PACE as Accountable Care Organizations: Implementing the Vision Today

America’s fee for service model of health care has promoted the development of a delivery system that consumes significant resources while offering uneven quality and outcomes. With numerous entry points into the system and significant specialization among physicians, consumers are often at a loss on how best to access the care they need and how to coordinate it to maximize their health. For America’s senior citizens and frail elderly the problems are more acute as they often dealing with multiple, concurrent chronic illnesses and numerous doctors. As a result, this patient population consumes significantly more resources, which drives health care expenditures and contributes to the long term insolvency of Medicare and Medicaid.

In an effort to contain these costs, and as part of the national health care reform debate, the concept of Accountable Care Organizations (ACO) has been promoted as a mechanism to increase and sustain care quality, better manage chronic conditions among the elderly, and control expenditures. First introduced by Elliott Fisher, MD, MPH, Director of the Center for Health Policy Research at Dartmouth Medical School, and colleagues in 2006, ACOs have quickly become popular among reformers looking to broadly increase quality while maximizing resources.

The defining characteristic of ACOs is that a set of providers (physicians and hospitals) accept joint responsibility for the quality and cost of care received by the ACO’s patients. The goal is to create an incentive for providers in the ACO to constrain volume growth while improving the quality of care. If the ACO achieves both quality and cost targets, its members receive a bonus. If it fails to meet both quality and cost targets, its members could face lower reimbursement payments.

As the health reform debate has continued, ACOs and their potential implementation have become better defined, yet despite the tremendous interest expressed by a diverse set of policy and advocacy groups, there have been no ACO demonstration projects to date. While some non-Medicare projects are slated to begin in 2010, the clearest expression of ACOs potential and depiction of how they would work continues to be the nation’s PACE® programs. With more than 70 Programs of All-inclusive Care for the Elderly (PACE) serving dual eligible Medicare and Medicaid populations in urban and rural service area, PACE offers the most significant insight into the operations and subsequent benefits of ACOs.
PACE is a unique health care delivery model that provides acute and long term care through home and community-based care and services for frail elderly people. The care is facilitated through a central location, the PACE Center where an interdisciplinary team, including physicians, nurses, therapists, social workers, pharmacists, health care aides and others, collaborate to develop and implement a personalized care program for each enrollee. This team is directly responsible for patients’ care, giving them the unique ability and perspective to regularly assess patients’ needs and progress, as well as develop comprehensive care plans specific to each individual. PACE’s integrated care system gives both the patients and the caregivers the option to participate in the planning of their health care programs. All enrollees in PACE programs are nursing home eligible, but the overwhelming majority continues to live at home and receive their benefits in the community.

PACE’s delivery model is facilitated by the integration of its funding mechanism. With resources provided by both Medicare and Medicaid, PACE providers are responsible for the quality and cost of health care for a population of Medicare and Medicaid beneficiaries known as “dual eligibles” because they are eligible for both programs. (PACE is also available to private pay patients, but the overwhelming majority is dual eligibles.) Because the government provided reimbursement does not change depending on the acuity or chronicity of a patient’s illness, PACE has an incentive to keep patients healthy, provide quality care, and avoid costly institutional based care, whether in a hospital or nursing home.

The similarities between proposals for ACOs and PACE organizations are striking with two exceptions. The PACE Center is not a hospital or extended care facility, but the program will create partnerships with hospitals and other facilities to ensure each enrollee has access to the PACE medical staff and planning if they enter a facility. Secondly, PACE organizations do not receive a bonus for their sustained quality or for keeping their enrollees healthy and out of more acute care settings; instead, PACE organizations reinvest any savings into an expansion of services that furthers their goal of keeping frail elderly in the community.

With more than 15,000 enrollees being served by organizations across the country, each PACE is a working example of an Accountable Care Organization that currently exists. Policymakers and media interest in finding out more about the PACE Model of Care can visit www.PACE4You.org or contact Robert Greenwood at the National PACE Association at (703) 535-1565.