The rise of for-profit operated and private equity backed Program of All-Inclusive Care for the Elderly programs: How corporate interest undermines policy and program evaluations

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The Program of All-Inclusive Care for the Elderly (PACE) has provided for over 40 years, high quality, cost effective comprehensive medical and social care to older people with high care needs. PACE integrates Medicare and Medicaid via a capitated rate that's adjusted for a beneficiary's health status and in turn, provides comprehensive medical and social care. A team of registered nurses, doctors, social workers, drivers, dieticians, counselors, and more provide care coordinated by PACE centers where dialysis, vaccinations, mental health care, check-ups, meals, and social activities are provided whenever possible. PACE's holistic approach allows vulnerable older people to avoid expensive nursing home care. This issue brief argues that PACE's success is largely attributable to its non-profit operation, that a recent ruling allowing for-profit operation was made contrary to the evidence that non-profits have better outcomes, and that the decision will undermine the program's efficacy.

Since the 1970s, non-profits have operated PACE and in 1999 an interim final regulation officially established non-profits as permanent PACE program providers under Medicare and Medicaid. The Balanced Budget Act (BBA) of 1997 allowed the secretary of the Department of Health and Human Services (DHHS) to establish for-profit PACE sites as permanent providers, but only after an evaluation study of their cost-effectiveness, quality of care, and access to care was completed. The final ruling required that the total number of enrollees in the demonstration evaluation be at least 800 and that participating plans be in operation for 3 years before they could be included in the evaluation. It also required that the evaluation assess whether enrollees in for-profit PACE were frailer than enrollees in non-profit PACE, whether access to and quality of care was lower in for-profit than non-profit PACE, and whether the cost to Medicare and/or Medicaid was higher in for-profit PACE. The evaluation was conducted in 2013 and released in 2015 by Mathematica (a research corporation), commissioned by the Centers for Medicare and Medicaid and the results were presented to Congress.

Unfortunately, there were several issues with the study design, methodologies, and the findings of the evaluation did not ultimately reflect the final decision. All of the for-profit operated PACE programs were located in Pennsylvania and so the evaluation was conducted there, which is problematic because states have different reimbursement rates, limiting generalizability to other states. Although the BBA evaluation required a minimum of 800 enrollees, 695 enrollees were included in the evaluation. Another requirement—that plans should have been in operation for at least 3 years—was largely ignored with the inclusion of 3 out of 4 for-profit plans and 1 out of 4 non-profit plans in operation for less than 3 years. Furthermore, findings comparing frailty, access to care, and quality of care showed that non-profit operated PACE programs outperformed for-profit PACE programs on most measures. Finally, the study did not evaluate cost-effectiveness by profit status despite the BBA requirement. This issue is perhaps the most important because cost-effectiveness is often the rationale behind allowing for-profits to deliver public sector services.

Nonetheless, based on the evaluation, the DHHS stated that, "With respect to the BBA statements, the Department of Health and Human Services (HHS) cannot conclude that any of

the four statements are true." In August of 2016, a notice was placed in the Federal Registry that proposed removing the restriction governing profit status in its entirety. CMS received multiple comments from aging advocates and long-term care recipients opposing the decision—questioning both the validity of the evaluation and the ability of for-profits to deliver care to the vulnerable population that PACE serves. CMS dismissed these concerns and stated that, "As a result of the comments, we are making no changes to our proposal and finalizing this provision as proposed" and the Final Rule removed the non-profit operator requirement.

If the evaluation showed real differences, and PACE was already providing quality care and cost savings under non-profit operation, then why the push to allow for-profits? The impetus behind allowing for-profit operation of PACE programs came from several sources. Studies showed that PACE was cost-effective, making the expansion of the program attractive to the federal government seeking to control Medicare and Medicaid spending. The BBA of 1997 allowed for-profit PACE operators on a demonstration basis with the hope that for-profit operators could expand the program and save money. Existing non-profit operators and advocates, however, viewed the goals of PACE as being at odds with for-profit operation and were opposed to the legislation. Nonetheless, expansion proved slow and a decade and a half later, only 4 for-profit demonstration programs were operating, all in Pennsylvania. In early 2016, for-profit interest in PACE began to grow with the support from the National PACE Association who viewed for-profit investment as a mechanism to expand the number of programs. Since then, interest has increased. Recently InnovAge—a for-profit corporation—stated that they have become the largest PACE operator based on the number of older people served. InnovAge, previously a non-profit PACE provider, became a for-profit PACE operator in 2016 after a private equity investment was made by Welsh, Carson, Anderson & Stowe. One of their general partners, Tom Scully is a former CMS administrator. Andrew Slavitt—another former CMS administrator and founder and General Partner of Town Hall Ventures, a venture capital and private equity firm—has also taken an interest in PACE by investing in Welbe Health which delivers 2 PACE programs in California.

Clearly, both for-profits and private equity firms see the benefit and value of PACE and want to expand the program, but is their interest in operating and investing in PACE programs cause for concern? For-profit ownership is often justified as being more efficient and cost effective than non-profit operated healthcare—although evaluations after for-profit turnover shows that this is not often the case, especially with regard to delivering quality care to frail populations. This is primarily due to the differences between for-profit and non-profit ownership in motivation, incentives, and accountability. For-profits are motivated by market forces—that is—to control costs while delivering a product or service in the hopes of making a profit to be distributed among leadership and shareholders. Non-profits are typically motivated by a social cause to provide a service—and like for-profits—they are incentivized to control costs, however, they differ in that non-profits tend to reinvest funds into the organization for the benefit of the people it serves. For-profits are accountable largely to shareholders and investors; non-profits are accountable to boards of directors and to the community in which they operate.

Alarmingly, private equity investment in healthcare has increased over the last few decades, and these companies' goals differ from that of non-profits and for-profits. Private equity firms gather large sums of capital from wealthy individuals and institutions and make high-risk, high-return

investments by buying and trading well-established, private companies and loading them up with debt.

Are for-profits able to deliver the same high quality, cost effective care and access to a vulnerable population given their differences from non-profits? Worry about their ability to deliver care comes from what we know in similar settings such as nursing homes and hospices which also serve medically frail populations. Today, the majority of nursing homes—70 percent—are operated by for-profits. Systematic reviews and meta-analyses of these studies show lower quality of care—especially, a greater number of pressure ulcers—and lower staffing levels in for-profit compared to non-profit nursing homes. A 2016 GAO showed that margins reported in Medicare cost reports were larger in for-profit operated skilled nursing facilities. The report also shows that for-profit and chain facilities spend less on both direct and indirect care. Similarly, hospice has provided end-of-life care in the U.S. since the 1970s. The number of hospices grew rapidly between 2000 and 2015 almost doubling during this time, mostly due to the rise of for-profits. Studies show that for-profit hospice has been found to employ profit maximizing strategies including retaining longer stay patients who have a greater number of low cost days compared to shorter stay patients, providing care in Assisted Living where reimbursement can be higher, and inappropriately billing for expensive general inpatient care.

To date, no scholarly research beyond the Mathematica report has been conducted on profit status and PACE. However, CMS is required to monitor the performance of PACE programs and in 2018, CMS released a report that audited 74 of the 124 existing PACE programs. CMS scored PACE programs based on its review of PACE programs' quality of care, care planning, and services requested and provided. With regard to profit status, the report showed that non-profits compared to for-profits scored better. As the number of for-profit programs increase along with continued private equity investment, this report, along with future research, will hopefully further elucidate for-profit versus non-profit PACE performance.

The final ruling has the potential to undermine a program that has successfully operated for more than 4 decades under non-profit operators. For-profits and private equity are promising to give PACE the capital it needs to expand—which is laudable, given the program's success. However, how will for-profits and private equity backed programs provide health and social care to a population with high needs using a fixed payment—all while generating a profit? Studies of for-profit and private equity backed nursing homes and hospices indicate that they use strategies to generate a profit that result in a diminished quality of care. It's unlikely that the final decision will be overturned, even in light of the problems with the evaluation, and given the evidence of how for-profits have operated in other healthcare sectors. Therefore, accountability and transparency will be key to maintaining the original goals of PACE—serving frail older people in the community in a cost-effective manner.