



**Evaluation of Practice Models for Dual Eligibles
and Medicare Beneficiaries with Serious
Chronic Conditions**

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PACE Site Visits Summary Report – FINAL

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BARRIERS TO LARGE-SCALE EXPANSION OF PACE MODEL OF CARE

Summary of Findings

The Program of All-Inclusive Care for the Elderly (PACE) is a provider-based model of care that integrates all Medicare and Medicaid services (including preventive, primary, acute, behavioral, and long-term supports and services (LTSS)) for beneficiaries who are at least 55 years old, qualify for nursing facility-level services, and can be served safely in community settings at time of enrollment.

The program has been found to reduce the use of high-cost services (inpatient hospital and nursing facility) among the high-needs beneficiaries it serves. Despite these positive findings, longstanding questions about the program's scalability persist. In January 2011, more than a decade after the Balanced Budget Act of 1997 (BBA97) made PACE a permanent Medicare and Medicaid service, the program had a national enrollment of about 23,000 participants.

As part of a larger project on models of care for dual eligibles and other high-need Medicare beneficiaries, we conducted site visits to two PACE programs to explore why the programs have difficulty growing and what it would take for PACE to enroll much greater numbers of beneficiaries.

Barriers identified through interviews and observation included:

- High start-up and expansion costs;
- Unwillingness of potential participants to change physician, plan, or residential facility;
- Unwillingness of potential beneficiaries to attend a day center;
- Staff-intensive care planning and related processes;
- Small, narrow target group of the program;
- Preference of many state Medicaid programs for statewide models serving persons with a more diverse range of needs than is currently possible in PACE;
- Inability to offer flexible pricing and service packages; and
- High regulatory compliance costs.

PACE is a specific model of care prescribed in federal law. Many of the barriers identified are difficult or impossible to address within the current constraints of the model. Variations on the model could be tested to see whether or not enrollment can be increased substantially without significantly decreasing quality. Variations to test could include:

- More decentralized services and virtual communication;
- Broader target population;
- Payment and service flexibility; and,
- Regulatory integration.

Background and Purpose of PACE Site Visits

The Program of All-Inclusive Care for the Elderly (PACE) is a provider-based model of care that integrates all Medicare and Medicaid services (including preventive, primary, acute, behavioral, and LTSS) for beneficiaries who are at least 55 years old and have significant needs that qualify them for nursing facility-level services. Key features of the model include:

- **Facility.** The heart of a PACE program is the day center, a physical space that includes prevention and health promotion, primary care, therapies, recreation, and socialization;
- **Transportation.** Critical to the day center's viability is transportation. PACE programs have fleets of wheel chair accessible vans and buses, and they provide door-to-door transportation to day centers and outside medical appointments;
- **Target group.** The specified target group is persons 55 and older whose needs qualify them for nursing facility-level care, who can be served safely in community settings at the time of enrollment;
- **Staff model.** The site employs most doctors, nurses, therapists, direct support workers, drivers, and other staff;
- **Interdisciplinary team.** All staff, from doctors to direct support workers, participate in care planning through in-person interdisciplinary team meetings; and,
- **Comprehensive, accountable care.** Sites receive capitated payments from Medicare and Medicaid for dually eligible participants and are accountable for providing all needed care and meeting quality standards.

Many health system attributes promoted under the Affordable Care Act can be found in the PACE model. It resembles an accountable care organization in that it is provider-based and accepts accountability for its members over time. The organization directly employs most of its physicians, nurses, therapists, and direct support staff. It serves as a medical home for its members. It uses interdisciplinary teams to develop comprehensive, patient-centered care plans that address both physical and mental health needs. Prevention, primary care, and patient engagement are emphasized. The model has been found effective at decreasing high-cost services. PACE participants have significantly lower utilization of nursing facility and inpatient hospital services than comparable beneficiaries not enrolled in PACE.¹

The PACE model was developed by On Lok Senior Services in San Francisco in the 1970s and 80s. A national replication demonstration expanded the model to several states in the late 1980s and 1990s. The Balanced Budget Act of 1997 made PACE a permanent Medicare service and gave states the option of offering PACE as an optional Medicaid service.

¹ Chatterji, P., Burstein, N., Kidder, D., and White, A. *Evaluation of the Program of All-Inclusive Care for the Elderly (PACE): The Impact of PACE on Participant Outcomes*. Abt Associates, 1998. Prepared for the Health Care Financing Administration, Contract #500-96-0003/T04.

More than a decade after PACE was recognized as a permanent Medicare and Medicaid service, national enrollment remains small relative to the total number of Medicare beneficiaries. As of January 2011, 75 PACE programs operated in 29 states with combined enrollment of about 23,000 persons.² This is nearly five times the national enrollment of 1997, when the program was made permanent. Yet with an average enrollment of just over 300 persons per program, longstanding questions of scalability remain. What are the barriers to large-scale expansion of PACE? What would it take for PACE to reach a much greater number of high-need, dually eligible beneficiaries?

As part of a larger project studying Medicare quality and costs in several hospital referral regions (HRRs) around the country, the Centers for Medicare & Medicaid Services (CMS) asked L&M Policy Research and its partner Thomson Reuters to explore these questions in two HRRs with mature PACE sites: Portland, Oregon, and Rochester, New York. The objectives of the site visits were to identify:

1. Key characteristics contributing to successful PACE programs.
2. Barriers to implementing and sustaining PACE programs.
3. Lessons learned by early PACE implementers.

Approach

The PACE sites in Portland and Rochester have been in operation for about 20 years. We sought to identify key success factors, innovations, and barriers to growth by visiting both sites and comparing their current status, histories, and regional contexts. A team of three researchers visited each site over the course of three to four days, conducting semi-structured interviews with dozens of key individuals within each program and in the community. Visits to the sites included observation of interdisciplinary team meetings, visits to associated housing and alternative care sites, facility tours, interaction with participants in day centers and on transportation runs, and document review. The community stakeholders we interviewed included county and state officials knowledgeable about the states' LTSS, aging and disability resource center staff, contracted providers, and competitors.

Overview of Sites

Table 1 provides a high-level overview of the characteristics of the two sites visited and the regional and state contexts in which they operate. Providence ElderPlace Portland (PEPP) in Portland and Independent Living for Seniors (ILS) in Rochester were both early demonstration sites, offering PACE services since 1990 and 1992, respectively. As required under the original demonstration, both are nonprofit organizations, and both have substantial health systems as their parent sponsors, though PEPP's sponsor, Providence Health and Services, is much larger than ILS's sponsor, Rochester General Health System.

² Memo from Shawn Bloom, President and CEO of the National PACE Association, to the Federal Coordinated Health Care Office. January 15, 2011.

Table 1. Overview of PACE Programs in Portland, OR, and Rochester, NY

	Portland	Rochester
Name of Program	Providence ElderPlace Portland (PEPP)	Independent Living for Seniors (ILS)
Location	East side of metro Portland area	North and east sides of metro Rochester area
PACE Provider Since	June 1990	April 1992
Enrollment (Feb. 2011)	912	293
Percent of Dually Enrolled Participants (Medicare and Medicaid)	92%	98%
Staff (FTEs)	355	190
Average Monthly Rates Per Participant (2010-11)	Medicare A and B: \$2,100 Medicare D: \$ 430 Medicaid: \$3,036	Medicare A and B: \$2,200 Medicare D: \$ 600 Medicaid: \$3,905
Program Annual Revenue	\$69 million	\$27 million
Average Annual Expenditures per Participant	\$70,272	\$88,594
Number of day centers	5 PEPP Day Centers 2 Partnership Centers (with Volunteers of America)	1 Day Center
Housing	2 Residential Care Facilities 1 Assisted Living Facility	Subsidized apartments physically connected to Day Center are governed by separate affiliate of Rochester General Health System; Shared aide services are provided to clusters of apartments in 4 subsidized apartment buildings
Sponsoring Organization	Providence Health and Services	Rochester General Health System
Sponsor's 2010 Operating Revenue	\$8 billion	\$900 million
Notable Community Relationships	PEPP leases clinic space and shares day center space in two facilities owned by Volunteers of America	ILS provides services to residents of McAuley Mother House, Sisters of Mercy, using a shared aide model

	Portland	Rochester
Dual Eligibles in HRR Relative to National Average³	0.81	0.88
Medicare Beneficiaries in HRR	132,763	68,235
State Medicaid HCBS Expenditures per total State Population⁴	Adults/Elderly Waiver:\$96.62 Personal Care \$ 7.34 Home Health \$.27	Adults/Elderly Waiver:\$ 2.07 Personal Care \$139.26 Home Health \$ 90.85

PEPP is larger and has more day centers than ILS, and PEPP also has residential care and assisted living facilities the site directly operates. In contrast, ILS has partnerships with housing facilities but does not operate them.

Both areas have a lower percentage of dual eligibles than the national average, with Rochester being closer to average than Portland. The Portland HRR is significantly larger in population than Rochester and has nearly twice as many Medicare beneficiaries. Like most cities in upstate New York, Rochester has lost population over the last two decades, while Portland has experienced growth.

Both sites operate in states with relatively rich Medicaid home- and community-based service (HCBS) options, though the specific program emphasis differs between the states. Oregon consistently ranks near the top, nationally, in spending on HCBS waiver services and near the bottom on Medicaid home health spending. Conversely, New York relies much more heavily on home health and personal care services and much less on HCBS waiver services under its Medicaid program.

Providence ElderPlace Portland

Providence ElderPlace Portland started in 1987 and became an approved PACE provider in June 1990. It is the only PACE program in Oregon and is among the largest PACE programs in the country, with over 900 participants (only three programs have greater enrollment: Comprehensive Care Management in the Bronx at 2,500, Total Longterm Care in Denver at 1,400, and On Lok in San Francisco at 1,000). PEPP employs about 400 people, and supplements this with contracted staff, as needed. The annual operating revenue was \$69 million in 2010.

PEPP is sponsored by Providence Health and Services, a Catholic health system that is operated by the Sisters of Providence and based in Renton, Washington. Providence operates services in Alaska, Washington, Montana, Oregon, and California, including 27 hospitals, 35 non-acute facilities, physician clinics, a health plan, a liberal arts university, and a high school. It has approximately 49,000 employees, and its stated mission is: “As People of Providence we reveal

³ Number of dual eligibles in HRR with full Medicaid benefits, divided by total Medicare beneficiaries in the HRR, divided by the national average. HRR data provided by CMS to L&M Policy Research.

⁴ Expenditures divided by the total state population as reported by the U.S. Census, Current Population Estimates, July 2009. From Thomson Reuters Annual Expenditure Report, 2009.

God's love for all, especially the poor and vulnerable, through our compassionate service." The sponsor reportedly has a very strong positive reputation in the community, stemming in part from its nursing homes, assisted living and residential care homes, and more generally from a perception that it is strongly committed to the communities in which it operates.

PEPP leaders believe the program is well suited to contribute to the sponsor's mission and reported strong and consistent support from the organization. Interviewees cited the sponsor's financial strength as both critical for access to start-up and expansion capital as well as to provide cash flow and reserves in an environment of high operating costs, where just a few utilization outliers can result in significant losses to the program. Although PEPP has balanced its books for most of its history, it lost about \$900,000 in 2010.

PEPP has seven sites, all in eastern Portland:

- Two traditional PACE day centers;
- Two day centers owned by Volunteers of America (VoA). PEPP leases clinic space at these centers and pays VoA a per diem rate for PEPP participants who attend there;
- One assisted living facility with day center on site; and,
- Two residential care facilities with day centers in each facility.

Two of these sites (one of the residential facilities and one of the VoA partnership sites) were new in 2010. Both took longer than expected to implement, contributing to the program's losses last year.

Current centers are all in eastern Portland, but in response to community demand, PEPP is planning to open its next center in Beaverton, west of Portland. However, the program management has postponed the Beaverton expansion until PEPP stabilizes its budget, demonstrates that recent losses were a one-time event caused by delays in opening expansion sites, and shows the program's budget is structurally sound. Given the high costs associated with building and staffing new day centers, PEPP is looking for more cost-effective ways to expand. The partnership with VoA was in part an experiment to see if using another organization's facilities is viable.

The site is also experimenting with PACE in-Home and PACE at Home, two variations on the model that make day center attendance flexible. PACE in-Home is an option that reduces the frequency of day center attendance for participants that do not wish to attend. They are encouraged to attend at least once every two weeks (as opposed to the more regular schedule of three-plus days per week), and they continue to go to the day center's clinic for health appointments. PACE at Home was designed for participants who are not able to attend a day center. To ensure adequate health monitoring for these participants, PEPP has established a PACE at Home team that includes a doctor, nurse, and social worker who visit the participant at home on a staggered schedule. As of May, 2011, 20 PEPP participants were receiving PACE in-Home, and 50 were receiving PACE at Home.

PEPP receives a Medicaid rate of \$3,036 per person per month, an average risk-adjusted Medicare rate of \$2,100 for Parts A and B, and a Part D payment of \$430. About eight percent of

participants do not qualify for Medicaid and pay the Medicaid rate amount as private pay patients. The percent of private pay participants has been as high as 12 percent in the past, and the site believes it can attract more. The site has come under financial pressure recently due in part to changes in the Medicare payment method. In 2008, CMS began implementing revisions to the PACE frailty factor, which adjusts rates based on functional impairment. The frailty factor revisions were based on more recent expenditure data and a different population (respondents to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, rather than respondents to the Medicare Current Beneficiary Survey). PEPP estimates that the revised frailty factor has reduced Medicare rates by about five percent in the past year. Medicaid rates have been flat, and PEPP is concerned that the state may reduce its Medicaid rate due to budget difficulties. With payment rates declining and participants' needs constant or rising, the site has focused on identifying new efficiencies, such as using flex staffing to increase or decrease day center staffing as attendance decreases or increases, implementing a formulary and protocols for durable medical equipment, and developing policy for the provision of dental services and acupuncture.

Notwithstanding the concern about possible Medicaid rate cuts, the site has felt well supported by the state. There is no Medicaid cap on enrollment. The site's Medicaid contract includes a limit on total expenditures, but expenditures have been within the limit to date, and PEPP believes a contract modification would not be difficult if it ever became necessary. Oregon is planning a major initiative where the state would accept responsibility for managing Medicare funds and oversee all care for the state's dual eligibles. PEPP is represented on a large stakeholder committee the state has convened to help design the initiative (CMS recently announced that Oregon was one of 15 states that received federal funding to plan initiatives to improve care for dual eligibles.) Although PEPP could potentially grow as a result of the state's initiative, it would have difficulty serving less-populated areas of the state, and its capital-intensive model would constrain the rate at which it could grow, even in the face of potentially large numbers of new referrals. The state is also considering some ideas, such as ending the requirement that individuals demonstrate they need the level of care provided in a nursing facility to qualify for LTSS, which would not benefit PACE given its current mandate to serve only persons who need that level of care. Other possible changes to the state's Medicaid program (the Oregon Health Plan) include integration of LTSS, which are still largely provided on a fee-for-service basis, with health services, which are largely delivered through health plans. PEPP has experience integrating health and LTSS for beneficiaries with nursing facility level-of-care needs, but in a large-scale redesign of the Oregon Health Plan, PEPP could be at a disadvantage vis-à-vis full service health plans that are able to serve people with a broader range of needs.

Independent Living for Seniors

Independent Living for Seniors (ILS) began providing PACE services in 1992 as one of the original PACE demonstration sites in New York. At 293 participants, it has slightly fewer than the national average. At its height in 1998, ILS had three adult day centers with total enrollment of over 400 participants. The program then experienced a series of problems, including a long-term home health survey with many regulatory citations. In retrospect, long-time employees of ILS attribute the challenges of that period to insufficient attention to orientation, training, and supervision of home health aides, resulting in documentation and other compliance issues.

A decision in 2004 by the parent sponsor to put ILS up for sale exacerbated its problems. That effort was ultimately scrapped, but the protracted and public sale process and related atmosphere of instability further undermined the program as staff turnover increased and enrollments waned. ILS lost an estimated \$750,000 over the four-year period (2004-2007) while the sale, to a local nursing home operator, was pending. One of the three day centers closed in 2004, and a second was closed in 2008. Following the 2008 closure, CMS imposed an enrollment cap of 290, reflecting its estimate of ILS's maximum capacity at that time.

ILS is sponsored by Rochester General Health System (RGHS), a nonprofit system with Rochester General Hospital as the flagship institution. Rochester General Hospital is one of three large tertiary care hospitals in the Rochester area and has a reputation as a high-quality provider.⁵ In addition to ILS and Rochester General Hospital, RGHS has a community hospital, two affiliated nursing homes, a behavioral health network, geriatric services such as consultations, and a large physician independent practice association (the Greater Rochester Independent Practice Association). The mission of RGHS is “[t]o improve the health of the people served by providing high-quality care, a comprehensive range of services, convenient and timely access with exceptional service and compassion.”

The 1990s and early 2000s were a period of considerable turbulence and consolidation in Rochester's health care market. RGHS was competing for position with the city's other two major systems, the University of Rochester Medical Center, with Strong Memorial hospital at its core, and Unity Health System, formed in 1997 by the merger of a suburban hospital (Park Ridge) and a city-center Catholic hospital (St. Mary's). As ILS was experiencing its regulatory citations and related organizational stresses, RGHS leadership was working to sharpen the system's strategic focus and investments. It was in this context that RGHS decided to put ILS up for sale. As word of the proposed sale became public, confidence in ILS waned. Staff turnover climbed and referrals slowed as families wondered about the program's stability. The situation began to stabilize a few years ago, when RGHS hired a new chief executive officer with a different view of ILS's strategic importance. As the direction of health care reform came into focus, ILS's experience with care management, accountability, patient-centered medical home, and transitions of care gave it an important new value to the system. The sale was called off, a former site director from ILS's early years rejoined RGHS as a senior vice president, and a new ILS director was appointed. The appointments were taken as strong positive signs of RGHS's renewed commitment to ILS. The enrollment cap was lifted in September 2010, and the ILS director characterizes the program as “poised for growth.”

The current ILS sites are:

- One day center, which was recently renovated and represents ILS's core facility. It houses a primary care clinic and a large common room where a variety of recreational activities are provided (We observed “Current Events,” in which a staff person read newspaper headlines of the day and engaged participants in discussion of the news.). While at the day center, participants attend physical or occupational therapy as needed,

⁵ *U.S. News and World Report* recently named RGH as the second highest ranked hospital in the Rochester region its new Best Regional hospitals 2010-11 ranking report at: <http://health.usnews.com/best-hospitals/area/rochester-ny>. Interviewees also uniformly described RGH as having a good reputation in the area.

go to appointments at the clinic, and are weighed regularly by direct support workers. The day center is physically attached to Hudson Housing, which provides subsidized apartments to nursing home eligible seniors. Several (but not all) Hudson Housing residents are ILS participants. Hudson Housing is owned by RGHS and managed by Conifer, a private real estate development and management company.

- Two alternative care settings (ACS), open to any enrollee, located in large subsidized apartment buildings. ILS has a critical mass of participants who live in these buildings, allowing it to efficiently provide some services on site. Direct support workers and nurses maintain a small office in the building from which they can provide in-home services, and a recreational therapist organizes activities in a common room. These services do not replace clinic or day center activities, but they do relieve pressure on the center, since ACS residents can attend the day center fewer days and still benefit from the group activities provided in the apartment building. The ACS also enables ILS to suggest a housing option to prospective enrollees when one is needed (neither building is fully occupied).
- One shared aide building, at the McAuley Motherhouse, owned by the Sisters of Mercy, and open to members of the religious order, retired priests, and persons related to members of the order. The McAuley House had previously housed one of the day centers that closed, and it was the closure that precipitated the innovative arrangement that now exists. McAuley House is home for the sisters who live there, and having a day center on site had allowed the order to avoid placing their members in nursing homes. ILS and the Sisters of Mercy designed the current arrangement, in which ILS participants who live at McAuley receive most of their services there, in the home setting. Shared aides provide direct support services, and in-home therapy is provided as needed. An ILS doctor makes home visits to provide primary care. Sisters are transported to the clinic when tests or other interventions that cannot be provided at home are needed. Socialization is provided through the regular daily activities and rituals of the order, such as daily mass and group meals.
- A transitional housing apartment, which ILS uses for residents who need more support for a short period of time. The transitional unit is used to provide respite to family members, as part of a post-acute recuperation, and for some participants, at the end of life.

ILS receives a Medicaid rate of \$3,905 per person per month, an average risk-adjusted Medicare rate of \$2,200 per person per month for Parts A and B, and an average Part D payment of \$600. ILS managers report that implementation of changes to the Medicare frailty factor, which adjusts rates based on functional impairment, has resulted in about a five percent decrease in Medicare payments in the past year (similar to the experience reported by PEPP). As noted earlier, CMS began implementing revisions to the PACE frailty factor in 2008. The revisions were based on more recent expenditure data, and a different population (respondents to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, rather than respondents to the Medicare Current Beneficiary Survey). With revenue per person decreasing and enrollment capped for the past few years, much effort has been focused on improving efficiency.

ILS is one of eight PACE programs in New York state, but none of the other sites compete directly with ILS (the closest are 75 miles away in Buffalo and 90 miles away in Syracuse). New York's Medicaid program classifies PACE as one of three types of managed long-term care (MLTC); the other two are Managed Long Term Care Partial Capitation programs (Medicaid managed care plans that provide community-based and institutional long-term care services) and Medicaid Advantage Plus (the combination of a Medicaid Managed Long Term Care Partial Capitation program and a Medicare Advantage Special Needs Plan). The two other types do not operate in Rochester, making ILS the only MLTC option in the area; however, ILS competes with numerous home- and community-based options for Medicaid beneficiaries in Monroe County (comprised of Rochester and several surrounding communities), and many individuals pointed to the "service rich" market as a factor in limiting ILS's growth. ILS's most direct competition is the New York Long Term Home Health Care program (LTHHCP), which operates under a Section 1915(c) HCBS waiver. Participants in this program must meet nursing home level-of-care criteria and receive waiver services up to an individual cap of 75 percent of the cost of an average nursing home stay. This is the largest of Monroe County's home care services programs, accounting for nearly 40 percent of people served. Services are provided through three certified home health agencies (CHHAs). ILS also competes with other home care programs, nursing homes, and assisted living facilities in the county.

The average cost to Medicaid for Monroe County participants in LTHHCP is \$2,604, compared to the flat ILS rate of \$3,905. However, both state and county officials reported that the acuity of ILS participants is higher than acuity of individuals enrolled in competing fee-for-service programs, and that ILS is at risk for nursing home placement of participants, which the alternative fee-for-service programs are not. Many of those interviewed said that ILS is the best place for people with very high needs. ILS agrees that this is a common belief in the community, and that it has suffered from adverse selection as a result.

The state is currently planning to expand its use of MLTC as part of a larger initiative to redesign its Medicaid program. Details have yet to be decided, but the preliminary direction could offer significant new opportunities to ILS and other PACE programs in the state. One model under discussion would make MLTC mandatory in all regions of the state where two or more plans are available. Because PACE must be a voluntary program under federal regulations, it is unclear whether or not it can be considered a program choice within a mandatory Medicaid managed care program and whether it could accept "auto-assigned" participants as part of a state enrollment process (New York has received one of the 15 state planning contracts from CMS for initiatives to improve care for dual eligibles).

Factors Affecting the Viability of the Current PACE Model

Many PACE leaders and staff describe the distinctive features of the PACE model as critical to delivering the level of quality and the high-touch, personal interaction associated with the program; however, these features bring with them significant resource requirements that make PACE a challenging model to implement and expand. Based on our observations and interviews, the key factors that affect the viability of PACE programs are:

- **Consistent support from a financially strong sponsor.** Estimates of start-up costs for a new day center range from \$1.5 to \$3 million. Capital is required to build a site and pay

initial staffing costs while the number of enrollees builds to the break-even point. Large health systems can provide this level of financial backing, but a PACE program must be viewed as promoting the mission of the sponsoring organization to gain sponsorship and maintain support over time. The PACE site must also be able to compete for resources with the needs of other units within the organization.

- **Positive visibility in the community.** PACE programs compete with many options in the marketplace and offer a product that is unusual and sometimes difficult to explain. To compete successfully, the program must achieve visibility and develop a reputation for high-quality services. A sponsor that is well regarded in the community can help immensely with this (as in Portland), but the sponsor's good reputation does not help when the community does not associate the site with the sponsor (as in Rochester).
- **Relatively high population density.** Although some PACE sites have successfully expanded their services into rural areas, the costs associated with building day centers and transporting participants are more manageable in densely populated areas. Even within a metro area, geographic proximity to a day center is important to the operation of the model, and both programs we visited had targeted only certain sections of their metro areas. Density is also beneficial because the mandated target group (individuals who are at least 55 years of age and qualified to receive nursing facility level of care) is small relative to the total Medicare population.
- **Ability to recruit, train, and retain staff.** The PACE model requires its staff to provide care using a collaborative approach that relies heavily on interdisciplinary teams. Adjusting to this model can be difficult for both direct support professionals, who may be used to working alone with patients in their homes, and doctors, who may be accustomed to being the sole decision makers in their practices. Retention keeps the costs of turnover down and promotes long-term relationships among staff and participants.
- **Ability to manage financial risk.** The fully capitated model serving a high-risk population requires a relatively high level of financial risk to be spread over a relatively small number of participants. This is not necessarily a skill set that health systems have or understand fully.
- **Supportive state policy.** Although Medicare-only beneficiaries may be enrolled in PACE, the program is designed for dually eligible beneficiaries who require significant amounts of LTSS. Thus, a PACE program will not be launched unless a state adds PACE services to its Medicaid plan. In addition, states have considerable discretion when regulating PACE sites. The sites we visited offered contrasting approaches to this issue. Oregon has a relatively easy regulatory process for PACE, reflecting the state's approach to LTSS in general. In contrast, New York requires PACE sites to obtain a certificate of need (CON) for the clinic portion of a day center, which can take two years. ILS must maintain separate licenses for its clinic and home care services and must also be licensed as a managed care program.

Barriers to Large-Scale Expansion

The people we spoke to at the two PACE sites in New York and Oregon identified several barriers in common. They include the following.

- **Start-up costs.** Even after initial start-up, incremental expansion costs are considerable, in large part because they involve development of a new day center. Unlike an MCO, a PACE site is not able to grow by making marginal investments in an expanded provider network or adding a few care managers. Once a day center's capacity is reached, it limits growth until new space can be secured. When a new center opens, initial staffing costs exceed revenue until the number of enrollees hits the break-even point. (For example, a new day center needs a fully functioning interdisciplinary team with a doctor, nurse, social worker, therapists, etc., but initially the team serves a very small number of participants.) Both sites we visited have experimented with strategies to reduce day center costs, such as working closely with other organizations (e.g., the formal partnership between PEPP and Volunteers of America, and the shared aide approach that ILS uses to deliver services at the Sisters of Mercy Motherhouse), but the relationships themselves take time to develop. Capital costs may be reduced, but expansion still takes time and a space must still be developed. State regulatory requirements add more or less time to the process, depending on the state. For example, New York, as noted above, requires new PACE sites to obtain a CON for a new clinic.
- **Loss of physician, health plan, or residential facility.** Both sites affirmed previous research that loss of one's personal physician (due to the staff model, which generally requires participants to use program physicians) is a major barrier to enrolling prospective participants.⁶ In Oregon, where most dual eligibles are enrolled in health plans through the Oregon Health Plan, loss of plan was also cited as a barrier. PEPP also noted that some prospective participants choose not to enroll because they would need to move from their current residential care home to one associated with PEPP. ILS has experimented with allowing a limited number of "waivered" doctors to continue seeing their patients on a contract basis.⁷ Still, the site has found waived doctors are difficult to engage, given that only a few of their patients attend ILS.
- **Day center attendance.** Although attendance at a day center is not required per se, it is clearly strongly encouraged, but both sites are using various strategies to be flexible, since some beneficiaries do not want to attend. The dilemma for the sites is that the day center is where most of the prevention, primary care, therapy, socialization, etc. occur. However, the sites are interested in alternatives in part because having people spend fewer days at the center stretches its capacity and allows growth without needing to add a new center. The PACE at Home, PACE in-Home, and the alternate care settings are described below in the next section.

⁶ See, for example Gross, D. et al. . "The Growing Pains of Integrated Health Care for the Elderly: Lessons from the Expansion of PACE." *The Millbank Quarterly*, v. 82, n. 2, 2004 (257-82).

⁷ The PACE regulation allows CMS to waive the requirement of a staff doctor on a limited basis.

- **In-person interdisciplinary team (IDT) meetings.** IDT meetings are very labor intensive, with a dozen or more staff engaged in planning for each participant. This is a costly and logistically demanding process that is applied uniformly to all participants. Such a process would be quite expensive to apply to all high-needs Medicare beneficiaries and arguably would be much less efficacious for some than for others. Furthermore, in a vastly expanded PACE scenario, far more geography would need to be covered, arguing for more virtual participation by team members.
- **Shortage of aides/home care workers.** Though all types of staff are difficult to recruit, both sites feel the shortage of direct support workers in particular. This barrier is not unique to PACE but does constrain rapid growth.
- **Limited pool of participants.** PACE sites are trying to attract a narrow target group of beneficiaries, and in the two HRRs we visited, they are competing with a rich set of fee-for-service options. In order for PACE to have a significantly greater impact on Medicare spending and quality, eligibility would need to be loosened to enable sites to serve people before they become nursing facility eligible, before they turn 55 years of age, or both.
- **Perceived or actual inability to meet larger LTSS system goals.** Coincidentally, both sites we visited are in states planning major changes in their LTSS systems. Both states are promoting managed care approaches, with some components, such as capitation, that PACE pioneered. But they are also promoting statewide systems that can serve a broad group of beneficiaries with diverse needs. Both states expressed admiration for what PACE does but were skeptical about the model's ability to adapt to a much broader set of needs, spread out across a much larger geographic area.
- **Lack of pricing and service flexibility.** Both sites visited are operating in markets with substantial private pay markets, much of it in the form of assisted living. The sites would like to diversify funding by serving more Medicare-only beneficiaries and collecting the Medicaid portion as private payments, but they find they have trouble competing with an assisted living facility where, for example, the resident can purchase services a la carte. PACE must provide the entire package, at the comprehensive rate, regardless of the beneficiary's preference or budget.
- **Lack of regulatory alignment.** Oregon and New York take different regulatory approaches to PACE, with Oregon's being less intensive than New York's. But both states have requirements that do not align well with federal requirements. Examples include the following.
 - As a Long Term Home Health Care Program in New York, ILS must document its care planning functions in a specific format that is different from the PACE protocol care planning format. The two are also required at different intervals. In order to satisfy both, ILS maintains two separate formats for the same care planning process.

- As a residential care provider in Oregon, PEPP is required to conduct housing service plans every three months, even though housing is addressed in the PACE-mandated care plan every six months.

Innovations

The sites we visited are experimenting with model variations and other innovations designed to address some of the barriers to growth. Notable examples include the following:

- **Volunteers of America (VoA) Day Center Partnership.** PEPP has partnered with Volunteers of America to use VoA's existing adult day care facilities, which were being underutilized, instead of building new centers of their own. PEPP leases space at the centers for clinic space and pays a per diem rate to VoA for each PEPP participant who attends a VoA day center. For VoA, the partnership is an opportunity to increase use of struggling facilities. For PEPP, it's an opportunity to expand PACE at a lower capital cost. When we visited, it was too early to tell if the partnership would be successful over time.
- **McAuley House Shared Aide Program.** ILS has long provided services to the Sisters of Mercy at its Motherhouse in Rochester. By taking some PACE services to the Motherhouse, ILS has essentially applied PACE in a naturally occurring retirement community (NORC). The sisters highly value being able to keep members of the order at the Motherhouse until death, and the ability to provide many PACE services on site makes that possible. The limitation of this model is that it is not open to the public, but the same concept might be applied to other closed or open communities where clusters of high-needs beneficiaries live. PACE doctors make home visits to the Motherhouse very efficiently, since the building is home to several ILS participants. This meets the preferences of the enrolled sisters and reduces pressure on ILS's day center.
- **Alternate Care Settings.** ILS also has established alternate care settings in two large subsidized apartment buildings in Rochester. ILS has helped participants secure apartments in the building, developing a cluster of participants. Nurses and direct support workers have a small office on the premises that serves as a staging area for their home visits. A recreational therapist offers activities in the buildings' common rooms.
- **PACE at Home and PACE in-Home.** PEPP has developed two alternatives for participants who do not wish or are not able to attend day centers. The PACE at Home program is for those who are not able to visit the center. To ensure that they continue to receive primary care and other key services, a team including a doctor, nurse, and social worker provides home visits. Initially started as a strategy for retaining existing participants whose declining conditions made it no longer possible to attend day centers, PEPP is now considering opening the service to new participants. It currently has one PACE at Home team, serving its existing participants on the east side of Portland, and it is considering adding a second team for the west side when it expands into Beaverton. The PACE in-Home program was designed for participants who are able but wish not to attend a day center. These participants are encouraged to attend at least every two weeks and travel to the clinic as needed for medical appointments.

- **Multi-purpose transitional housing.** ILS has converted an apartment with two bedrooms into a flexible transitional housing unit for its participants. The unit can be used as part of a post-acute transition, when a person could leave a skilled nursing facility but does not have enough support at home, or at the end of life, as a hospice-like setting.

Implications

Our findings are largely consistent with previous research on PACE. In many ways, the attributes that make PACE a much-admired program – high touch, consistent staff, on-site interdisciplinary teams – are also barriers that make it difficult to expand.

More than 10 years after PACE became a permanent Medicare and Medicaid service, opportunities may exist to experiment with variations on the theme, to see if it is possible to serve substantially more people without losing the essential qualities of PACE. Through the Center for Medicare and Medicaid Innovation, CMS now has unprecedented authority to experiment with new ways of delivering Medicare services. Several states have expressed interest in working with CMS on innovative ways to promote cost-effective care for dual eligibles. The two sites we visited are both in states that have been awarded planning contracts to develop initiatives to improve care for dual eligibles, and both states hope to make large-scale changes to their LTSS systems. The National PACE Association has engaged its members to develop possible variations of the model.⁸

The following design features could be considered in developing variations on the PACE model:

- Provide services in a more decentralized fashion and use virtual communication to test whether PACE can be implemented effectively across larger geographic areas and whether participants' existing doctors could be used with less face-to-face contact. These changes could also lower start-up and expansion costs.
- Broaden the target population to test the effectiveness of offering “pre-PACE” services to persons whose needs do not yet meet nursing facility criteria and to test the efficacy of PACE for younger beneficiaries.
- Give PACE sites greater flexibility to design benefit packages to test whether PACE-like services can be made more attractive to private-pay beneficiaries.
- Strengthen state and federal collaboration to experiment with full integration of regulatory oversight for PACE sites.

⁸ “PACE Policy Summit: Summary and Recommendations.” Accessed 5/11/11 at: <http://www.npaonline.org/website/article.asp?id=4>

