PACE Expansion Can Meet Growing Needs Of Frail Older Adults

SHAWN M. BLOOM

The COVID-19 pandemic has been devastating for older adults, especially those with significant and complex medical conditions. Individuals over the age of 65 account for 16% of the U.S. population, yet so far, they have accounted for over 80% of all U.S. deaths due to COVID-19.[1] Especially hard hit have been residents of long-term care facilities: they have made up 45% of these deaths in the U.S. as of Sept. 1, 2020.[2]

Growing numbers of adults need long-term services and supports (LTSS), which include assistance with medical and personal care. It's also believed policy makers will increasingly seek community-based service options to minimize the impact of COVID-19 on older adults. Such service options have long been preferred by consumers and could significantly expand in the near future as the number of older Americans continues to increase.

Due to these circumstances, and the growing numbers of consumers needing long-term services and supports, state and federal policy makers likely will begin seeking community-based service options proven to be effective at minimizing the impact of COVID-19 on those they care for. Community-based service options have long been preferred by consumers and could significantly expand in the near future as the number of older Americans continues to increase.

Dating back to February when COVID-19 first emerged in the United States, Programs of All-Inclusive Care for the Elderly (PACE) have innovated and flexibly adapted to meet the significant medical, LTSS, nutritional and social needs of those they serve. As of October 2020, the COVID-19 fatality rate among PACE participants is 1.5%. Among the PACE participants that have died from COVID-19, 40% resided in long-term care facilities.[3] Most PACE participants live in the community and less than 1% of community-based PACE participants have died from COVID-19.

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Moving forward, our country needs to engage in a serious and long overdue discussion about reorganizing our long-term care delivery system, especially for older adults who rely on Medicaid to cover their LTSS costs. PACE has proven to be a cost-effective,[4] comprehensive, consumer-centric model of care that should be part of future discussions.

BACKGROUND

On Jan. 11, 2020, China's Centers for Disease Control reported its first COVID-19 fatality: a 61-year-old man who regularly shopped at a market in

Wuhan. Data released in February by the same agency clearly revealed that the COVID-19 fatality rates were directly correlated with advanced age.[5]

On Feb. 28, 2020, when the first reported U.S. case of COVID-19 was identified in a female resident of a long-term care skilled nursing facility in King County, Washington, we had more insight into the vulnerability of frail older adults. Epidemiologic investigation of the facility identified 129 cases of COVID-19, including 81 residents, 34 staff members and 14 visitors; 23 persons died, the first being a female resident whose death occurred on March 6.[6]

The outbreak in the Seattle nursing home was truly a "wake-up call" that the PACE community faced head on and with a goal of minimizing the impact of COVID-19 on the vulnerable older adults in their care.

THE PACE MODEL OF CARE

PACE is a well-established care delivery and financing model for adults. PACE organizations serve those people who are among the most vulnerable of Medicare and Medicaid recipients—adults over age 55 who are assessed and certified by their state as needing a nursing home level of care. Participants have both multiple, complex medical conditions and functional and/or cognitive impairments.

Fully integrated PACE organizations provide program participants with all needed medical and supportive services, including the entire continuum of Medicare- and Medicaid-covered items and services, with the objective of maintaining the independence of participants in their homes and communities for as long as possible.

The hallmark of the PACE model is an interdisciplinary team, made up of directly employed primary care providers, nurses, social workers, physical, occupational and recreational therapists, and numerous other health care professionals. As a team, they comprehensively assess participants' care needs, and develop and implement participant-centered care plans. Services are provided by staff in the PACE center, a unique setting that combines the attributes of a primary care clinic, adult day health care center, physical therapy and occupational therapy clinic. Services are also provided in participants' homes and, when necessary, inpatient settings.

Today there are 135 PACE organizations in 31 states, with their enrollments ranging from about 50 to over 3,000 participants. Ninety percent of PACE participants are dually eligible for Medicare and Medicaid, 9% are eligible only for Medicaid, and less than 1% are eligible only for Medicare.

Although all PACE participants are certified as clinically eligible to receive nursing home care by their state, few are placed in a facility: only about 5% of PACE participants actually reside in a nursing home.[7] This low percentage is achieved despite the fact that, on average, PACE participants have six chronic conditions (including 46% who have dementia and over 40% who have serious mental illness).[8]

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In 2020, the mean Medicaid capitation rate paid by states to PACE organizations for each PACE participant was $3,981 and the mean Medicare capitated payment was $2,797,[9] with no service limitations, co-pays or deductibles. Capitated payments for all Medicare and Medicaid services align PACE organizations' financial incentives with the quality of care their participants seek. Under this capitated arrangement, PACE organizations are incentivized to keep participants as healthy as possible in order to reduce inpatient hospital and skilled nursing facility costs. Evidence shows PACE organizations generally have lower inpatient hospital use and shorter hospital lengths of stay.[10]

To achieve these outcomes, PACE interdisciplinary teams work together to assess participants' individualized needs, develop care plans and provide and coordinate all primary, acute, behavioral health and LTSS services. The teams meet daily to discuss the emerging and ongoing care needs of the individuals for whom they are responsible. While people can see the PACE center and the PACE vans, the interdisciplinary care team serves as focal point of the PACE model of care and plays a vital role in the outcomes achieved.

Once enrolled, nearly all participants remain in the PACE program through the rest of their lives, unless they move out of the geographic service area. In a 2018 National PACE Association survey of 973 family members and other primary care providers for PACE participants, 96% reported overall satisfaction with the services and 97% said they would recommend PACE to a family member in a similar situation.[11]

PACE ORGANIZATIONS RESPOND QUICKLY TO COVID

In early March, prompted by the outbreak of COVID-19 in Seattle, the National PACE Association organized a call with its PACE organization members to discuss the outbreak, learn how a PACE organization in Seattle had responded to the outbreak and begin outlining strategies to reorganize their operational delivery model to both meet the ongoing needs of their participants and protect them from COVID-19. Individual PACE organizations turned to telehealth to monitor participants; reassigned vans to deliver home-based care and services, nutrition services, medical equipment and medications rather than bring participants to a PACE center; turned some PACE centers into COVID-19 infirmaries; used PACE Centers to offer respite care (including overnight care) for families who need a safe place for their elderly loved ones to be while they are working or need a break; and developed new programs to address participants' social isolation.

TIME FOR CHANGE AND GROWTH

Since the passage of the Social Security Act of 1965, nursing homes have been and remain the only mandatory state LTSS option for Medicaid beneficiaries. Over the last 10 years in particular, state and federal initiatives have been effective at expanding home and community-based waiver options that offer a limited range of home care, adult day care and other services to mitigate nursing home use. However, we can do better by offering other models of care. PACE customizes a range of primary, therapy, acute and home-based services and supports that control costs and have been found to achieve positive outcomes and high levels of satisfaction among frail elderly and their families.

Most recently, and with the support of the John A. Hartford Foundation, the Gary and Mary West Foundation and the Weinberg Foundation, the National PACE Association has launched the PACE 2.0 growth initiative that aspires to double the number of people served by PACE organizations from 100,000 in 2021 to 200,000 by 2028.

The PACE 2.0 initiative targets three streams of growth to meet its goal:

1. **Scale** — Provide current PACE organizations with the tools to achieve scale by growing exponentially. The tools will be based on best practices from high-performing, high-growth PACE programs.

2. **Spread** — Support new program development by identifying models for expedited start-up and growth for organizations that are well positioned to reach unserved or underserved communities by establishing new PACE programs.

3. **Scope** — Expand service eligibility beyond the current population to Medicare-only participants and make it available to high-need populations not currently eligible for the program because they are under age 55 or do not meet a nursing home level of care.

AN IMPROVED SYSTEM OF CARE

Redesigning our current systems of care for frail older adults will require a significant and broad-based effort, with the support of consumers, providers interested in developing new community-based options and policy makers motivated to support proven, comprehensive and consumer-centric options. We can and must redesign our LTSS delivery system. As we do so, we should focus on advocating for services that achieve the mutual triple aim goals of lowering costs, improv-

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ing outcomes and enhancing the consumer experience with care.

The population of Americans age 65 and older is growing at an unprecedented rate. In 2014, there were 46.2 million adults age 65 and older, and this number is expected to more than double to about 98 million older adults by the year 2060.[12] The majority of these older adults will require at least some support with activities of daily living as they age—activities like cooking, bathing, or remembering to take medicine.[13]

The time to act is now. Given the social, economic and ethical implications associated with caring for the fastest growing segment of our population, we can no long assume that the primary pillars of our LTSS system established in 1965 can accommodate the future needs of our aging population.

SHAWN M. BLOOM is chief executive officer of the National PACE Association, based in Alexandria, Virginia.

NOTES

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2. "COVID-19 Outbreaks in Long-Term Care Facilities Were Most Severe in the Early Months of the Pandemic, but Data Show Cases and Deaths in Such Facilities May Be On the Rise Again," Kaiser Family Foundation, Sept. 1, 2020.
3. NPA COVID-19 positive case and fatality data reported weekly by PACE organizations, April-November 2020.
4. Under federal statute 42 U.S. Code § 1396u–4 (d) (2) Medicaid rates paid to capitated programs must be less than the amount that would otherwise have been made under the state plan if the individuals were not so enrolled.
5. Yanping Zhang, "The Epidemiological Characteristics of an Outbreak of 2019 Novel Coronavirus Diseases (COVID-19) — China, 2020," Feb. 17, 2020, doi: 10.46234/ccdcw2020.032.
6. Temet M. McMichael et al., "COVID-19 in a Long-Term Care Facility — King County, Washington, February 27–March 9, 2020," Centers for Disease Control and Prevention, Morbidity and Mortality Weekly report 69, no. 12 (March 27, 2020): 339-42.
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