



Model Variations Report

Maintaining High Quality Standards in PACE

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Overview

The Program of All-Inclusive Care for the Elderly (PACE) is a comprehensive, fully-integrated, provider-based health plan for the frailest and costliest members of our society – those who require a nursing home level of care. The PACE model is centered on the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible. Even though all PACE participants are eligible for nursing home care, 90 percent continue to live at home.

When a participant enrolls in PACE, they receive all of their health and long-term care services through the PACE organization. Services are provided by an interdisciplinary team (IDT) of doctors, nurses, therapists, social workers, dietitians, personal care aides, transportation drivers and others, most of whom are employees of the PACE organization (i.e., are **not** providers in private practice).

Care is generally coordinated through and delivered at a PACE Center. Participants are transported to the PACE Center – on average, three times a week -- where they receive primary care, therapy, meals, recreation, socialization and personal care. PACE also coordinates home care, visits to specialists, hospitalizations, nursing home care and other services. The use of the PACE Center allows participants to receive care in the least-restrictive, lowest-cost setting.

While the PACE model is proven effective in improving outcomes and controlling costs for participants and payers, current regulatory and statutory limitations inhibit PACE innovation and growth. For example, PACE organizations cannot contract with community-based physicians (CBP) or Alternative Care Settings (ACS) to provide services. The requirement that participants see only PACE physicians – therefore leave their family physician – may dissuade some beneficiaries from enrolling in PACE. Similarly, if a PACE organization reaches capacity in one location, it must construct a new PACE Center – at a cost of \$4 - 6 million – rather than be able to partner with a local adult-day health center or seniors center.

The National PACE Association (NPA) is currently working with members of Congress on the PACE Innovation Act (PIA), which would expand eligibility and provide greater flexibility in PACE operations. Many of the approaches proposed in PIA, such as the use of Alternative Care Settings community-based physicians and increased use of nurse practitioners, are currently in place for PACE programs that have received regulatory waivers. The following is an examination of current model variations in PACE, and will inform policy discussions about ways to expand access to PACE without compromising PACE's effective, high quality care model.

PACE Authority and Waivers

The *Balanced Budget Act of 1997* made PACE a permanent part of Medicare and a state Medicaid option. Additionally, the *Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)* specified that CMS can “modify or waive provisions of the PACE protocol...as long as any such modification or waiver is not inconsistent with and would not impair the essential

elements, objectives and requirements” of the PACE model. (Federal Register, vol. 67, no.190, p.61497)¹ BIPA Section 902 allowed PACE to “grandfather” the modifications that programs had implemented as of July 1, 2000, and Section 903 reinforced the Secretary’s authority to allow waivers of the PACE protocol and regulation.

Model Variations in PACE

In January 2013, NPA surveyed all PACE organizations to examine the extent of their use of regulatory waivers and other model variations to determine whether use of these modifications has an effect on PACE’s high quality standards. Of the 91 programs in operation at that time, 84 sites were surveyed. **Of those 84 PACE sites, 42 use at least one type of regulatory waiver (community-based physician or nurse practitioner) and/or an alternative care setting, representing 50% of all organizations surveyed.**

While waivers can be granted for the full range of PACE regulations, the following are the model variations most commonly used by PACE organizations.

Community-Based Physician--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 a physician who works in the community. A community-based physician is contracted with -- but not employed by -- the PACE program and takes care of non-PACE participants in the community. **Thirteen out of 84 (15%) programs use a CBP waiver.**

Nurse Practitioner- This waiver allows the nurse practitioner on the interdisciplinary team at the PACE organization to assume duties typically carried out by the PACE primary physician, consistent with state law. The nurse practitioner works in collaboration with the physician to carry out primary care services assigned to the physician under current PACE regulations. **Twenty-four out of 84 (28%) programs use a nurse practitioner waiver.**

Alternative Care Settings -- The use of an alternative care setting (ACS) by a PACE organization does not involve a regulatory waiver but instead a notification to CMS that requires approval. An ACS is any physical location in the PACE organization’s CMS approved existing service area other than the PACE participant’s home, an inpatient facility, or PACE center, where a PACE participant receives PACE center services on a fixed basis during usual and customary PACE center hours of operation, that supplement and do not replace services provided at the PACE center (42 CFR § 460.98(c)). Currently, a PACE organization must notify the CMS Central Office, the CMS Regional Office and their State Administering Agency (SAA) in writing before opening or contracting with an ACS. **Nineteen PACE organizations reported using at least one alternative care setting (23%).**

¹ *How Integrated Care Programs Use Community-Based, Primary Care Physicians. Final Report.* Cheh, Valerie. Mathematica Policy Research, Inc. 2006.

Model Variations At Work

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 on site. The 27 PACE participants use this ACS because the main center is on a single lane mountain highway- the alternative site allows these individuals to stay in their community to receive services and provides an enrollment opportunity for those who have limited socialization and healthcare access.

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

Most PACE organizations utilize only one or two model variations:

- **Sites with only 1 core waiver (Community Physicians or Nurse Practitioner): 25 out of 84 (30%)**
- **Sites with both of the core waivers (Community Physician and Nurse Practitioner): 6 out of 84 (7%)**
- **Sites with both core waivers and use of ACS: 4 out of 84 (5%)**

Of the four sites using both core regulatory waivers and an alternative care setting, two of those sites (Northland PACE, ND and Senior CommUnity Care, CO) are located in rural communities. As PACE organizations continue to expand to rural communities, programs will need more model flexibility since these areas frequently have fewer physicians and limited enrollees. The community-based physician waiver also allows PACE enrollees to have the option of continuing to receive care from a physician that they have seen for many years, ensuring continuity of care. The community-based physician waiver is especially important since many times the only physician available in a rural area is a physician that already has a community-based practice.

Finally, NPA asked PACE sites to describe how many PACE participants are currently using the community-based physician waiver and what percentage of their total census this represents.

- Of the 13 sites reporting use of community physician waivers, the 7 responses we have received so far have indicated that the waiver serves between 3%-90% of their current

PACE census; a significant variation in utilization. Two sites reported that they were only recently approved and therefore had no current waiver use by PACE enrollees at their site.

Impact on Quality and Cost

To determine whether the use of model variations had an impact on quality of care or operational costs, NPA compared differences in hospitalization and readmission rates, voluntary disenrollments, and per member per month (PMPM) costs across programs. Based on the data collected, there was little indication that model variations had an adverse impact on care. The following is an overview of the findings:

Community-Based Physician Waiver:

- Thirteen PACE Organizations currently use this waiver.
- Nine of the 13 reported their Hospital Readmission Rate (30 day) as of 2008 and these ranged from 6.9%-23.7%.
- Four of the 13 reported their Quarterly Voluntary Disenrollment rate for quarter 2 of 2012 which were 1.4% – 3.2 %
- Six of the 13 sites using the CBP waiver reported their PMPM primary care costs for FY 2011, which ranged from \$262-\$631. The same six sites reported their PMPM PACE center costs for FY 2011 which ranged from \$428-\$1,054.

Nurse Practitioner Waiver:

- Twenty-four PACE Organizations currently use this waiver.
- Fifteen of the 24 reported their Hospital Readmission Rate (30 day) as of 2008 and these ranged from 4%-20.4%.
- Eleven of the 24 reported their Quarterly Voluntary Disenrollment rate for quarter 2 of 2012 which ranged from 0.59% - 2.1%.
- Seven of the 24 sites using the Nurse Practitioner waiver reported their PMPM primary care costs for FY 2011 which ranged from \$190-\$928. The same sites reported PMPM PACE center costs for FY 2011 which ranged from \$293-\$1,311.

Alternative Care Setting:

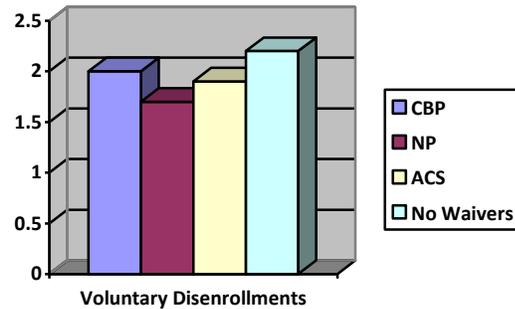
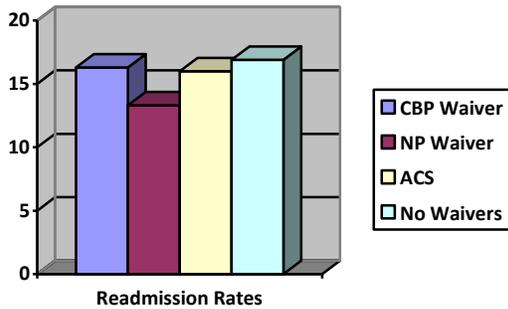
- Nineteen PACE Organizations currently use Alternative Care Settings.
- Twelve of the 19 reported their Hospital Readmission Rate (30 day) as of 2008 and these ranged from 3.9%-27.3%.
- Twelve of the 19 reported their Quarterly Voluntary Disenrollment rate for quarter 2 of 2012 which ranged from 0.59% - 6.1%.

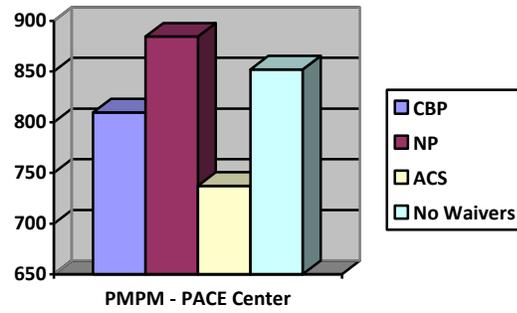
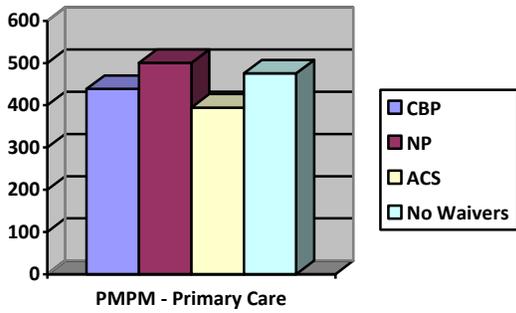
- Six of the 19 programs reported their PMPM primary care costs for FY 2011, which ranged from \$291 – 631. The same six sites reported their PMPM PACE Center costs for FY 2011 which ranged from \$502 – %1054.

No Core Waivers

- Forty-two of the 84 PACE organizations surveyed were using no core waivers or ACS:
- Twenty of these 42 reported their Hospital Readmission Rate (30 day) as of 2008 and these ranged from 13.6%- 25%.
- Twenty-five of the 42 reported their Quarterly Voluntary Disenrollment rate for quarter 2 of 2012 which ranged from 0.78%- 4%.
- Seventeen of the 42 sites reported their PMPM primary care costs for FY 2011 which ranged from \$198-\$774. The same sites reported their PMPM PACE center costs for FY 2011 which ranged from \$587-\$1,696.

Framed differently, the bar-graphs below illustrates the impact model variations have had on readmission rates, voluntary disenrollment, PMPM – primary care and PMPM – PACE Center. In most cases, outcome measures are consistent across programs, irrespective of whether they use a model variation. The only significant difference can be found in average per member/per-month costs for the PACE Center. While the data are fairly limited, PACE Center costs are significantly lower for programs that utilize ACS, lending credibility to the argument that expanded use of ACS would allow PACE organizations to serve individuals more efficiently.





Conclusion

The model variations proposed by the *PACE Innovation Act* have been tested through use of waivers over many years. These waivers have allowed PACE organizations to develop policies and procedures to ensure the changes do not adversely affect PACE quality, as evidenced by similarity in readmission data, voluntary disenrollment rates, and PMPM costs across programs. 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.