Model Variations Report
Summary

Programs of All Inclusive Care for the Elderly (PACE) are comprehensive, fully-integrated, provider based health plans for the frailest and most costly members of our society – those who require a nursing home level of care. Federal regulations define much of how PACE programs are operated, including their care model and service delivery systems. Trough regulatory waivers, however, PACE programs have implemented a range of model variations. NPA surveyed all PACE organizations to examine their use of these waivers and other model variations to assess their scope and their potential impact on quality or costs of care. The survey identified the following frequent waivers and variations:

- *Community-Based Physician (CBP)* -- Current PACE regulation stipulates that a PACE physician must be employed by the PACE organization and serve primarily PACE enrollees. This regulatory waiver allows a PACE site to contract with physicians to provide primary care to PACE participants. **Thirteen out of 84 (15%) programs use a CBP waiver.**

- *Nurse Practitioner*- This waiver allows nurse practitioners – working in collaboration with physicians and consistent with state law -- to take on duties typically carried out by the PACE primary physician. **Twenty-four out of 84 (28%) programs use a nurse practitioner waiver.**

- *Alternative Care Settings (ACS)* -- An ACS is any physical location in the PACE organization's CMS approved existing service area where a PACE participant receives PACE center services on a fixed basis during usual and customary PACE center hours of operation. Operating an ACS does not require a waiver, but PACE organizations must notify CMS Central Office as well as the Regional CMS Office and their State Administering Agency in writing on a patient-by-patient basis. **Nineteen PACE organizations reported using at least one alternative care setting** (23%)**.**

Model Variations at Work: ACS Case Study

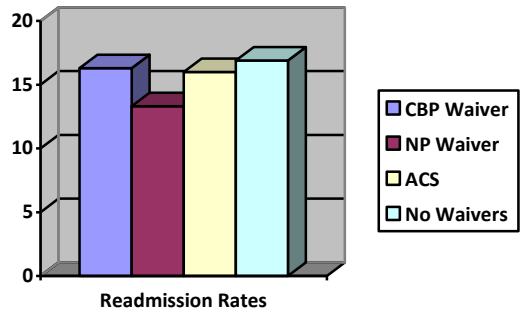
Senior CommUnity Care, CO- At this site, there is one established ACS with another in development. The current ACS is 30 miles from the primary PACE site, is staffed with a Registered Nurse and 3 Certified Nursing Assistants (CNAs) and serves 27 PACE participants twice a week. These individuals use the ACS for meals, bathing assistance, activities, therapy as needed, nursing care and labs. One day a week there is a physician or nurse practitioner available at the site. The 27 PACE participants use this ACS because the main center is accessed via [not sure – is it on a single lane mountain road?] a single lane mountain highway- the alternative site allows these individuals to stay in their community to receive services that address limited socialization and improve healthcare access.

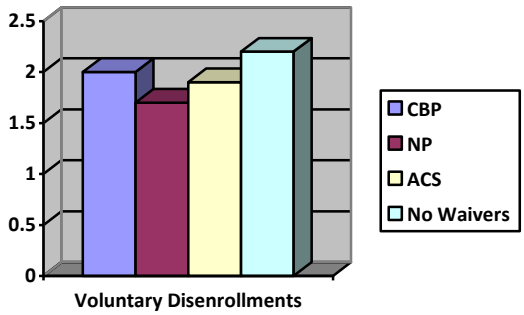
Model Variations at Work: CPB Case Study

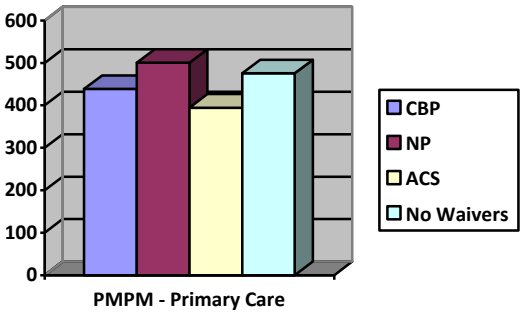
On Lok, CA – On Lok serves 65 nuns using community-based physicians (CBPs). The CBPs serve as the primary care physicians – managing the nuns' medical situations and overseeing their specialty and inpatient care. On Lok supplements these physicians by employing a physician who provides clinical support to the interdisciplinary team and urgent care to participants when they attend the PACE Center.

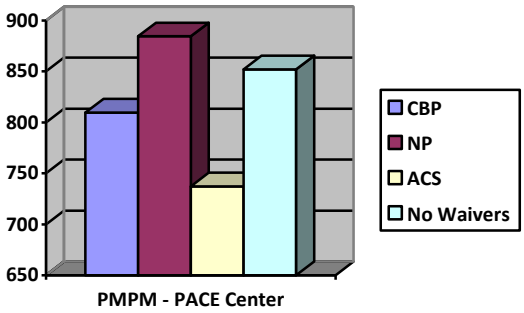
To determine the effect of model variations on PACE cost and quality, NPA compared differences in hospital readmission rates, voluntary dis-enrollments, and per member per month (PMPM) costs across programs. Based on the data collected, represented in the following charts, the model variations do not appear to have any impact on quality of care as measured by hospital readmission rates and voluntary disenrollment rates had any impact on care.

Similarly, the model variations do not appear to alter the resources expended to provide care, with the notable exception that the use of alternative care sites appears to lower the cost per member per month of PACE centers. This makes sense given that the ACS settings are providing socialization and other services that would offset the need for those services to be provided at a PACE Center.









In conclusion, the model variations currently in place through the use of waivers suggest that they can be effectively incorporated into the PACE program. These waivers have allowed PACE organizations to develop policies and procedures to assure PACE quality, as evidenced by

consistency in readmission data, voluntary disenrollment rates while making effective use of the program's resources.

Looking Ahead

NPA believes that widespread adoption of these flexibilities would allow PACE programs to grow more rapidly and provide high-quality care to an even greater number of high-risk, frail individuals. Opportunities to expand the use of model variations include modifications to the PACE protocol, changes to Federal Regulations that govern the PACE program, or enactment of the draft PACE Innovation Act. NPA will be working with policymakers to advance these changes to promote growth and innovation of the PACE model.