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REPORT TO CONGRESS

Evaluation of the Rural PACE Provider Grant Program

Kathleen Sebelius
Secretary of Health and Human Services
2011

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The author of this Report to Congress was Karyn Kai Anderson, Ph.D., M.P.H. at the Centers for Medicare & Medicaid Services.

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Executive Summary

The Program of All-inclusive Care for the Elderly (PACE) is an innovative model of care and an established Medicare benefit and Medicaid State Plan option designed to help the frail elderly population continue to enjoy the comforts of home and community by delaying or altogether avoiding nursing home placement. Although PACE is an enrollment option for very frail Medicare-only and Medicaid-only beneficiaries, ages 55 and older, the great majority of participants are dually eligible for both Medicare and Medicaid. Multiple evaluations have found PACE to result in fewer hospitalizations and nursing home placements and improved health status and quality of life (Beauchamp et al., 2008; Wieland D et al, 2000; Chatterji et al., 1998), thus Congress encouraged the expansion of PACE into rural communities by authorizing the rural PACE provider grant program in section 5302 of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109-171). This Report to Congress (RTC) fulfills section 5302(d) of the mandate requiring an evaluation of the initiation and early implementation experiences of these rural PACE pilot sites.

In evaluating the experience of the rural PACE pilot program, this RTC includes a descriptive section in which the rural PACE sites are characterized in terms of their physical structure, staffing arrangements, parent or sponsoring organization, outreach and marketing strategies, relationships with their surrounding communities (e.g., physicians, nursing homes, the state, etc.), CMS-approved flexibility waivers, and state contract and payment features. The evaluation study also explores the following research questions: 1) Given that approved PACE sites had to become operational before becoming eligible for a CMS grant award, what additional funds and relationships made it possible for them to do this? 2) Did any site activate the cost outlier protection reimbursement fund and if so, why? 3) What were the sites' experiences with start-up, enrollment and implementation of their PACE programs; what were some challenges, and what factors were particularly helpful? 4) What types of changes did sites make as they were getting off the ground and did these modifications aid their success? 5) To

what extent were the CMS grants effective in facilitating PACE program startup and how were CMS funds used? 6) What are States' perspectives on rural PACE?

This study is primarily a qualitative analysis. Descriptive information was gathered and synthesized from site visits, guided conversations with PACE providers and program staff, and informal conversations with PACE participants and family members and CMS and state officials. Sources of data also included grant applications, PACE Program Agreements, the Health Plan Management System (HPMS), and other administrative data.

This study found that in spite of multiple contextual challenges, 14 out of 15 (93%) rural PACE pilot sites launched successfully. Sites found the CMS grant to be indispensable to their successful launch. According to the rural PACE pilot site directors, this type of one time grant in the form of seed money has been an essential investment, especially given the challenges of starting a new program with a novel approach in rural communities. Startup funds were primarily spent on staffing (i.e., development of the interdisciplinary team), construction and renovation, and equipping sites with furniture, equipment, supplies and vehicles. The cost outlier protection fund was also indispensable to their successful launch. Even though it was used only once by one site to date, the cost-outlier protection fund has provided a level of insurance that made taking the risk of starting a PACE program more palatable. According to the sites, seed money from CMS or a parent or sponsoring organization is critical especially in rural areas still unfamiliar with the PACE model.

Challenges generally included staffing shortages in rural areas, perceived competition with Area Agencies on Aging (AAAs) in certain states and difficulties implementing such a novel model of care. A main challenge was that participants did not want to give up their primary care physician, an issue that was ameliorated by the use of the Community-based Primary Care Physician (CBPCP) waiver at many sites. Over the course of the second year of operation, two sites faced possible termination. The first site, *Vermont PACE*, was made whole financially by a new sponsor. The second site, *Maui PACE*, terminated its program August 31, 2010. A key factor in the Maui PACE outcome is the fact that its initial feasibility study was built on an

incorrect assumption regarding Medicaid eligibility (300% Federal Poverty Level (FPL) versus 100% FPL).

Thus far, PACE sites with the highest enrollments are those with reputable, experienced and financially strong sponsoring organizations supporting them. For example, the AAA provides positive referrals for PACE when PACE is offered as part of AAA services. Finally, rural PACE sites have been better able to survive, especially during periods of very low enrollment, when they are connected operationally to a non-rural PACE component, commonly referred to as the PACE “hub and spoke” model.

PACE sites that were able to overcome the challenges of starting an innovative model of care in a rural area have been able to experience the multitude of benefits associated with PACE. Qualitative data gleaned from conversations with PACE directors, staff and participants suggest that the rural PACE program preserves, enhances, and, in many cases, restores the independence, health and well-being of its participants. PACE also reduces burden among family care-givers, thereby allowing them to be more productive members of their communities. There may be an additional positive ripple effect created when PACE organizations in rural communities become established enough to require full time staff in that PACE both creates full time jobs and also fortifies local small businesses to stimulate the economy of rural America. This report finds overall favorable experience by beneficiaries, communities and the rural PACE pilot sites in the early phases of implementation. CMS will continue to monitor the development of the rural PACE sites over time.

Section 1. Introduction to the Mandate and Background

The Program of All-inclusive Care for the Elderly (PACE) is an innovative model of care that was originally developed in 1971 to help the frail elderly Chinese population living in San Francisco remain in their community and enjoy the comforts of home and family as long as possible and to delay or avoid nursing home placement. In the 1970s and 1980s the model continued to be refined and in 1986 legislation was passed to replicate the model (then called “*On Lok*”) through ten demonstration projects. In 1997, the Balanced Budget Act (Pub. L. 105-33) established PACE as a permanent provider under Medicare (section 1894 of the Social Security Act) and allowed states the option to pay for PACE services under Medicaid (section 1934 of the Social Security Act). The PACE model includes a comprehensive set of services delivered primarily at a given PACE center at which PACE participants spend much of their time. These services include medical care, physical, occupational and speech therapy, nutrition, transportation, respite care and recreational therapy, and social work. Each PACE site operates under its own unique mix of federal, state and private funds, thereby assuming full financial risk while conforming to the PACE model as closely as possible. PACE sites are allowed to apply for certain parameters of flexibility (i.e., “flexibility waivers”) from the standard PACE model; this is particularly helpful given the resource and other challenges unique to rural areas. Participants must be at least 55 years old, live in the PACE service area, currently live safely in the community with assistance, and be certified as eligible for nursing home level of care by the appropriate state agency.

Multiple evaluations over time have found PACE to result in fewer hospitalizations and nursing home placements and improved health status and quality of life (Beauchamp et al., 2008; Wieland D et al, 2000; Chatterji et al., 1998). In 2006, Congress encouraged the expansion of PACE into rural communities by authorizing the rural PACE provider grant program in section 5302 of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109-171). This initiative is also in recognition that rural areas of the United States tend to have older and poorer populations with fewer and more financially distressed health care options (Bailey 2009, AHRQ). According to

the Medical School Graduation Questionnaire All Schools Summary Report, of the roughly one fifth of graduating physicians indicating an intention to practice in an underserved area, the proportion wishing to serve rural areas has steadily declined from 40% in 2005 to 30% in 2009 (http://www.aamc.org/data/gq/allschoolsreports/gqfinalreport_2009.pdf). Data from the Pennsylvania Department of Health found that in 2006, there was one primary care physician (PCP) for every 1,167 residents in urban counties in Pennsylvania, compared to one PCP for every 1,681 residents in rural counties in the state (<http://www.rural.palegislature.us/about.html>).

Section 5302 also includes a mandate that CMS evaluate the experience of rural PACE pilot sites. In responding to this mandate, this Report to Congress (RTC) will examine the rural PACE pilot sites thus far, as per three critical sections of the legislation, sections 5302(b) (site development and technical assistance), 5302(c) (cost outlier protection) and 5302(d) (evaluation of the experience of rural PACE pilot sites). This last section will include a description of the enrollment, implementation, and fiscal experiences of these rural PACE pilot sites.

1.1 Background on the PACE Model of Care

The Program of All-inclusive Care for the Elderly (PACE) model is founded 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. The PACE model involves a center where participants congregate several times a week for socialization and a complete range of health and supportive services, including primary care, thereby allowing participants to maintain independence in their homes as long as possible. However, it is important to note that if institutional care is unavoidable, the participant continues to be enrolled in PACE.

PACE is a capitated benefit authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. The PACE model was developed to address the needs of long-term care clients, providers, and payers. Participants must be at least 55 years old, live in the PACE service area, currently live safely in the community with assistance, and be certified as eligible for nursing home level of

care by the appropriate state agency as per the requirements of section 1915(c) of the Social Security Act home and community based services (HCBS) waiver program. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees. For most participants, the comprehensive service package permits them to continue living at home while receiving services, rather than be institutionalized.

The BBA established the PACE model of care as a permanent entity within the Medicare program and enables states to provide PACE services to Medicaid beneficiaries as a state option. The state plan must include PACE as an optional Medicaid benefit before the state and the Secretary of the Department of Health and Human Services (DHHS) can enter into program agreements with PACE providers. At the time of the rural grant review process, CMS had 35 signed PACE contracts and 6 pending applications with organizations in urban areas. By May 2010, CMS had 75 approved PACE sites across 29 states, indicating growth of the model, even without counting the rural sites.

An interdisciplinary team (IDT), consisting of professional and paraprofessional staff, assesses participants' needs, develops care plans, and delivers all services (including acute care services and when necessary, nursing facility services) which are integrated for a seamless provision of total care. Capitated financing allows providers to deliver all services participants need rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems. PACE programs provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participant's needs. The PACE service package must include all Medicare and Medicaid covered services, and other services determined necessary by the IDT for the care of the PACE participant. PACE providers receive monthly Medicare and Medicaid capitation payments for each eligible enrollee. PACE also includes the Medicare Part D pharmacy benefit. Medicare eligible participants who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount, but no deductibles, coinsurance, or other type of Medicare or Medicaid cost-sharing applies. PACE providers assume full financial risk for participants' care without limits on amount, duration, or scope of services. (CMS Website: <http://www.cms.gov/PACE>)

1.2 CMS Grants Initiative That Was Installed Per Section 5302

On April 21, 2006, CMS issued the Rural PACE Provider Grant Program Solicitation Announcement to implement section 5302 of the Deficit Reduction Act of 2005, which appropriated \$7.5 million in FY 2006 for the award of up to 15 PACE site development grants (Appendix I). Each grant was not to exceed \$750,000 per rural PACE pilot site. This funding could be spent on activities critical to the successful start-up of the PACE program including feasibility studies, development of the interdisciplinary team and provider network, and other expenses approved by the Secretary. Startup funds were primarily spent on staffing (i.e., development of the interdisciplinary team), construction and renovation, and equipping sites with furniture, equipment, supplies and vehicles. In addition, the funds could be spent on the establishment of a working capital fund to sustain fixed administrative, facility, or other fixed costs until the provider reaches sufficient enrollment size. Funds could also cover startup and development costs incurred prior to the approval of the rural PACE pilot site's PACE provider application by CMS.

The new Rural PACE Provider Grant Program provided 15 grantees with \$500,000 each to support the development of a rural PACE program for some of the most vulnerable Medicare, Medicaid and dually eligible beneficiaries within thirteen states across the country. CMS awarded all of the possible funds and the maximum number of grants available to expand patient-based care to a greater number of people with Medicare and Medicaid who live in rural areas. Additionally, when the Charleston Area Medical Center (CAMC) Health Education and Research Institute in Charleston, West Virginia withdrew, its allotted \$500,000 was dispersed equally to the remaining 14 sites. West Virginia withdrew before being approved by CMS because it was not able to come to an agreement with the State of West Virginia regarding the Medicaid payment rate. All 15 original grantees are listed in Table 1, below.

Table 1. Original Awardees

<u>State Abbrev</u>	<u>State</u>	<u>City</u>	<u>Awardee</u>	<u>Site Name</u>
AR	Arkansas	Jonesboro	AllCare of Arkansas	Total Life Healthcare
CO	Colorado	Grand Junction / Montrose	Volunteers of America	Senior CommUnity Care
HI	Hawaii	Kahului	Hale Makua	Maui PACE
IA	Iowa	Sioux City	Hospice of Siouxland	Siouxland PACE
MT	Montana	Billings	Billings Clinic PACE Foundation	Billings Clinic PACE
NC	North Carolina	Carrboro	Piedmont Health Services	Piedmont Health SeniorCare
ND	North Dakota	Bismarck	Northland Healthcare Alliance	Northland PACE
NY	New York	Olean	Community Care of Western New York	Total Senior Care, Inc.
PA	Pennsylvania	Kulpmont	Geisinger Health System Foundation	LIFE Geisinger
PA	Pennsylvania	Chambersburg	Lutheran Social Services of South Central Pennsylvania	LIFE Lutheran Services, Inc.
SC	South Carolina	Orangeburg	The Methodist Oaks	The Oaks PACE
VA	Virginia	Cedar Bluff	Appalachian Agency for Senior Citizens	AIRCARE for Seniors
VA	Virginia	Big Stone Gap	Mountain Empire Older Citizens	Mountain Empire PACE
VT	Vermont	Rutland	PACE Vermont	PACE Vermont, Inc
WV	West Virginia	Charleston	CAMC Health Ed and Research	N/A

1.3 Methods

The study is primarily a qualitative analysis. Descriptive information was gathered and synthesized from grant applications, PACE Program Agreements, the Health Plan Management System (HPMS), other administrative data, site visits, guided conversations with PACE providers and program staff, and informal conversations with PACE participants, their family members and government officials at State Medicaid offices and CMS.

Section 2. Results

2.1 Overview of PACE Pilot Sites and Their Beneficiaries

2.1.1 PACE Participants

As depicted in Table 2, the majority of PACE participants are female. While eligibility is open to those 55 years of age and older, the vast majority of participants were 65 years of age and older. The exception was *Siouxland PACE* in Iowa which had much more balanced ratio of aged to disabled enrollees especially when compared to other sites.

Table 2. PACE Participant Demographics

State	Dually Eligible	Female	Male	Aged	Disabled	ESRD
AR	100.0%	74.3%	25.7%	91.4%	8.6%	0.0%
CO	92.4%	80.3%	19.7%	90.4%	9.6%	1.9%
HI	84.0%	68.0%	32.0%	96.0%	4.0%	0.0%
IA	89.5%	59.6%	40.4%	52.6%	47.4%	10.5%
MT	100.0%	72.4%	27.6%	82.8%	17.2%	0.0%
NC	92.5%	69.8%	30.2%	81.1%	18.9%	0.0%
ND	87.0%	87.0%	13.0%	95.7%	4.3%	2.2%
NY	93.5%	74.2%	25.8%	80.6%	19.4%	0.0%
PA ¹	95.6%	79.6%	20.4%	97.8%	2.2%	0.0%
PA ²	93.9%	66.7%	33.3%	93.9%	6.1%	0.0%
SC	88.9%	87.0%	13.0%	94.4%	5.6%	3.7%
VA ¹	100.0%	80.6%	19.4%	90.3%	9.7%	0.0%
VA ²	100.0%	78.6%	21.4%	96.4%	3.6%	0.0%
VT	88.4%	58.0%	42.0%	85.5%	14.5%	1.4%

PA¹: Kulpmont

PA²: Chambersburg

VA¹: Cedar Bluff

VA²: Big Stone Gap

Siouxland PACE also had a disproportionate proportion of participants with end-stage renal disease (ESRD) relative to other sites. The director of *Siouxland PACE* explained that the

disproportionate number of disabled versus elderly beneficiaries has had a severe economic impact on its viability. For its continued survival, the site has recently had to shift its marketing efforts toward rural elderly persons. The director believes that the reason for this situation is that many participants shifted to PACE from a community-based palliative care program for persons with disabilities developed by the same parent organization, Hospice of Siouxland. She believes it is also possible that the community-based primary care physicians may tend to refer mostly individuals with disabilities, who are not yet elderly, to the program.

2.1.2 PACE Sites

2.1.2.1 Physical Structure

While PACE programs always occupy a building or part of a building as the PACE center, there is a range of physical locations for the rural PACE sites. For example, *Siouxland PACE* in Iowa is co-located in a senior center, and as a result they benefit by getting walk-in self-referrals every month. *Northland PACE* in North Dakota is attached to a nursing home which has been helpful for referrals. *Maui PACE* is also co-located in a nursing facility. *LIFE Geisinger* in Pennsylvania is located in a renovated former school. Both Virginia sites are located in the same building as their Area Agency on Aging (AAA), one of which also shares space with a children's daycare center.

In spite of all these differences in actual structure, PACE centers are more similar than they are different. In addition to administrative offices for program management, PACE sites typically have one large common room in which socialization, recreation therapy and meals are provided. These rooms are often bright and cheery. Sites also have clinical rooms in which medical care, physical and occupational therapy, and mental health services are provided.

Some sites are single entities while others have what is called "hub and spoke". Hub and spoke describes the arrangement in which a rural and a non-rural site within driving distance are connected operationally. Montana (Billings and Livingston), North Dakota (Bismarck and

Dickenson), Pennsylvania (Scranton and Kulpmont), and Vermont (Burlington and Rutland) all employed the hub and spoke model. These rural sites are able to benefit from the experience of the pre-existing non-rural PACE sites in getting off the ground. Since most pairs even share administrative staff, they are also able to benefit from lower administrative costs. In general, it appears to be an effective model. North Dakota's *Northland PACE* found that tying the rural PACE program to a more urban hub is an effective model, and particularly so when the rural population is small. While not exactly hub and spoke, *AllCARE for Seniors* in Cedar Bluff, Virginia has a small number of participants in a daycare that is about 1.5 hours from the main center. Colorado's *Senior CommUnity Care* rural PACE program has two rural locations. Almost conversely, *Siouxland PACE* in Iowa has one location that serves both rural and non-rural participants, currently at a 1 to 9 ratio, but with an ultimate goal of 3 to 7, respectively.

2.1.2.2 PACE Services and Staffing Arrangements

PACE services include the full range of comprehensive care:

- Adult day care that offers nursing; physical, occupational and recreational therapies; meals; nutritional counseling; and social work at the PACE Center, as required.
- Medical care provided by a PACE physician familiar with the history, needs and preferences of each participant
- Home health care and personal care assistance (PCA)
- All necessary prescription drugs
- Social services
- Medical specialists such as audiology, dentistry, optometry, podiatry, and speech therapy
- Hospital and nursing home care when necessary
- Durable medical equipment
- Transportation
- Respite care and end-of-life palliative care
- Quality Assurance and Program Improvement (QAPI) program

These services are mostly offered in the typical PACE “one-stop-shopping” model. However, while rural PACE pilot sites report that most services are offered on-site, in some cases certain services are provided off-site. For example, dental health care is offered off site at the Colorado, North Dakota, and Chambersburg Pennsylvania rural PACE sites.

Many PACE sites have found that, especially when they were in their infancy, it has been more efficient to contract for certain services than to hire a full-time equivalent (FTE) staff person in spite of the additional cost associated with contractors. As their census increases, some sites have been able to support an FTE. Contractual relationships have been arranged for virtually all staffing positions, from transportation and PCA (many sites) to skilled nursing, registered dietician, social work and occupational, speech and physical therapy (many sites) to primary care physicians (Colorado’s *Senior CommUnity Care* and Cedar Bluff, Virginia’s *AllCARE for Seniors*). *AllCARE for Seniors* even contracts for its QAPI program as well, though this is required to be overseen and implemented by the medical director. However, several program directors mentioned that in spite of their advantages, the use of contractors can be costly.

2.1.2.3 Parent or Sponsoring Organization

Table 3 that follows describes the parent or sponsoring organizations associated with each rural PACE pilot site. More than one X will appear under a given PACE site in cases where more than one entity have teamed up as co-sponsors. *Vermont PACE* is an interesting case study. It had no parent organization for almost two years. Because enrollment was slow and expenses were high, the site eventually came to the decision to close in late 2009. After a first potential sponsor showed interest and then backed out, the Volunteers of America (VOA) board voted affirmatively to help *Vermont PACE*. However, this decision was contingent on having *On Lok*, the original PACE organization, as a partner. The two entities created a new organization called On Lok VOA, Inc. (OVI). On January 30, 2010, OVI signed an agreement with *PACE Vermont*, formally agreeing to support this PACE organization, including its rural site in Rutland, and help bring it to success. With the support of OVI, *Vermont PACE* remained open.

Table 3. Parent or Partnering Organization

	AR	CO	HI	IA	MT	NC	ND	NY	PA ¹	PA ²	SC	VA ¹	VA ²	VT	Total
No Parent														*	1
Health care system	X				X	X			X						5
Area Agency on Aging	X											X	X		3
Faith-based sponsor										X	X				2
Health care delivery network							X								1
Home and community based health care services organization			X												1
Hospice and home-health care organization				X				X							1
Volunteers of America (VOA)		X												X [^]	2

*Before PACE VT partnered with OVI on January 29 2010, PACE VT had no parent or partnering organization.

[^] On Lok VOA, Inc. (OVI), as of January 29 2010.

PA¹: Kulpmont

PA²: Chambersburg

VA¹: Cedar Bluff

VA²: Big Stone Gap

2.1.2.4 Outreach and Marketing Strategies

Rural PACE pilot sites have relied on a range of marketing strategies to spread the word about their unique program. While all sites included comprehensive strategic marketing plans in their program agreements, Table 4, as follows, specifies marketing strategies that the PACE organization directors and other staff described when they were asked about marketing in an open-ended format. The strategies below fall into two categories, indirect and direct. Indirect strategies are those efforts that are aimed at potential referral sources (e.g., the physician community, the area agencies on aging, social workers, etc.). Direct strategies target the prospective participants themselves, often via mass marketing and information-sharing at events where elderly persons or their family members might be in attendance. The most common strategies employed were direct strategies such as attending health fairs, trainings, support groups and community events and advertising in local newspapers. Developing a referring relationship with the Area Agencies on Aging also proved to be fairly common, and quite effective. Some sites made no reference to use of indirect strategies (MT, ND, SC) while Colorado’s *Senior CommUnity Care* used no direct strategies.

Sites reported being challenged by the fact that marketing could not commence until the site had been approved by CMS. They explained that their inability to pre-market PACE seriously compromised their enrollment success in the beginning. While this was the case for all sites, certain sites were able to capitalize on their association with other entities or existing PACE sites. For example, PACE in Montrose Colorado (*Senior CommUnity Care*) benefitted substantially from its urban counterpart, *Total Long Term Care* in Denver which already had built a strong brand awareness for itself. As a result, even after becoming approved, *Senior CommUnity Care* has not had to market using traditional and often costly methods. Similarly, the two rural PACE sites in Virginia (*AllCARE for Seniors* in Cedar Bluff and *Mountain Empire* in Big Stone Gap) have been able to benefit from other programs in their AAAs that feed almost effortlessly into PACE. A third asset to sites has been the hiring of certain staff that happen to have existing relationships and ties to the community. For example, the social worker in North Dakota and the Medical Director in Big Stone Gap, Virginia both had pre-existing ties to the clinicians in their communities.

The marketing strategies employed by *Vermont PACE* experienced quite a turnaround after being sponsored by OVI. Prior to OVI becoming the sponsoring entity, *Vermont PACE* employed minimal marketing and outreach strategies due to a constrained budget. They had occasional advertisements in community newspapers and met with a select group of providers for potential referrals. However, when OVI stepped in, there was renewed focus on program sustainability, and therefore enrollment, and thus new investment in both direct and indirect marketing strategies. Greater media coverage was solicited. A larger newspaper ran a feature article. An advertisement was run repeatedly on the public broadcasting television channel. In addition, *PACE Vermont* committed to making 90 outreach visits within 90 days to potential referring entities such as nursing homes, residential care homes, physicians' offices, home health agencies, and the health department.

Table 4. Outreach and Marketing Strategies by Rural PACE Pilot Sites

	AR	CO	HI	IA	MT	NC	ND	NY	PA ¹	PA ²	SC	VA ¹	VA ²	VT	Total
INDIRECT STRATEGIES															
AARP										X					1
Area Agency on Aging		X	X			X				X		X	X		6
City developers				X											1
Hosting events for social workers and nurses			X									X			2
Information sharing and speaking	X	X						X							3
Presentations to medical staff at hospitals			X						X				X		3
Visiting doctors' offices and nursing homes								X						X	2
Visiting emergency departments and discharge at hospitals; senior services, assisted living, independent living housing directors; hospice staff	X		X	X										X	4
Visiting the Health Department and home health agencies														X	1
Visiting nursing and social work departments at universities				X											1
DIRECT STRATEGIES															
Advertisements and "wrapping" on vehicles	X										X				2
Advertisements and articles in local newspaper			X		X		X		X	X	X		X	*	8
Advertisements on TV, radio and/or magazines				X		X		X	X		X	X		*	6
Billboards						X		X	X	X					4
Churches										X					1
Health fairs, trainings, support groups and community events	X		X		X	X		X	X	X	X	X			9
Hosting open houses, meals, and events					X		X		X	X					4
Periodic newsletter										X					1
Radio-spot										X					1
Visiting clubs, community groups, senior housing			X	X		X		X			X		X	X	7

* *PACE Vermont's* strategies before gaining OVI as its sponsor, January 2010.

PA¹: Kulpmont

PA²: Chambersburg

VA¹: Cedar Bluff

VA²: Big Stone Gap

2.1.2.5 Relationships with Surrounding Community

PACE sites' relationships with professional and lay members of their surrounding communities have proven to be pivotal to their success. In fact, certain entities have been more critical than others. Table 5 below, and the text that follows, describe the perceived support versus resistance by the state, the AAAs, physician groups, nursing homes, local hospitals, and the surrounding community.

Table 5. Perceived Relationships Between Rural PACE Pilot Sites and their Surrounding Communities: Positive (P), Negative (N), and Neutral (-)

	Total Positive	Total Negative	Total Neutral
State	11	1	2
AAA	7	6	1
Physicians	5	2	7
Nursing homes	7	3	4
Hospitals	11	1	2
Community	9	0	5

Area Agencies on Aging: The level of support supplied by the Area Agencies on Aging (AAAs) is a particularly strong marker for successful program enrollment. Some rural PACE pilot sites have very positive relationships with their AAAs. At these locations, the AAAs are a reliable source of referrals and are in general very supportive of the PACE model. At three sites in particular, this relationship is especially strong given that the local AAAs actually serve as the parent or sponsoring organization. As a result, PACE is an actual AAA program and is typically housed in the same building as the AAA. Referrals flow naturally from this relationship without the sense of competition that can affect other sites. These AAAs also provide certain services for PACE and strengthen the name recognition of the PACE programs.

At several other sites, however, the AAAs have been a significant barrier to enrollment. According to these PACE directors, not only do the local AAAs often have competing programs for nursing home eligible participants, but the AAAs serve as the central point of contact for seniors looking for services. Additionally, nursing home eligibility is actually determined by the AAA in some of these states. At one site it was noted that during the early phases of implementation, the AAA would not approve beneficiaries for the PACE program unless they were extremely sick and frail. As a result, the vast majority of this program's PACE enrollees (estimated at 80%) had extraordinarily high levels of need when they first entered the program and thus necessarily high expenses to stabilize these participants at intake. Another site noted that the local AAAs view PACE as competition even when the AAA has long waiting lists, perhaps because AAA staff do not understand how PACE differs from the community based waiver programs.

Physicians: Almost all rural PACE pilot sites have experienced difficulty piercing the physician network. It was widely reported that many community physicians have viewed PACE as a threat to their patient populations and thus have been slow to refer participants to the program. PACE programs have also learned that many potential participants are wary of joining because they are reluctant to give up their personal physician. This issue has been addressed to a large extent by the Community Based Primary Care Physician flexibility waiver that is discussed in Section 2.4.1.6 of this Report. Alternatively, as a sort of weaning process to deal with this issue, one site pays for its participants to see their own physician three final times over the first three months that the participant is enrolled in PACE.

In spite of the almost universal resistance from the physicians in rural areas, some sites experienced positive relationships. For example, most referrals at *Senior CommUnity Care* in Colorado have come from community physicians. It is believed that physicians see the positive impact of PACE on their patients. *Mountain Empire PACE* staff in Virginia also believe that physicians in their area are not threatened by PACE because their clinics are so overloaded.

One site noticed that once PACE began demonstrating its ability to truly care for its participants, some physician groups have started referring participants more regularly. At another site, the main barrier to referrals was that physicians were accustomed to operating in a fee-for-service environment and thus did not understand the PACE model. Yet another site noted that even though community physicians seemed to support the PACE model in theory, they were the source of very few referrals. These PACE staff acknowledge that there is work to do in building this relationship.

Nursing Homes: Considering that the very goal of PACE is to help beneficiaries avoid nursing home placements, it is not at all surprising that there is quite a mix of relationships with the area nursing homes. Vermont, Iowa, North Carolina, South Carolina and Pennsylvania (Chambersburg) report positive relationships with their area nursing homes with some even serving as a source of referral. At *Hale Makua PACE* in Maui, the PACE program is physically located in one of the two nursing homes operated by its parent organization. This structure has been very positive for the PACE program. On the other hand, while some nursing homes near some of these rural sites seemed to understand the importance of community based programs, it is also perceived that nursing homes are directly threatened by the new PACE programs in their rural communities. *Senior CommUnity Care* in Colorado has the particular advantage of being linked to two of the six nursing homes in the area, since these two are VOA nursing homes. The PACE site sponsor; however, believes the remaining six nursing homes view PACE as competition.

Hospitals: Most of the rural communities that house the rural PACE pilot sites have only one or two hospitals. These hospitals often struggle financially especially in the midst of a demographic shift away from rural areas. For example, the hospital near one PACE pilot site recently downsized from 100 beds to 25 beds due to declining population in the area. Rural PACE pilot sites in several states noted particularly positive relationships with area hospitals and have contractual relationships with these hospitals. For example, the Medical Director at Big Stone Gap secured a contract with one of the two area hospitals by agreeing to pay 105% of the Medicare rate. The Arkansas PACE site has the benefit of being a subsidiary of St. Bernard's

Healthcare, which has most area medical centers in its geographic area under its one umbrella. As a result all contracted services are first contracted from under the same umbrella whenever possible.

However, some rural PACE staff perceive that some hospitals do not yet know how they can benefit from a PACE program in the community. Alternatively, PACE staff at another site report that its area hospitals have been somewhat resistant to PACE in their communities, though this may be due to the fact that many PACE staff are actually recruited from these community hospitals. At one site, the relationship with one of the two area hospitals has been improved since the hospital began noticing how quickly the PACE site pays its bills.

Community: All sites reported their communities being somewhere on the spectrum between having never heard of PACE and very much appreciating PACE. Most rural PACE sites report that the community has been very supportive, especially once they have come to understand PACE. The rural PACE pilot sites' communities in Colorado, Iowa, Montana and North Dakota seem to be aware of and excited about the PACE model. However, residents of the areas near the New York, Pennsylvania (Chambersburg) and Vermont PACE sites are still only beginning to become aware of PACE in their communities, though the programs seem to be embraced by those who know of them. At *Total Senior Care, Inc.* in New York, the top two questions from community members regarding PACE are: 1) "Do you have to participate 5 days/week?" and 2) "Do you have to give up your own doctor?" *Maui PACE* experienced potential enrollees being reluctant to join out of fear of giving up their health plan and primary care physician only to have the PACE organization cease operations. Indeed, for *Hale Makua PACE*, this did in fact transpire since this site has notified CMS of its plans to terminate its PACE program, as describe in greater detail later in Section 2.4.2 of this Report.

States: The majority of PACE sites have described their relationships with their states as positive. The State of Pennsylvania has been extremely supportive of the PACE model and has committed to a PACE site in every county. The State of Colorado is also very positive about the PACE model due to its experience with the urban PACE program in Denver, *Total Long Term*

Care, which is seen as a benchmark. Other sites, especially those with particularly slow enrollment progress, described challenges in working with their states. It is believed that some of these states felt like they already had effective nursing home alternatives. States range in their resources dedicated to the rural and non-rural PACE programs from one staff member who handles all PACE matters to an entire division.

The role of states as one critical member of the three-way PACE program agreements is to: set Medicaid payment rates, oversee the PACE programs in the state; answer questions from and provide information to sites, adjudicate any grievances that are not resolved by the PACE organizations; “pre-review” applications, contracts and marketing materials before they are submitted to CMS; and receive and review reports from the sites. To a certain extent, states vary on some contract features. For example, one site has a separate side agreement containing state-specific requirements that are more stringent than the standard PACE program agreement (e.g., PACE programs are required to inform the state when a participant disenrolls).

2.1.2.6 Medicare and Medicaid Rate Setting

Medicare: Before January 1, 2004, Medicare payment to PACE organizations was based entirely on the Medicare Part A and Part B demographic rate for “aged” individuals for the county in which the participant lived, adjusted by a frailty factor of 2.39. This payment was referred to as the demographic rate. Over the course of January 1, 2004 to December 31, 2007, PACE organizations transitioned to risk adjusted payment methodology per the Medicare Advantage program, which is then further modified to reflect the organization-level frailty of each PACE organization’s enrollees. Under this new methodology, individual enrollee payment rates comprise the sum of the individual risk score per their Hierarchical Condition Categories (HCC) score and the organization’s frailty score multiplied by the county-level rate.

Medicare Part D: The Part D payment to PACE organizations comprises several components, including the direct subsidy, reinsurance payments, risk sharing, and low-income subsidies

(LIS). LIS premium payments cover the entire beneficiary premium for dual eligible enrollees in PACE plans.

Medicaid: All State Medicaid programs use the prospective per member per month (PMPM) capitation payment method for paying PACE sites. Table 6 below presents site-specific PMPM Medicaid rates for those with Medicaid-only and dual eligible beneficiaries with Medicaid and Medicare. Medicaid PACE rates must be less than states would have otherwise paid for a comparable population under Medicaid. Thus, states obtain an upper payment limit (UPL) by trending forward fee-for-service historical data from a comparable population of persons ages 55 and older who are receiving nursing home-level of care. The resulting rate must be less than this UPL. Some states state openly that they will pay 95% of the UPL. Others do not disclose their UPL so that they may negotiate a rate with the PACE sites that is some point beneath this UPL.

Table 6. Medicaid and Medicare PMPM by Site at Time of Program Startup

Site	State	Site Name	Dual Eligible PMPM	Medicaid-only PMPM
1	AR	Total Life Healthcare	<65 y.o.: \$3619.37 65+: \$3232.34	<65 y.o.: \$5380 65+: \$3232.34
2	CO	Senior CommUnity Care	\$3711	<65, not disabled: \$3393 <65,disabled: \$4891 65+: \$3711
3	HI	Maui PACE	\$2,875.55	\$3,302.91
4	IA	Siouxland PACE	<65 y.o.: \$2833.00 65+: \$2507.00	\$4350.00
5	MT	Billings Clinic PACE	\$2545.00	\$3653.35
6	NC	Piedmont Health SeniorCare	\$3310.02	\$3561.86
7	ND	Northland PACE	<65y.o.: \$4035 65-74: \$3462 75+ y.o.: \$3624	\$5623.00
8	NY	Total Senior Care, Inc.	\$3518.09	\$5714.09
9	PA	LIFE Geisinger	\$3688.00	\$5050.80
10	PA	LIFE Lutheran Services, Inc.	\$3,799.00	\$5,050.00
11	SC	The Oaks PACE	\$2246.00	\$3668.00
12	VA	AlICARE for Seniors	\$2591.57	\$4111.80
13	VA	Mountain Empire PACE	\$2591.57	\$4111.80
14	VT	PACE Vermont, Inc	\$4017.00	\$5205.00

2.1.2.7 Establishing Nursing Home Certifiability

Potential PACE participants are deemed eligible to participate if they are 55 years of age or older and both able to live safely on their own while also meeting their state’s criteria for nursing

home eligibility. The process of determining nursing home eligibility is often called a level of care (LOC) determination. Per the 1915(c) program, CMS leaves LOC determinations in the hands of the states, thus there is wide variability between states in their LOC determination methods. To probe these differences, Rutgers Center for State Health Policy prepared a report for CMS (<http://www.cshp.rutgers.edu/Downloads/7720.pdf>). In spite of LOC determinations being the responsibility of the state Medicaid agency per CFR 440.230(d), Rutgers found that the LOC function was located in comprehensive health, human or social service agencies in 34 states and in state Medicaid agencies in five states. Similarly, there were no commonalities in the assessment tool or its administration. A contractor was involved in some aspect of the assessment in 40 states, medical staff in nursing homes in 25 states, and Area Agencies on Aging in five states. There was similar variability in the type of staff who administer the assessments in terms of their qualifications and membership to professional organizations, etc. Table 7 portrays greater information on the range of assessment methods employed by states of the rural PACE pilot grant recipients.

2.2 Examination of Rural PACE Development Per Section 5302(b) of the Legislation

2.2.1 Site Development

2.2.1.1 PACE Site Selection Process

On April 21, 2006, CMS issued the Rural PACE Provider Grant Program Solicitation Announcement in response to section 5302 of the Deficit Reduction Act of 2005 which appropriated \$7.5 million in FY 2006 for the award of up to 15 PACE site development grants. Each grant was not to exceed \$750,000 per rural PACE pilot site. Grant awardees could not access the funding until after the awardees had submitted a PACE application for review and approval by CMS per a signed PACE agreement. The PACE agreement is a 3-way contract between the PACE organization, the State Medicaid agency and CMS. Most program agreements are for an initial term of approximately 15 months, and all program agreements automatically renew, indefinitely, unless or until terminated by any of the three parties.

Table 7. State Means of Assessing “Nursing Home Eligibility”

State	LOC Defined*	Name of LOC Assessment Form	Website	Who administers it?	Where?	Con-tractors involved?
AR	Mixed (Clinical & ADL)	DHS-703 Arkansas Dept. of Human Services Evaluation of Medical Need	https://www.medicaid.state.ar.us/InternetSolution/General/units/oltc/forms/forms.aspx	Nursing facility staff or hospital staff	Resident domicile	Yes, to determine if specialized services are required
CO	Mixed (Clinical & ADL)	Uniform Long Term Care, 100.2 (ULTC 100.2) IADL^ Assessment	http://www.chcpf.state.co.us/HCPF/LTC/sepindex.asp	Single Entry Point Agencies	Nursing facility	Yes, 23 Single Entry Point Agencies, for assessments
HI	Mixed (Clinical & ADL)	Level of Care (LOC) Evaluation, Form 1147	http://www.medquest.us/PDFs/Frequently%20Used%20Forms%20for%20Providers/1147%20Form.pdf	Facility or Referring agency staff	Facility or Referring Agency	Yes, to conduct Assessments
IA	ADL	Form 470-4393 LOC Certification form for Facility	http://www.ime.state.ia.us/LTC/LevelOfCare.html	Medical Professional (MD, DO, ARNP, PA) Conducts assessment and information reviewed by IME nurses	Resident Domicile	Yes
MT	Mixed (Clinical & ADL)	Level of Care	None	NF staff with phone contact with contractor	Resident Domicile	Yes
NY	Mixed (Clinical & ADL)	Patient Review Instrument (HC-PRI)	http://www.health.state.ny.us/forms/doh-694.pdf	Assessors, qualified through the Dept of Health PRI Training Program	Resident Domicile	Yes, Assessors who are discharge planners, RN's, and other utilization review personnel employed by facilities
NC	Mixed (Clinical & ADL)	Medicaid Uniform Screening Tool (MUST)	None	NF staff, County Health staff, Hospital discharge planners, etc.	Resident Domicile	Yes, to develop the new Uniform Assessment Tool
ND	Mixed (Clinical & ADL)	Level of Care Continued Stay Determination Form	http://www.ascendami.com/ND/forms/NDLOCScreen.pdf	DDM Ascend of Nashville, TN	Resident domicile	Yes, to be responsible for all level of care Screens
PA	Clinical	Level of Care Assessment (LOCA)	HTTP://www.aging.state.pa.us/aging/cwp/view.asp?a=558&Q=	AAA assessors	Resident domicile	AAAs
SC	Mixed (Clinical & ADL)	South Carolina Long Term Care Assessment Form	http://www.dhhs.state.sc.us/dhhsnew/insidedhhs/bureaus/BureauofLongTermCareServices/forms.asp	RN's employed by DHHS and Case Manager employed by/contracted with DHHS	Resident domicile	No
VT	Mixed (Clinical & ADL)	Independent Living Assessment, Form 703 Choices for Clinical Care Assessment	http://www.ddas.vermont.gov/ddas-forms/formscfc/forms-cfc-highest-needs-documents/clinicalassessment	state nurses for LOC assessment Case Managers from AAAs, Home Health Agency or Adult Day for functional assessment used for care planning	Resident domicile	AAA and Home Health Agencies are reimbursed as part of the FFS Choices for Care services for functional assessment
VA	Mixed (Clinical & ADL)	DMAS99C Community-Based Care Recipient Assessment Report	http://www.dmas.virginia.gov/downloads/forms/DMAS-99.pdf	Nurses employed by provider agencies	Resident domicile	No

* ADL: Activities of Daily Living

^ IADL: Instrumental Activities of Daily Living

The information presented in this table is extracted from research by Rutgers Center for State Health Policy:

<http://www.cshp.rutgers.edu/Downloads/7720.pdf>.

2.2.1.2 Applications Received

CMS received 25 rural PACE grant applications from across each of the ten CMS regional areas except the Seattle region. Six applications were received from the Philadelphia Region and five applications from the Dallas Region. Twenty four of the 25 applications qualified as “rural” PACE applicants.

2.2.1.3 Panel Review Process

Two panels comprising 15 qualified individuals from CMS and the Health Resources and Services Administration (HRSA) reviewed the 24 qualified applications. Each panel reviewed and scored 12 applications using the criteria set forth in the grant solicitation. The six evaluation areas were the following: 1) background and prior experience (15 points), 2) project description, methodology and work plan (30 points), 3) significance and sustainability (25 points), 4) collaboration, agreements and capacity (15 points), 5) budget narrative, justification and resources (10 points), and 6) application organization detail (5 points). For each application, the individual criterion scores were aggregated to form an average composite score by which all applications were then ranked. It was decided that awards of \$500,000 were to be given to the top ranking 15 applications.

2.2.1.4 Discussion of Panel Recommendation in the Context of the Statutory Boundaries of the Grant Program

The rural PACE grant program was required to meet the following criteria: 1) no more than 15 awards 2) awards cannot exceed \$750,000 each and 3) total dollar limitation for the rural PACE grant was \$7.5 million. In addition to the limitations, awardees were to have submitted approvable PACE applications to CMS for signed PACE agreements by 9/30/2008 before they could claim any money from the rural PACE grants. If any awardees failed to obtain signed PACE agreements by September 30, 2008, the funds were to revert back to the United States Treasury.

CMS was faced with the dilemma of whether to award the maximum amount of \$750,000 per rural PACE pilot site, and thus be limited to 10 awards, or to award to the maximum number of awards (15), and thus be limited to \$500,000 per award. Since the purpose of the rural PACE grant was to promote the development of PACE in rural service areas, awarding the maximum number of awardees would give the greatest number of beneficiaries residing in rural areas access to PACE services. Otherwise, the awarding of only 10 grants would have limited the potential impact of the initiative. The end result was that CMS made the maximum number of awards (15) allowed under the statute of identical amounts (\$500,000) to ensure equal financial footing for all awardees.

Awarding the maximum number of grants had the effect of reducing the funding amount of each grant from \$750,000 to \$500,000, a decrease of 33%. Since all grant requests targeted the maximum amount of \$750,000, awardees were to submit a revised budget not exceeding \$500,000.

When the Charleston Area Medical Center (CAMC) Health Education and Research Institute in Charleston, West Virginia withdrew, its allotted \$500,000 was then dispersed equally to the remaining 14 sites. West Virginia withdrew before being approved by CMS because it was not able to come to an agreement with the State of West Virginia regarding the Medicaid payment rate.

A key requirement of the rural PACE grant was that awardees were to have submitted approvable PACE applications and obtained signed PACE agreements before funds were disbursed from the grants. The PACE application review by CMS was a thorough examination and critical analysis of all aspects of the awardees' viable operational plan and approach to provide and deliver PACE services to beneficiaries. Additionally, before the program agreements were signed, the state performed a "readiness review" to ensure that certain environmental, structural and contractual factors were in place. Awardees could only claim

CMS funds after fulfilling all the requirements of the PACE application and obtaining a signed PACE agreement by 9/30/2008.

2.2.2 Technical Assistance

Also per 5302(b), a technical assistance program was to be established by the Secretary to provide outreach and education to state agencies and provider organizations interested in establishing PACE programs in rural areas; and technical assistance necessary to support rural PACE pilot sites. For the selected applicants, each was assigned a CMS Team Lead to provide technical assistance. PACE organizations were also encouraged to seek the services of one of the Technical Assistance Centers (TACs) endorsed by the National PACE Association. The TACs provided feasibility studies for selected applicants prior to the signing of its three-way program agreement between itself, the State and CMS.

2.3 Examination of the Cost Outlier Protection per Section 5302(c)

The cost outlier protection fund was established by Congress to provide applicants with some insurance against extremely high participant expenses (i.e., inpatient costs). Reimbursement requests include only costs for hospitalizations and ancillary services (e.g., physician care related to follow-up), and is not inclusive of other health care costs, such as community care, prescription medicines or subsequent Skilled Nursing Facility stays. PACE sites are eligible to receive 80% of the amount by which recognized outlier costs exceed \$50,000. Given the extensive start up costs of a rural PACE, the outlier protection could be a key factor in sustainability of new programs.

One rural PACE site requested Rural PACE Outlier Protection for services provided to a participant with multiple chronic conditions. After enrollment the participant had several major hospitalizations primarily related to the chronic conditions through eventual death. The site is requesting reimbursement of \$25,000 (80% of hospitalization costs greater than \$50,000). It is in the process of preparing documentation to request another submission for the cost outlier

protection fund. The program is anticipating a reimbursement request of approximately \$20,000-\$30,000 from CMS. This site anticipates the possibility of additional requests for two participants who are close to reaching the \$50,000 hospitalization threshold.

Several other sites have had inpatient stays with unanticipated high costs, though these have not been expensive enough to meet the outlier protection threshold. In these cases, the programs had to rely on their own reserves to cover the cost of the hospitalization and follow-up care. While only one site triggered the fund by the time this Report to Congress was written, it is broadly believed that the cost outlier protection fund was responsible for encouraging organizations to apply for the CMS startup grant to open a PACE program in their area.

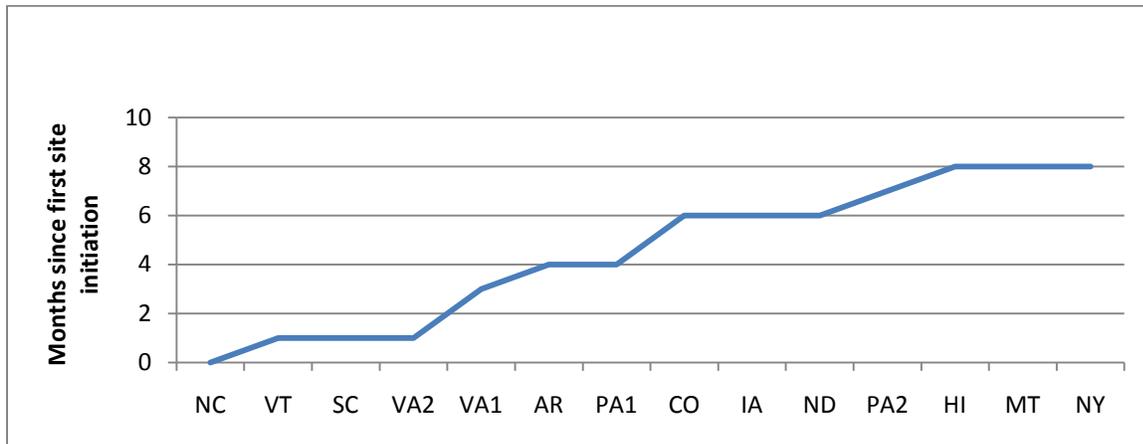
2.4 Report on the Experience of Rural PACE Pilot Sites per Section 5302(d)

2.4.1 Ramp-up and Enrollment

2.4.1.1 Timeline for Site Ramp-up

In February 2008, *Piedmont Health SeniorCare* was the first rural PACE pilot site to open its doors. The remaining 13 sites followed over the course of the next eight months. The last sites to initiate were *Maui PACE* (HI), *Billings Clinic PACE* (MT), and *Total Senior Care, Inc.* (NY) in October of 2008. The timeline of rural PACE program initiation dates is as follows.

Figure 1. Timeline of Rural PACE Pilot Site Kickoff (In Months since First Site Initiated)



PA¹: Kulpmont

PA²: Chambersburg

VA¹: Cedar Bluff

VA²: Big Stone Gap

2.4.1.2 Enrollment Trends

An analysis of the CMS Health Plan Management System (HPMS) has revealed that enrollment trends have varied by PACE site. As depicted by Figure 2 and Table 8 below, Colorado’s *Senior CommUnity Care* experienced very rapid program enrollment. Enrollment at the remaining sites has been more gradual to moderate, with the *Billings Clinic PACE* and *Siouxland PACE* enrolling participants at a lower rate than other sites. These two sites have been able to survive with the support of their non-rural hub and non-rural participant population, respectively.

Figure 2. Enrollment Trends (Number of Participants) by PACE Site

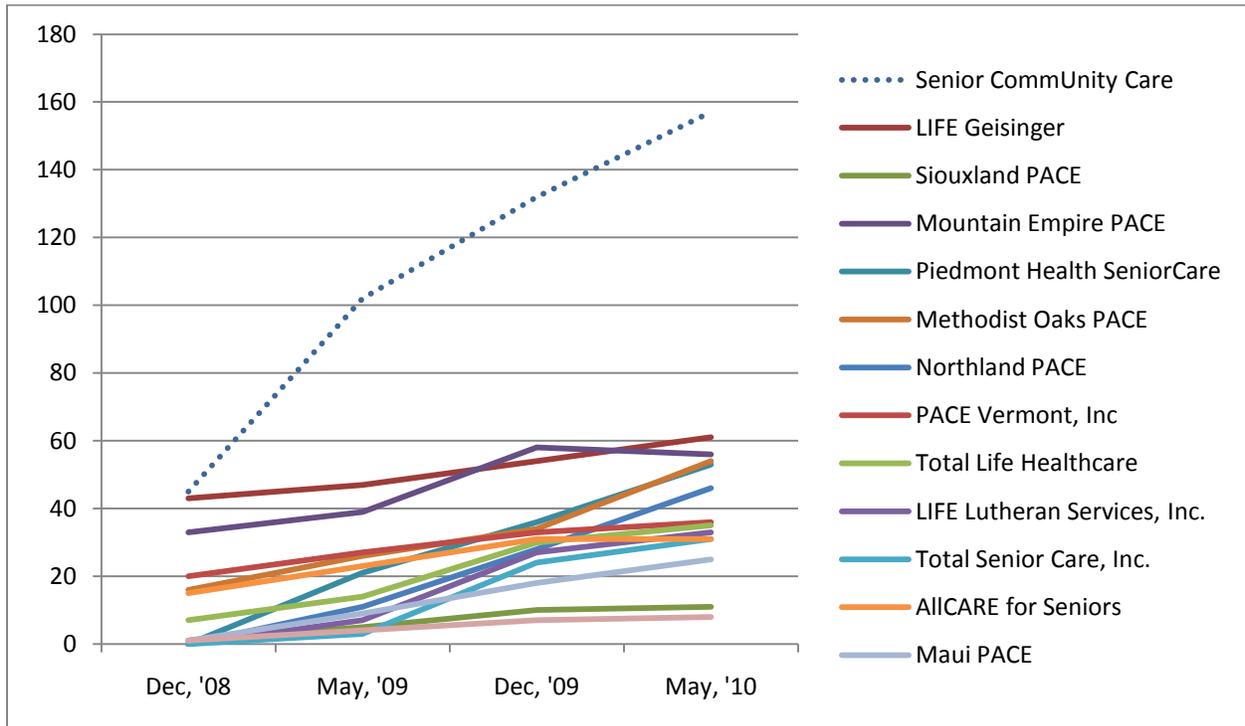


Table 8. Enrollment Trends by PACE Site

State Abbrev.	Site Name	Census 12/08	Census 05/09	Census 12/09	Current Census (as of 5/10)
CO	Senior CommUnity Care	45	102	132	157
PA ¹	LIFE Geisinger	43	47	54	61
IA	Siouxland PACE	1	5	10	11
VA ²	Mountain Empire PACE	33	39	58	56
NC	Piedmont Health SeniorCare	0	21	36	53
SC	Methodist Oaks PACE	16	26	34	54
ND	Northland PACE	0	11	28	46
VT	PACE Vermont, Inc	20	27	33	36
AR	Total Life Healthcare	7	14	30	35
PA ²	LIFE Lutheran Services, Inc.	0	7	27	33
NY	Total Senior Care, Inc.	0	3	24	31
VA ¹	AllCARE for Seniors	15	23	31	31
HI	Maui PACE	1	9	18	25
MT	Billings Clinic PACE	1	4	7	8
TOTAL		259	458	671	795

PA¹: Kulpmont

PA²: Chambersburg

VA¹: Cedar Bluff

VA²: Big Stone Gap

2.4.1.3 Challenges Experienced with Startup, Enrollment & Implementation and How Some Sites Have Evolved to Deal with the Challenges Presented

Given that the rural PACE pilot grant was a new model of care for rural areas with multiple resource and staffing issues, it is understandable that sites experienced some challenges in getting off the ground. This section describes some of the challenges with startup, enrollment, and implementation described by sites.

Mountain Empire PACE in Big Stone Gap, Virginia, summed up well the sentiment of many sites in saying that the PACE model was challenging for its staff to understand because they were accustomed to nursing home and home-health guidelines. However, PACE staff also expressed that this capitated model of care was personally rewarding because it allowed them to care for the participants with their best interests in mind rather than to make decisions driven by fee-for-service payment incentives. With PACE there is an incentive to keep frail, elderly beneficiaries healthy and out of hospitals and nursing homes. In spite of these benefits, however, a common theme expressed by rural PACE staff persons was that it was stressful to be a part of an organization that was being formed from the ground up, as a novel model of care, in a community still unfamiliar with that model of care. The fact that staff members often had to fill different positions simultaneously, especially as the PACE organizations were getting off the ground, only added to this level of stress. In the words of an Iowa PACE staff member:

“It was extremely challenging to be surrounded by uncertainty in the beginning. You are building a road and driving on it at the same time which is very challenging. Some people have difficulty dealing with uncertainty.”

Staffing: The number one challenge raised by PACE staff is the issue of staffing. Rural areas have shortages of skilled clinical professionals (e.g., master’s in social work, physical therapists, occupational therapists, speech therapists, primary care and specialty physicians). However, not only is there a smaller pool of skilled individuals from which to recruit workers, but also, since the PACE programs were just getting off the ground and the PACE model itself is unique, there

has been the added challenge of retaining workers in an ever-evolving environment. Multiple sites noted difficulty retaining staff in such a “trial and error” environment.

As a creative solution to the staff shortage and evolving nature of the program, sites such as *LIFE Lutheran Services Inc.* in Chambersburg, Pennsylvania and *Total Senior Care, Inc.* in New York have rotated their staff through different roles and have had their staff wear multiple “hats” at one time. To deal with the issue of limited pools of qualified applicants, *AllCARE for Seniors* in Cedar Bluff, Virginia explained that it made the decision to recruit specialists from outside its own service area. The most common solution to the staff shortage issue however, is for the PACE sites to contract with certain provider types rather than hiring them full time, which allows contracted staff to serve both an area hospital, for example, as well as the PACE site. This solution has the benefit of also allowing the program to build a greater participant population before hiring certain staff (e.g., physical therapist) full time. However, this solution is not without its own drawbacks; *Vermont PACE* explained that contracting out for inter-disciplinary team staff members was problematic because the members’ home organizations ended up consuming most of their time and PACE-related notes tended to end up at these home organizations thus not getting into the PACE files in a timely manner.

Transportation: Transportation is a challenge at most sites due to the great distances that beneficiaries must travel to attend their PACE center. It is costly to purchase and maintain a fleet of vehicles or to contract through a transportation company. However, the main issue with transportation noted by staff is the expense of gasoline cost; especially given the great distances the vehicles must travel. *LIFE Geisinger* in Kulpmont Pennsylvania has dealt with this challenge by moving away from the mini-buses and opting instead for more fuel efficient minivans and passenger cars.

Area Agency on Aging: As described in Section 2.1.2.5, while the Area Agencies on Aging were extremely helpful at some rural PACE provider grant sites, they posed a great barrier to enrollment at many others. Several PACE staff believe that their AAAs have viewed PACE as competition, especially during the startup phase. The AAAs are the central point of contact for

seniors and their families looking for services as the AAAs often determine nursing home eligibility, and they have programs under their purview that compete for the same nursing home-eligible population. At certain sites, program directors reported that the AAA tends to only approve the frailest beneficiaries from those determined to be nursing home certifiable. One site commented on the need for a central point of connection that is unbiased (as opposed to the AAA).

Medicaid Eligibility: Several rural PACE sites have had issues with Medicaid eligibility determination. The *Billings Clinic PACE* in Montana found the process of getting participants approved for Medicaid to be quite a lengthy process. Likewise, *Vermont PACE* staff mentioned that since it takes two to six months to determine Medicaid eligibility, prospective participants must wait for approval before starting, which often results in lost potential enrollees to the program. According to *Mountain Empire PACE* in Big Stone Gap, Virginia, the policy stating that participants can only be enrolled on the first of any month is challenging for enrollment.

Finally, certain states (e.g., Montana, North Carolina and North Dakota) require 100% of the Federal Poverty Level for Medicaid eligibility. This severely limits the pool of potential enrollees since very few people seek to enroll if they are not Medicaid eligible because they would have to pay the monthly Medicaid PACE fee out-of-pocket. According to *Mountain Empire* staff, the result is that only the very poor and very frail can benefit from the valuable resource that PACE provides. Iowa PACE staff believe that PACE should be made realistically affordable and available to all potential private pay participants.

Community Physicians: Multiple sites identified two major challenges related to the issue of community physicians. First, potential participants are reluctant to give up their personal doctor. Participants have allegiance to their own personal community based physician whom they may have had for 40-50 years. Second, physicians fear losing their patient populations to PACE. The Community-based Primary Care Physician flexibility waiver (discussed later) is designed to ameliorate these issues to a large extent.

Differences between Expected and Actual Enrollment: Differences between expected and actual enrollments have proved particularly challenging at both ends of the spectrum. Several sites (e.g., Hawaii, Iowa, Montana, New York, North Dakota, Vermont) have found low enrollments to be the source of great financial stress. *Total Senior Care, Inc.* in upstate New York has described its slow ramp-up as being financially challenging because this affects planning for staffing. Iowa's *Siouxland PACE* projected too high of a census during pre-implementation and has since discovered that in spite of much publicity, the number of PACE enrollments have been few. Both *Northland PACE* and *Maui PACE* explained that the predicted enrollment numbers in the feasibility studies provided by their technical assistance consultants included technical errors in the projected market of persons eligible for Medicaid (discussed later). To deal with slower than expected ramp-up, several sites (e.g., Vermont, and Big Stone Gap and Cedar Bluff in Virginia) decided to contract out for PT/OT and other services until the census grows enough to support full time positions.

In contrast, *Senior CommUnity Care* in western Colorado has actually found its rapid growth rate to be challenging since rapid growth magnifies any problems they are experiencing. Colorado PACE sites made the particular point that the pre-implementation sensitivity analysis should cover the spectrum from sluggish to accelerated enrollment.

Marketing Issues / CMS Approval Requirements: Some sites found it to be a significant barrier that they were prohibited by CMS from pre-marketing or using the word "PACE" before being approved by CMS as a PACE site. One site commented that they wished they could have advertised something to the effect of "PACE is coming to a site near you!" In addition, sites expressed frustration with a longer CMS approval process than desired for marketing materials.

Relationships: Several sites commented on how critical it is not to underestimate the importance of community based physicians, the state, counties and the community. *Mountain Empire* in Virginia found it very difficult getting hospitals to contract with them. To resolve this issue the Medical Director attained credibility by meeting with the largest cardiology group. Once this relationship had been established, the pulmonologists also got on board, followed by other

physician groups. *Northland PACE* in North Dakota commented that it wishes it had understood the importance of relationships in the community before launching. *Vermont PACE* stated that it had been very difficult having no parent organization.

Technical Assistance: Many sites described their early days as operating by trial and error. The *Siouxland PACE* in Iowa believed that they should have had a stronger knowledge base before launching their PACE program. The *Billings Clinic PACE* in Montana would have appreciated technical assistance for the entire first year of operation. Instead, this site felt that the technical assistance provided by the technical advisory committee (TAC) ended soon after the program began, although CMS technical assistance continues indefinitely. *Billings Clinic PACE* says there is a need for a basic informational document on reporting requirements specifically for PACE providers.

Several sites (Colorado, Montana, North Dakota, New York, Vermont) also had a problem with the quality of the technical assistance provided. Montana's *Billings Clinic PACE* appreciated the TAC's expertise on becoming approved as a PACE site, however *Billings Clinic PACE* staff expressed that it would have also appreciated additional technical assistance on the topic of PACE operations once becoming approved, especially related to the Medicare Part D program. *Vermont PACE* found that the technical assistance offered by the National PACE Association was not the right fit. The TAC had not worked in a rural environment and as a result the enrollment predictions were inflated. Technical assistance was also problematic at North Dakota's *Northland PACE* and Maui PACE, both of which are 100% FPL states. Unfortunately, the TAC conducted its market assessment based on the more common 300% FPL levels.

2.4.1.4 Factors that were Helpful to Startup, Enrollment & Implementation

Relationships: Several sites described the hiring of particular individuals with extremely strong connections to the community as being particularly helpful to the early phases of implementation. Other key staff persons include those with an existing understanding of Medicaid eligibility and how to set up contracts and maneuver through bureaucracy. One site

attributes its early success to the hiring of its Medical Director, a very well respected physician in the community with a broad network of contacts (especially specialty doctors) who have been able to supply referrals. Another site believes it has benefited greatly from its strong relationships with foundations and its Board of Directors (which includes members from Hospice and Homecare), physicians, and community members who have an affinity and understanding for the PACE model.

AAA as the Parent Organization: The two rural PACE sites in Virginia are each a division of their local Area Agency on Aging (AAA). *Mountain Empire PACE* in Big Stone Gap, Virginia and *AllCARE for Seniors* in Cedar Bluff, Virginia ascribe their early success to the fact that their parent organization and physical location is their local AAA. Mountain Empire Older Citizens, Inc. (MEOC), the local area agency on aging, already had personal care attendant services, transportation, respite care, home delivered meals, and other social services. The only piece missing was physician services. The Chief Financial Officer believed that adding the medical component to the existing comprehensive social services component could be a feasible partnership. This arrangement has also resulted in a significant source of in-house referrals for *Mountain Empire PACE*. Similarly, *AllCARE for Seniors* is a part of the AAA which already had many social services in place (transportation, nutritionist, personal care services, case management and adult day care). Like their more southern neighbors, it was simply a matter of adding the physician services component. In addition, *AllCARE for Seniors PACE* was able to benefit from being co-located with a children's day care, allowing for an intergenerational model that is not only very appealing to seniors but also is believed to lead to better mental health. Similar to these Virginia sites, *Billings Clinic PACE* in Montana, also described the ease of adding a medical component to the social services and adult day pieces that were already in operation. Like the Virginia sites, *Billings Clinic PACE* already had a good network of senior services (e.g., senior center, meals on wheels, etc.) so it was simply a matter of pulling all the pieces together.

Pre-launch Reputation: Because sites were prohibited from marketing themselves prior to CMS approval as a PACE site, those sites with pre-existing solid reputations were able to enroll

participants much more quickly than those without any such reputation. For example, with a 30 year presence, the VOA was already known in the Colorado community. Therefore they did not need to create name recognition for themselves. Similarly, the nursing home and assisted living center where North Dakota's *Northland PACE* is located have benefited from a positive pre-launch reputation. Finally, *Mountain Empire PACE* has had an easier time than most PACE sites because of existing high level of respect for Mountain Empire Older Citizens, Inc. (MEOC) in the community which has enjoyed a 34 year history as the local Area Agency on Aging.

Technical Assistance: Several sites appreciated the National PACE Association (NPA) website and found NPA staff quite helpful. Iowa's *Siouxland PACE* felt that it was helpful to have consultants for the feasibility study and startup. They also mentioned that visiting other sites to understand the model was helpful. Likewise, North Carolina's *Piedmont Health SeniorCare* rural PACE site found it helpful to visit and learn from the well established *Palmetto PACE* site. Palmetto is a mature PACE program in South Carolina and one of the first PACE sites to open its doors. Twenty staff members visited Palmetto before this NC PACE site opened its doors.

2.4.1.5 Changes Sites Made as They Were Getting Off the Ground to Aid Success

Initial grant applications, the rural PACE Program Agreements and discussions with PACE and CMS staff have revealed that rural PACE pilot sites have been largely successful in maintaining the integrity of the PACE model. There have been no significant changes made after sites launched. Some PACE sites have made minor adaptations that are within the established PACE parameters. For example, some sites (e.g., *LIFE Geisinger* in Pennsylvania, *Hale Makua* in Hawaii, and *Total Senior Care, Inc.* in New York) have proposed expanding their service areas in order to expand their pool of potential participants and increase enrollment. Sites have also had the option of applying to CMS for flexibility waivers, or exceptions from the certain PACE program requirements, in order to better serve rural areas, as discussed below.

Flexibility Waivers: CMS understands that the PACE model does not uniformly fit each community. Therefore, flexibility waivers allow sites to adhere to both the PACE model and also certain pre-approved expanded parameters. While all PACE organizations (rural and non-rural alike) may apply for flexibility waivers, they are particularly helpful to those in rural locations due to the unique challenges posed by rural communities. Some rural stressors include the remoteness of the communities, the great distance beneficiaries must travel to attend the PACE center, and the dearth of qualified staff across the breadth of disciplines that are required to serve on the PACE inter-disciplinary team. After careful review, CMS approves waiver requests separately for each PACE organization.

Flexibility waivers may be applied for and approved of in advance of program start-up or as they proceed with implementation. Regarding the latter, in some cases programs simply found it easier to apply for these after becoming approved PACE providers, while in other cases the applications were stop-gap measures to increase enrollment success or otherwise reduce financial risk. Table 9a describes and assigns a reference number for each flexibility waiver. Table 9b details the dates of all flexibility waiver determinations and pending determinations.

Table 9a. Flexibility Waiver Reference Numbers

Flexibility Waiver #	Flexibility Waiver Description
	Effective Date (Kickoff)
0	None
1	Community-based Primary Care Physician (CBPCP)
2	Involuntary disenrollment for failure to pay share of costs
3	Involuntary disenrollment of participants for disruptive or threatening behavior by participant's family member that jeopardizes safety of self or others
4	Primarily serve PACE participants
5	Involuntary disenrollment of participants without decision making capacity for disruptive or threatening behavior by participant's family member resulting in non-compliance with participants plan of care
6	Involuntary disenrollment due to disruptive or threatening behavior by participant's family member
7	PACE allowed to function despite having members of the governing body with direct interest in contracts that supply administrative or care-related services to the PACE organization.
8	On select marketing materials, the omission of two points: 1) that PACE participants must receive all health care from PACE, and 2) that PACE participants are fully and personally liable for all unauthorized or non-PACE costs
9	Hire PCAs, social workers, nurses, and therapists lacking one year of experience in working with frail/elderly population
10	Ability to deny participation to private pay beneficiaries
11	Waiver of requirement for Master's level social worker
12	PCP and dietician assessments can be done via telemedicine
13	Ability to deny participation to private pay and Medicare-only beneficiaries
14	MSW assessments can be done via telemedicine
15	Nurse practitioner in the clinic

Waivers that are particularly pertinent to the rural experience are described in the text that follows. The “X” in the North Carolina column denotes that the site has had no waiver requests prior to or since beginning its PACE program. The shaded cells highlight flexibility waivers that were awarded after kickoff of the PACE program. These are particularly important to note because they signify areas where sites had to make modifications in order to increase their chances of success.

Table 9b. Rural PACE Pilot Sites’ Effective Date (Kickoff) and Dates that Flexibility Waivers were Granted by CMS

	AR	CO	HI	IA	MT	NC	ND	NY	PA ¹	PA ²	SC	VA ¹	VA ²	VT	Total
Effective Date (Kickoff)	6/08	8/08	10/08	8/08	10/08	2/08	8/08	10/08	6/08	9/08	3/08	5/08	3/08	3/07	
Flexibility Waiver #															
None						X									1
1	5/08	6/08		6/08	5/10			4/10	5/10	**		11/07			8
2			5/08					9/08		5/08	8/07	11/07	1/08	6/06	7
3			8/08					9/08		8/09	8/07	11/07	1/08		6
4		6/08	8/08	6/08			5/08							10/07	5
5								9/08		8/09	8/07	11/07	1/08		5
6														6/06	1
7														6/06 [^]	1
8														6/07	1
9								9/08							1
10							5/08								1
11							5/08							5/10 ^{^^}	1
12							5/08								1
13					1/09										1
14							1/10								1
15								*							1

* Waiver request was retracted, pending the release of CMS guidance that will outline the criteria PACE organizations should include in requesting waivers that would permit an expanded role for the use of nurse practitioners.

** This waiver request was withdrawn. Given that this site has contracted a physician who provides primary-care to PACE participants on-site, physician services were seen as more contractual in nature, and thus the site is in compliance with PACE requirements.

[^] The December 8, 2006 PACE Final Rule (71 FR 71335), revised §460.68 of the PACE regulation to permit a direct or indirect conflict of interest in terms of contracts, as long as the organization identifies the member(s) of its governing body or any immediate family member who has a direct or indirect interest in any contract that supplies any administrative or care-related service or materials to the PACE organization. However, in the event of a direct or indirect conflict of interest by a member of the PACE organization’s governing body or his or her immediate family member, the board member must (1) fully disclose the exact nature of the conflict to the board of directors and have the disclosure documented and (2) recuse himself or herself from discussing, negotiating, or voting on any issue or contract that could result in an inappropriate conflict. As a result of this change in the PACE regulation, it is no longer necessary for CMS to issue waivers pertaining to conflicts of interest.

^{^^} Vermont PACE rescinded its need for this waiver after having successfully hired an MSW.

PA¹: Kulpmont

PA²: Chambersburg

VA¹: Cedar Bluff

VA²: Big Stone Gap

2.4.1.6 Community-based Primary Care Physician (CBPCP) waiver

Community-Based Primary Care Physician (CBPCP) waivers that have been approved, to date, waive the requirements that primary care must be furnished to a participant by a PACE primary care physician and that the physician must primarily serve PACE participants. CBPCPs have the same responsibilities as staff PCPs including: participant assessments, care planning, involvement with Quality Assessment Performance Improvement (QAPI) activities and regular participation in IDT meetings (either via face-to-face interaction or via conference call) when the CBPCP's patients are being discussed.

Eight rural PACE pilot sites applied for the Community Physician waiver making it the most popular waiver. *LIFE Lutheran Services Inc.* in Chambersburg, Pennsylvania applied for a community physician waiver but because the site wanted to identify an entire practice rather than individual physicians, CMS considered it to be more contractual in nature. Following the CMS' recommendation, the site withdrew its waiver request.

Elders in rural regions have often had their personal doctor for all or most all of their lives. This finding is supported by earlier PACE research which found that attachment to an established provider-patient relationship is an important barrier to PACE enrollment. In addition, sites report that physicians felt like they were losing their patients to PACE. Several sites were particularly challenged by securing primary care physician staff in sparsely populated, rural areas. Therefore, this waiver was granted in recognition that these physicians have responsibilities to the broader community, making it impractical for them to devote their services exclusively to PACE participants.

Because one of the largest barriers to participant enrollment in rural PACE has been the fear of leaving one's primary care physician, most sites have been satisfied with the results of this waiver thus far. At *AllCARE for Seniors*, however, the Program Director was somewhat disappointed in the results of the community physician waiver. *AllCARE for Seniors* found that contrary to expectation, a few of the eleven community physicians covered under their waiver

were not referring their patients to PACE. While the waiver allows the CBPCPs to attend the IDT meeting by telephone, *AllCARE for Seniors* has still found it challenging to get these physicians on IDT meetings. This has resulted in multiple delayed and rescheduled meetings and has required significant amounts of coordination, flexibility and patience. In addition, while most CBPCPs have worked well with the team, some have had to be reminded of the PACE philosophy and procedures. *AllCARE for Seniors* continues to work with these particular CBPCPs to ensure compliance with the PACE model.

2.4.1.7 “Primarily Serve” Waiver

Five sites have the Primarily Serve waiver. The Primarily Serve Waiver is an arrangement where certain PACE staff members are allowed to serve both PACE and non-PACE participants in one physical location. This is a waiver from the PACE requirement §460.102(d)(3), which indicates members of the IDT must primarily serve PACE participants. The reasoning behind §460.102(d)(3) is the belief that IDT staff members who primarily serve PACE participants are more likely to fully understand and preserve the PACE model. The rationale for this waiver is to allow separate, yet similar, populations of individuals to share space and services, something particularly helpful for PACE organizations operating in sparsely populated rural areas. It is a way to help offset costs especially when a PACE site is just beginning to enroll participants. As an example, types of *Vermont PACE* staff members who are allowed to serve both PACE and non-PACE participants in one space are the Center Manager, Activity Coordinator or Recreational Therapist, Personal Care Attendants, Licensed Nursing Assistants, and Transportation Drivers. Primarily Serve waivers were granted with the expectation that the ratio of PACE to non-PACE participants would grow to the point where sites would not need the waiver any longer. However, contrary to these expectations, all sites with the Primarily Serve waiver have provided rationales for not meeting their original projections and have renewed the waiver.

2.4.1.9 Nurse Practitioners

Some sites have requested the ability to use nurse practitioners (NPs) as an extension of and collaborative partner of the primary care physician on the interdisciplinary team. In rural settings, many sites believe that it is not realistic for the physician to be present every time the IDT meets. *Siouxland PACE* in Iowa expressed strong feelings about this given that in the state of Iowa NPs can practice independently. Currently, NPs can be used at sites to help with providing care. However, NPs' assessments, re-assessments and involvement on the IDT do not replace those of the physician as required under the PACE regulation. CMS is in the process of developing guidance that will assist organizations in requesting waivers to permit an expanded role for NPs (e.g., conducting assessments and reassessments). CMS will not issue NP waivers until it has released this guidance.

2.4.2 Terminations

In April 2010, with 26 PACE beneficiaries under its care, *Maui PACE* informed CMS of its plans to terminate its program agreement and close their program due to low enrollment. The site had expensive hospitalizations and nursing home stays which have impeded its efforts to become self-sustaining. Most importantly, as the Maui PACE Director explained, and as corroborated by the National PACE Association, the feasibility study conducted by the technical assistance consultant contained an error. Medicaid eligibility rules are not consistent across states, with some states being more stringent (e.g., Medicaid eligibility at 100% FPL) and others being more generous (e.g., Medicaid eligibility at 300% FPL). *Maui Pace's* TAC used the more generous assumption of 300% FPL rather than the correct Medicaid eligibility criteria for the State of Hawaii of 100% FPL. As a result, the feasibility study estimated 564 potential PACE enrollees instead of the 168 potential PACE enrollees that would have been projected under the correct eligibility assumption. Not surprisingly, the Maui PACE Director stated that that if they had initially received a correct feasibility study, they never would have moved forward in developing a PACE program. *Maui PACE* officially closed August 31, 2010 after following the Phasedown Plan in the PACE regulation and ensuring that all enrollees were transitioned back to

Medicaid, Medicare and Medicare Part D, as appropriate. This is the first and only operational PACE organization, rural or non-rural, ever to close.

2.4.3 Fiscal Issues

2.4.3.1 Non-CMS Sources of Funds

Several PACE directors made the point that CMS funds were absolutely critical to start-up. However, an interesting facet of the CMS award is that approved PACE sites had to become operational before becoming eligible for a CMS grant award. Therefore, due to the timing of the CMS award, it was necessary for sites to garner other funds in order to become operational. For some sites this meant requesting funds of their parent organization, usually as a loan. For other sites it meant taking out a line of credit or another type of loan with or without interest. Some sites were fortunate in that they received start-up grants. For example, the State of Virginia allocated \$1.5 million for PACE development, thereby granting \$250,000 to six PACE sites, including the two rural PACE pilot sites. Table 10 below describes the non-CMS funds that sites used to initiate their PACE programs. *Vermont PACE* also benefited from government grants. This site, and many others, found it necessary to spend these funds early on to purchase facility and equipment in order to be ready for business as soon as the application was approved.

Table 10. Non-CMS Sources of Startup Funds by Site

	AR	CO	HI	IA	MT	NC	ND	NY	PA ¹	PA ²	SC	VA ¹	VA ²	VT	Total
None							X								1
Parent Organization	X	X	X		X	X		X			X				4
State government									X			X	X	X	4
Gift				X					X	X					3
Grants				X						X		X	X		3
Loans									X	X					2
Foundations		X				X								X	2
Fundraising efforts														X	1

PA¹: Kulpmont

PA²: Chambersburg

VA¹: Cedar Bluff

VA²: Big Stone Gap

2.4.3.2 CMS Grant

As depicted by Table 11, CMS startup funds were used for a range of activities, though most frequent use of funds included paying for staff salaries, remodeling and furnishing the PACE site.

Table 11. Use of CMS Startup Funds

	AR	CO	HI	IA	MT	NC	ND	NY	PA ¹	PA ²	SC	VA ¹	VA ²	VT	Total
Staffing / salaries / fringe	X	X	X			X		X		X	X	X	X		6
Remodeling		X	X		X				X			X	X	X	6
Equipment / furniture			X	X	X				X	X	X	X	X		6
Application (staff time and/or consultant)		X		X			X					X			4
Technical assistance, training and legal consultation					X			X			X	X			4
Vehicle(s)				X			X								2
Information system hardware & EMR				X			X								2
Technology to tie their two sites together		X													1
Licensing				X											1
Laptops and audio-conferencing equipment				X											1
Marketing; networking with potential referral sources	X														1
Physician network development and training	X														1
Provider network development and training	X				X										1
Travel between the two sites					X										1
Repay parent organization for up-front money								X							1

PA¹: Kulpmont

PA²: Chambersburg

VA¹: Cedar Bluff

VA²: Big Stone Gap

2.4.3.3 Key Monetary Issues

As described elsewhere in this report, key financial issues have hinged on both steady enrollment into the program and nursing home and hospital admittances. Many sites have come close to breaking even, as their enrollments climbed, only to have an untimely hospitalization cause them to regress from that target.

Several rural PACE pilot sites found starting up and running the PACE program to be extremely capital intense. There was great time pressure to launch after the grant funds were received; this was particularly stressful since PACE could not market itself prior to being awarded the CMS grant. Some sites found it challenging to figure out, from a business perspective, how to deliver services most efficiently and how to generate enough revenue to be self-sustaining. Sites that have a hub site are at an advantage since they are able to rely on the critical mass of participants coming from the hub-site. One site noted that financial pressure can also be attributed to the fact that 80% of its participants come to the PACE center four to five days a week because they feel socially isolated.

PACE directors recognize that it is crucial to have adequate financial and community support before launching a PACE program in a rural community. They universally believe that the CMS startup funds were essential to their startup. One site expressed its fear that if Medicare or Medicaid rates are reduced, this could result in a compromised PACE model and its eventual termination.

2.4.4 Benefits of PACE in Rural America

PACE programs benefit rural areas in a multitude of ways, affecting not only the beneficiaries, but also their families and local communities. This study was not designed to evaluate the economic impact of PACE on local communities. However, there were some anecdotal reports that PACE has been good for business and local economies. This is particularly true for sites that have had time to grow a sizeable staff of full time positions, and less so for sites that still contract out for part-time positions that are shared with area hospitals or other agencies. *LIFE Geisinger* in Kulpmont Pennsylvania is an example of a site that appears to be boosting its local economy by its existence in the community. It is believed that the full-time staff of forty persons is largely responsible for the local pizza parlor and the few other small businesses in town that appear to be thriving.

2.4.4.1 Select Staff Comments

PACE directors and staff members commented that they believe PACE improves the health, well-being and independence of its beneficiaries, while also reducing burden among family caregivers. According to PACE staff, freeing these caregivers to a certain extent allows them to better enjoy work and leisure pursuits in their rural communities. One director expressed concern that during the current recession, as property values decline, rural towns may become abandoned and people may leave their homes in search of opportunities in non-rural areas. This director sees rural PACE as a means to both invest in towns and provide access to care to frail seniors.

According to PACE staff, there is a strong need and demand for people to stay in their homes. However, the significant geographic isolation that is common among rural elders can affect their health, mental health and overall well being. PACE solves this problem by bringing people together for socialization at the PACE center. PACE staff also describe their beneficiaries as independent and reluctant to ask for help. The services and the unique coordination of care offered by the PACE model allow participants to remain in their own homes and preserve the dignity of the individual.

According to PACE directors, the PACE model promotes quality and access. Since rural areas have limited health care and ancillary resources; the amalgamation of managed care with the interdisciplinary team brings access to multiple specialties to which beneficiaries would not otherwise have access. Several directors also expressed their strong convictions regarding the quality of PACE services and its role as the perfect medical home. One director believes that PACE dovetails with the health reform goals of promoting wellness, improving quality of care and avoiding hospitalizations through the use of coordinated care. This director believes PACE to be superior to both managed care and fee-for-service because the former puts too much stress on the primary care physician and the latter can promote wasteful practices.

Site visits to the two PACE sites in Virginia and the two PACE sites in Pennsylvania revealed that community participants had only positive comments on the program. When asked what they would change about the PACE program if they could change anything at all, participants continually stated that they would not change anything. These rural-residing beneficiaries were beyond satisfied with the PACE program. Multiple elders commented that the PACE program, and its social integration component in particular, helped them feel worthwhile and in good spirits again. Time and time again, participants commented that they had been depressed and lonely before coming to PACE; they felt that PACE saved their lives and helped them feel like life was worth living again.

Section 3. Discussion

3.1 Successes and Failures

Fourteen out of 15 (93%) rural PACE pilot sites launched successfully, however over the course of the second year of operation, two sites faced possible termination. The first site, *Vermont PACE*, was rescued in January 2010 by a new, yet experienced, parent organization which infused a large sum of money to boost enrollment. In April 2010, the second site, *Maui PACE*, submitted their request to CMS to terminate their program agreement; it officially closed August 31, 2010. A key factor in the Maui PACE outcome is the fact that its initial feasibility study was built on an incorrect assumption regarding Medicaid eligibility (300% FPL versus 100% FPL).

The success of each PACE site hinges on a delicate balance between enrollment and the ability of PACE centers to keep their participants healthy and out of hospitals. Enrollment requires that beneficiaries know of PACE in the first place, which can come about either by marketing avenues that directly target the consumer (e.g., advertisements, health fairs, etc.) or by indirect methods that focus on potential referral sources (e.g., AAA, physicians, hospital discharge staff, etc.). This report finds that the most successful sites had pre-existing positive reputations and fostered new referral-based relationships with multiple entities in their communities. The most successful site, *Senior CommUnity Care* on the western slope of Colorado benefited immensely from the pre-existing reputation of PACE in other parts of the state and by VOA sponsorship as a long-standing community provider. In fact, due to this positive reputation, *Senior CommUnity Care* was able to minimize spending on mass media and other direct marketing efforts. A program's relationship with its Area Agency on Aging was also pivotal to enrollment success. Those sites that had strained or nonexistent relationships with their Area Agencies on Aging experienced some struggle, and those with positive and referring relationships with their AAAs were at a particular advantage. PACE programs that were physically and organizationally a part of the AAA experienced an even greater advantage.

The second ingredient to a successful PACE program is its ability to keep participants healthy and out of the hospital. This factor is affected by both the healthiness of its nursing home certifiable participants at intake to the PACE program and the quality of care provided by PACE. For example, the *PACE Vermont* Director stated that it was at a distinct disadvantage since its Area Agency on Aging tended to only refer those who are extremely ill to the PACE program. As a result, the program has had to expend great amounts of resources stabilizing their participants upon enrollment. Not only is this expensive to the PACE program, but it means that their beneficiaries are more likely to end up requiring hospitalization, a further expense to the program. Also related to the ability to keep participants healthy and hospital-free is the quality of care piece that is central to the entire premise of the capitated PACE program. Better health care and palliative care translates to participants' health and quality of life, and thus fewer hospitalizations, which again translate to a prosperous, flourishing, and sustainable PACE program.

3.2 Observed Changes From the PACE Delivery Model in the Rural PACE Context

AllCARE for Seniors in Cedar Bluff Virginia stated that “Maintaining the integrity of the PACE model can be especially challenging given that it was built on the urban setting.” Overall, the PACE model has survived fairly well in the rural setting. While its implementation has not been without challenges, sites appear to have coped fairly well and developed creative strategies to circumvent some of these challenges. For example, to deal with an otherwise cost-inefficient ratio of staff to participants during periods of sluggish enrollment, sites have had their staff members serve multiple roles and they have used contractors instead of hiring permanent staff.

Deviations from the PACE model come in the form of flexibility waivers, to which sites have done fairly well adhering. These flexibility waivers were granted by CMS on a one-by-one basis after application and careful review. The most popular flexibility waiver has been the Community-based Primary Care Physician (CBPCP) waiver. Allowing PACE sites to have more than one physician participating on the interdisciplinary team, the CBPCP waiver has been critical in ameliorating two significant barriers encountered when the PACE model was imported

to rural areas. First, many potential participants across multiple PACE sites were reluctant to join the program due to fear of giving up their personal physician. Many of these rural-residing elders and their family members have often been with a certain doctor for decades. PACE sites realized early on that it was simply too much to ask that prospective participants give up their personal physician for an unknown entity. Second, sites were concerned that community-based primary care physicians were fearful of losing their patients to the PACE program. The CBPCP waiver has helped sites overcome both issues while also encouraging CBPCP's to be referral sources for PACE. Most sites have been satisfied with the results of their CBPCP flexibility waivers and most have adhered to the conditions of the waivers fairly well.

3.3 Implications for Future Expansion of PACE into Other Rural Communities

According to the rural PACE pilot sites, this type of one time grant in the form of seed money has been an essential investment. Sites found both the CMS grant and cost outlier protection fund to be indispensable to their successful launch. Even though it was used only once by one site to date, the cost-outlier protection fund has provided a level of insurance that made taking the risk of starting a PACE program palatable. There is the potential for other rural areas to follow in developing PACE programs. In fact, the State of Pennsylvania has committed itself to installing one PACE program in every county. However, the reality is that starting such a program is extremely capital intense. According to the sites, seed money from CMS or a parent or sponsoring organization is critical especially in rural areas still unfamiliar with the PACE model.

There are some ongoing concerns about rural PACE enrollment. For example, due to the non-rural components of *Billings Clinic PACE* and *Siouxland PACE* that support these sites, they continue to survive even with extremely gradual enrollments; will this model continue to work for them? How can the relationships between the AAAs and PACE be improved at several locations? The two Virginia sites provide a useful model for future PACE development in that their PACE programs are actually a division of their AAAs. Would it be feasible to apply Virginia's model to existing or new rural PACE sites? Given the continuing budget challenges

at the state level, how difficult might it be to sustain adequate Medicaid payment in an era of Medicaid budget cuts?

3.4 Limitations

This qualitative study was designed to explore the usefulness of the relatively modest CMS start-up grant which could only be acquired when interested local communities stood up to “ring the bell”. The purpose of this analysis did not encompass a quantitative study of the effectiveness of the rural PACE care delivery system per se, nor did it make comparisons to a comparable non-eligible population. Nevertheless, CMS will continue to study these aspects in further through intramural research and evaluation.

Section 4. Conclusion

For most sites, due to low funds and a lack of prior awareness of and limited experience with the model in their communities, launching PACE was a successful though difficult endeavor. However, once the PACE administrators were able to gain the trust of the community physicians, AAAs and community members, most programs have been able to enroll participants and achieve clinical results. Reputable sponsoring organizations with long standing experience in delivering community supportive and long-term care services and non-rural PACE hub sites had more successful early experiences than those without such sponsors or hub sites. In a few cases, the very existence of a non-rural hub site allowed those rural sites with very low enrollments to survive. Most rural PACE pilot sites have been able to successfully deliver this innovative model of care to the beneficiaries residing in their geographic areas thereby allowing them to enjoy a multitude of benefits associated with the PACE model that were not available to them previously.

This Report to Congress found that, true to its goal, rural PACE preserves, enhances, and in many cases restores, the independence, health and well-being of PACE participants. It helps them continue to live at home or with their families and delays or altogether avoids nursing home placements and hospitalizations. Because PACE reduces burden among family care-givers, it also frees them to be more productive members of their communities. There is some anecdotal evidence that PACE has the potential to stimulate the economies of rural communities by creating jobs and fortifying local small businesses. For these many reasons, this Report finds an overall favorable experience by the rural PACE pilot sites, as well as their beneficiaries and communities, in the early phases of implementation.

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Appendix I: The Mandate

The following is the text of the law authorizing the rural PACE provider grant program, Sec. 5302 of the Deficit Reduction Act of 2005, Pub. L. 109-171.

SEC. 5302. <<NOTE: 42 USC 1395eee note.>> RURAL PACE PROVIDER GRANT PROGRAM.

(a) Definitions.--In this section:

(1) CMS.--The term "CMS" means the Centers for Medicare & Medicaid Services.

(2) PACE program.--The term "PACE program" has the meaning given that term in sections 1894(a)(2) and 1934(a)(2) of the Social Security Act (42 U.S.C. 1395eee(a)(2); 1396u-4(a)(2)).

(3) PACE provider.--The term "PACE provider" has the meaning given that term in section 1894(a)(3) or 1934(a)(3) of the Social Security Act (42 U.S.C. 1395eee(a)(3); 1396u-4(a)(3)).

(4) Rural area.--The term "rural area" has the meaning given that term in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)).

(5) Rural pace pilot site.--The term "rural PACE pilot site" means a PACE provider that has been approved to provide services in a geographic service area that is, in whole or in part, a rural area, and that has received a site development grant under this section.

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(6) Secretary.--The term "Secretary" means the Secretary of Health and Human Services.

(b) Site Development Grants and Technical Assistance Program.--

(1) Site development grants.--

(A) In general.--The Secretary shall establish a process and criteria to award site development grants to qualified PACE providers that have been approved to serve a rural area.

(B) Amount per award.--A site development grant awarded under subparagraph (A) to any individual rural PACE pilot site shall not exceed \$750,000.

(C) Number of awards.--Not more than 15 rural PACE pilot sites shall be awarded a site development grant under subparagraph (A).

(D) Use of funds.--Funds made available under a site development grant awarded under subparagraph (A) may be used for the following expenses only to the extent such expenses are incurred in relation to establishing or delivering PACE program services in a rural area:

(i) Feasibility analysis and planning.

(ii) Interdisciplinary team development.

(iii) Development of a provider network, including contract development.

(iv) Development or adaptation of claims processing systems.

(v) Preparation of special education and outreach efforts required for the PACE program.

(vi) Development of expense reporting required for calculation of outlier payments or reconciliation processes.

(vii) Development of any special quality of care or patient satisfaction data collection efforts.

(viii) Establishment of a working capital fund to sustain fixed administrative, facility, or other fixed costs until the provider reaches sufficient enrollment size.

(ix) Startup and development costs incurred prior to the approval of the rural PACE pilot site's PACE provider application by CMS.

(x) Any other efforts determined by the rural PACE pilot site to be critical to its successful startup, as approved by the Secretary.

(E) Appropriation.--

(i) In general.--Out of funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this subsection for fiscal year 2006, \$7,500,000.

(ii) Availability.--Funds appropriated under clause (i) shall remain available for expenditure through fiscal year 2008.

(2) Technical assistance program.--The Secretary shall establish a technical assistance program to provide--

(A) outreach and education to state agencies and provider organizations interested in establishing PACE

programs in rural areas; and

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(B) technical assistance necessary to support rural PACE pilot sites.

(c) Cost Outlier Protection for Rural PACE Pilot Sites.--

(1) Establishment of fund for reimbursement of outlier costs.--Notwithstanding any other provision of law, the Secretary shall establish an outlier fund to reimburse rural PACE pilot sites for recognized outlier costs (as defined in paragraph (3)) incurred for eligible outlier participants (as defined in paragraph (2)) in an amount, subject to paragraph (4), equal to 80 percent of the amount by which the recognized outlier costs exceeds \$50,000.

(2) Eligible outlier participant.--For purposes of this subsection, the term "eligible outlier participant" means a PACE program eligible individual (as defined in sections 1894(a)(5) and 1934(a)(5) of the Social Security Act (42 U.S.C. 1395eee(a)(5); 1396u-4(a)(5))) who resides in a rural area and with respect to whom the rural PACE pilot site incurs more than \$50,000 in recognized costs in a 12-month period.

(3) Recognized outlier costs defined.--

(A) In general.--For purposes of this subsection, the term "recognized outlier costs" means, with respect to services furnished to an eligible outlier participant by a rural PACE pilot site, the least of the following (as documented by the site to the satisfaction of the Secretary) for the provision of inpatient and related physician and ancillary services for the eligible outlier participant in a given 12-month period:

(i) If the services are provided under a contract between the pilot site and the provider, the payment rate specified under the contract.

(ii) The payment rate established under the original Medicare fee-for-service program for such service.

(iii) The amount actually paid for the services by the pilot site.

(B) Inclusion in only one period.--Recognized outlier costs may not be included in more than one 12-month period.

(3) Outlier expense payment.--

(A) Payment for outlier costs.--Subject to subparagraph (B), in the case of a rural PACE pilot site that has incurred outlier costs for an eligible outlier participant, the rural PACE pilot site shall receive an outlier expense payment equal to 80 percent of such costs that exceed \$50,000.

(4) Limitations.--

(A) Costs incurred per eligible outlier participant.--The total amount of outlier expense payments made under this subsection to a rural PACE pilot site with respect to an eligible outlier participant for any 12-month period shall not exceed \$100,000 for the 12-month period used to calculate the payment.

(B) Costs incurred per provider.--No rural PACE pilot site may receive more than \$500,000 in total outlier expense payments in a 12-month period.

(C) Limitation of outlier cost reimbursement period.--A rural PACE pilot site shall only receive outlier

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expense payments under this subsection with respect to costs incurred during the first 3 years of the site's operation.

(5) Requirement to access risk reserves prior to payment.--A rural PACE pilot site shall access and exhaust any risk reserves held or arranged for the provider (other than revenue or reserves maintained to satisfy the requirements of section 460.80(c) of title 42, Code of Federal Regulations) and any working capital established through a site development grant awarded under subsection (b)(1), prior to receiving any payment from the outlier fund.

(6) Application.--In order to receive an outlier expense payment under this subsection with respect to an eligible outlier participant, a rural PACE pilot site shall submit an application containing--

(A) documentation of the costs incurred with respect to the participant;

(B) <<NOTE: Certification.>> a certification that the site has complied with the requirements under paragraph (4); and

(C) such additional information as the Secretary may

require.

(7) Appropriation.--

(A) In general.--Out of funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this subsection for fiscal year 2006, \$10,000,000.

(B) Availability.--Funds appropriated under subparagraph (A) shall remain available for expenditure through fiscal year 2010.

(d) <<NOTE: Deadline. Reports.>> Evaluation of PACE Providers Serving Rural Service Areas.--Not later than 60 months after the date of enactment of this Act, the Secretary shall submit a report to Congress containing an evaluation of the experience of rural PACE pilot sites.

(e) Amounts in Addition to Payments Under Social Security Act.--Any amounts paid under the authority of this section to a PACE provider shall be in addition to payments made to the provider under section 1894 or 1934 of the Social Security Act (42 U.S.C. 1395eee; 1396u-4).