California HealthCare Foundation

Aging in PACE:
The Case for California Expansion

July 2010

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About the Foundation

The **California HealthCare Foundation** is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information visit www.chcf.org.

Acknowledgments

This report reflects the thoughtful contributions of almost 30 interviewees and reviewers, who are listed in Appendix B. Three writers composed the report: Fred Setterberg, Jill Lodwig, and Michelle Ponte.

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I. Introduction and Background

The Program of All-inclusive Care for the Elderly, known as PACE, is a model of care that enables frail elders to live independently in their communities. Designed as an alternative to nursing homes, PACE started in San Francisco as an adult day center almost 40 years ago. It has since evolved into a national program offering a full continuum of coordinated care and services for seniors who qualify to receive care in a nursing home.

PACE, which operates in 31 states, has received many accolades for meeting the complex needs of frail elders. The program, however, has spread very slowly in California. In fact, the state has developed only five PACE organizations over its long history, while some others such as Pennsylvania, with 14 programs, are enjoying rapid growth.

Why has growth in California been sluggish? PACE veterans say there are a number of factors, including high start-up costs, a limited pool of sponsors that can afford to start a program, California's weakened financial system, and a complex legislative and regulatory environment. Many agree that strategic changes must be made in order for the program to experience faster growth.

Through research and interviews with PACE program executives, state leadership, PACE national leaders, and consumer advocates, this report examines the program in California, including:

- PACE's history in California;
- Unique factors impacting growth in California;
- The potential to attract new sponsors;
- How other states are successfully growing their PACE programs; and
- Ideas for growth in California.

Background

In 1973, a new model of elder care was pioneered in San Francisco's Chinatown-North Beach community. The program's founders originally intended to build a nursing home in the Chinatown area to meet the needs of elders in that community. Limited funds made that impossible, so a more "grassroots" solution developed —one of the nation's first adult day centers and with a focus on immigrant elders from Italy, China, and the Philippines. Since then, On Lok Senior Health Services expanded to offer an entire community-based system of care for older adults, a model that has been adopted by organizations in California and across the nation.

Today, there are 79 PACE organizations in 31 states, including five programs that are pre-PACE but that receive Medicaid capitated payments and fee-for-service Medicare payments. As of January 2009, 17 of the 79 existing programs were inactive or not yet up and running, but the remaining PACE organizations served more than 17,000 elders across the country; as of December 2009, California's five PACE organizations served just over 2,400 clients. National sponsors are typically community-based organizations, health systems, hospitals, and continuing care retirement communities (CCRC).

PACE is a program for people over 55 who are certified to need nursing-home-level care. It is funded primarily by Medicare, Medicaid, and some private payers. It offers the entire continuum of care by integrating primary and preventive care along with nursing and prescription drugs. It also provides social services, day health center activities, transportation, meals, and physical, occupational, and recreational therapies to sustain participants' well-being and independence. Home care services are also provided.

The program has been consistently praised for delivering high quality, efficient care. "PACE clients, while far more frail than the average Medicare recipient, cost taxpayers less money in government-funded medical care, have fewer and shorter hospital stays, rarely wind up in nursing homes (even though they must be eligible to enroll in one), and report satisfaction rates close to 100 percent," Jane Gross wrote recently in *The New York Times*. [http://newoldage.blogs.nytimes.com/tag/health-care-system]

Nevertheless, PACE development in California has lagged. In the past ten years, the state has added only one organization, compared to some other states that have started several. This report examines the issues surrounding the development of PACE organizations in California, focusing on:

- Fiscal factors, such as start-up costs impacting PACE growth;
- Program model concerns and areas for improvement;
- Regulatory and legislative challenges specific to California;
- Strategies for building hospital and health system sponsorship;
- New ways to build name recognition;
- Lessons learned from other states and rural PACE organizations; and
- The future of PACE in California.

PACE's Record

- Turnover among staff is low, including personal care aides who have high turnover rates in other long term care settings, especially nursing homes.
- PACE clients have a significantly lower risk of dying than similar populations who receive care in other home- and community-based services.
- Hospitalization rates for PACE enrollees remain at or below levels for the general population and far below levels for comparably frail groups.
- Studies in Texas and Tennessee have demonstrated 14 percent and 17 percent savings, respectively, relative to nursing home costs.

II. PACE History in California

That California's progress in developing PACE has been slow is a perception shared by virtually all of the people interviewed for this report. The state has only five PACE organizations—in San Francisco, Oakland, San Diego, Los Angeles, and Sacramento. A full third of the state north of Sacramento has none, and the San Diego organization was the first to open in a decade.

Some existing PACE organizations are expanding with additional sites, and one new organization may come online in the next few years. Nevertheless, California is well behind other states. Pennsylvania, for example, has 14 PACE programs and another six in development. There are seven PACE organizations in New York and six in Massachusetts. Other programs have opened in Kansas, Tennessee, Texas, Wisconsin, Ohio, North Carolina, Hawaii, Louisiana, New Mexico, Iowa, and 18 other states. In comparison to California, all are relative latecomers to PACE; they have cultivated proficiency and leadership in a complex medical model that California developed and nurtured for almost four decades.

Why Has California Been Slow to Adopt PACE?

The reasons behind California's leisurely adoption of PACE fall into several interrelated categories:

- High start-up costs;
- Challenges in finding health care sponsors;
- Program model issues and organizational complexities;
- Name recognition; and
- California's legislative and regulatory environment.

III. Key Factors Impacting Expansion in California

Costs

High capital demands to develop a PACE center, purchase equipment, and hire staff have restrained the launch of new PACE organizations, according to some veterans, who say start-up costs can run between $5 million for a "bare bones" budget to as steep as $9 million. There may be added costs when there is a delay in program enrollment—an all-too-common occurrence in California over the past two decades. Therefore it is necessary to have substantial start-up capital on hand. Said one site director, "If we hadn't raised $5 million, we would have gone broke in six months."

New organizations must face the probability of running at a loss of several million dollars for the first 18 months to two years, with the deficit's size dependent on the number of staff and participant enrollment. "The program makes very substantial capital demands," emphasized one PACE veteran. "Then, when you are finally up and running, you're taking a managed care approach with very frail elderly who have extensive medical needs. They can be a very expensive population." Even the healthiest PACE organizations operate with an understanding of their financial precariousness. "Our margin is very slim now," said a PACE executive. "We earn just a few percent over costs, which we need to pay back our loans on capital expenditures." Furthermore, PACE is unlikely to relieve its financial burdens in the near future by substantially increasing its private-pay enrollees. "We're still at 3 to 5 percent with private pay," said a national PACE activist. "We want to see that number grow, but it's not our focus now."

PACE Start-Up Costs

New PACE organizations can expect the following initial outlays:

- $3 million to develop and furnish the PACE center (clinic, day center, transportation).
- $3 million for staffing. This includes hiring all staff and preparing for state licensing inspection before the program opens. The budget should include 18 months from application development and approval process as well as site selection in between.
- $75,000 per transport van to shuttle enrollees to and from sites.
- $400,000 – $500,000 for equipment and furniture.
- $100,000 for computers, software, and support.

Source: National PACE Association

California programs must cope with additional financial burdens because the state is an expensive place in which to do business. Real estate, insurance, and salaries are on the high end, despite the present economic downturn. "The only place we've seen exceeding the costs of California was Anchorage, Alaska," recalled a PACE replication specialist. In addition, California is also earthquake country. Over the past decade, likely PACE sponsors, such as health systems and hospitals, have been forced to commit millions of dollars to seismic upgrades, draining both financial and staff resources.

Hospitals: Making the Business Case

With high start-up costs central in slowing development in California, observers stressed that PACE advocates must be more strategic in targeting organizations that actually have millions of dollars to invest. Major health

systems and hospitals have significantly more access to capital than many of the current community-based organizations interested in PACE.

Nationally, about one-fourth of PACE sponsors are hospitals or organizations that operate acute-care services, which is down from one-third in the early years of the program, said Shawn Bloom, president and CEO of the National PACE Association. The drop in hospital sponsors comes at a time when there is growing interest in PACE among long term care entities, as well as growth in rural health care sponsors such as agencies on aging, hospices, and nursing homes. Early on, the PACE model wasn't as widely known and, logically, the acute care organizations were the ones that had the capacity to develop a program, said Bloom.

In California, where PACE development has been mostly among community-based organizations, Sutter Health is the only health system sponsor. But with just two sites, Sutter Health's PACE program barely grew as the system built its large hospital network across Northern California in the 1990s and 2000s.

With little interest from hospitals in California, industry veterans question whether PACE is competitive enough with health care organizations' other lines of new business. John Shen, is a former On Lok senior executive who led the national replication of PACE for many years. He wondered if advocates have made a reasonable business argument that investment in PACE would be as good as or better than investment in outpatient surgery centers, medical practice buildings, or hospital expansions.

Shen and others pointed out that PACE offers core business benefits to hospitals. For example, hospital sponsors can expect fewer hospital days from PACE participants, and they can capture a larger share of the frail elderly market. PACE may make good business sense for hospitals that are not in a managed care environment or in communities where they are struggling with low Medicare margins. Partnering with or starting a PACE organization means that capital isn't being invested in admissions for frail Medicare patients who are losing margin each day. To make the business case, said Shen, advocates must understand the capital needs of a health care organization along with the risk and return on investment on other health care options that are competing with the large PACE investment.

Former hospital leaders acknowledged that the business case for PACE may not be enough to motivate a multi-million dollar investment. "They're thinking, 'Oh my God, I'm going to spend three or four million dollars to take care of 200 seniors? Wow, we don't have that right now,'" said Cheryl Phillips, M.D., chief medical officer at On Lok, and a former chief medical officer for Sutter Health's PACE program. Some hospitals may contract with the PACE organization in a community to show that they are good community members, but in general they don't want to take on the risk, Phillips added. Hospital business models are about admissions and bed days, and, for the most part, they have a provider-referral relationship with outpatient community services. PACE doesn't fit well into that scenario, she observed, unless the organization happens to be highly integrated, such as Geisinger Health System in Pennsylvania, which started a PACE organization in 2006. To date, Geisinger has two PACE sites. "It is very hard for the hospitals to even imagine what this outpatient model of care would look like and how they would integrate services," explained Phillips.

Sutter Health invested in PACE, she said, because it had a very strong community mission and a strong local champion who showed leaders that the PACE model did fit into the system's vision of creating an integrated community-based network of services. Also, in 1994, when Sutter Health embarked on starting a PACE organization in its Sacramento/Sierra region, it owned seven nursing homes, which it has since divested. Today, Sutter Health has 201 participants at its two PACE sites, and is growing enrollment. Nevertheless, Phillips said the system has not leveraged the PACE program to its highest potential. For example, Sutter Health has the capability of identifying frail, vulnerable, and poor elders within its system who could be moved into the

PACE program, but this doesn't happen because each provider is accountable for his or her individual balance sheet. "And that's also the problem with systems that aren't yet fully integrated," said Phillips.

Because there is not a strong return on net assets up front for a PACE program, "I think we're going to continue to struggle with health systems," said Phillips. "Most hospital systems right now are looking at expanded secondary and tertiary services, direct partnerships with employers, and at wellness programs. And somehow, frail elders and poor frail elders don't fit on anybody's strategic business plan."

Looking ahead, Phillips and other PACE advocates agreed that strategic solutions for generating interest among large hospital and health systems must be developed. This could include developing PACE wraparound services—PACE collaborates with other providers to fill in service gaps—to make the financial case with hospital leaders. Such services would target populations who aren't quite yet eligible for PACE or for Medicaid but who may need alternative services. Programs could be created for these individuals that would serve as the transition points between hospital systems and the PACE programs, said Phillips. "Those can be some of the early wins for the hospitals to invest in."

Others recommended targeting groups or individuals who have influence with the health care organization's board and executive suite. Shen said that possibilities include "partnership with California health care associations, major consulting firms, or CPA firms that have reach into the board rooms and CEO offices." Shawn Bloom suggested reaching out to individuals responsible for the strategic positioning of the hospital and to those who manage long term care. For example, he said, between 2001 and 2006, when there was significant grant support from the Robert Wood Johnson and the John A. Hartford foundations for PACE replication, advocates "proselytized" among potential sponsor groups during an American Hospital Association conference in Washington, D.C. Targets included strategic planners and new product development executives. That one meeting, according to Bloom, helped bring Pennsylvania-based Geisinger Health System on board as a PACE sponsor.

PACE's cross-industry model adds to the difficulty of finding PACE sponsors, which must be comfortable across all of the service arenas, or willing to take on the steep learning curve. Industry leaders recalled that hospitals and health systems, in general, did poorly when they attempted to create integrated delivery systems in the 1990s. In fact, many health care organizations have stopped taking on capitation or managed care risk, or creating integrated delivery systems, said Shen. Many have retreated back to their core businesses of inpatient or outpatient care.

Organizational Complexities

In addition to the financial requirements, bringing a PACE program online involves challenges such as organizational distraction, staffing issues, and the model's intricate design that integrates acute and long term care services through team-based decisionmaking. Prospective sponsors, including health systems, hospitals, and continuing care retirement communities (CCRCs), are always occupied with numerous projects and program objectives. In California, a hospital might be engaged in seismic retrofitting, while concurrently acquiring an additional campus. An ambitious senior group could be planning a CCRC along with its PACE site. These multifaceted efforts compete for the same resources such as staff, time, money, and most critically, organizational commitment. Such distractions can hamper internal support and spark a reshuffling of priorities, which causes further delays.

If PACE development were personally guided along by the organization's most powerful person, the problem of distraction might be minimal. But the professional in charge of a start-up is typically a high mid-level manager, the equivalent of a vice president, reporting to both the executive and board. Most vice presidents don't have the power or influence to push PACE

through a programmatic or budgetary bottleneck. "It boils down to one person with vision and power," said a veteran of numerous replication efforts. "If you care enough about PACE, you can get it up quickly, say, in two years. But that requires somebody standing in the gap, negotiating between the various factions and imperatives, and pulling it all together."

The PACE program model is demanding because it offers comprehensive services and operates a health plan with financial risks. Staff must sustain their energy and resolve over a period of years, tolerating a degree of uncertainty as to whether the program will ever get off the ground. If key staff depart, the effort is likely to experience setbacks or cancellation. At least one prospective PACE organization failed to launch as a result of these factors. On the outside, confided a former staffer close to the replication effort, the state appeared to be needlessly complicating the application process. On the inside, however, the venture was perceived as doomed due to project overload, under-capitalization, mission drift, and the absence of an individual fully committed and empowered to move PACE through the sponsor's own bureaucratic channels.

Name Recognition

Another factor inhibiting widespread adoption is a general lack of familiarity with the PACE model's benefits. It has yet to achieve status as a "brand" outside of the small world of gerontology. This problem is national in scope, and also affects expansion in California. The public's lack of understanding of or interest in addressing long term care issues adds to this challenge.

The PACE model can be described as a cross between an HMO, a health care provider, and long term care, three traditionally very different segments of the health care industry with different regulations, financing, incentives, and risks. "Last year, all the directors of California PACE sites visited Sacramento," recalled one participant. "We quickly realized that very few of our legislators grasped what PACE is. They couldn't distinguish us from an HMO."

One PACE leader agreed. "When I first applied to work here, I had to do independent research to find out what PACE was. I had spent my career in an HMO, and nobody in my world had heard of it." On Lok, PACE's founding organization in San Francisco, has experienced the same challenge. After nearly 40 years of operation, thousands of clients and families served, and solid support from the local political establishment and media, it remains relatively unknown on its home turf. "We still find people confusing us with a transportation service," said a staff member at On Lok. "They see our vans buzzing around town, but they don't understand where people are being taken and what goes on there."

When word does reach the public, the results can be impressive. In Los Angeles, the Spanish-language television network Univision held an on-air discussion about PACE. The local PACE site subsequently received 150 inquiries from families, followed up by 40 visits by prospective participants—more than the site then had room to enroll. The task is to convey the story of PACE with sufficient accuracy, conviction, and enthusiasm that people throughout California can begin to translate its promise into widespread reality.

Confusion about the model is not limited to the public. The PACE model pushes all health care industry players beyond their comfort zones, observed Shen with Marin Community Clinics. For example, he said, HMO leaders might not necessarily understand long term care or the intricacy of interdisciplinary team management, while the hospital industry does not know community-based programs and long term care. "While the unifying theme of the PACE model is the care of frail elderly, that theme gets lost quickly in the complex discussions of interdisciplinary teams, capitation financing…market potentials, enrollment risk, rate setting, utilization risk, and other PACE jargon," added Shen.

Regulatory and Legislative Challenges

From its beginnings, PACE has cultivated allies from all points on the political spectrum. At crucial moments, PACE has received assistance in securing waivers, writing regulations, and appropriating funds from some of the most liberal and the most conservative members of state and federal legislatures. PACE advocates earned a reputation for pragmatism, stressing the linkage between service and cost-effectiveness.

PACE advocates point to lost opportunities for expansion from the early 1990s through 2006 caused by the Department of Health Care Services (DHCS) State Office of Long-Term Care (OLTC). They say a slow approval process of PACE organization applications and regulatory complexities led to the start-up process of new PACE organizations taking several years in some cases. Most notable is San Diego's struggle to gain final authorization to open its doors. From 1999 to 2007, the program's board and staff experienced persistent delays during the review and approval process. "When I started with PACE," recalled an administrator, "I questioned how the state could justify taking eight years to get San Diego on line. Three years, okay, I know it's complicated. But not for eight years." Since then, no other PACE organizations have opened in California.

Even PACE organizations currently in operation have experienced bureaucratic difficulties. An area of concern has been the slow processing of enrollments into PACE and, in particular, the process for nursing facility level of care certifications. PACE eligibility requires an individual to meet the state's level of care (LOC) criteria for nursing home care. In the past, California has required that all the program staff, including physicians, nurses, occupational therapists, physical therapists, social workers, and others, perform a two- to four-week patient review process and construct a treatment plan prior to enrolling an individual at a PACE site. The protocol meant that substantial professional resources and time were consumed by many individuals who ended up not joining the program. One PACE site estimated that 20 to 25 percent of its prospective enrollees end up in the hospital during the application process. Recently, this problem has been somewhat alleviated in that DHCS no longer requires that a treatment plan be developed as part of the PACE enrollment package.

Some observers pointed out that OLTC and their bureaucratic challenges do not bear sole responsibility for the lack of growth in California. "Such blame may be misplaced," said Shen; "If there were sufficient interest from health care providers or elderly consumers for PACE, no office can stop the development of any program." Shen explained that PACE organizations bear some burden of missteps as well, including casting themselves as a community-based long term care program as opposed to a managed care program or a health care program for the elderly, both of which would have allowed them to align with Medi-Cal Managed Care, the state's Medicaid managed care program. Instead of participating in the vigorous debate and development of Medi-Cal Managed Care in the late 1990s and early 2000s, Shen said, PACE organizations used the OLTC to stay outside of the fray when various models were being established; in doing so, they missed an opportunity to establish and define PACE within Medi-Cal Managed Care.

Shen also noted that in the early 2000s, instead of promoting the development of new PACE organizations, the leading PACE organizations, such as On Lok, expanded their service areas with new centers close to home. Those efforts, he said, faced high capital costs, risk of slow enrollment, and challenges of developing functional interdisciplinary teams who could provide services and manage risk. Even for experienced PACE organizations, there were scalability challenges. "The result was marginal growth in PACE enrollment and absolutely no development of new PACE organizations in the Bay Area, Sacramento, and Los Angeles, where there is a high concentration of Medicare and Medi-Cal elderly," said Shen.

The regulatory environment has changed for the better since the difficulties facing PACE were at their worst. In 2004 with funding from the California Endowment, a project called the "Regulatory Integration Project to Mainstream PACE," brought together federal and state regulators as well as PACE providers in an attempt to streamline the regulatory process for PACE and address duplicative and conflicting regulatory requirements. The DHCS reorganized in 2007, merging the Office of Long-Term Care with the In-Home Operations Unit, responsible for the Home and Community-Based Services (HCBS) waivers, which allow states to develop alternative programs under Medicaid for those who are nursing home-eligible. Now called the Long Term Care Division, it manages DHCS's programs designed to keep elderly and disabled persons out of long term care institutions by providing them with effective home- and community-based services. Legislative observers said that with this change, PACE now represents a major unit in the division and has access to the clinical resources supporting the other HCBS programs. Also, legislation passed in recent years now authorizes DHCS and other departments to grant exemptions to a PACE program from specific requirements under specified circumstances. However, DHCS has granted few exemptions and the process is cumbersome. CalPACE believes there are more opportunities to streamline and "looks forward to working with the department to address this."

IV. Lessons Learned from Other States

PACE's very slow expansion in California has not been altogether out of step with the program's nationwide growth. Over the past decade, PACE has launched 73 sites at some level of operation in 31 states, along with 14 demonstration projects in rural communities. But given the small number of people served at each PACE site—up to 150—the program has not had a large impact on elder care overall.

Some states have made substantial progress, and PACE observers noted that those states all have had a long term care vision embedded at the highest levels of state government. "PACE adoption can't be a matter of ad hoc approval at the state level," said a former PACE staffer. "States need corresponding policies for taking care of the frail elderly, and a progressive policy regarding nursing homes."

A few states have also benefited from having a champion at the top level of administration. With a champion working alongside and negotiating between legislators and civil servants, these states led the growth of PACE programs nationwide. "We hope the 30 new programs that have opened over the past four years will bring us close to a tipping point," said a program specialist at the National PACE Association. There has been a flurry of PACE start-ups in Virginia (five), Massachusetts (six), and in Michigan (six). "What they have in common is very supportive state staff," the program specialist added. "These people are aiming to build an infrastructure for long term care in their states and get cost savings. They're also very interested in program quality."

Pennsylvania has been a national leader in developing PACE programs, with 14 sites operating 21 day centers. The state also has awarded state licenses to open sites in 45 out of 67 counties. PACE advocates around the country credited Pennsylvania's boom in part to having long term care leadership at the state level that is visionary and focused on the needs of Baby Boomers, creating a product valued by consumers, and promoting widespread, high-quality services.

As part of expansion efforts, Pennsylvania actively solicits potential PACE sponsors and holds public meetings to apprise urban and rural communities of the program's benefits. "We consider PACE the gold standard in long term care," said the state's administrative director for long term care. "We also make a positive economic argument for PACE's existence within the community….If there's construction needed, you're talking about a $2 million payroll with 100 construction jobs, plus another $1-$2 million dumped into the local economy."

Additionally, Pennsylvania has worked closely with the National PACE Association and has recently concluded a two-year contract with the organization. During that time, leaders developed and implemented a five-step process for Pennsylvania, where PACE markets are exclusive, said Bloom with the National PACE Association. The plan included:

- Identifying open markets;
- Estimating the number of nursing home-eligible individuals in that market;
- Creating a market area to sustain a single provider within a 30-minute driving radius of all enrollees;
- Executing market outreach—PACE partnered with the state on a large mailing to state Medicaid vendors, inviting them to spend the day discussing PACE opportunities; and
- Implementing training—PACE and the state offered to help participants with board training and the decisionmaking process.

Each market was created taking into consideration major metropolitan areas, highways, roads, and mountains, said Bloom. It was also important that each area have at least 1,000 nursing home-eligibles, which would yield a 10-percent market penetration rate and produce a program of at least 100 people. The market outreach component was critical, as it led to vetting interested participants. "Left standing were a group of pretty interested, viable organizations ready to move forward with PACE," said Bloom. Looking ahead, Bloom estimated that by early 2011, every consumer in the state would have access to PACE, with the exception of one small market, which is too rural. "And this is all with state support. It's a state that's really pretty forward-thinking in saying, 'We want to move away from an institutional delivery model.'"

Virginia, too, is taking bold steps to grow its PACE program, and is currently developing five sites. The state effort enjoys the support of state leaders, strong interest from a group of providers and state Medicaid officials, along with a series of small grants appropriated by Gov. Mark Warner. "Equally as important as just dangling financial support, the state really demonstrated their commitment to get PACE going in meetings with providers, and they wrote a blueprint for how they wanted care for seniors to look in ten to 20 years," said Bloom. "It's a very effective state." The experience of Pennsylvania, Virginia, and a handful of other activist states underscores the importance of having administrative leadership, support from various health care constituents, and a strong marketing plan.

V. The Outlook for PACE in California

PACE advocates as well as policy and industry observers offered insights on the program's future in California, given current statewide fiscal challenges, bureaucratic challenges, and lack of identified PACE investors.

Rethinking the Legislative and Regulatory Process

PACE veterans said overhauling California's legislative and regulatory environment is critical for increasing replication. An important step, they suggested, would be to accelerate the PACE review process. "The federal government uses a 90-day clock to complete their end of the applications," said one observer. "So can the state. Or you could give the state 120 days. The point is to connect the process to a reasonable timeline." Others said that California's Long-Term Care Division could improve its procedures by using the state application review guide designed by the National PACE Association.

California PACE organizations report that protracted delays have persisted in DHCS' processing of nursing facility level of care certifications and are concerned that delays have created barriers for frail older adults in accessing PACE services. In some instances, individuals applying to PACE programs have experienced hospitalizations and nursing home placements while waiting for DHCS approval.

State leaders also suggested removing a requirement for an adult day health care (ADHC) license, which was a key requirement for PACE organizations until recently. Using the exemption process authorized by Assembly Bill 847, the state approved a PACE organization and a PACE site without ADHC licenses, said Helmar, former chief of the Long-Term Care Division. Instead of going through the exemption process for every case, state law could specify that ADHC licensure is optional as long as the PACE site meets the federal requirements for having "areas for therapeutic recreation, restorative therapies, socialization, personal care, and dining."

Similarly, PACE is subject to many federal and state regulatory and policy requirements, which often impose additional administrative burdens on PACE organizations, such as having different federal and state reporting requirements, said Helmar. "California could simplify the implementation of PACE by defaulting to the federal PACE regulations or by having an exemption process for PACE program requirements."

Helmar also suggested that County Organized Health Systems (COHS) counties be required to assume responsibility for adult day health care services and in-home supportive services (IHSS). Currently federal and state law provide that COHS organizations have exclusive rights to provide health care services to the Medi-Cal beneficiaries in their catchment areas, said Helmar. To date no COHS operates a PACE program, although some are exploring this option. "Requiring COHS to also assume responsibility for ADHC and IHSS services over the next three to five years would be a good strategy for developing PACE in COHS counties," he said.

Marketing Strategies

Changes within the PACE community itself may also affect the program's direction. CalPACE, an association of California providers founded in 2007, is presently improving the environment for expansion through both its advocacy and mutual aid activities. CalPACE has hired a Sacramento lobbyist and coordinated meetings between its members and the Long Term Care Division, and plans in the coming year to work with the legislature's health sub-committees to extend name recognition and understanding of the program.

"We're also sharing crucial information with one another," said a CalPACE board member. "When a site needs procedures, forms, or budget information, we pass them along in an effort to be as transparent as possible about our own work. Everybody feels part of a team, rather than an individual petitioning the state. And when we meet as a group with the Long Term Care Division, we feel that they're part of the team, too."

The struggle to advance widespread understanding of PACE may prove the most demanding challenge, according to many experts. They agreed that sharpening the program's public profile will be key to bringing new sponsors on board, especially since PACE is a unique blend of three more familiar models. Some experts suggested a rewrite of the unwieldy language used to describe PACE to potential sponsors, legislators, and providers. "We have to stop talking in terms of 'the frail elderly' being treated by 'the interdisciplinary team' through the 'integration of services,'" said a National PACE Association board member. "Most people don't understand that kind of language. We have to speak in ways that appeal directly to the consumers' needs and their understanding about the kind of care they want." The organization has recently hired a public relations firm to help craft a strategy to promote the PACE program and values.

Attracting Foundations

PACE advocates must do more to bring in organizations that have the financial wherewithal to support the program, including foundations. Some advocates believe that foundations were initially interested in the program because it was "innovative," but have drifted away as PACE became more familiar. "Lots of foundations chase the new," said a foundation executive specializing in health care policy. "Programs like PACE get partially implemented, but not fully. It's important to help promising programs take the next step."

Unfortunately, advocates find themselves perpetually introducing PACE to potential funders. "It's like starting at ground zero with each person," said one staffer. And yet with the huge growth of community foundations throughout the 1990s, there now exist a network of locally based funders primed to embrace a neighborhood-centered care program like PACE. The community foundation network looks particularly promising in California, where major donors have seeded endowments on a county basis. But community foundation boards and administrators must be made aware of PACE and be able to understand its potential before they can contemplate sizeable investments. Such a feat would prove easier to accomplish with a strong partner-advocate in Sacramento.

Revamping PACE

Some PACE advocates said it's time to address problems inherent to the model. For example, Shen pointed out, housing has become a higher investment and higher risk. While housing is not part of the service model, some PACE enrollees have community housing that is not safe or accessible. PACE organization have worked with local housing providers to co-locate PACE services in housing."How does housing fit into the model of community-based care?" asked Shen. He also questioned whether the model is scalable beyond the current "codified PACE center." He and others have suggested new strategies for mitigating PACE's financial risk, including sharing resources and risk among partner organizations. Shen envisions a partnership between a PACE organization and "PACE-lite" organizations that offer less-intensive services to elders who are not as frail as required by PACE. "We might think about a cafeteria model in which enrollees select among services offered on a sliding scale, taking, say, three-fifths of what's offered, while limiting their participation in the day center," said a PACE executive.

By forming clinical and financial partnerships with other organizations, PACE enrollment would grow in all kinds of communities, Shen added. "In that process, PACE organizations may indeed find a new model of organizing delivery, raising capital, minimizing risks, growing enrollments, and more importantly, breathing a new vigor in this 20-some-year-old innovation." Shen pointed out that not addressing these problems

could create the perception that PACE is an immature business model with limited market advantage for California health care providers who have enough challenges and distraction with the day-to-day running of their core business.

The 14 rural demonstration projects now operating across 12 other states may offer pointers toward such a new model. They are sponsored by the National PACE Association and the Centers for Medicare & Medicaid Services (CMS), with grants of $750,000 each to compensate for operating losses during their first three years. These projects are experimenting with an array of adaptations, including reduced reliance on the day center, use of community physicians as a part of the medical team, and the integration of home health aides into the staff. The rural model also includes greater use of alternative delivery sites, telemedicine, and electronic medical records to link their rural and urban sites. In addition to programmatic innovations, the rural demonstration projects have underscored a planning strategy that could strengthen future adoption efforts.

The rural program has brought the model to communities that would not have otherwise been served. PACE's unprecedented growth among some rural providers reflects the fact that there are no other non-institutional options available in these communities, said Bloom. "When you plunk a PACE program down in western Colorado or Appalachia, people flock to it." The rural programs differ from urban PACE organizations in terms of payment. Starting in 2009, the rural PACE organizations began receiving medical cost outlier protection through 2011, which grants them cost-sharing for enrollees who incur hospitals costs over a set amount. The outlier protection guards against expensive hospitalizations. Urban PACE organizations receive a flat payment rate from Medicare and Medicaid.

"It's not just the funding and technical assistance that's helped these programs get off the ground," said one observer. "It's also the structure—with its peer group prestige and pressure to perform. There's a healthy competition among groups. Continuing aid is tied to commitment, priorities, and performance. This is how the first ten post-On Lok sites got started—with the world watching them. Without accountability, and given the other needs and demands on most sponsoring organizations, they will dawdle."

The rural programs have been successful at serving large service areas, said Peter Fitzgerald, former vice president of strategic initiatives for the National PACE Association. The model works by using a combination of PACE centers, which offer the full range of services, and alternative delivery sites; the alternative sites extend the service area and provide most of the daily needs of participants so they don't have to travel all the way to the central sites. Those are essentially adult day centers, with nursing staff on hand, said Fitzgerald. Since many of the programs have yet to reach their one-year anniversary, it is still too early to judge whether enrollment is high enough to remain financially viable. "Some have had great success with enrollment," said Fitzgerald, while others are lagging behind their projected enrollment. "It's good for PACE if it can be not only a solution for one or two urban areas, but be a part of a statewide approach. Most states have at least some rural areas."

The SCAN Foundation in Long Beach, California, is currently funding an effort to address the needs of rural Californians. Their support helps On Lok to use their national experience and partner with local providers to broaden the availability of PACE to rural Californians. This will lay the groundwork for developing PACE for rural California through collaborative planning and program development. This project is extending national efforts on rural PACE expansion to California."

Current Activities

CalPACE and state regulators are currently working on a number of issues, including the following:

PACE Expansion and Development. The existing PACE organizations are seeking to increase enrollment and expand services. In addition to the five operating organizations, an application for a new PACE organization is in the final stages of review at DHCS, and two others have been working with technical assistance providers to develop a program. Planning for PACE in rural areas is also underway. Despite these promising developments, PACE organizations report that it is critical to further streamline DHCS' application process and shorten review timeframes so that PACE can effectively respond to community need and the changing health care environment.

Regulatory Streamlining. PACE organizations have benefitted from the exemption requests approved under AB 847. However, the process remains cumbersome. In 2009, AB 577 was enacted to refine the authority established under AB 847 in the hope of addressing concerns. PACE organizations and state regulators agree that additional discussions are needed to further streamline the regulatory requirements for PACE. Unnecessary duplication and conflicting requirements create inefficiencies for both state regulators and PACE organizations without benefit to PACE participants.

Nursing Facility Level of Care Process. PACE organizations continue to work with DHCS to decrease delays in processing certifications for nursing facility level of care. DHCS staff recently initiated some promising strategies for addressing these concerns, including on-site review of nursing facility level of care applications and development of a new documentation tool.

Revised Rate-Setting Methodology. Historically, PACE rates in California have been set as a percent of the costs for Medi-Cal beneficiaries in skilled nursing facilities, adjusted for age, sex, and geographical area. The DHCS is in the process of refining the methodology to consider cost data for Medi-Cal beneficiaries who are served in home- and community-based waiver programs. PACE organizations, working with DHCS on this effort, want to ensure a fair and equitable rate-setting methodology that accounts for the unique features of the PACE model.

Section 1115 Waiver Renewal

As part of the 2009-10 budget, legislation directs the administration to replace California's existing Section 1115 waiver for hospital financing and uninsured care with a more comprehensive waiver that would improve the delivery of care, reduce Medi-Cal costs, and lay the groundwork for implementation of federal health reform. This new waiver includes two initiatives focused on people eligible for PACE: promoting organized delivery systems for seniors and persons with disabilities, and better coordination and financing of care for individuals who are eligible for both Medicare and Medicaid— "dual eligibles."

PACE organizations are actively participating in the stakeholder process, including work groups related to seniors and people with disabilities and dual eligible beneficiaries. PACE is identified as one of four options for integrating care for this population in a paper from the Center for Health Care Strategies in March 2010, "Options for Integrating Care for Dual Eligibles." While the majority of PACE participants are eligible for both Medi-Cal and Medicare, some PACE organizations also serve a significant percentage of Medi-Cal beneficiaries who are not eligible for Medicare. Advocates are working with DHCS to ensure this latter group can continue to enroll in PACE.

Federal Health Reform Implications

How will PACE be affected by the Patient Protection and Affordable Care Act (PPACA) that was signed into law on March 23, 2010? The law will extend health care coverage to 32 million people who are currently uninsured, and also create incentives for innovation and improved care delivery, particularly for Medicare and Medicaid beneficiaries. PACE is aligned with several of the elements embedded in health care

reform goals: delivery of effective primary care through a person-centered medical home; coordination of services over time and across delivery settings; provider accountability for the quality and quantity of all services provided; and bundled payments to align incentives and provide efficient care.

With an increased emphasis on innovation and models that integrate care, opportunities exist for PACE in PPACA's implementation.

- PPACA creates the Federal Coordinated Health Care Office in the Center for Medicare and Medicaid Services (CMS) to better integrate Medicare and Medicaid benefits for dual eligible beneficiaries. This office could be a vehicle for increased awareness and promotion of PACE as a proven model with more than 25 years of success in integrating care for these populations.
- With regard to payment policy, PPACA distinguishes PACE organizations as community-based, provider-sponsored entities, from Medicare Advantage plans. This protects the PACE programs from rate reductions planned for Medicare Advantage, although other changes to Medicare payments, including a revised frailty adjustor, would still apply.
- PPACA establishes a voluntary long term care insurance program, Community Living Assistance Services and Supports (CLASS), to provide a modest cash benefit for people with functional impairments, which can be used to purchase support services. PACE is identified as one of the home and community-based services that individuals can purchase under the CLASS program. The CLASS program could make PACE more attractive for individuals who are not Medi-Cal eligible.

VI. Conclusion

Nearly all observers agreed that PACE's spread within California and nationally will be predicated on widespread public discussion of long term care needs, which will likely be expedited as the Baby Boomers age into the system. "It's time to look at what the next generation of frail elderly want," said a former PACE staffer. "Desires and expectations are very generational. The first PACE sites worked with the pre-World War II generation, who wanted very much to stay home. Other seniors coming along may be more flexible in their wants. PACE's interdisciplinary approach is a very successful clinical model. But it must be overlain with the needs of the upcoming generation of frail elderly."

Cost will be an issue of growing national concern. As of 2005, long term care costs—including nursing homes, services for the disabled, home-based care, and hospice—reached an estimated $207 billion. This figure did not account for "an estimated 70 percent of informal caregiving provided to the elderly by family members or friends," according to the Rockefeller Institute of Government.

PACE advocates are optimistic that the program will experience a resurgence given key changes. "California could have 50 PACE sites or more," said a CalPACE member. "For that to happen, we need a long term strategy—not just a plan for survival, but a vision of the next ten to 20 years. We need to clarify among ourselves where PACE wants to be in relation to the huge number of Baby Boomers coming down the pike."

PACE veterans say legislative and regulatory changes must be made to speed up the approval process and to ease the burden of program requirements. Advocates within community-based organizations also will need to make a stronger business case to large health care entities and foundations about the benefits of becoming a PACE sponsor. This may include forming new partnerships with organizations that have a direct reach to hospital and health system decisionmakers.

Finally, if PACE is to thrive in California, leaders will need to consider adaptations outside of the clinical model, such as offering fewer services on a sliding scale, partnering with other organizations to share risks and resources, and offering less-intensive services for individuals who may not qualify for PACE.

Summed up one PACE executive, "There are lots of possibilities, but we also have to keep in mind the philosophy that is at the heart of this program: PACE is a revision of the social compact. It's about changing our obligations between generations, between the comfortable and the miserable. PACE may not be the wave of the future, but I'm going to stick with it until something better can be invented."

Appendix A: PACE Timeline

The following is a brief timeline of PACE development, provided by the National PACE Association (www.npaonline.org).

1971 William Gee, DDS, and two others execute articles of incorporation for the nonprofit Chinatown-North Beach Health Care Planning and Development Corporation (later renamed On Lok Senior Health Services) and retain Marie-Louise Ansak to study the feasibility of building a nursing home in the community. She finds a nursing home would be both financially infeasible and culturally inappropriate. Instead, she obtains funding to train health care workers, in cooperation with University of California, San Francisco. She also outlines a comprehensive system of care combining housing and all necessary medical and social services, based on the British day hospital model.

1973 On Lok opens one of the nation's first adult day centers, in San Francisco.

1974 On Lok begins receiving Medicaid reimbursement for adult day health services.

1975 On Lok adds a social day care center and includes in-home care, home-delivered meals, and housing assistance in its program.

1978 On Lok's model of care expands to include complete medical care and social support of nursing home-eligible older individuals.

1979 On Lok receives a four-year Department of Health and Human Services grant to develop a consolidated model of delivering care to persons with long-term care needs.

1983 On Lok is allowed to test a new financing system that pays the program a fixed amount each month for each person in the program.

1986 Federal legislation extends On Lok's new financing system and allows ten additional organizations to replicate On Lok's service delivery and funding model in other parts of the country.

1987 The Robert Wood Johnson Foundation, the John A. Hartford Foundation, and the Retirement Research Foundation provide funding to On Lok and to the first replication sites to support their efforts.

1990 The first Programs of All-inclusive Care for the Elderly (PACE) receive Medicare and Medicaid waivers to operate the program.

1994 With support of On Lok, the National PACE Association is formed. Eleven PACE organizations are operational in nine states.

1996 Twenty-one PACE programs are operational in 15 states.

1997 The Balanced Budget Act of 1997 establishes the PACE model as a permanently recognized provider type under both the Medicare and Medicaid programs.

1999 Interim regulation published in November. Thirty PACE programs are operational in 19 states.

2000 The Robert Wood Johnson Foundation and the John A. Hartford Foundation fund the PACE Expansion Initiative to assist the National PACE Association in expanding the benefits of the PACE model of care to more families in need.

2001 Alexian Brothers Community Services in St. Louis becomes the first PACE provider to become a full, permanently recognized part of the Medicare and Medicaid programs.

2006 Final regulation published in November. Congress awards grants of $500,000 to 15 organizations for rural PACE expansion.

2007 Forty-two PACE programs are operational in 22 states.

2008 Sixty-one PACE programs are operational in 29 states.

Appendix B: Interviews Conducted

Chris van Reenan, National PACE Association, Senior Vice President of Public Policy

Shawn Bloom, National PACE Association, President and CEO

Peter Fitzgerald, formerly with the National PACE Association, Vice President, Strategic Initiatives

Jennie Chin Hansen, American Association of Retired Persons (AARP), President

Amanda Lehning, Mack Center for Nonprofit Management in the Human Services School of Social Welfare, Mack Fellow

Mark Helmar, formerly Chief, Long Term Care Division, California Department of Health Care Services

Bruce Chernof, The SCAN Foundation, President and CEO

Sarah Steenhausen, The SCAN Foundation, Senior Policy Fellow

Cheryl Phillips, On Lok, Chief Medical Officer

Carol Van Steenberg, On Lok, Planning and Development Consultant

Eileen Kunz, On Lok, Director of Policy and Government Relations

Gretchen Brickson, On Lok, Director of Technical Assistance

Eleanor Errante, On Lok, Program Manager

Sue Wong, On Lok, Chief Financial Officer

Bob Edmondson, On Lok, Executive Director

Blythe Todd Collins, On Lok, Project Analyst

Peter Szutu, Center for Elders Independence, Executive Director

Jennifer Spalding, AltaMed, Program Director

Jhones D. T. Vergara, AltaMed, Center Manager

Cheryl Wilson, St. Paul's Senior Homes & Services, Chief Executive Officer

Ed Thomson, St. Paul's Senior Homes & Services, Chief Financial Officer

Todd Kaprielian, St. Paul's Senior Homes & Services, PACE Foundation Director

Allan Allgood, St. Paul's Senior Homes & Services, PACE Executive Director

John Shen, former senior level staff member at On Lok

Jim Pezzuti, Pennsylvania Office of Long Term Living, Director of the Bureau of Community Development

Cindy Proper, Pennsylvania Bureau of Individual Support, Director of the Division of Integrated Care

William Clearwater, Sutter Health Senior Care, Executive Director

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On Lok Lifeways PACE, San Francisco, www.onlok.org

Sutter SeniorCare PACE, Sacramento, http://checksutterfirst.org/seniorservices/seniorcare.html

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