

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY

COMMONWEALTH OF MASSACHUSETTS

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Executive Summary

Background

In partnership with the Commonwealth of Massachusetts (Commonwealth), Office of Long Term Care, and MassHealth (MassHealth), Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, was asked to conduct a study of the Commonwealth's Program of All-Inclusive Care for the Elderly (PACE).

The PACE program is a Medicare managed care program and a Medicaid state plan option which provides coordinated acute and long-term care services to nursing home eligible individuals age 55 or older. All PACE participants must be certified to need nursing home care to enroll in PACE, however nationally only about 7 percent of PACE participants reside in a nursing home¹. PACE programs work to provide all necessary medical and support services covering the entire continuum of care and services to participants with chronic care needs while maintaining independence in their home for as long as possible.

The goal of this PACE Study was to conduct an assessment of the Commonwealth's PACE program that considers impact on cost, utilization, quality of care, and quality of life. The Study considers the participant's perspective, chart reviews, as well as a review of available cost and utilization data.

This report provides the findings from the review of the MA PACE program and reflects Mercer's process and findings in four key areas:

- **Operational Review:** a summary of various areas related to operations of the PACE providers including staffing, culture, and organizational structure.
- **Clinical Review:** a limited chart review with a focus on consumer quality, consumer outcomes, and care plans amongst other areas. The review was performed on a sample by members of our clinical consulting group.
- **Member and Caregiver Experience:** interviews with PACE participants and/or family members to determine their satisfaction with the PACE program as compared to when they were receiving services prior to enrolling in the PACE program.
- **Financial Analysis:** an analysis of historical costs and reimbursement in order to examine the cost effectiveness of PACE.

¹ www.npaonline.org

Methodology

The methodology used by Mercer during this review process was organized into five critical phases including the following:

- Request for information.
- Desk review.
- On-site review.
- Analysis.
- Reporting.

Request for Information

Mercer developed a Request for Information (RFI) inclusive of areas such as clinical and quality management, care management, administration and organization, and participant satisfaction. Please see Appendix B for the RFI sent to providers. This RFI was released to the MA PACE providers in June 2014. Six of the eight Massachusetts PACE providers were included in this study as the remaining two providers were new to the program. Please refer to Appendix A for a list of the Massachusetts PACE providers. Subsequent to the distribution of the RFI, Mercer participated in a teleconference with a representative of each PACE provider to review the structure and intent of the operational review, as well as respond to any questions regarding the RFI. All PACE providers submitted some or all of the requested information prior to each of their schedule visits.

Desk Review

Upon receipt of information requested in the RFI, Mercer conducted desk reviews in preparation for each of the on-site reviews. Results of these desk reviews assisted Mercer in focusing on-site interviews to areas where additional information was still necessary.

On-site Review

The on-site reviews took place between July 8, 2014 and July 15, 2014 (please refer to Appendix C for the on-site review schedule). Mercer staff conducted one site review each day. Each on-site meeting began with an introductory session including Mercer and senior level staff members from the PACE provider. The meeting agenda and overall flow of the meeting can be found in Appendix D.

Mercer was able to conduct the operational portion of the review primarily through the introductory session, as well as subsequent discussions with various staff within each organization. Throughout the on-site process, participants in the interview group were adjusted to include representatives from various departments, as required, to address issues and reflect the flow of processes conducted by various departments in delivering information, education, and health care services to PACE participants.

The introductory session was typically preceded by or followed immediately by Mercer's observation of the morning meeting. PACE provider staff then led Mercer staff through a tour of the facility.

Mercer staff then split into two groups so that the chart review and participant/caregiver interviews could be conducted simultaneously.

Mercer conducted one in-person discussion with the clinical team from each of the six PACE providers in the Commonwealth. While on site, Mercer also conducted a review of five charts. In instances where the PACE provider utilized electronic medical records, the PACE provider's clinical staff assisted Mercer's clinical staff in navigating through records.

Participant/caregiver interviews were conducted in private rooms in order to provide privacy to the participants and caregivers during the interviews. Mercer developed an interview guide in order to facilitate comprehensive and consistent information gathering. Mercer reviewed areas such as: experience prior to PACE, enrollment processes, participant rights and responsibilities, family involvement, satisfaction level with the multi-disciplinary team approach, access to services, participation in plan of care, quality of care and services received, and overall satisfaction with the program.

Mercer conducted four in-person interviews of participants from each of the six PACE organizations in the Commonwealth. Mercer conducted two in-person interviews with family members from each of the six PACE organizations. Each interview took no more than sixty minutes with the understanding that the rights and comfort level of the PACE participant or their family members was top priority. Mercer worked with each PACE center director or designee to select the most appropriate time for the interviews.

Analysis and Reporting

Information from all phases of the review process was gathered, and a comprehensive analysis was completed. Results of this analysis make up this report and are intended to provide:

- An overview of the operational review process for each participating PACE provider.
- Identification of strengths and opportunities for improvement for the MA PACE program.
- An overall assessment of the value of the MA PACE program.

Strengths and Opportunities

Strengths

- Mercer observed strong leadership teams (including the Interdisciplinary Team [IDT]) at the six PACE providers with each program and medical director fully engaged in the program. All sites had on-site medical directors participating in team meetings, seeing participants during clinic hours, or working with the medical staff.

- Each of the six PACE providers had strong mission-driven cultures of doing what is necessary to keep participants in the community and out of nursing facilities.
- At each PACE provider visited by Mercer, staff in the various disciplines had been working with the program on average eight or more years. Many staff interviewed indicated that they can focus on delivery of care and not worry about paperwork or limits on services. This factor also contributes to the high satisfaction of PACE staff with their jobs.
- Two of the programs have supportive housing co-located with their PACE centers, which provides greater access for members to participate in PACE, as well as an opportunity to market their program to other residents.
- Several PACE providers visited indicated they used an on-site hospital Case Manager to conduct in-person discharge planning at high volume or program affiliated hospitals to facilitate transition of care for participants. Some of the programs reported their physicians have privileges at contracted hospitals that allowed the primary care PACE physician to serve as the attending physician for admissions or serve as consulting physician during hospitalizations and discharge planning. Both interventions demonstrated an integrated approach to coordination of care for hospitalized participants. This level of planning decreases issues with discharge planning and re-starting services when the participant arrived home.
- The daily IDT meetings demonstrated the team's ability to quickly identify issues and provide immediate intervention and highlight the team's deep understanding of the participant's health conditions, home issues, living situations, preferences, and personalities. The development of strong relationships extended to participant's families and caregivers.
- Many of the programs reviewed have geriatricians on their staff, and the level of expertise in managing geriatric health care needs was clearly evident at each site, as was the passion for serving an aged population.
- Reassessment findings are incorporated into the care plan by the IDT. This process results in care plans that contained relevant, measurable goals, and documentation regarding participant progress toward goals.
- The PACE providers reviewed demonstrated innovative methods to partner with housing entities (public and private) to provide elder participants an opportunity to retain independence and remain in their community.
- The PACE providers demonstrated dynamic multidisciplinary teams consisting of both primary care practitioners, and on-site dedicated behavioral health (BH) practitioners that work collaboratively with the participant to address their medical and BH needs with patient-centered care-plans that reflect joint strategies to ensure all service needs are addressed.
- Most of the PACE providers have developed specialty services for podiatry, vision, and dental services that are located on-site with regularly scheduled visits by providers. Coordination across service systems, which are often co-located, can have profound effects for outcome, cost, and quality of life for a PACE participant.
- Each of the six Massachusetts PACE providers visited by Mercer conduct their own participant satisfaction surveys annually. Based on these surveys, the six Massachusetts PACE providers reported high levels of satisfaction with the medical care received, communications with

medical staff, activities that are engaging and varied, and active participation in their plans of care.

Opportunities

- Not all programs had on-site program directors and those programs with on-site presence appeared to be more engaged in day-to-day activities/issues and have more buy-in from staff than those separated from the program on a day-to-day basis. PACE providers without on-site program directors can find ways to become more involved in day to day issues and communication with on-site staff.
- Because of the smaller size of the PACE providers as compared to larger health plan delivery systems, and the personal involvement of the IDT with each participant, processes tend to be more informal which can lead to inconsistencies. There are opportunities for the PACE providers to continue to formalize their policies and procedures and ensure all staff, especially members of the leadership and IDT are knowledgeable and use them consistently.
- It is important for the Massachusetts PACE providers to continue to invest in the Electronic Medical Record (EMR) for their programs and ensure staff are adequately trained on how to access and input key information. It is also important for PACE providers to think about how to maximize the output of data and how to analyze the data to improve their programs.
- Monitoring outcomes by tracking 7, 15, or 30-day readmissions could provide insight to the program's success with coordinating discharge planning.
- Many of the PACE providers indicated they are experiencing a shift in participant referrals from an elder population to a younger (55-65 year old) disabled demographic with increased BH and substance abuse (SA) issues. The PACE providers shared the challenge of building staff competencies and program modifications that support this newer demographic. Providers should continue to monitor this shift and adjust staffing as necessary to meet the needs of the participants.
- The PACE providers reported limited interfacing with community BH providers for services such as crisis intervention, psychiatric management, detoxification, and outpatient SA treatment with the exception of a few organizations that indicated having Seboxone and Methadone treatment providers within their network. There appeared to be limited utilization of community based SA treatment options. Opportunities exist to increase these interfaces and community based treatment options.
- There were no evidence-based standardized medical necessity resource tools or consistent processes to evaluate medical necessity and the cost benefit analysis for the requested service, medication, or assistive device. Opportunities exist to acquire such tools and processes and implement in order to better manage the population.
- There was limited ability, either using the electronic medical system or through tracking of utilization management (UM) decisions to consistently report, track, and trend UM activities for quality of care, outcomes, and business planning purposes. As PACE providers continue to develop their use of EMR, opportunities exist to monitor and utilize UM data.

- Opportunities exist to facilitate discharges over weekends; especially, when PACE models have relationships connected to sub-acute/transition level of care, or community supportive care, through housing/PACE home health support.

Recommendations

The PACE providers have clearly demonstrated value in the level of care and attention provided to participants. The PACE model provides an approach to care that is beneficial to participants as well as family members. The value has been evident through the on-site reviews in the areas of clinical management, quality management, care coordination, and participant/caregiver satisfaction amongst other areas. A significant cost component for the PACE program is related to the PACE Center Services which is not included under the FFS delivery model. The PACE Center is the cornerstone of the PACE program and is crucial in achieving the family-like atmosphere, high levels of member satisfaction and potential cost savings related to delayed nursing home placement. Many of the areas demonstrating value are not immediately discernable through PACE provider-submitted cost data, therefore additional analysis is necessary to investigate further.

Mercer recommends that the Commonwealth and the PACE providers continue to partner to determine the best plan of action to continue to enhance the data reported to the Commonwealth for purposes of monitoring and rate development. Additional participant level data as well as additional detail within the PACE provider cost reports would facilitate more robust analysis. In addition, PACE providers currently utilizing systems that would allow for detailed cost or utilization reports could explore additional reports or data elements that could be provided to the Commonwealth.

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Operational Areas

Organizational Structure and Leadership

The organizational structure of each of the Massachusetts PACE providers was consistent with the requirements set forth in federal rules at 42 CFR Part 460.60. The federal requirements necessitate the PACE provider be a distinct part of either an entity of city, county, State or Tribal government, or a private not-for-profit entity formed under the Internal Revenue Service 501(c)(3) rules. The six Massachusetts PACE providers visited by Mercer were private not-for-profit entities that were either stand-alone 501(c)(3) organizations or affiliated with a larger corporation.

The PACE regulations also require each PACE provider to have the following leadership positions in place:

- Program director who is responsible for the oversight and administration of the entity.
- Medical director who is responsible for the delivery of participant care, for clinical outcomes, and for the implementation, as well as oversight of the quality assessment and performance improvement program.

The leadership requirements and the requirement of the interdisciplinary team (IDT) approach (discussed in detail below), are seen as key to the success of the PACE programs. Mercer observed strong leadership teams (including the IDT) at the six PACE providers with each program and medical director fully engaged in the program. Their on-site presence is another critical contributing factor to the success of this model. All sites had on-site medical directors participating in team meetings, seeing participants during clinic hours, or working with the medical staff. Not all programs had on-site program directors and those programs with on-site presence appeared to be more engaged in day-to-day activities/issues and have more buy-in from staff than those separated from the program on a day-to-day basis.

The PACE organizational structure does lend itself the opportunity for additional efficiencies within their operational processes. Because of the smaller size of the PACE providers as compared to larger health plan delivery systems, and the personal involvement of the IDT with each participant, the processes tend to be more informal which can lead to inconsistencies. There are opportunities for the PACE providers to continue to formalize their policies and procedures and ensure all staff, especially members of the leadership and IDT are knowledgeable and use them consistently.

Culture

The culture of the PACE program is its heart and soul. It is a major contributing factor to the success of the model seen nationwide. PACE programs across the country have been touted as mission-driven and providing a family-like atmosphere as well as showing a high level of commitment to participants. The program is designed with the holistic approach as the key theme but being able to successfully implement that and carry it forward in an organization's mission can be challenging. This was not a challenge for any of the Massachusetts PACE providers visited by Mercer. Each of the six programs had strong mission-driven cultures of doing what is necessary to keep participants in the community and out of nursing facilities. These PACE providers go beyond focusing solely on participant's medical needs by striving and taking pride in the involvement of family in all aspects of care.

Part of this mission-driven culture is the family-like atmosphere within each PACE provider. Many participants felt they were part of the "PACE family" and caregivers were comforted knowing their family members were treated like family amongst the PACE team. This type of approach or level of comfort for family members is invaluable; it is one of the unique aspects and successes of the PACE program.

Staffing

The PACE providers are required by federal regulations to have staff to meet the individual needs of each participant. PACE providers employ necessary staff to meet the needs of their participants in service areas such as primary care (physician and nursing services), social services, restorative therapies (physical and occupational therapies), person care, supportive services, nutritional counseling, recreational therapy, and meals. In addition, staff must demonstrate the skills and knowledge necessary to perform their position through regular competency evaluations and ongoing training.

In addition to having a vast array of staff available and involved in the health care needs of participants, the Massachusetts PACE providers had one thing in common — the longevity of their staff. At each PACE provider visited by Mercer, staff in the various disciplines had been working with the program on average eight or more years. This type of longevity is unusual for a health care program. Common contributing factors to the longevity of staff are the integrated model of care and the ability to focus solely on activities related to their profession. Many staff interviewed indicated that they can focus on their trained profession (that is, nursing, primary care, physical therapy, etc.) and not worry about paperwork or limits on services. They can focus on delivery of care that meets the needs of the participant. This factor also contributes to the high satisfaction of PACE staff with their jobs. The Mercer team heard several times from staff that they enjoy their work and enjoy making a direct impact on someone's life.

IDT Approach

The PACE providers are required by federal regulations to establish an IDT at each PACE center to comprehensively assess and meet the individual needs of each participant. Composition of the IDT is also laid out in regulations requiring at a minimum the following members:

- Primary care physician.
- Registered nurse.
- Master's level social worker.
- Physical therapist.
- Occupational therapist.
- Recreational therapist or activity coordinator.
- Dietician.
- PACE center manager.
- Home care coordinator.
- Personal care attendant.
- Driver or representative.

All Massachusetts PACE providers visited by Mercer employed the appropriate and required staff within their IDTs. Mercer had the opportunity to observe IDT meetings during our visits, which is discussed in more detail in Section 3 of this report.

Electronic Medical Records (EMR)

PACE providers are not required, per federal PACE regulations, to utilize EMR. There are requirements for maintaining a medical record that are a single comprehensive record for each participant, containing documentation for all services and advance directives, if applicable. The Medicare and Medicaid programs are promoting EMRs with incentives and new requirements for providers moving in that direction. PACE is no exception to this evolving movement. Many PACE providers, including those in the Commonwealth, are shifting from traditional paper medical records to EMR. The PACE providers are relatively new to the EMR world and are still learning how to utilize and leverage reporting functions to benefit their tracking and utilization reviews. They are also learning how best to share data amongst providers so their participants can gain the most from the care they are receiving in a real-time manner while maintaining health care privacy.

It is important for the Massachusetts PACE providers to continue to invest in the EMR for their programs and ensure staff are adequately trained on how to access and input key information. It is also important for PACE providers to think about how to maximize the output of data and how to analyze the data to improve their programs. Additional discussion related to EMR appears Section 3.

Contracted Services

Transportation, food services and supportive housing are the more common services offered by PACE providers that are often delivered by contracted entities rather than by in-house staff. The decision to contract to outside entities for these services is dependent upon the organizational structure of the PACE provider as well as the cost to bring these services in-house as compared to contracting separately. The PACE providers in Massachusetts utilize both methods for each of these services as discussed below.

Transportation

Transportation is a required PACE service, and organizations can decide if the service will be provided by direct PACE center employed staff or by contracted entities. In either arrangement, drivers play a key role in the integrated/team approach to PACE care. They are usually the first source to identify changes in the participant since they are seeing them first thing in the morning and at the end of their days. The drivers are able to report those changes to the PACE IDT team.

Transportation is also one of those service areas that receives a high satisfaction rating amongst participants while also receiving a higher volume of grievances from participants. The drivers become like family members to the participants; developing relationships with them and learning their likes and dislikes as they drive to and from the PACE center. Participants generally prefer to have the same driver each time as a result of these ongoing relationships. The grievances tend to be focused on a late arrival or no-show by the driver for a designated appointment. In Mercer's review of grievances, the PACE providers with contracted transportation vendors had more complaints than those organizations that keep the service in-house. PACE providers have more challenges managing a vendor than monitoring and managing in-house staff.

In some instances, PACE providers that use contracted vendors may also contract with multiple transportation vendors to meet variable service level needs. This can cause lack of consistency for participants and increased wait times, which influences the number of grievances filed.

The Massachusetts PACE providers utilize both methods for providing transportation. Three organizations incorporated transportation in-house, while three organizations used a contracted entity. One organization contracted with two additional transportation vendors to supplement their in-house vans in order to better meet the needs of the participants.

Food

Food service is another common service for PACE providers to contract with an outside entity to provide the daily PACE center meals, as well as the home-delivered meals for participants. For most PACE providers, food elicits the most comments and complaints from participants regardless of whether the service is provided by an in-house kitchen staff or a contracted vendor. It is challenging for PACE providers to cater to all participant preferences.

Despite complaints about food services, this tends to be an area reported in the annual surveys with high satisfaction. The Massachusetts PACE providers use both contracted food service vendors and in-house food service. Four out of the six PACE organizations use a contracted vendor, and two PACE providers make the meals in-house and deliver them to each site. All PACE providers have kitchens on-site for morning coffee/snack service and reheating food if necessary.

One best practice observed during the on-site visit involved the food vendors. Due to the numerous complaints regarding the food service provided by the contracted entity, one PACE provider brought together a group of participants to speak directly to the food service contractor to hear the issues first hand. This was a novel approach to deal with the issues and have the contractor directly involved. This approach also empowered the participants and gave them the ability to speak directly with the contractors.

Supportive Housing

Affordable housing is a challenge for lower income, aged, and disabled populations including those with behavioral health needs nationwide. Many community-based programs struggle to find housing options where the individual can maintain their independence with supports and remain safe in the community. A unique aspect of the Massachusetts PACE providers is their strong relationship with the supportive housing programs within their catchment areas. Two of the programs have supportive housing co-located with their PACE centers, which provides greater access for members to participate in PACE, as well as an opportunity to market their program to other residents. Co-location is a trend that is increasing nationwide as programs are developing with housing programs to meet the needs of their communities. In 2003, a housing survey conducted by the National PACE Association found that at least 32% of the PACE providers surveyed were co-located with senior housing². The survey also indicated that nearly 45% of surveyed programs indicated future involvement with senior housing in their plans for growth.

The strong relationship with housing authorities strengthens the PACE program by truly being able to provide or assist with coordination of all services necessary to live safely in their community. Additional detail regarding housing and its impact on clinical care appears in Section 3.

² National PACE Association. *PACE and Senior Housing Survey*. 2003

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Clinical Review

Interdisciplinary Teams

With complex health, cognitive, emotional, housing, and physical impairments, populations such as those served by PACE providers have multifaceted issues that impact their ability to be adequately managed and maintained in a community setting. Without effective coordination of these complex issues, these participants frequently end up being placed into skilled nursing facilities at increased expense to the state and federal government and at the expense of quality of life for the participant. Advantages to using an IDT approach to improve healthcare outcomes for those with complex needs is well established in the literature, and use of this health care delivery strategy is seeing a resurgence as a best practice intervention in both the Coleman and Naylor Transitions of Care Models and in national efforts, such as state Duals Demonstrations, where some states plan to use IDTs to increase collaboration and coordination of care³. Rationales are clear - IDTs increase coordination of care across the continuum of care, as well as improve safety and quality of care⁴. The PACE model requires the utilization of an IDT that includes, at a minimum, the following individuals either employed or contracted with the organization⁵:

- Primary Care Physician.
- Registered Nurse.
- Master's level social worker.
- Physical therapist.
- Occupational therapist.
- Recreational therapist or Activity coordinator.
- Dietician.
- PACE Center Manager.
- Home Care Coordinator.
- Personal Care Assistant or his/her representative.
- Driver or his/her representative.

³ "Core Components of Transitional Care": Jacobs, D. Managing the gaps with transitional care. March 14, 2013. Accessed 4/22/2014 <http://www.mcknights.com/managing-the-gaps-with-transitional-care/article/284417/>

⁴ RJWF, Interdisciplinary Collaboration Improves Safety, Quality of Care, Experts Say, November. 22, 2010.

⁵ Programs of All-Inclusive Care for the Elderly (PACE) Manual. Chapter 8-Interdisciplinary Team, Assessment and Care Planning. Rev.2, Issued: 06-09-11.

Many of the PACE providers reviewed as part of this study include other specialized staff as part of their IDTs, including: nurse practitioners (NP), palliative care NP, pharmacists and pharmacy technicians, psychiatrists, psychiatric nurse practitioners, psychiatric clinical nurse specialists, and licensed clinical social workers (LICSW) to support the behavioral health (BH) needs of the population (the expansion of BH services and competencies is further explored below in the section titled BH and Substance Abuse (SA) Disorders competencies). Several PACE providers visited indicated they used an on-site hospital Case Manager to conduct in-person discharge planning at high volume or program affiliated hospitals to facilitate transition of care for participants. Some of the programs reported their physicians have privileges at contracted hospitals that allowed the primary care PACE physician to serve as the attending physician for admissions or serve as consulting physician during hospitalizations and discharge planning. Both interventions demonstrated an integrated approach to coordination of care for hospitalized participants. This level of planning decreases issues with discharge planning and re-starting services when the participant arrived home. Monitoring outcomes of this type of coordination by tracking 7, 15, or 30-day readmissions could provide insight to the program's success with coordinating discharge planning.

In addition to improving coordination of care for all services received by participants, the PACE model requires that all staff, in collaboration with the participant, are involved in the development of the participant's care plan, which increases the likelihood that identified issues are addressed. The daily IDT meetings demonstrated the team's ability to quickly identify issues and provide immediate intervention and, moreover, highlight the team's deep understanding of the participant's health conditions, home issues, living situations, preferences, and personalities. The development of strong relationships extended to participant's families and caregivers. The building of relationships in conjunction with the intimate knowledge of their participants translated into strong trust relationships where participants and families more freely communicate and collaborate with program staff. Examples were shared where confidence in the program and the team gave caregivers the reassurance they needed to trust that a family member could be managed safely and effectively in the home when the family initially was in support of skilled placement.

Challenges with a diverse interdisciplinary model include increased staffing costs to employ or contract with highly licensed and experienced clinicians, team meetings, and frequent collaboration that are staff and time resource intensive, and challenges recruiting and retaining required staff to meet staffing standards, which can translate into increased costs for this type of model. Programs also shared that the model can be challenging, especially at first, for new participants and caregivers who are not accustomed to having "so many people" involved in their care. This is generally resolved as the participants and caregivers become adjusted to the program and build relationships with the team, but may mean this model is not appropriate for everyone in need of long-term care services.

Geriatric Healthcare Expertise

The PACE model was designed to support the care of geriatric populations. Many of the programs reviewed have geriatricians on their staff, and the level of expertise in managing geriatric health care needs was clearly evident at each site, as was the passion for serving an aged population. Many of the PACE providers indicated they are experiencing a shift in participant referrals from an elder population to a younger (55-65 year old) disabled demographic with increased BH and SA issues. The PACE providers shared the challenge of building staff competencies and program modifications that support this newer demographic.

BH and SA Disorders Competencies

As noted above, BH has been an area of reported growth for each of the PACE providers reviewed. The programs all reported an increase in referrals of participants with pre-existing BH and SA disorders. In response, several of the PACE providers have added BH specialized staff including psychiatric nurse practitioners, psychiatric clinical nurse specialists, and LICSWs. It is important to note that these staff are in addition to licensed and non-licensed social work staff that traditionally supported social and community linkage needs. This BH and SA team's primary focus is BH identification, referral and treatment through individual and group therapy, diagnosing BH conditions, and prescribing BH medications when appropriate. The professional level and number of BH specialized staff varied considerably across the six organizations and although most programs utilized screening tools to identify potential BH issues, there were opportunities noted to improve the non-behavioral staff's competency to identify potential BH/SA issues, make prompt referrals and ensure that comprehensive BH and SA assessments were conducted either by PACE licensed staff or through appropriate referrals to BH providers in the community.

This expansion of BH care has expanded to psychiatric inpatient admissions where the PACE plans report the building of relationships with psychiatric inpatient facilities and beginning efforts to collaborate with attending physicians during admissions and at discharge. While there has been progress within the PACE providers to develop BH collaborations, this did not appear to extend to community-based BH providers. The PACE providers reported limited interfacing with community BH providers for services such as crisis intervention, psychiatric management, detoxification, and outpatient SA treatment with the exception of a few organizations that indicated having Seboxone and Methadone treatment providers within their network. There appeared to be limited utilization of community based SA treatment options such as: Alcoholics Anonymous, Narcotics Anonymous, or like programs, which can be treatment options for some participants. Collectively, the PACE providers reported identifying SA treatment services as a gap in the service array they are able to provide. Each reported an increase in SA treatment needed within their newer referrals; especially, those in the 55-65 year old age group. Each program shared their early efforts to address the increase in SA needs including, identifying provider partners, considerations to expand their IDTs to include SA professionals, training staff on SA identification and interventions, and adapting their center activities to support younger participants with diverse BH and SA issues.

Nearly all of the PACE providers reported they manage all medications prescribed to their participants including the filling of the prescriptions, with the exception of one provider that indicated they do allow some specialty physicians to prescribe medications on a limited basis. Having this level of oversight provides the opportunity to monitor medications for participants who may have SA issues with prescription medications and to monitor adherence to medication regimens for participants, particularly those with BH issues, who may have medication adherence challenges.

EMR

Electronic medical records were being utilized by several of the PACE providers reviewed with some demonstrating moderately mature EMR systems, a few newly utilizing EMRs, and at least one program looking to change EMR systems due to their software company's buy-out by another organization with no plans to continue to support the current platform. Agencies were typically using one of two EMR platforms, NextGen or Epic. Each system required some modifications to support a PACE program medical record, but agencies reported positive results in working with these vendors to adjust standard platform functions and document templates to support their program model. Epic users reported benefits of accessing participant information for inpatient admissions as these organization's partner hospitals were also using a version of Epic. This allowed information sharing between the hospital and the PACE program that reportedly improved coordination of care and communication of participant issues and needs.

Reporting functions varied across both platforms depending on the functionalities of the software and the function purchased by the programs but showed tremendous promise in allowing PACE organizations to begin utilizing reporting metrics from the EMR, or for the more advanced user programs, to expand their reporting and tracking abilities. This was one area where there was universal agreement by the PACE providers that reliable reporting would change the way these programs monitor, track, trend, and report outcomes. Increased standardized reporting functionality may be an opportunity to provide the Commonwealth with valuable metrics to track and trend program outcomes in the future as the programs continue to enhance reporting capabilities.

Clinical Record Review

Mercer's clinical team reviewed up to five agency-selected clinical records at each of the PACE providers, with at least one record corresponding with the participant interviews. In several cases, the records reviewed included three to four of the interview participant records. The record review demonstrated detailed assessments, strong individualized care plans that address medical, social, activities of daily living, and housing issues and, for some participants, behavioral health and substance use issues. As outlined in the Centers for Medicare & Medicaid Services PACE Manual, the PACE model requires that key interdisciplinary staff (physician, registered nurse, masters level social worker, and recreational therapist/activity coordinator) must conduct a face-to-face assessment of the participant semi-annually. In addition, any specialty staff "actively involved in the

implementation or development of the care plan” must also conduct their own face-to-face assessment semi-annually. The team then meets to consolidate the reassessment findings into the care plan. This process resulted in care plans that contained relevant, measurable goals, and documentation regarding participant progress toward goals. While the care plans generated by this process clearly demonstrated a deep understanding of the participant in addressing multiple identified problems or issues, the amount of staff time and resources to develop each care plan was significant.

The file reviews contained multiple assessments conducted with participants to identify open issues and concerns. Most of the PACE providers conduct cognitive assessments, depression and behavioral health screens, fall risk assessments, activities assessments, and in-home environmental assessments. The assessments and medical record notes offered a ‘picture’ of the functional status of the participants.

Supportive Housing

While housing is not a covered benefit under the PACE Program, there are recognizable and undeniable interdependencies between housing and PACE’s goal to maintain participants in the community. One of the top priorities for any PACE provider is to provide long-term care services and supports to fragile elderly participants in the least restrictive environment. The goal to keep participants in the community, and out of long-term nursing homes, is one of PACE’s fundamental objectives. The profile of an individual who met the requirements for participation in PACE programs is a Medicare or Medicaid eligible with a nursing home level of care as determined by the state. Traditionally many of these elders may have received those services in some institution/long term nursing home facility. With the emergence of PACE programs, the overlay of housing has been woven into the tapestry of many state-supported programs. The role of safe, decent, and affordable housing in promoting wellness, and quality of life for older persons is a vital component in support of maintaining individuals in their community⁶. Research evidence supports the position that care provided in a home setting facilitates slower decline in health status, reduction in hospitalizations secondary to chronic conditions, better outcomes and quality of life.⁷ The connection to housing for PACE participants is a vital component of a comprehensive system of integrated care.

There are significant numbers of PACE enrollees nationally who currently reside in senior living and/or public housing. Collaboration between public housing authorities, private partnerships, and

⁶ McNickle, Larry, Keeping PACE with Seniors’ Needs: Housing Symbiotic Partnerships, Retrieved from; http://www.npaonline.org/website/download.asp?id=3402&title=Health_Care_Meets_Housing_-_2004

⁷ The Joint Commission (2011). Home- The Best Place for Health Care, A positioning statement from Joint Commission on the state of the home care industry. Retrieved from; http://www.jhartfound.org/images/uploads/resources/Home_Care_position_paper_4_5_111.pdf

PACE provides a timely opportunity to address health care service needs of their aging residents⁸. Benefits of having housing partnerships with PACE programs include:

- Health care team members have better access to PACE participants for timely assessment and/or service delivery.
- Transitional and swing beds are available for participants who have behavioral health conditions, which impact their physical health status. Many of these participants have some of the highest needs for skilled services and care coordination. Alternative housing provides a mechanism to keep these high-acuity participants out of long-term nursing facilities.
- Residents have easy access to adult day care services and are heavily invested in the PACE community.
- Decreased transportation cost when residents are on-site or are located in close proximity to the PACE center.
- Participants have after-hour support systems available via nursing assistance and other care providers directly on-site.
- Transitional housing for participants who would otherwise default to institutional care settings.
- Greater collaboration among interdisciplinary team – on-site staff can contact clinicians in real time after hours resulting in possible avoidance of acute care admissions and/or emergency department visits.
- Some of the PACE programs reviewed in this study demonstrated successful collaborations with Boston's Public Housing Authority, as well as with other residential alternatives.

The PACE program review demonstrated several sites where the clinical teams are heavily vested in working with assisted-living facility (ALF) staff to ensure continuity with the implementation of the participant-centric care plan. At several PACE provider sites, the programs had developed partnerships with higher volume ALFs. Secondary to this collaborative relationship, the ALF proactively contacted the PACE on-call provider with questions related to changes in the participant condition to potentially divert or avoid an emergency department visit or hospitalization. This communication often leads to either an on-site visit by the practitioner, or a home health nurse for assessment and treatment. Care planning sessions with housing partners such as ALFs/skilled nursing facilities are implemented by PACE staff to ensure the provisions of the care plan are being carried out. If barriers or quality concerns from the facilities are identified, a collaborative approach of education and quality improvement strategies are put into place as part of a joint effort to integrate services to meet the PACE participant's needs. At least one PACE provider has developed a program that works collaboratively with the Leominster Housing Authority. This partnership facilitates participants to remain in their home while receiving support services. Apartment homes have residents receiving day-to-day services including food services,

⁸ MCNickle, Larry, Keeping PACE with Seniors' Needs: Housing Symbiotic Partnerships, Retrieved from; http://www.npaonline.org/website/download.asp?id=3402&title=Health_Care_Meets_Housing_-_2004

transportation, and home care by PACE staff who are on-site twenty-four hours a day, seven days a week.

The PACE providers reviewed demonstrated innovative methods to partner with housing entities (public and private) to provide elder participants an opportunity to retain independence and remain in their community. Several organizations have developed their own housing options where they place staff on a large floor of a subsidized housing unit to manage larger volumes of participants on the floor, or other floors, of the housing unit. Other programs are actively building or converting community housing into shared dwellings for PACE program participants. As the number of seniors from the baby boom generation continues to grow, viable housing options to support the increasing numbers of people who are medically fragile, disabled, or chronically ill with complex behavioral and physical health combined needs will continue to necessitate innovative strategies to support community residential living.

Coordination of Care

There is tremendous interest in care coordination nationally. Modern health care reform focuses on patient centered, comprehensive care system delivery. Whether you are a health care provider, acute care facility, health care legislator, patient advocate, health care fiduciary, or consumer of health care, integrated and coordinated service delivery is a priority. For both commercial and publically funded programs, care coordination is a fundamental challenge.

The PACE model's premise is to provide all-inclusive care via a team of professionals working with the participant and their representative to ensure health care needs are met⁹. PACE providers coordinate all of the care services that seniors need in order to remain as active and independent as possible. The concept is that it is best for the well-being of seniors with chronic-care needs and their families to be served in the community whenever possible¹⁰. Another benefit of the PACE program is not only does it provide traditionally skilled services by licensed practitioners, but it also provides supportive assistance to elderly participants such as; home maker services, shopping, preparation, and home health aides to assist with bathing or dressing, which gives elders the help they need to stay in their home instead of going into an institutional setting. A study by JEN Associates, Inc. included an assessment of the PACE program's effect on nursing home residency¹¹. This analysis compared data from a control population to PACE enrollees. It was found that the nursing home rate over time increased for the control population but decreased sharply for the PACE enrollees. PACE enrollment was therefore linked to a reduction in nursing home admission rates through the first 20 months of enrollment. This delay is likely linked to the care coordination and availability of supportive assistance to PACE participants upon enrollment.

⁹ Medicare.gov., <http://www.medicare.gov/your-medicare-costs/help-paying-costs/pace/pace.html>

¹⁰ Providence Health and Services, PACE Care Coordination, Retrieved from; <http://oregon.providence.org/our-services/p/pace-care-coordination/>

¹¹ "Massachusetts PACE Evaluation Nursing Home Residency Summary Report." JEN Associates, Inc., July 24, 2014.

Coordination usually involves the managing of care transitions across multiple settings along the health care continuum. Older adults with multiple complex conditions account for more than 75% of Medicare spending. It is estimated that up to 80% of Medicare members do not have access to care coordination¹².

All of the PACE providers have demonstrated service coordination to varying degrees. Some programs demonstrated best practices in service coordination in a variety of ways. These PACE providers demonstrated dynamic multidisciplinary teams consisting of both primary care practitioners, and on-site dedicated behavioral health practitioners that work collaboratively with the participant to address their medical and behavioral health needs with patient-centered care-plans that reflect joint strategies to ensure all service needs are addressed. Additionally, any of the IDT team can refer participants for medical or behavioral health services for unscheduled support while the participant is on-site for PACE activities. During the on-site visits conducted for this study, there were multiple examples of how care coordination was implanted naturally into the daily work of the programs and seemingly, without additional effort by the staff. One example was the dietitian providing supplement options for the participant to taste and select from in order to maintain a healthy weight, as the IDT team had identified weight issues with that participant. Another example is when the activities assistant noticed a participant's gait appeared to change from their baseline and immediately took the participant to the physical therapist for evaluation. In these examples, there was real time intervention during the time the participant was at the facility.

Another component noted for some of the PACE providers reviewed is that they have a large population of participants residing in ALFs, and as noted above, have routine collaborative meetings and work with staff in ALFs/nursing homes to ensure the participants are surrounded with support services. Additionally, whether the participant is in sub-acute facility, long-term nursing home, or ALF, the interdisciplinary team has built and fostered collaborative relationships so they are consulted on any change in the participant's condition, provide education to site staff, and create process improvement plans for any quality of care concern.

Although functionality and full integration into the programs varied, those programs using an EMR system allowed practitioners to have necessary data at their fingertips to make medical decisions regarding patient care when they are on call and receive communications from the residential partners regarding potential changes in the PACE participant's conditions. Some best practices to note were sites that demonstrated information technology capability to not only access internal PACE medical records of participants, but additionally, some programs had developed dedicated hospital partnerships and were able to access PACE participants acute care facility medical

¹² The American Geriatrics Society, Geriatric Health Professionals. Leading change. Improving care for older adults, Retrieved from; http://www.americangeriatrics.org/advocacy_public_policy/care_coordination/

records with affiliated hospitals. The technical enhancement provides the primary care clinical team the opportunity to monitor participant's progress and communicate with hospital list partners, subsequently enhancing care coordination and facilitating discharge planning activities. However, even without the capacity to view the hospital records, all of the sites visited were noted to have an on-site clinical case manager making rounds or even co-located within the PACE provider's primary admitting hospital, or affiliated hospital, whose primary role was to facilitate discharge planning and connect the participant to community and other PACE-related services.

Most of the PACE providers have developed specialty services for podiatry, vision, and dental services that are located on-site with regularly scheduled visits by providers. Coordination across service systems, which are often co-located, can have profound effects for outcome, cost, and quality of life for a PACE participant. For instance, the fragile diabetic needing podiatry services can have all of their services in one place. The primary care provider is aware of what appointments are scheduled that day and can readily consult with the podiatrist at the time the participant is being examined. This type of coordination could potentially prevent increased complication to a chronic condition up to, and including, a loss of a limb, decrease medical expenditures for potentially avoidable admissions, as well as enhancing the participant's quality of life.

The PACE providers visited demonstrated coordination of services for their participants. There was variation in program delivery models; however, the essential service coordination, which PACE programs support, were provided. For example, some programs had behavioral health providers dedicated and fully integrated into the IDT, in contrast to other sites with contracted behavioral providers who were called on a case-by-case basis. Another example in program variation was evidenced in the frequency of some specialty services on-site, such as dental or optometry. There were also different methods of fulfilling prescriptions for participants, for example on-site versus contracted pharmacy vendor, but all PACE providers provided medication fulfillment, as well as medication reconciliation services.

Another best practice noted during the on-site reviews is that each PACE provider held IDT rounds daily. The knowledge of the staff about their participants was truly impressive. Not only was the clinical team knowledgeable about the participant's condition, but each IDT member contributed, was aware of participant's baseline, and could readily speak to what was going on with them from a physical health and/or psychosocial perspective.

For those PACE providers with dedicated transportation vendors, the drivers served as staff extenders to the PACE team. As the first point of contact prior to arriving at the center, the transportation representative would report to the PACE team if the participant had any noticeable changes from their normal demeanor.

PACE providers are charged with providing an array of services to surround the participant with essential care and support they need to manage their chronic conditions, while remaining in the least restrictive environment. Services provided by PACE include, but are not limited to¹³:

- Physician/Nurse Practitioner
- Social Work
- Physical/Occupational Therapy
- Adult Day Care
- Nutritional Counseling
- Home Care
- Specialty Services – Podiatry/Optometry/ Dental
- Meals
- Prescriptions
- Radiology Services
- Lab Test
- Emergency Room Care
- Inpatient Services
- Transportation to PACE center and medically necessary transportation

The PACE integration model is a representation which truly exemplifies the type of quality and service driven delivery system that many accountable care organizations, federally qualified health centers, and other health home models are striving for. Coordination of care occurs via hands-on practice transformation and benefits not only the participant, but the health care community as a whole.

Utilization Management

The PACE care delivery model is unique in that it is not only the service provider entity but additionally, it is the managed care plan. The PACE provider serves as the primary care provider system, which refers participants to specialty, ambulatory, and other ancillary services as appropriate to facilitate participant wellbeing through a compliment of both medical and nonmedical supportive services.

When a participant joins the program, capitated monthly rates are paid to PACE providers to manage all of the participant's associated health care needs. In turn, each of the entities are responsible for contracting for services such as; inpatient hospitalizations, skilled sub-acute/transitional care, and respite services. Although this is not an all-inclusive list, it highlights that the PACE provider has direct oversight as to how and what the dollars are spent on.

There were several consistent themes echoed among the entire PACE providers visited, as well as opportunities identified.

- All decisions for service authorizations of any kind were made at the PACE center.

¹³ Medicare.gov., Retrieved from; <http://www.medicare.gov/your-medicare-costs/help-paying-costs/pace/pace.html>

- Decisions were made by the primary care provider, or an identified team which included a primary care physician or nurse practitioner.
- There were no evidence-based standardized medical necessity resource tools or consistent processes to evaluate medical necessity and the cost benefit analysis for the requested service, medication, or assistive device.
- The ability for the provider to make the decision removed barriers often found in traditional managed care programs via the removal of complex authorization procedures traditionally found in other managed care plans.
- There was limited ability, either using the electronic medical system or through tracking of utilization management (UM) decisions to consistently report, track, and trend UM activities for quality of care, outcomes, and business planning purposes.

Opportunities existed to facilitate discharges over weekends; especially, when PACE models have relationships connected to sub-acute/transition level of care, or community supportive care, through housing/PACE home health support.

Utilization of service data, such as hospitalizations and emergency room visits, can be used to evaluate fiscal well-being, as well as evaluate quality of care. The data can also be used to target reviews of PACE providers whose utilization data suggest, for example, that participants may be receiving fewer services than necessary to achieve expected outcomes. Additionally, by collecting and analyzing information regarding utilization reasons for emergency department visits, hospitalizations (include number of admissions, length of stay, top diagnosis for admissions, high utilizers-frequent admissions), nursing home admissions, and other areas of interest, PACE providers can identify opportunities for quality improvement to measure and promote better outcomes, as well as create innovative solutions to utilization trends affecting cost and the participant's quality of life.¹⁴ The ability to track and report on key outcomes metrics was markedly limited for most of the PACE providers reviewed.

¹⁴ Programs of All-Inclusive Care for the Elderly (PACE), (2011). Retrieved from; <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pace111c10.pdf>

4

Participant and Caregiver Experience

An important step in the assessment of whether PACE provides added value for the Commonwealth is in the measurement of participant and caregiver satisfaction. PACE is a strong participant-focused program whereby the needs of each participant and/or their caregiver, whether health or social related, are carefully considered in the development of the individual plans of care. Participant satisfaction is an important performance measure for the Massachusetts PACE providers and is validated through annual satisfaction surveys and reviewed during the grievance and disenrollment processes and plan of care development. Results from a satisfaction survey and how a PACE provider uses them is important to improving the delivery of PACE services.

Mercer conducted four in-person/on-site interviews of PACE participants and family members to determine their satisfaction with the PACE program, as compared to when they were receiving services prior to enrolling in the PACE program. Mercer developed an interview guide in order to facilitate comprehensive and consistent information gathering in areas such as experience prior to PACE, enrollment process, participant rights and responsibilities, including family involvement, satisfaction level with the multi-disciplinary team approach, access to services, participation in their plan of care, quality of care and services received, and overall participant satisfaction with the program.

Each of the six Massachusetts PACE providers visited by Mercer conduct their own participant satisfaction surveys annually. The surveys differ in format and types of questions asked of the participants, but in the end, all reach similar results regarding participant satisfaction. Their PACE participants report a high satisfaction with the PACE program and in particular, with the quality of care they were receiving. In aggregate, the six Massachusetts PACE providers reported high levels of satisfaction with the medical care received, communications with medical staff, activities that are engaging and varied, and active participation in their plans of care. Additionally, the PACE participants shared the following feedback regarding their PACE program:

- Participant's health has been maintained since joining the program.
- Participant loves the medical team approach.
- The participant looks forward to coming to "work".
- The participant is thrilled with the entertainment and loves to dance.
- The participant appreciates the assistance provided in the home; especially, laundry, shopping, and showers.
- Therapy is the best part of their day.
- The participant considers the PACE program "my home".
- The participant feels that people listen to "my needs".

- The participant appreciates the camaraderie of staff and participants.
- The participant feels the staff “catches things” since they see participants every day.
- The participant feels that the program helps maintain their independence.

The Mercer team posed a series of questions to each participant that was selected by the PACE provider. The participants varied in age, gender, and health condition which gave Mercer a perspective of the overall satisfaction from the younger participant with behavioral health needs to an older participant with more complex medical needs and frailty. The key questions posed to participants included:

1. Can you tell me how long you have been in the PACE program?
2. Are you pleased with the care that you are receiving? If not, can you explain why?
3. What is the best part of the program?
4. Are you pleased with the array of activities?
5. Are you satisfied with the medical care, including the physicians and staff?
6. Are you involved in your plan of care decisions?
7. Are you satisfied with the meals? If not, can you explain why?
8. Do you use the center’s transportation? If so, how is it? Do you have any concerns with their transportation?
9. What type of services do you receive?
10. Would you recommend the PACE program to family or friends?

PACE caregivers were also genuinely satisfied with the level of care their family members were receiving and felt a sense of relief that they were being cared for in such a positive manner. Many also discussed the ease of knowing all of their family member’s medical needs were being met and organized in one location. They no longer had to worry about coordinating the care themselves. The caregivers also felt their communication with the PACE providers was strong, and their concerns and opinions were taken into account with their family member’s medical decisions and plans of care. More than one caregiver felt the PACE provider was very responsive to their concerns. A few additional anecdotes from caregivers include:

- Elimination of the paperwork burden from multiple providers.
- Transportation needs are met.
- Bills from providers are no longer an issue.
- Follow-up with family members is appreciated.
- The medical team approach works well.
- Appreciative of the 24/7 approach to care.
- Participant is no longer as dependent on assisted living facility.
- Issues are resolved quickly.

The Mercer team also posed a series of questions to the caregivers interviewed regarding their satisfaction with the PACE program. The caregivers interviewed were chosen by the PACE

organization and related to the participants interviewed. The caregivers were children, nieces, or spouses of the PACE participant. The key questions posed to the caregivers included:

1. Are you satisfied with the level of care your family member is receiving? If not, please explain.
2. Are you involved in the care planning process?
3. Does the staff respond quickly to any concerns you might have regarding your family member's care? Even after hours, weekends, and holidays?
4. Are you satisfied with the array of medical care services your family member receives? Has there ever been an issue? Was it resolved timely?
5. What is your overall feeling regarding the PACE program? Would you recommend the program?

In an effort to continually monitor the PACE program and the impact on participants and their caregivers, each PACE provider regularly reviews their grievances from participants or caregivers/family members to determine if there are any systematic issues that need to be addressed. Each of the six organizations reviewed include a regular review of their grievances as part of their quality improvement activities. It is through this review process whereby any systematic issues are identified and then addressed with the participant's IDT and/or family member when appropriate. Common grievances impacting satisfaction with the program are centered around meals and transportation. For meals, Mercer's review found most grievances came from those PACE providers that used contracted meal service entities versus those that made the food on-site. In regards to transportation, common grievances stemmed from the vans arriving late or not showing up for their designated appointments. Again, more grievances tended to be placed regarding transportation when the service was contracted to an outside entity rather than a PACE organized service.

In addition, each PACE provider is required by the Commonwealth to track disenrollment reasons due to dissatisfaction with such issues as their health care and/or specialty care, transportation program, meals, receiving care, or language difficulties. The disenrollment, and reason for disenrollment, is reported monthly to the Commonwealth accompanied by a detailed explanation with all applicable documentation to the MassHealth PACE Operations Unit¹⁵.

¹⁵ A Guide to the Program for All-Inclusive Care for Elderly MassHealth Members. February 2013.

5

Financial Analysis

To appropriately review the financial performance of a PACE program, Mercer believes the entire benefit package of the PACE program, including all Medicare and Medicaid services, needs to be considered. As mentioned earlier, financing for the PACE program is capitated, which allows PACE providers to deliver all services participants need rather than limit them to those reimbursable under Medicare and Medicaid fee-for-service (FFS) plans. This financing arrangement allows the PACE provider to deliver services differently and in a more cost-effective manner. For example, a PACE provider may choose to spend a higher percentage of its funding on home care services compared to FFS, which can result in a reduction of high cost inpatient hospital and emergency room costs. The additional spending on home care services would traditionally be a Medicaid expense, while the savings in inpatient hospital and emergency room care would accrue to the Medicare program. An analysis that only compares the Medicare or Medicaid services of a PACE provider to the applicable FFS expenditures may lead to inappropriate conclusions since PACE plans may actually spend more on Medicaid services as compared to the FFS delivery model. It would be expected that the savings accruing on the Medicare program would exceed the additional dollars spent on the Medicaid services and therefore produce overall PACE program cost savings. This service delivery flexibility is not available under the FFS program since it crosses the Medicare and Medicaid programs. In addition, the challenge of identifying an appropriate comparison population given the unique set of health care services provided under PACE makes a comprehensive evaluation difficult¹⁶.

Mercer did not have access to historical Medicare FFS data for this analysis. Therefore, we were unable to complete a financial analysis where we could compare total PACE program costs (Medicare and Medicaid) to FFS costs for an actuarially equivalent unenrolled population. Mercer did have access to Massachusetts FFS Medicaid data in addition to the PACE provider-submitted cost reports. This data did allow Mercer to compare the Medicaid component of the programs to gain some level of insight into the cost-effectiveness of the Massachusetts PACE program. As stated in the preceding paragraph, Mercer believes a comprehensive cost-effectiveness evaluation for a PACE program needs to incorporate both the Medicare and Medicaid components of the program. Since only the Medicaid portion will be evaluated as part of this Study, Mercer will not be able to assess overall cost-effectiveness but can comment on the reasonability of cost-effectiveness based on the Medicaid-only results.

¹⁶ "Massachusetts PACE Evaluation Nursing Home Residency Summary Report." JEN Associates, Inc., July 24, 2014.

To evaluate the overall reasonability of costs of the Massachusetts Medicaid portion of the PACE program Mercer performed the following analyses:

- A comparison of PACE cost reports vs. FFS expenses
- An evaluation of the Massachusetts PACE provider payments vs. the PACE UPL
- A comparison of payment rates from other state PACE programs to Massachusetts PACE payment rates

Each of these items will be discussed in more detail below.

Comparison of PACE Cost Reports vs. FFS Expenses

The Massachusetts PACE provider cost reports include all PACE program costs including Medicare and Medicaid. Since this analysis is only focused on the Medicaid component of the program, Mercer developed a methodology to allocate the total costs from the PACE cost reports to each of the Medicare and Medicaid programs separately. Once the allocation process was completed, the Medicaid-only allocated costs from the PACE plans' cost reports were compared to the Massachusetts FFS data for an actuarially equivalent unenrolled population to help inform cost-effectiveness. Please note, this approach incorporates an allocation process to develop estimated costs for the Medicaid portion of the PACE program using the total costs from the PACE plans' cost reports. Mercer believes this allocation process is reasonable, however developing the true Medicaid costs for the PACE program is extremely difficult.

To complete this analysis, Mercer started with combining the cost report data from all PACE plans to develop the PACE cost report base data. The PACE plan cost report data was from the period of July 1, 2013 through June 30, 2014. There were two new PACE plans, Mercy LIFE and Serenity Care, Inc., that had relatively small membership during this time period and were excluded from the cost report base data for this analysis.

The PACE plan cost reports included combined Medicare and Medicaid covered services and payment responsibility. Therefore, in order to develop Medicaid-only costs, Mercer developed a methodology to allocate the expenses from the PACE plan cost reports to represent the Medicaid covered services. After first removing members with no Medicaid coverage, the methodology uses the PACE plans' reported Medicare and Medicaid revenue from the cost reports for the overall allocation between Medicare and Medicaid. After the overall allocation level is set based on reported revenue, Mercer developed an allocation at the category of service (COS) level based on both the Massachusetts Medicare and Medicaid data for Dual Eligibles, a study prepared by the Massachusetts PACE association, and Mercer judgment. As a final step, the allocation at the COS level was adjusted to achieve the overall allocation based on the revenue split between Medicare and Medicaid. The overall allocation to Medicaid based on this analysis was 55.3% of the total dollars on the combined cost reports.

The most recent Massachusetts FFS data available for this analysis included dates of service from the period January 1, 2013 through December 31, 2013. The FFS data and the PACE cost report data had an overlapping data period of July 1, 2013 through December 31, 2013. To complete the comparison, only data from this overlapping time period was included. The following table summarizes the Massachusetts FFS data and the PACE cost report data with PMPMs for each data source shown at a COS level of detail.

COS Description	FFS PMPM	Cost Report PMPM	Cost Report Compared to FFS
Inpatient - Non-MH/SA	\$ 34.86	\$ 59.98	72%
Inpatient MH/SA	\$ 8.24	\$ 169.78	1961%
Hospital Outpatient	\$ 35.25	\$ 26.74	-24%
Outpatient MH/SA	\$ 23.56	\$ 1.34	-94%
Professional	\$ 38.58	\$ 53.04	37%
HCBS/Home Health	\$ 1,648.24	\$ 794.93	-52%
LTC Facility	\$ 810.98	\$ 559.65	-31%
Pharmacy	\$ 22.49	\$ 60.38	168%
DME & Supplies	\$ 27.27	\$ 42.16	55%
Transportation	\$ 42.48	\$ 193.87	356%
All Other	\$ 96.18	\$ 944.42	882%
Total	\$ 2,788.13	\$ 2,906.30	4%

The mix of members residing in an institutional setting versus those in a community setting is significantly different between the Massachusetts FFS program and the PACE program. The Massachusetts FFS program has a much higher percentage of institutional members, so the FFS data has been adjusted to represent the same institutional/community mix as observed in the Massachusetts PACE program.

Overall, the allocated Medicaid expenses from the cost reports are 4% higher than the FFS data for an actuarial equivalent population. On the surface, this would seem to indicate that the Massachusetts PACE program is not cost-effective. However, Mercer does not believe this is an appropriate conclusion since this is only a view of the Medicaid expenditures and does not incorporate the Medicare costs for a comprehensive look at the PACE program. As stated earlier, it is very possible the PACE plans are spending additional dollars on traditionally Medicaid services in order to achieve cost savings on Medicare services. Additionally, a significant cost component for the PACE program is related to the PACE Center Services which is not included under the FFS delivery model. The PACE Center is the cornerstone of the PACE program and is crucial in

achieving the family-like atmosphere, high levels of member satisfaction cited in the previous section and potential cost savings related to delayed nursing home placement.

This table does clearly show how the Massachusetts PACE plans are utilizing resources very differently than the actuarially equivalent population enrolled in the FFS system. The HCBS/Home Health and LTC Facility services are significantly lower in the PACE program as compared to the FFS delivery model. The lower LTC facility costs are consistent with the PACE program goals of achieving a higher quality of life for their members while remaining in the community. Conversely, the PACE program has higher expenses for transportation and the all other category. The all other service category in the PACE program includes services such as PACE Center Services and the Interdisciplinary Team. The PACE Center Services and the Interdisciplinary Team are PACE program specific expenses not found in the FFS program. These expenses are a crucial part of a PACE program and are instrumental in achieving PACE program goals of improved member dignity, better quality of life and allowing members to remain in the community.

As mentioned earlier, a study conducted by JEN Associates, Inc. included an assessment of PACE's effect on nursing home residency. It was found that PACE in Massachusetts reduced nursing home admission rates at least through the first 20 months of enrollment. While an analysis of health care cost savings was not conducted as part of this study, these findings do seem to suggest that overall cost savings are achieved through the delay of nursing home residency and provision of home and community based alternatives contributing to that delay.

Evaluation of the Massachusetts PACE Provider Payments versus the PACE UPL

Current federal regulations regarding PACE Medicaid rate-setting at 42 CFR § 460.182 give states flexibility in setting the Medicaid component of the PACE capitation rate subject to an upper bound referred to as the Upper Payment Limit (UPL). While each state is required to set the UPL using the methodology set forth by the Centers for Medicare and Medicaid Services (CMS), each state can choose a rate level and rate setting methodology consistent with their own policy objectives so long as the capitation rate falls below the UPL established for the contract period. The UPL is the projected cost of an actuarially equivalent unenrolled population enrolled in the FFS program. This structure inherently implies cost-effectiveness for the Medicaid component of the PACE program since federal regulations require that the Medicaid component of the PACE capitation rate is less than the UPL.

Comparison to Other PACE Programs

Mercer also gathered publically available information on PACE UPLs and PACE Medicaid payment levels from various states. While the publically available data was fairly limited, it does give some insight into PACE Medicaid payment levels for other state PACE programs. The PACE Medicaid payment rates vary widely by state from a low of \$1,595 to a high of \$3,711 for dual eligibles. The Massachusetts PACE program Medicaid payment rates are in-line with other states' PACE rates

that were observed. While there have been many PACE studies that have reviewed the impact of PACE on cost with varying levels of robustness, there has not been a study that has provided strong evidence of the PACE program's impact on costs, whether a positive or negative impact.

Results of the Financial Analysis

As mentioned previously, since Mercer did not have access to the Medicare FFS data, a comprehensive cost-effectiveness study of the Massachusetts PACE program could not be completed. The analysis focused on the Medicaid component of the PACE program due to this data limitation. Please refer to the opening paragraph in the financial analysis section where we discuss the limitations of only evaluating a single component of a PACE program. Based on the results of this limited financial analysis of the Medicaid component of the Massachusetts PACE program, Mercer believes it is reasonable to assume the Massachusetts PACE plans are operating in a cost-effective manner. In addition, there are lower LTC facility costs in the PACE program versus the FFS program which is in line with PACE program goals of keeping members in the community versus institutional placement. The analysis of the Medicaid only costs was showing the Medicaid component of the allocated PACE cost reports was slightly higher than the Medicaid FFS expenses. Mercer believes these additional Medicaid expenditures on PACE are likely producing savings on Medicare expenses which are not evaluated in this analysis.

Additional Enhancements to the Financial Analysis

Mercer believes that a more robust analysis to determine cost-effectiveness for PACE programs can be performed by evaluating both the Medicaid and Medicare expenditures in aggregate. In order to complete this financial evaluation, Mercer would need member level claims data from the FFS Medicare and Medicaid programs to compare to the financial experience of the Massachusetts PACE providers from the PACE cost reports. As mentioned previously, member level FFS Medicare data was not available for this analysis.

APPENDIX A

Massachusetts PACE Providers

Elder Service Plan of the Cambridge Health Alliance

270 Green Street
Cambridge, MA 02139

Summit ElderCare

10 Chestnut Street
Worcester, MA 01608

East Boston Neighborhood Health Center

10 Grove Street
East Boston, MA 02128

Upham's Corner Health Committee, Inc.

1140 Dorchester Ave
Dorchester, MA 02125

Elder Service Plan of the North Shore

37 Friend Street
Lynn, MA 01902

Elder Service Plan of the Harbor Health Services, Inc.

1135 Morton Street
Mattapan, MA 02126

Mercy LIFE, Inc.

2112 Riverdale Street
West Springfield, MA 01089

Serenity Care, Inc.

604 Cottage Street
Springfield, MA 01104/4200

APPENDIX B

Request for Information

Please respond to the following questions. Please answer every question and indicate if a question is not applicable to you. Base your answers on current and in-process capabilities. We are not requesting that special reports be produced to answer these questions. Please include any related policies and procedures. These may be embedded directly in this document or sent with your completed questionnaire.

Clinical Operations

1. Provide an organization chart that includes the staff supporting the care coordination area.
2. Provide a description of the process used to transfer participants from a skilled facility into a community setting. Include any policies, procedures, tools/assessments used in the nursing facility to community transition process.
3. Briefly describe how you are notified when a participant is admitted to the hospital or utilizes the emergency room.
4. Describe the process to coordinate post hospital discharge needs (provider, pharmacy, equipment etc...), and how PACE services are initiated and/or re-started timely after a hospitalization.
5. Do PACE staff participate in hospital discharge planning meetings when a participant is hospitalized? Please provide any policies and procedures related to these activities.

Assessment and Plan of Care Development

6. Provide assessment and care plan development policies and procedures.
7. Describe the process to assess participant needs and develop an individualized plan of care.
8. Describe the process to ensure participants with behavioral health issues receive the services that they need.
9. Provide any tools care managers utilize to determine service needs including any tools that assist in calculating appropriate service frequency and service duration.

10. Describe the frequency of minimum contact with the participant and the method(s) of communication.
11. Describe the process for conducting medication reconciliation and any processes used to increase safety of participants taking multiple medications.

Quality Improvement

12. Provide a brief description of the quality improvement process within your organization including quality committee structure.
13. Provide your organization's most recent Quality Assessment Performance Improvement plan.
14. Please provide the most recent Level One and Level Two required reports as reported through the Health Plan Management System (HPMS).

Quality of Life/Participant Satisfaction

15. PO participant satisfaction survey and survey results (if available)
16. Participant Bill of Rights
17. Marketing material such as member facing materials, member handbook, etc.
18. Medicare's Health Outcomes Survey-Modified (HOS-M) for the last 2 years
19. Written policies and procedures (P&P) governing:
 - a. Participant Bill of Rights
 - b. Participant/Caregiver involvement in care planning process
 - c. Grievance/complaints and appeals process
 - d. Enrollment and disenrollment processes
20. Sample of grievance/complaints regarding satisfaction with the program over the last 2 years

Overall Program

21. Most recent CMS audit including findings and PO Corrective Action Required (CAR)/Corrective Action Plan (CAP)

APPENDIX C

On-Site Review Schedule

Date	PACE Provider
July 8, 2014	Elder Service Plan of the Harbor Health Services, Inc.
July 9, 2014	Elder Service Plan of the North Shore
July 10, 2014	East Boston Neighborhood Health Center
July 11, 2014	Elder Service Plan of the Cambridge Health Alliance
July 14, 2014	Summit ElderCare
July 15, 2014	Upham's Corner Health Committee, Inc.

APPENDIX D

General Agenda

Topic

Introductions:

- Opening remarks.
- Agenda overview.
- PACE provider presentation.
 - Site tour

Morning meeting:

- Observation of morning meeting.
- Questions.

Chart Reviews:

- Clinical staff from Mercer and PACE provider review selected charts
- Mercer clinical staff discussion/questions with PACE provider staff

Participant and Caregiver Interviews:

- Mercer staff interview participants and caregivers
- Mercer staff observe participants in center

Closing:

- Closing remarks by PACE provider and Mercer staff

Attendees**Mercer****Sundee Easter, Lisa Smith, Michele Walker and Cindy Ward**



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