends to underestimate the costs of care in rural areas, which often are higher than costs in urban areas. In general, state funding for new programs is very limited.

Strategy 3a: Show how PACE saves money. PACE programs cost less than nursing homes and can be a way for states to lower their long term care budgets.

Strategy 3b: Show how PACE creates jobs. PACE programs create jobs in communities by operating and providing care in the community setting. This can help revitalize economically challenged areas.

Challenge 4: Sharing Risk

Because risk is not shared by the rural PACE provider and its payers, programs are challenged to find ways in which they can share risk in order to limit their total risk exposure.

Strategy 4a: Obtain reinsurance. Rural providers can purchase reinsurance policies currently available that limit their risk exposure for hospitalizations. In addition to private reinsurance, some states offer state-funded reinsurance. Vermont is developing a Medicaid reimbursement rate for PACE that includes protection against outlier expenses while the rural provider builds census. Rhode Island is looking at a similar payment design. States also have maximized the Medicaid PACE rate at 100 percent of the upper payment limit (indefinitely or for some period of time while the program grows).

Strategy 4b: Pool risk reserves. Rural providers may be able to seek funding support from foundations to develop a pooled risk reserve shared across multiple providers during an initial period of program growth. Rural providers affiliated with a faith-based organization may be able to have the organization create a pooled risk reserve for all of its affiliates.

Challenge 5: Managing Care

Effectively managing care requires an interdisciplinary team with the ability to collaborate in care planning and implementation. In rural areas, PACE providers may contend with a lack of staff, difficulties in convening the health professionals involved in an individual’s care, and a population that is sicker due to prior years of inadequate access to health care.

Strategy 5a: Use community providers. To manage care across a large geographic area, rural programs can work with community physicians.

Strategy 5b: Use telemedicine. Many rural providers have experience in using telemedicine. This experience can be applied to ensuring adequate care management and disease prevention in a rural PACE population.

Challenge 6: Managing Network Services and Professionals

Because rural PACE programs will need to contract with a wide range of providers, managing those providers will be crucial. In addition, providers who are the sole sources of care in their area may not wish to contract with a PACE program on a defined-cost basis, thus increasing the risk of open-ended costs.

Strategy 6a: Monitor high-cost, high-frequency utilization. To improve the management of network services, PACE programs can generate and review information on patterns related to high-use and high-cost services.

Strategy 6b: Establish a contact for each network provider. Regular communication with a contact person for each network provider regarding PACE enrollees in their care can help integrate the practice of the network providers with the services of the program. For example, assigning a registered nurse to monitor care provided to a PACE enrollee during an inpatient stay integrates services more effectively and limits unexpected, and unnecessary, costs.

Challenge 7: Covering Liability Risk

It may be difficult for relatively small rural providers to acquire liability insurance for medical malpractice or coverage for directors and officers. If rural PACE programs rely more on home care, increased liability associated with a caregiver's unsupervised time with an enrollee may be an issue. Liability for providing emergency care may be a high risk for rural PACE programs, as these services often are unavailable or rely on volunteers. Some programs may be further exposed to risk by the absence or limitations of 911 services. Finally, rural PACE staff are likely to travel frequently in the course of their duties, adding to the program's liability risk.

Strategy 7a: Partner with Federally Qualified Health Centers (FQHCs) and Community Health Centers (CHCs). PACE programs sponsored by FQHCs or CHCs have the benefit of the protections against liability enjoyed by those types of organizations.

Conclusion

While rural PACE programs face many challenges, many strategies are available to help them overcome those challenges. Using the strategies described above, along with others, rural PACE programs can develop comprehensive risk management programs needed to succeed.