Health Resources and Services Administration
Office of Rural Health Policy

National Advisory Committee on Rural Health and Human Services

Fall Meeting
Lawrence, Kansas
September 14-16, 2022

Meeting Summary

The 91st meeting of the National Advisory Committee on Rural Health and Human Services was held September 14-16, 2022 in Lawrence, Kansas. The meeting topic was the Program of All-Inclusive Care for the Elderly (PACE).

The committee members in attendance: Jeff Colyer, Committee Chair; April Anzaldua; Robert Blancato, MBA; Kari Bruffett; Wayne Deschambeau, MBA; Molly Dodge; Isabel Garcia-Vargas; Craig Glover, MBA, MA, FACHE; Meggan Grant-Nierman, DO, MBA; George Mark Holmes, PhD; Cara V. James, PhD; Joe Lupica, JD; Michelle A. Mills; Brian Myers; Kellie M. Phillips, MSN, RN; Patricia Schou; James Werth, Jr., PhD, ABPP; and Loretta Wilson.

Present from the Department of Health and Human Services: Tom Morris, Executive Secretary; Office of Rural Health Policy; Sahira Rafiullah, Senior Advisor, Office of Rural Health Policy; Linda Bahrami, Administrative Officer, Health Resources and Services Administration; Jocelyn Richgels, Director National Policy Programs, Rural Policy Research Institute; Michael Fallahkhair, Principal Advisor, Health Resources and Services Administration.

Ex-Officio Members: Lacey Boven, Regional Administrator, Administration for Community Living; Humberto Carvalho, Public Health Advisor – Project Officer, Substance Abuse and Mental Health Services Administration; Darci Graves, MPP, MA, Special Assistant to the Director, Office of Minority Health, Centers for Medicare & Medicaid Services; Diane Hall, PhD, MSED, Senior Scientist for Policy and Strategy, Office of the Associate Director for Policy, Centers for Disease Control and Prevention; Kellie Kubena, USDA Rural Health Liaison, Department of Agriculture, Aleta Meyer, Senior Social Science Research Analyst; Office of Research and Evaluation, Administration for Children and Families; Benjamin Smith, MBA, MA, Deputy Director for Intergovernmental Affairs, Indian Health Service.

Wednesday September 14, 2022

Governor Jeff Colyer, Chair of the Committee, convened the meeting.

WELCOME AND INTRODUCTIONS

Jeff Colyer, MD
Committee Chair

Jeff Colyer thanked Kari Bruffett for hosting the meeting and stated the topic of the meeting is the Program of All-Inclusive Care for the Elderly (PACE). Dr. Colyer shared that the staff will collaborate with the committee to create a policy brief and to make recommendations to present to the Secretary of Health and Human Services.

The committee will be publishing four policy papers by the end of 2022 that include Behavioral Health and Primary Care Integration, Rural Emergency Medical Services, Rural Childcare, and the PACE program. In 2021, the committee produced a brief on the Rural Emergency Hospital Designation and the Centers for Medicare and Medicaid Services used the brief when issuing rulemaking. In 2019, the committee created a policy brief on Examining Rural Cancer Prevention and Control Efforts which the National Institute of Cancer sited and is using as a motivating factor in the development of their funding announcements.

PACE TOPIC INTROUCTION

Kari Bruffett
President &CEO
Kansas Health Institute

Kari Bruffett welcomed the committee members to Kansas. Ms. Bruffett said the committee would discuss potential opportunities of the PACE program not only for rural Kansas but rural areas across the nation. Rural areas are not all the same so it will be helpful to get a broad range of perspectives from the committee members.

The PACE program was chosen as the meeting topic because the committee's mission statement is to examine rural health care and human service innovations. The PACE program is an innovative program and is fully integrated care with a focus on people staying in their homes and communities. PACE participants are required to be fifty-five or older and meet the criteria of a nursing home level of care and live in a service area. Most PACE members are dually eligible for Medicare and Medicaid Services. The program requires an interdisciplinary team of support around the individuals. The program includes PACE centers, home-based services, and has a capitated payment system.

The Covid-19 pandemic increased the demand for in-home care. Adaptations that occurred by necessity during the pandemic has increased access to PACE in rural areas. Expanded use of telehealth for assessments, care planning and monitoring impacts how PACE can serve rural America.

Ms. Buffett said that her grandmother was born on a farm in Jewel County, Kansas. Her grandmother grew up on the farm her entire life except when she attended Emporia State Teacher's College leading up to WWII. After the war, she and her husband took over the family farm until they were unable to work so their son moved in to care for his parents and work on the farm. Their son needed support so that his mother was able to remain in the home after his father passed. There was a lack of aging services available in Jewel County. The PACE program would

have been a perfect opportunity for her to be able to get services, socialization, and other long-term supports.

A large majority of older adults prefer to receive care at home and there are less resources available in rural areas. Rural challenges are the demographics, a lack of transportation, lack of workforce, insufficient broadband services, and a shortage of providers.

NATIONAL PERSPECTIVES ON PACE

Peter Fitzgerald
Executive Vice President – Policy and Strategy
National PACE Association

Peter Fitzgerald thanked the committee for the opportunity to speak. He said that his grandmother grew up in Concordia, Kansas. She moved to Washington, DC but kept her rural Kansas customs. She planted a small farm in her backyard and washed her clothes on a scrub board, ran them through a ringer and hung them on a clothesline. She was an independent older adult and would have benefitted from the PACE program if it was available at that time.

Mr. Fitzgerald said he would discuss the availability of the PACE services, the benefits of the PACE program, and looking at opportunities to expand access to PACE in rural communities. PACE serves older adults who live in the PACE program service area. At the time of enrollment, an older adult must be able to live safely at home. PACE medical providers assess participant needs, develop, and implement care plans. The care plans are implemented 24 hours a day across all settings. The services can be delivered in-home, at a PACE center, or at a hospital or specialist office. Core PACE services include primary care, adult day care, hospital care, meals, transportation, rehabilitative care, nursing home care, and prescription drugs. Most services are provided by staff and others are provided under contract. PACE is capitated so it is not restricted by fee-for-services which allows more flexibility. For example, if a participant gets a skin condition because their pet has brought fleas into the home, then PACE pays to get the pet treated. The PACE program will also install air conditioners and install ramps to improve access to homes.

PACE originated in San Francisco, California, serving Asian American older adults who did not feel that the existing health care services were consistent with their culture and family priorities. PACE was established by a dentist and social worker who understood the importance of addressing social determinants of health and the need for older adults to be able to remain in their homes.

Unlike home and community-based services, PACE is not a waiver but a state option under the Medicaid program. There are 147 PACE organizations, 273 PACE centers in thirty-two states that serve 60,000 participants. The value of PACE was highlighted during the Covid-19 pandemic. The flexibility of services allowed transitioning from a center-based model of care to a fully home-based model of care. The positive impact of PACE during the Covid-19 pandemic is evident through the infection and death rate. The infection and death rate of PACE participants

was one-third of the infection and death rates of older adults in nursing homes. PACE participants were able to receive integrated services at home so there was less exposure.

PACE reduces the amount of caregiver stress which supports families and provides a better quality of life. The capitation model supports an innovative level of care with incentives to reduce excessive costs of care and increase access to more impactful home care. This includes addressing nutritional needs and behavioral health needs because it is based on a value-based model of care instead of a volume-based model of care.

Twenty-four of the current PACE organizations serve people in rural communities and there are urban hubs that extend into rural areas. About 4,000 individuals receive services by PACE in rural communities and PACE organizations are operated by federally qualified health centers (FQHC), Area Agencies on Aging (AAA), Adult Day Health Care Centers, and Native American Tribal Communities.

Recommendations to Consider:

- Pilot Changes to the PACE Model of Care seeking to better meet the needs of older adults in rural communities
    - Attract more Medicare-Only beneficiaries to PACE by increasing affordability
    - Increase use of contracted community partners to enhance accessibility
- Make Permanent all telehealth flexibilities currently granted through the public health emergency (42CFR460.104)
- Reduce regulatory barriers

Rani Snyder
Vice President, Program
The John A. Hartford Foundation

Rani Snyder told the committee that she will speak about other initiatives interconnected with the PACE program. Ms. Snyder shared that the John A. Hartford Foundation (JAHF) is a private philanthropy based in New York City and was established by family owners of the A&P grocery chain in 1929. Their mission is improving the care of older adults with priorities based on age-friendly health systems, family caregiving, serious illness, and end of life care. The program areas interconnect so various projects are funded to all three of the priorities. The John A. Hartford Foundation collaborates with individual grantees, foundations, and government agencies.

Older adults who live in rural areas are on average poorer and sicker. Compared to urban older adults, rural adults are more likely to live alone but have larger social networks. Even though older adults in rural communities have social networks, they report feeling lonely. Rural caregivers provide 3.8 more hours of care per week and have less access to paying providers. Rural areas are vastly different from urban areas in demographics, infrastructure, access to resources, and physical environment. To age in place in a rural community it is necessary to have access to healthcare, broadband access, social connectedness, and transportation.

In 2019, the John A. Hartford Foundation worked with the Harry and Jeanette Weinberg Foundation. Kathy Greenly, the former Kansas Secretary of Aging, organized a meeting of stakeholders in rural regions. The meeting participants created a list of thirteen priorities for advancing ageing in rural health.

The thirteen calls to action:

- Identify community assets for older people
- Engage older adults
- Integrate care
- Address social determinants of health
- Age-friendly rural health
- Address social isolation
- Backbone organizations
- Build upon the project ECHO model
- Capacity building and technical assistance
- Partnerships
- Promote greater use of technology by seniors
- Map the rural landscape
- Upskilling and advancement of direct care workforce

Examples of work that the John A. Hartford Foundation has funded are Age-Friendly Health Systems (AFHS), Programs of All-Inclusive Care of the Elderly (PACE), Geriatrics Emergency Department Collaborative (GEDC), Home Based Primary Care (HBPC), palliative care, dementia caregiver programs, and Age-Friendly Health Systems (AFHS).

The PACE program aligns well with Age-Friendly Health System's 4Ms framework which are: mobility, what matters, medication, and mentation. There are nineteen PACE sites that are AFHS participants.

The John A. Hartford Foundation was an early supporter of the PACE program and addresses all three of the JAHF priority areas:

- Serving as a model of age-friendly care
- Including and supporting family caregivers
- Attending to the needs of serious illness while allowing people to live their best lives

The PACE program has evidence of positive outcomes for older adults:

- Fewer hospitalizations
- Improved quality of care for certain aspects of care
- Effective in reducing institutional care, especially for people with dementia
- Higher levels of participant satisfaction

The PACE 200K: Building for Sustainable Growth and Quality is a JAHF grant with a goal to improve the quality of life and care for older adults through increased access to PACE as a nursing home alternative. The grant aims to double the PACE monthly enrollment, engage twenty-five percent of PACE organizations in a Provider Recognition Learning Community and

have three to five states adopt the model practices for growth, access, and quality, creating a trajectory to achieve a national PACE census of 200,000 by 2028. This initiative is co-funded by West Health and The Harry and Jeanette Weinberg Foundation.

The John A. Hartford Foundation will continue to amplify the value of the PACE program and advance Age-Friendly Health Systems (AFHS) in rural areas. The foundation will continue working with the Federal Office of Rural Health Policy (FORHP) to identify additional opportunities and explore workforce and community health worker training.

Q&A

Patricia Schou asked how the capitated payment models work and if there are financiers to cover capitated payments.

Peter Fitzgerald responded that the payments are capitated on Medicare and Medicaid. Medicare works like Medicare Advantage capitation using the county rate that is risk adjusted. States have latitude to set the Medicaid capitation rate. The rate for PACE must be less than the amount the state estimates it would have spent on an individual. For dual eligible, the two capitation payments are combined. The program is financially viable under the capitation.

James Werth asked if 340B is involved with the PACE payment model and if PACE is part of an accountable care organization so it can benefit from shared savings.

Peter Fitzgerald there is interest in PACE from FQHCs because it is a value-based payment model. FQHC sponsored PACE organizations can purchase medications under the 340B program. PACE organizations are not authorized 340B purchasers. The difference between ACOs and PACE organizations is that an ACO is an assignment model and PACE is a fully capitated model with participants enrolled. The PACE enrollment agreement states that an individual will receive Medicare and Medicaid benefits from the PACE program under the capitation.

Kellie Phillips asked how PACE service areas are created.

Rani Snyder responded that each individual PACE site serves an area in their geographic proximity. There may be additional sites that exist outside the primary PACE center. There is a limitation of forty-five minutes to drive older adults to a site.

Loretta Wilson asked at what point does a PACE program participant transfer to a nursing home.

Peter Fitzgerald said that they continue servicing a participant if they are transferred to a nursing home. There are older adults in nursing homes who may be able to transition back into the community. PACE participants who live in nursing homes can also go to the PACE program day programs.

Molly Dodge asked if there are recommendations or strategies that could be included in the policy brief related to organizations supporting and partnering with PACE

Peter Fitzgerald said that it would be beneficial if regulations allowed CAHs to utilize unused space to create a PACE center or offer PACE services. The PACE program regulations could allow partnerships for delivery of services through use of alternative care settings and could involve mobile health clinics.

FEDERAL AND STATE PERSPECTIVES ON PACE

Amy Penrod
Commissioner of Long-Term Services and Supports
Kansas Department for Aging and Disability Services

Amy Penrod shared that the PACE program began in 1973 and created an innovative and comprehensive way to serve aging individuals in their homes and support caregivers. As a result of the success of the demonstration program, PACE became a permanent provider type. The Balancing Budget Act of 1997 approved the granting of provider status to PACE programs under Medicare and gave states the option of including PACE as a Medicaid benefit.

The PACE program is a comprehensive, fully integrated, provider-based health care program based on the belief that it is better for frail individuals and their families to be served in the community whenever possible. PACE programs coordinate and provide all preventive, primary, acute, and long-term care services so that participants can continue to live in their community when possible. Participants and their caregivers meet with an interdisciplinary team that includes doctors, nurses, therapists, social workers, dieticians, personal care aides, transportation drivers, and others. Their needs are assessed, and an individualized care plan is developed.

Local PACE centers, in-home care, and community specialists provide PACE services. At the PACE center, participants may receive primary care, therapy, meals, recreation, socialization, and personal care. In-home care provides skilled care, personal care services and various supports. PACE supports access to specialists and other providers throughout the community.

Individuals who are age fifty-five or older and certified by the state as needing a nursing home level of care are qualified for PACE services. The average PACE participant has multiple complex medical conditions, cognitive and/or functional impairments, and significant health and long-term care needs. Participants must live in a PACE service area and be able to live safely in the community with PACE services at the time of enrollment.

PACE covers all Medicare Parts A, B, and D benefits, all Medicaid-covered benefits, and any other services or supports that are medically necessary to maintain or improve the health of PACE program participants. PACE organizations receive a fixed monthly payment from Medicare, Medicaid, and private payers (for participants who are not dually eligible). The funds are shared, and care is provided based on the assessed needs of the participant. The capitated payment provides incentive to the PACE organizations to avoid duplicative or unnecessary services and encourages the use of appropriate community-based alternatives to hospital and

nursing facility care. The state budget includes funding for the PACE program. FY 2023 funding for PACE totals $49.4 million, of which $19.1 million is from the State General Fund.

Kansas' first PACE organization was Via Christi HOPE PACE and began in 2002. Midland Care became a PACE organization in 2007 followed by Bluestem Communities in 2015. Ascension Via Christi HOPE PACE program has 311 enrollees. Midland Care has 105 enrollees and Bluestem Communities has 880 enrollees in the PACE program. PACE enrollment is increasing in Kansas and there is opportunity for expansion.

PACE program challenges including transportation, viability of programs in low population areas, and workforce shortages.

Brad Ridley
Commissioner, Financial and Information Services
Kansas Department for Aging and Disability Services

Brad Ridley informed the committee that he would share information about the financial aspect of PACE. Each of the PACE organizations receive a per member per month rate to cover the costs of the member. The state Medicaid rates are not based on the financial status of the PACE provider but on KanCare, which is the Medicaid managed care program. CMS requires the state to set the PACE rate at a lesser cost of the general Medicaid rate.

Each PACE provider receives a different rate based on the population. There is a rate for the dual population who are 55-75 years old, 75-plus, and a third rate is for the non-dual population. When the state sets the rate for general Medicaid, it is set by regions. CMS requires states to rebase rates every three years at a minimum.

There is a patient liability in Medicaid that is driven by a protected income limit. In the past few years, the legislature appropriated additional funding to raise the protected income limit for the long-term care populations which includes the PACE population. There are very few Medicaid recipients who have patient liability following the raising of the protected income limit.

Donna Williamson
Management Analyst
Centers for Medicare and Medicaid Services

Donna Williamson thanked the committee for the invitation to speak about the PACE program. As outlined in Sections 1894 and 1934 of the Social Security Act, PACE is a unique managed care program that provides comprehensive health care services to frail older adults. PACE was created to provide participants, their families, and caregivers the flexibility to meet a person's healthcare needs while living safely in the community. PACE organizations must provide Medicare and Medicaid covered services as specified in the State's approved Medicaid Plan, and other services determined necessary by the interdisciplinary team (IDT), to improve and maintain a participants overall health status.

Medicare and Medicaid benefit limits and conditions related to the amount, duration, and scope of services, deductibles, copayments or coinsurance or other cost sharing do not apply to PACE participants who receive all benefits solely through the PACE organization. PACE services are delivered in the PACE center, the home, or inpatient facilities. PACE participants cannot be disenrolled from the program when they need to transition to a skilled nursing facility.

Individuals cannot be enrolled in PACE and other Medicare and Medicaid programs concurrently. PACE organizations are responsible for providing palliative and end of life care. The IDT is comprised of multidisciplinary providers who are responsible for meeting the needs of each participant by managing, delivering, and coordinating care. The IDT consists of a primary care provider, registered nurse, social worker, physical therapist, occupational therapist, dietician, recreational therapist, PACE center manager, homecare coordinator, personal care assistant and a PACE driver. At a minimum there are eleven members on the PACE IDT.

The PACE center provides the physical space for required services. Those services include primary care, social services, restorative therapy, personal care, supportive services, nutritional counseling, and recreational therapy. PACE mobile clinics are considered an alternative care setting to provide clinic services to participants. The IDT are required to conduct comprehensive assessments on PACE participants that includes physical and cognitive functions, medication use, participant and caregiver preferences for care, socialization, family support, current health status and treatment needs, nutritional status, home environment, participant behavior and psychosocial status, medical and dental status, and participant language and preferences. The IDT develops and maintains a comprehensive plan of care with measurable outcomes.

CMS is responsible for implementation of the PACE statute, regulations, program policies, guidance, and oversight. CMS is allowed to waive certain PACE program requirements for some organizations to adopt the PACE model but there are certain elements that cannot be waived. CMS is also responsible for issuing the PACE program agreement.

Angela Cimino
Health Insurance Specialist
Centers for Medicare and Medicaid Services

Angela Cimino said she would be discussing the role of the state regarding the PACE program. Because PACE is a Medicare and Medicaid program it is a three-way partnership between CMS, the state, and the PACE organization. The state is the primary driver of the implementation of PACE and must elect PACE as a Medicaid state plan option. The state determines how many PACE organizations can be established, the number of individuals who can enroll, and the defined areas for each organization. There are numerous responsibilities when moving forward with a PACE application and entering into the three-way agreement. An on-site review of the PACE center is performed before the program is operational to determine the organizations readiness to administer the program and enroll participants. PACE participants must meet the states nursing facility level of care and comply with the annual recertification process to determine continued level of care. Stated decide how PACE participants are enrolled and disenrolled from the states management information system, as well as a process to make payment adjustments as needed.

A process is established to ensure that PACE participants have an external appeal avenue for service and payment denials through the Medicaid fair hearing process and have an appeal avenue for enrollment denials and involuntary disenrollment. States establish Medicaid capitation rates in compliance with PACE regulatory requirements and CMS guidance. CMS works with the states to develop their state attestation pages.

Q&A

Patricia Schou asked if the PACE program ever removes a participant from the program and if services are ever denied.

Donna Williamson replied that anyone who is enrolled in PACE is enrolled until they choose to disenroll, or they pass away. When a PACE participant transitions to a facility, they cannot be disenrolled from the program. A participant can voluntarily disenroll at any time. There must be services in place before a participant disenrolls.

Angela Cimino responded that if a participant transfers to a nursing facility that the payments would go to that facility.

Robert Blancato asked how the PACE program measures up in the CMS 5-point equity agenda.

Donna Williamson replied that advancing health equity is a top priority for CMS. PACE is such a comprehensive model that it makes it difficult to identify inequities in the program.

Angela Cimino responded regarding social determinants of health, many of the participants are dual eligible so they are getting their needs met even though they have low income. PACE includes transportation and different services and benefits that help participants stay in the community and ensure their overall wellbeing.

Tom Morris asked for more information about PACE programs using mobile units.

Donna Williamson said that PACE centers must provide a full range of services. CMS allows PACE to provide limited services at alternate care settings. A mobile unit can be an alternate care setting and provide limited clinic services.

HUMAN SERVICES CONSIDERATIONS IN PACE

Lacey Boven
Regional Administrator
Administration for Community Living

Lacey Boven shared that she is from Kansas and worked at the AAA that serves Mitchell and Republic Counties. The PACE program blends health and human services, so it has been a refreshing topic without so much focus on fee-for-service models and payment structures. There

is a lack of knowledge in rural communities about the PACE program, so it is necessary to use the existing infrastructure to inform and educate people about PACE.

Area Agencies on Aging are part of the ACL network and are located throughout the United States serving older adults. Part of AAA's role is to assess and identify needs for old adults within their communities. Human service factors for aging adults are not specific to the PACE model so finding ways to work collaboratively with other initiatives is necessary. The ACL Strengthening the Direct Care Workforce initiative is a capacity building and technical assistance initiative designed to strengthen the direct care workforce. There are opportunities to work to improve staff shortages with a technical assistance center. The National State Health Insurance Assistance Program (SHIP) holds annual open enrollment events. This is another avenue for educating people about the PACE program.

The National Strategy to Support Family Caregivers is a broad cross-section of the Federal Government collaborating with the private sector to create a comprehensive system of caregiver support. ACL has a strong working relationship with aging tribal programs. There may be additional challenges establishing PACE programs in tribal communities, therefore ACL will be working in collaboration with tribes to support the creation of the programs.

Jocelyn Richgels
Director – National Policy Programs
Rural Policy Research Institute
Fellow – HRSA

Jocelyn Richgels shared that she has been working with the committee for many years and the PACE program is likely the most direct integrated health and human service program that the committee has assessed.

Human service provisions in the PACE program and the availability of human services in a rural community effect whether a rural area can it apply for a PACE program. Ninety percent of PACE participants are dual eligible. There is a disproportionate need for human services in rural areas as compared to the urban areas. Scott Allard is a nonprofit human service researcher who studied the differences in county expenditures of nonprofit human services, by level of county rurality. Dr. Allard found that in non-metropolitan counties, there is $39 of spending on nonprofit human services per person living in poverty, compared to $420 per person in metropolitan areas. There is a cost-of-living difference to consider, but that is a stark difference.

Shoshana Shapiro is a former Truman Fellow at the Office of Rural Health Policy and staffed the committee. She is now a PhD candidate at the University of Michigan. When she was staffing the committee, she was committed to understanding human services in rural areas, so she has completed dissertation work on the inequality of the safety nets by examining expenditure data for every nonprofit that filed an IRS 990 form. She found that the most rural counties, with the Rural-Urban Commuting Area (RUCA) codes have around a thousand dollars of spending on nonprofit human services per person living in poverty, as compared with almost four thousand dollars of spending per person, living in poverty in the most urban counties. A greater percentage of federal funds in rural are direct transfer payments compared to urban areas. Rural areas have a disadvantage in the amount of federal funding going to program delivery so there is a discrepancy in how much capacity rural areas can accomplish with the federal funds they receive.

Human Service workforce challenges and factors are not any different than healthcare workforce challenges. The PACE program requires the ability to provide a complete service package regardless of frequency or duration of services. The lack of human service providers could be a reason some rural areas do not apply for PACE, so more flexibility is required to allow rural areas to use more community-based services than the statute allows. In 2011, HHS evaluated the rural pilot program for PACE. Access to social services was not examined as an area of assessment. Programs sought waivers for the requirement for master's level social workers. Community health workers being permitted to assume some responsibilities of social workers in rural areas would be beneficial due to the lack of human service providers. Another consideration is for rural PACE programs to be considered as a site for social work candidates to do their practicum hours.

The Northland PACE Program in Bismarck, North Dakota can only provide services within a 30-mile radius due to a lack of reimbursement for drive time. Rural Maryland is starting a PACE program that will designate a service area.

The Evaluation of Rural PACE Provider Program noted that physicians do not understand the importance of social services. The main barrier of PACE programs referrals was because physicians are customed to operating in a fee-for-service environment and did not understand the PACE model. Establishing human services delivery in a capitated payment program is a question that should be considered.

States with Medicaid MCOs are beginning to make provisions that cover human services, such as North Carolina's new incorporation of community health workers into the managed care model. This will assist in determining what social services and Medicaid capitated payment systems have been the most effective at reducing costs.

Q&A

Patricia Schou asked who credentials PACE medical providers and do they have to apply to be part of PACE. She also inquired if participants get medications mail ordered or if they go to a pharmacy.

Peter Fitzgerald said there is either an on-staff pharmacist or a consulting pharmacy. There are also PACE programs that have contracts with network pharmacies. PACE centers dispense medications onsite with a vending machine.

Loretta Wilson asked if there are PACE programs that are already using community health workers and is there reimbursement for CHWs.

Peter Fitzgerald replied there are community health workers through PACE, and it is easier to reimburse through PACE.

James Werth said that PACE demonstrates the intersection between health and human services and asked what type of human services are offered.

Lacey Boven said that PACE is a comprehensive program and a PACE participant receives services designed to maintain their lifestyle within their community. For example, it can include in-home support, assistance needed with finances, and pharmaceutical needs. It is a whole person approach to health care. Another example is grandchildren who are living with grandparents and need assistance will receive services through the PACE program as well.

RURAL HEALTH SERVICES ASSESSMENT BY ADMINISTRATION FOR CHILDREN AND FAMILIES

Lisa Zingman
Social Science Research Analyst
Administration for Children and Families

Lisa Zingman stated she would share preliminary findings from the Human Services Programs in Rural Contexts Study with a focus on opportunities to strengthen capacity in rural areas. The presentation will be based on qualitative findings from site visits in twelve rural communities.

Rural contexts present unique opportunities and challenges for administering human services programs. Rural communities have assets but also face difficulties due to a lack of access to economic opportunity, transportation challenges, limited broadband, and a lack of health and human services. These disparities in a population's access to services and benefits can lead to people's basic needs going unmet.

Human services include a broad field of diverse programs serving a variety of populations. The focus of the study will be the following ACF and HRSA programs:

- Temporary Assistance for Needy Families (TANF)
- Maternal, Infant, and Early Childhood Home Visiting (MIECHV)
- Healthy Marriage and Responsible Fatherhood (HMRF)
- Healthy Profession Opportunity Grants (HPOG)

Human service program leaders and staff in the rural communities shared that Covid-19 has changed the landscape for programs in rural communities. The impacts of Covid-19 were social isolation, job loss, mortality, and community trauma. Virtual delivery modes of human services

have improved accessibility but widened the digital divide. Covid-19 increased federal funding and flexibilities in rural areas, and this has increased the capacity of programs.

There is a need for a tailored approach to human services funding, data reporting, and program delivery in rural contexts. A request for greater local autonomy was a common theme among interviewees from all programs and program staff recognize the need for, and value of, federal guidelines for quality control.

It was recognized that nonprofit partners help fill in service gaps in rural communities. They function as a bridge between communities and human services programs, helping to establish trust and cultural capital. Nonprofit organizations have more flexibility in terms of funding streams and service delivery models.

Aleta Meyer
Lead for Prevention and Resilience
Administration for Children and Families

Aleta Meyer said that the Human Services Programs in Rural Contexts studied three primary goals including providing a description of human services programs in rural contexts, determining the remaining need for human services in rural communities, and identifying opportunities for strengthening the capacity of human services programs. The objective is to promote the economic and social wellbeing of individuals, families, and communities in rural settings.

The study used quantitative and qualitative data through literary reviews, hot spot analysis, and administrative and survey data. The study includes 1,976 rural counties with a focus on twelve counties for virtual site visits. In addition to the counties, there was a focus on four rural regions which include Appalachia, Colonias, Delta, and Native Lands, each of which capture diverse cultural rural contexts. The intensive qualitative interviews were performed in New York State, Ohio, Alabama, South Carolina, Texas, Alaska, Montana, Colorado, Iowa, and Kentucky.

The study found that unified human services improve service delivery in rural areas. There is a benefit to having physical colocation of services, aligning applications and eligibility requirements, and establishing formal collaborative networks between human services programs and associated nonprofits. An example provided by a community partner was having a main hub with concentrated services that consist of a childcare facility, Head Start, senior center, work ready program, and transportation and housing application services. Embedding staff in the community was also a suggestion so the staff can build relationships with the people in the area and get familiar with community culture and norms. PACE staff visit places of worship, school sporting events, and community centers to speak to local members of the community.

A virtual peer learning group can allow staff to share best practices and engage in professional learning. A TANF program staff member stated it is important that counties share best practices with surrounding regions that may be struggling. Sometimes the peer-to-peer connection can be even stronger than state level supervisory guidance.

Q&A

Craig Glover asked the difference between human service providers and nonprofits that were referred to in the study.

Aleta Meyer replied that the difference is the source of funding. They are both focusing on basic needs but the funding for nonprofits can come from a community organization and human service providers get grants from the federal government so there is a change in the regulations and expectations.

Patricia Schou said that there are inconsistent EMRs in rural areas and it is necessary to have a common platform for health and human services so that there is shared information.

Aleta Meyer said that ACF asked grantees if they wanted a platform created to use for the Tribal Maternal, Infant, and Early Childhood Home Visiting Program and grantees wanted to be able to create their own network that worked best in their local community. ACF has provided resources for technical assistance for grantees for local IT departments to create EMRs locally across systems.

Thursday, September 15, 2022

Thursday morning the subcommittees departed for site visits as follows:

SITE VISIT
Programs of All-Inclusive Care for the Elderly (PACE)
Midland Care Connection
Topeka, Kansas

The subcommittee members present at the meeting: Patricia Schou (Chair); Robert Blancato MPA; Wayne Deschambeau, MBA; Isabel Garcia-Vargas; James Werth, Jr., PhD, ABPP; Loretta Wilson.

Present from the United States Department of Health and Human Services: Tom Morris, Associate Administrator, ORHP; Jocelyn Richgels, National Policy Programs, RUPRI; Linda Bahrami, Administrative Officer, HRSA.

Community Panelists and Attendees

- Lea Chaffee – PCE Executive Director, Midland Care, Topeka Kansas
- Connie Davis (Virtually) – Executive Program Director, Cherokee Elder Care, Tahlequah, Oklahoma
- Dr. John Galdamez (Virtually) – Medical Director, Cherokee Elder Care, Tahlequah, Oklahoma
- John and Linda Gilbert – Midland Care Pace Participants, Midland Care, Topeka, Kansas
- Melissa Hooven (Virtually) – CEO, Humboldt Senior Resource Center, Eureka, California
- Shawn Sullivan – President and CEO, Midland Care, Topeka, Kansas

SITE VISIT
Programs of All-Inclusive Care for the Elderly (PACE)

Midland Care Connection
Emporia, Kansas

Subcommittee members: Michelle Mills (Chair); April Anzaldua; Kari Bruffett; Molly Dodge; Craig Glover, MBA, MA, FACHE; Mark Holmes, PhD.

Present from the United States Department of Health and Human Services: Meredith Anderson, Public Analyst, HRSA; Lacy Boven, Regional Administrator, ACL; Shahi Rafiullah, Senior Advisor, ORHP; Benjamin Smith, Deputy Director for Intergovernmental Affairs, Indian Health Service.

Community Panelists and Attendees

- Dr. Jennifer Heidmann (Virtually) – Medical Director, Humboldt Senior Resource Center, Eureka, California
- Justin Loewen, Executive Director, Bluestem PACE, McPherson, Kansas
- Adrianne Meyer, Senior Care Consultant, Midland Care Connection
- Regina Sayers (Virtually), Executive Director, Appalachian Agency for Senior Citizens, Cedar Bluff, Virginia
- Mark Wiles, MD, Chief Medical Officer, Midland Care Connection
- Wayne and Gayle Woodhouse, Midland Care PACE Participants, Midland Care, Emporia, Kansas

The subcommittees' returned to Spring Hill Suites, Lawrence, Kansas, to discuss site visits.

PUBLIC COMMENT
There was no public comment.

Friday, September 16, 2022

Jeff Colyer, MD
Committee Chair
Chairman Colyer thanked the committee for their time and dedication. The chair asked the committee members to review the possible PACE recommendations and consider key themes and policy issues that may impede the creation of PACE programs in rural communities.

DRAFTING OUTLINE OF POLICY BRIEF

Tom Morris, MPA
Associate Administrator
Office of Rural Health Policy
Health Resources and Services Administration
U.S. Department of Health and Human Services

Tom Morris shared that ORHP staff reviewed the committee's data from site visits and meeting discussions and created a list of possible recommendations. The recommendations are presented to the Secretary of Health and Human Services for more immediate action and there are also considerations that would require Congress or the State to act.

Key Themes

- PACE addresses equity issue for smaller population areas and is a value model.
- PACE empowers clinicians and patients
- PACE is part of a group of care delivery approaches focused on preserving seniors' ability to live at home that includes Medicare Advantage and Medicaid Home and Community-Based Services.
- PACE is also a unique model that holds great promise for rural areas.

Discussion:

- Embodies all that the committee believes integrated health care can be. Triple/quintuple aim alignment very tight. This is what long-term care should be.
- More emphasis on the outcomes.
- The need to provide up-front capital.
- Addresses Social Determinants of Health
- Includes home and community-based services
- Propose promoting more partnerships with existing safety net (CAHs, REHs, CHCs, RHCs LHDs,)
- A rural PACE model could create a stronger link to housing. Mobile home park, apartments, etc.
- More flexibility on workforce staffing including nurse practitioners and physician assistants as opposed to a MD.
- Incorporate more tele-health enabled services.
- Chief Medical Officer at central location but allow the NP or PA to lead a rural clinical team.
- Encourage HHS to work with USDA, HUD on housing for PACE, etc.
- CHWs to provide additional support to enrollees.

Recommendations – Steps within the Secretary's existing authority

- The Secretary allow PACE-related contractual and other costs to be included in the CAH cost report to reduce barriers to CAH participation in PACE models.
- Create a rural PACE resource guide to promote the benefit to rural and tribal communities and provide technical assistance and case studies from successful rural programs.
    - Promote existing sources of capital such as outreach, USDA, NMTC, Social innovation bonds. Philanthropies.
- Allow existing PACE sites to have an expedited approval process for expanding to new service populations on a rolling basis.
- Allow PACE organizations to submit multiple applications simultaneously.
- Make PACE sites eligible for loan repayment under the National Health Service Corps and the Nurse Corps.

- Encourage students trained through HRSA Health Profession and IHS training programs to rotate to PACE service sites.
- Discussion
    - More flexibility providing alternate care sites.
    - A PACE pilot focused on Medicare and VA to address Part D challenge.

Considerations – Issues the committee believes should be considered but authority rests with Congress or the states, etc.

- FCC permitting PACE sites to be eligible for broadband and telecommunication program resource allocations
- Congress and the Administration make PACE sites eligible for an auto-HPSA
- Congress and the Administration 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 amend the PACE regulations to create a travel distance adjustment to the payment methodology to account for the higher transportation costs in rural areas.
- The Administration work with Congress to continue the flexibilities offered for Medicare telehealth service provision and allow PACE sites to be both originating and distant sites.
- HHS consider public-private partnerships to address the high start-up costs of starting rural PACE organizations.

Discussion on Future Topics

- Challenges with federal poverty guidelines missing the eligibility thresholds like Head Start as wages have increased.
- Home Visiting building on maternal care
- Health Information Exchange
- Public health workforce
- Further utilization of telehealth
- Human Service workforce

Governor Colyer thanked the committee and staff for their challenging work. There may be an opportunity for subgroups meet with other rural healthcare programs and groups in different agencies.

PUBLIC COMMENT

There was no public comment.