

# PACE and Its Future In the New Landscape

By ROBERT GREENWOOD

**T**he roots of PACE (the Program of All-inclusive Care for the Elderly) stretch back several decades. In the early 1970s, clinicians and administrators at On Lok, a community organization deeply rooted in San Francisco's Chinese-American community, recognized the limitations of a system of senior care built around Medicare's and Medicaid's traditional approach of reimbursing providers for an approved set of care and services. The goal of On Lok was not to just provide effective medical care. It was seeking a way to keep the community's elders at the center of their families and their neighborhoods, something the traditional approach of nursing-home care could not accomplish.

As a result, leaders at On Lok developed one of the first adult day centers in an effort to provide in a community setting the care and services available in a nursing home. However, it quickly became apparent that providing medical services would not be enough to enable elders to successfully age in the community. Doctors and other clinical staff would need to have much greater flexibility to work directly with their patients and their families to develop care plans that would work for each individual situation. And they would need the help of social workers and others to better understand and address the informal support networks around each person.

Through a process that took several years, On Lok was able to create a demonstration project that enabled the program to receive a monthly capitated (or set) payment for each enrollee from Medicare and Medicaid. From those funds, an interdisciplinary team made

up of primary care, nursing, dietary, physical therapy, recreational therapy, transportation, pharmacy and social work would both develop the care plan and provide the care unencumbered by what was reimbursable through Medicare or Medicaid.

The success of the On Lok program in keeping frail elders out of the nursing home led to a national demonstration program. Researchers wanted to see if the model of care would be as successful with other sponsor types, ethnic groups and state Medicaid pro-

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grams. With assistance from the Robert Wood Johnson Foundation, 15 not-for-profit sponsors across the country were able to successfully replicate what came to be called the PACE model. As part of the Balanced Budget Act of 1997, Congress approved PACE as a permanent provider type under Medicare and Medicaid.

Today there are 87 organizations sponsoring PACE programs in 29 states serving a total of approximately 25,000 enrollees. About 90 percent of them are "dual eligibles" — people who, because of age or disability, are eligible to receive benefits under both Medicaid and Medicare. Some individuals meet the PACE criteria but don't qualify for Medicaid or Medicare; these enrollees pay PACE a monthly premium.

With the expansion of Medicaid for potentially millions of formerly uninsured individuals, some are wondering where PACE will fit into this new landscape. Despite the success of PACE in effectively caring for elderly populations at a cost well below that of nursing home settings, with Medicaid expansion on the horizon, many states are moving toward other forms of managed care — programs that may be better suited to providing health care to broader populations who do not require



intensive care. Meanwhile, the national PACE organization is working with its members, the Centers of Medicare and Medicaid Services (CMS), and interested states to expand the PACE model beyond the elderly to other high-need individuals, such as those with various forms of disabilities, who might benefit from PACE's highly monitored, interdisciplinary approach.

#### THE BASICS OF PACE

To qualify to enroll in a PACE plan, a person must meet four criteria:

- Be 55 or older
- Live in a PACE service area
- Be certified by the state to meet its nursing home level of care criteria
- Be able to live safely in the community at the time of enrollment with the assistance of the PACE organization

At the heart of the PACE model of care is the interdisciplinary team that both plans their patient's care and directly provides the vast majority of it. One of the keys is that each member of the team assesses the needs of and directly provides care to those served by PACE. A PACE participant is never just a set of diagnoses on a chart to any of the PACE staff.

It is a tremendous challenge to keep safe in the community a person with multiple difficulties with activities of daily living, and who may or may not have family members who are helpful, and who may or may not live in a house that they can manage. Under the PACE model, every care plan starts with an understanding of how each participant defines his or her quality of life. By identifying the most important goals, the care plan can be created to provide

each individual the best chance to meet those goals for as long as possible.

In addition to affirming each participant's goals through the plan of care, PACE physicians realize that the best plan of care will do no good if the participant is not motivated to follow it. PACE organizations provide a great deal of physical and occupational therapy. In traditional Medicare and Medicaid, such therapy is covered only in certain circumstances and only for as long as it can be demonstrated to show improvement. PACE organizations may do therapy to assist a person to perform functions in their home that provide them more independence or to slow the rate of decline.

Another critical aspect of the interdisciplinary team is communication. Typically the team meets each morning to share information about changes

in participants, review any participants in the hospital and discuss other issues. Each PACE enrollee also is assessed by each member of the team during enrollment and then every six months. The team works together to create a common care plan and communicate updates to the care plan.

PACE organizations provide transportation to its participants, and the drivers are members of the team. While it is not uncommon for new PACE organizations to contract for transportation, most PACE organizations quickly find that PACE transportation services are different from other transportation providers in the community. Drivers are trained to be attentive to signs of changes in a person's physical and mental health status and to communicate these observations to the rest of the PACE team. A PACE medical director once observed that many enrollees will tell their drivers things they would never tell their doctor.

### PACE CENTER

The PACE center itself is required to have space for an adult day center, primary care clinic, occupational and physical therapy and space for the interdisciplinary team to meet. Many PACE centers also have a smaller activity room for participants with a dementia diagnosis.

PACE participants attend the center three times a week, on average. Many persons enroll in PACE not planning to attend the center often, but then they find friends and activities that they enjoy and look forward to on the days they attend the center. However, there is no requirement that enrollees attend more often than is appropriate for their care plan.

PACE centers typically have facilities for doing laundry, assisting with bathing, serving meals as well as space for meeting with families or even holding classes for caregivers. Most PACE centers are designed to house one

interdisciplinary team and will serve fewer than 200 participants. However, a few PACE centers have been built to serve two interdisciplinary teams.

Most PACE organizations operate more than one PACE center, but the construction of a PACE center and the development of a new interdisciplinary team present constraints on how fast PACE organizations are able to grow.

Although the center provides a location for members of the interdisciplinary team to work closely together, the team is able to deliver care across all care settings — in the home, in senior housing, assisted living and in the nursing home. The PACE program might also deliver services in a senior center or in a day setting. As the PACE model spreads to less populated cities and towns, sponsors are experimenting with ways to deliver a subset of PACE services in smaller congregate settings closer to where participants live.

The PACE benefit is all-inclusive, so for care and services beyond what the PACE interdisciplinary team can provide directly, the team coordinates through contracts with specialists, hospitals and nursing homes. Regardless of the setting that a PACE participant finds himself or herself in, the PACE organization is responsible for the care that is delivered. Besides specialists, this also extends to hospital stays and even to nursing homes in the case of participants who ultimately reside there — about 7 percent, at any given time.

### PACE PAYMENT

It is an unfortunate fact that in health care, delivery models are often organized around payment policy. In PACE, the interdisciplinary team provides the expertise as well as the hands that give much of the care, and the PACE center furnishes a location in which to both coordinate and provide care and services. The third key to PACE is the payment model, which provides the needed flexibility and incentives to

## CALCULATING PACE PAYMENT

**F**or participants who are Medicare eligible, PACE receives a capitated payment each month based on the average cost of Medicare spending in that county adjusted by the diagnosis codes submitted for each enrollee.

PACE is also the Medicare Part D prescription drug plan for its enrollees. Like other Part D plans, the PACE organizations are required to submit an actuarially developed Part D bid. The bid amount is risk adjusted for each enrollee based on the diagnosis codes submitted for them. Each month, the PACE program is paid a Part D payment based on the bid. During the year, the PACE organization submits prescription drug event (PDE) data for each prescription provided. Like other Part D plans, the amount of the bid and the amount submitted for Part D-covered drugs go through a reconciliation process after the year is complete.

On the Medicaid side, the state must develop a methodology for calculating a PACE rate. The federal government requires that states also calculate what an average PACE enrollee would cost Medicaid if they were to remain in the traditional fee-for-service program. States cannot pay an amount greater than this estimate (called the upper payment limit) and, of course, most states pay less than this calculation to ensure they are saving Medicaid dollars.

Individuals who do not qualify for either Medicare or Medicaid pay a monthly premium to enroll in PACE.



make possible the best care decisions for each individual. Since its beginning in San Francisco, the PACE model has given participants, families and providers the ability to focus on the needs of the participant without limiting care choices to what would be reimbursable under Medicaid or Medicare.

Although the intricacies of calculating PACE payment are very complex, the basic idea is very simple: The PACE program is paid a capitated payment based on a percentage of the estimated fee-for-service costs for a Medicare or Medicaid beneficiary of a similar health care status. The key is that the PACE organization receives the same amount regardless of the number, intensity or type of care and/or services delivered to the participant. For the PACE organization there is no financial benefit in providing unnecessary care, services or medications.

On the other hand, the PACE organization has incentives to provide appropriate and high-quality care and services to their participants in order to avoid more costly nursing home and hospital stays. In PACE the clinical incentives and the financial incentives are aligned more closely than in any other care delivery model. The payment flexibility enables PACE to provide preventive and primary care services not covered under Medicare. It allows the program, for example, to provide services to retrofit homes to make them safer or to provide respite care or training for family caregivers to make them more effective caregivers over a longer period of time.

The flexible model of payment also allows very creative approaches to maintaining the health and wellness of an individual. In the hot climate of the South, PACE organizations may choose to purchase window air conditioners for participants with congestive heart disease, an intervention that is a fraction of the cost of emergency room visits or hospital stays. A monthly trip to

the beautician might be more effective for an individual than an antidepressant — with fewer risks of side-effects.

**HOW PACE FITS INTO THE NEW LANDSCAPE** PACE has long been recognized as an innovative and cost-effective care delivery model. Many of the most

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agreed-upon components of health care reform reflect the experience of PACE. “Medical homes,” “bundled payments,” “coordinated care” and “accountable care organizations” are all terms that reflect concepts that PACE has put into practice for decades.

The 2008 recession reduced state revenues, encouraging many states to look for new ways to control or reduce their Medicaid spending. New CMS offices that are focused on innovation and on Medicare and Medicaid coordination for dually eligible individuals amplify the opportunities for change.

A number of states are looking to develop Medicaid managed-care plans as a way to better control costs and to better coordinate care. Some states are seeking to create fully integrated Medicaid-Medicare plans to allow coordination over an even broader range of care. These models are similar to PACE in one way, in that the state would pro-

vide a predetermined payment for plans to provide all covered care to their enrollees. Policymakers expect the plans to do a better job of coordinating care in order to achieve the savings they need.

The new Medicaid managed-care landscape presents both opportunities and challenges to PACE providers. In order to achieve savings, states want to encourage tens of thousands of Medicaid-eligible individuals to enroll in these plans in a short period of time. Since traditional health plans do not provide care directly, but rather may provide some care coordination and mainly provide claims adjudication, they can take on this function for large numbers of individuals literally overnight.

In contrast, a high-touch model like PACE that directly provides most of the care received by enrollees cannot enroll large numbers of people all at once. In addition, those able to meet the eligibility criteria for PACE enrollment will be only those who need day-to-day care from the first day they enroll.

Over the past year, the National PACE Association has worked with its members, CMS and interested states to develop ways the PACE model could be expanded. One approach the association has considered is to serve other high-cost, high-touch populations beyond the frail elderly. The association is working with providers of services to individuals with behavioral health issues, intellectual disabilities, younger disabled individuals and those with multiple chronic conditions as new populations that could benefit from the PACE interdisciplinary team approach of organizing and providing care and services.

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