PACE Policy Summit

SUMMARY AND RECOMMENDATIONS
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On December 6, 2010, the National PACE Association (NPA) convened a policy summit in Washington, D.C. Summit participants were health policy experts including federal and state policymakers, health services researchers, and consumer and provider representatives. The summit aimed to address three primary questions:

1. How can the Program of All-inclusive Care for the Elderly (PACE) evolve and expand, building on its track record of providing comprehensive, integrated, high quality care to high-cost, high-need individuals?

2. What methods and measures can be used to evaluate PACE and compare it to alternative care models focused on comparable populations?

3. What are the opportunities for PACE as payers, providers, and leaders to pursue innovations designed to improve the effectiveness of care, manage costs, expand community-based alternatives to institutional care, and promote other positive changes to the health care delivery system through implementation of the Affordable Care Act (ACA)?

Ideas and recommendations of summit participants are presented in this summary. The format follows the summit agenda, which began with a brief description of PACE and discussion of the model’s current strengths and challenges. The remainder of the summit focused on identifying opportunities for PACE to lead, advance, and evolve in the future.
PACE—An Innovation with a Successful Track Record

PACE is a comprehensive, fully integrated health care delivery system for frail, older adults. PACE was initially developed by On Lok, a community-based organization in San Francisco, CA, to address the shortcomings of an often fragmented health care delivery system for older adults with complex medical and long-term supports and services (LTSS) needs. Based on comprehensive assessment of program participants’ needs, PACE organizations provide and manage a full spectrum of services, including preventative, primary, acute, and LTSS, regardless of the type or location. PACE organizations are fully accountable for the quality and cost of all services provided, either directly by PACE organization staff or by contracted providers. To be eligible for PACE, individuals must be 55 or older; certified by the state as requiring nursing home level of care; reside in a PACE service area; and be able to live in the community safely with the assistance of PACE at the point of enrollment. PACE organizations are sponsored by a variety of different types of organizations, primarily non-profits, including health systems, free standing community agencies, hospices, community health centers, LTSS providers, and hospitals.

PACE Strengths

Summit participants identified many strengths of the PACE model, noting that it originated as an innovation in response to a specific need. In 1983, at the time of PACE’s origins, the health care system was not equipped to support frail, older adults who wanted to remain at home and in their communities—nursing home placement was often the only long-term option. To address this need, On Lok, the first PACE program in San Francisco, developed the model and its key components for which PACE is now recognized and valued. Because PACE’s core competencies have proven successful in providing high quality care over time, other programs targeting frail individuals may benefit from including components of PACE into their care coordination models. These include:

- **Comprehensive, Coordinated, and Continuous Care.** PACE organizations provide person-centered, comprehensive, integrated care using an interdisciplinary team (IDT) approach to needs assessment and care planning. The IDT integrates care provided by multiple, individual providers into a single, comprehensive, individualized care plan that takes into account program participants’ need for care 24 hours a day, 7 days a week, 365 days a year. PACE IDT members—physicians, nurses, therapists, social workers, pharmacists, health care aides and others—deliver much of the participants’ health care directly, enabling

“It’s a place where geriatric care is the norm and it’s the gold standard.”
—PACE Policy Summit Participant
Integrated, Capitated Financing. PACE integrates financing for people who are eligible for Medicare and Medicaid, receiving fixed, monthly payments for individuals enrolled in the program. These payments are pooled at the program level, providing PACE organizations flexibility to comprehensively address the needs of program participants. As a result, PACE providers consider all care options, are not restricted by fee-for-service reimbursement requirements, and have strong incentives to proactively address each individual’s person-specific needs to improve health and reduce the need for acute care and long-term institutionalization.

Accountability. PACE organizations are fully accountable for the quality and cost of all care provided both directly and through contracted providers, as well as the consequences of not providing needed services.

A “Gold Standard of Geriatric Care.” PACE has focused on geriatric care, resulting in a model with expertise in the assessment, treatment, and care of older adults. As one summit participant stated, “It’s a place where geriatric care is the norm and it’s the gold standard.” In PACE, primary care providers, working closely with other key members of the PACE interdisciplinary team, have a crucial role in the delivery of medical care. PACE providers are knowledgeable in geriatrics and able to respond to their patients’ multiple medical conditions, health care goals and preferences, and follow their patients over time and across settings. The concept of the medical home is an integral part of the PACE model.

Prevention and Timely Intervention. PACE participants match the profile of some of the costliest beneficiaries in both the Medicare and Medicaid programs. PACE organizations improve upon the care these individuals receive in the fee-for-service system by emphasizing preventive, primary and community-based care over avoidable high-cost specialty and institutional care. PACE organizations develop comprehensive systems of care as an alternative to the fragmented, poorly coordinated non-systems in which PACE-eligible individuals often find themselves. The result is greater independence and improved functioning in the community, and far less need for hospital, emergency room, and long-term institutional care.

Transportation. Transportation for PACE participants is another covered benefit and key way in which PACE supports participants and their caregivers. Transportation is provided to and from the PACE Center, as well as to other appointments. Providing transportation also places a driver, who has been trained to observe cues, in the home of the PACE participant. Drivers can then report cues that may signal a change in health status or other changes that should be monitored.

Family Caregivers. PACE organizations support family members and other caregivers with caregiving training, support groups, and respite care to help families keep their loved ones in the community.
Over the past 25 years, as PACE has expanded to new communities under the sponsorship of new organizations, these components have established a track record of proven results. PACE is recognized by policymakers, health care professionals, and researchers as a model of care that achieves excellence for frail, older adults who wish to live at home, in their communities. Currently, there are 75 PACE organizations serving over 23,000 people in diverse communities across 29 states, in both urban and rural areas. PACE also is working with the Veterans Administration to offer older veterans care at up to twelve pilot sites across the country.

PACE Challenges

As PACE expanded, initially as a demonstration and then as a permanent Medicare and Medicaid provider, assuring its effectiveness relied on implementing the key components originated by On Lok, which were eventually incorporated into federal and state regulatory requirements. Several of these requirements, in addition to obstacles directly related to PACE operations, were identified as having contributed to PACE’s limited growth, and include:

- **Start-up Costs and Prescriptive Regulations.** High start-up costs for PACE, which are a consequence of: 1) the required establishment of a PACE center, 2) the length of time necessary to obtain regulatory approvals, and 3) the requirement to provide many PACE services directly rather than through contracts with community providers and physicians.

- **Marketing.** Marketing challenges include a general lack of consumer awareness, the inaccurate perception that PACE requires attendance at the PACE center, and the requirement that individuals often must give up their community physicians.

- **Financial Risk.** Many capable community-based organizations that could sponsor PACE are concerned about the financial risk inherent in PACE’s fully capitated financing model.

- **Cost Effectiveness.** The absence of a comprehensive evaluation of PACE cost-effectiveness, particularly Medicaid cost-effectiveness, that enables state and federal policymakers to fully understand the positive fiscal impact of the program has hindered PACE expansion.

- **Expansion of PACE Beyond the Dual Eligible Population.** PACE has focused its enrollment on low-income individuals who are typically dually eligible for both Medicare and Medicaid with minimal success serving individuals with higher incomes. PACE could propose payment alternatives that make PACE more attractive to beneficiaries from various income levels.

- **Standardized Outcome Measures.** PACE programs lack a standardized system to measure outcomes, making it difficult for PACE to compare outcomes across PACE programs and with other LTSS providers. PACE should work with CMS and other stakeholders to develop and implement the use of standard outcome measures.

“PACE is viewed as a boutique model that can’t be scaled up.”

—PACE Policy Summit Participant
PACE is seen as a successful, if not widespread, model of care by policymakers and researchers. But, despite the program’s recent growth, summit participants noted that PACE serves a limited number of older adults. The challenge for PACE is to renew the creativity and energy that characterized its initial development and to expand to meet the needs of growing numbers of PACE eligible individuals as well as other high-cost, high-need populations. In meeting this challenge, PACE can draw on the core strengths of its care delivery model, the expertise of its leadership, and the high esteem of those seeking to reform the broader health care system.

Opportunities in Health Care Reform for PACE

Health care reform seeks to address many of the weaknesses in the current system that the PACE model was originally designed to resolve: fragmented, often duplicative delivery of services; lack of coordination and continuity of care for persons with multiple chronic conditions and functional impairment; misaligned financial incentives; poor access to geriatric primary care; and a reliance on institutional rather than community-based care. PACE is well-positioned to capitalize on the new opportunities provided by the ACA through: increasing access to the existing PACE model, expanding the PACE model to serve new populations, and acting as a resource to emerging care coordination programs that would like to incorporate components of PACE into their models.

Increasing Access to the Existing PACE Model

For the frail, low-income, older adults that PACE primarily serves, increasing the number and size of PACE organizations would provide greater access to the type of fully integrated, effective model of care intended by health care reform. Health reform and policy initiatives already underway can support this growth through:

• **Regulatory Reform.** Assuring that state and federal regulations allow existing and developing PACE programs greater flexibility to try new operational and care delivery approaches that would improve care, increase efficiency, and enhance consumer appeal. For example, expediting the regulatory approval process for new PACE programs would reduce start-up costs and increase speed to market.

• **Access to New Funding and Programs.** Ensuring that PACE has access to new funding and/or programs could enhance PACE services. Examples include the Money Follows the Person program, designed to help individuals residing in nursing homes return to the community; medical/health homes, designed to promote integrated primary care; the Community Living Assistance Supports and Services (CLASS) Plan designed to help individuals receive the LTSS they need; and Community First Choice, designed to cover home and community-based attendant services as a Medicaid state option.

“PACE is exceptional because all the pieces are there.”

—PACE Policy Summit Participant
• **Consumer Education and Choice.** Advising older adults, their caregivers, and their physicians of their eligibility for PACE services upon determination that they require a nursing home level of care would enable more consumers to determine if PACE is right for them. Informing older adults of PACE as an option could be required of Medicare and Medicaid health plans, and incorporated into transitional care programs being developed to improve outcomes for people who transition from one care setting to another, e.g., from a hospital to a nursing home. Additionally, hospitals could provide information about PACE upon discharge. Finally, older adults can be informed of PACE as a care option through Aging and Disability Resource Centers (ADRC) and organizations funded under the Older Americans Act, including area agencies on aging and senior centers.

• **Housing Integration.** Locating PACE services in or near senior assisted/public housing would improve residents’ access to services that would help them remain in their homes and communities, and avoid permanent nursing home institutionalization.

**Expanding the PACE Model to Serve New Populations**

Because of PACE’s history in serving individuals with complex health care needs, expansion of PACE to new populations could be beneficial. The PACE community and policymakers should consider expanding PACE to enable additional populations to participate, such as:

• **Complex Care Individuals.** PACE strengths could be applied to high-risk, high-cost populations beyond older adults. Services for people with complex care needs, such as those with severe physical disabilities, mental illness, and intellectual disabilities, who require nursing home level of care, could benefit from PACE services. These individuals use significant amounts of emergency care and inpatient care, and PACE provides an excellent opportunity for both improved outcomes and cost reductions.

• **Medicare-only Beneficiaries.** Currently, PACE can serve individuals with Medicare benefits who are not eligible for Medicaid benefits. However, to date, these individuals make up a very small proportion of PACE enrollment. Developing payment arrangements that make it affordable and attractive for Medicare-only beneficiaries to participate in PACE would result in greater access to the program for this population.

• **At-Risk Individuals.** A subset of PACE services could be made available to people who are “at-risk” for nursing home placement due to the presence of multiple, chronic conditions, functional disabilities, and/or cognitive impairments. PACE’s coordinated care model could intervene to prevent avoidable complications and improve health status. Adaptations to the PACE model may be necessary for at-risk individuals who do not require the full intensity of services generally provided by PACE.

**Incorporating Key Components of PACE into Emerging Care Models**

PACE organizations can help providers adapt PACE components as well as aspects of its operations to enhance the effectiveness of emerging care models and delivery systems included in health care reform. Summit participants identified the following health reform initiatives as ones that could benefit from incorporating components of the PACE model:
• **Health Reform Initiatives.** New ACA models and initiatives attempting to reform health care through delivery and payment systems could include PACE programs or specific PACE components. Examples of these reforms are accountable care organizations (ACO), bundling of related services, shared savings, medical/health homes, Independence at Home, care transition payments, and additional pilots being developed by the Center for Medicare and Medicaid Innovation, and the Federal Coordinated Health Care Office. PACE organizations could provide technical assistance regarding components such as coordinated care, service integration, or polypharmacy management for at-risk patients.

• **State Demonstrations to Integrate Care for Dual Eligible Individuals.** PACE organizations may want to pursue their own demonstrations or work with states that receive federal grants to develop and test integrated care systems for people who are eligible for both Medicare and Medicaid. PACE is experienced with this population, as over 90 percent of its participants are dually eligible for Medicare and Medicaid.

• **Workforce.** PACE provides an optimal setting for training of a full range of interdisciplinary professionals in effective geriatric care. There is a critical need for more competency and training in the treatment of frail, older adults, providing PACE with an opportunity to share its experience with other organizations interested in geriatric care training.

• **Preventing Elder Abuse.** PACE can work with the Department of Health and Human Services Coordinating Council and Advisory Board created by the Elder Justice Act to identify and disseminate effective strategies for preventing elder abuse. In particular, other coordinated care models could benefit from PACE’s experience in conducting background checks of staff.

**Recommendations: Using Health Care Reform Opportunities to Advance and Evolve PACE**

Based on the health reform-related opportunities for PACE identified above, summit participants recommended several ways to advance and expand the program. These include new PACE demonstrations, state and federal policies, payment alternatives, PACE operations and communication, and research.

1. **Demonstrations**

PACE programs should work with the CMS Center for Medicare and Medicaid Innovation and CMS Federal Coordinated Health Care Office to develop and implement demonstrations that would improve eligible individuals’ access to PACE as well as expand PACE to new populations. Demonstration areas for consideration include:

- Payment alternatives could be explored, particularly for pricing PACE services for Medicare beneficiaries who are not financially eligible for Medicaid.

“PACE is the epitome of the medical home.”

—PACE Policy Summit Participant
• PACE programs and/or services could be developed for other populations that would benefit from comprehensive, highly coordinated care. One example is to expand the PACE model to people with severe mental illness, as previously suggested. However, the PACE model would require a greater focus on services for people with mental illness, staff competency development, and development of an appropriate payment methodology. Because many people with mental illness may require the comprehensive care coordination offered by PACE before they are 55 years old, lowering the eligibility age for people with mental illness would be an important consideration.

• PACE programs could operate as a health home for a broader population including those with complex chronic illnesses and those at risk of needing nursing home level of care. This would require adjusting the clinical eligibility criteria for PACE and developing payment systems appropriate for those who are at lower levels of acuity, and operational changes to the model.

• Medicare and Medicaid could work together to develop a reimbursement methodology that allows for the total savings achieved by PACE to be shared across both programs. Considering the comprehensive costs and savings, relative to other care delivery systems, would provide an incentive to states to expand PACE services to the extent that these services demonstrated their ability to reduce costs for both the Medicare and Medicaid programs.

2. State and Federal Policies

• State and federal regulations to allow PACE greater flexibility to try new operational and care delivery approaches that would improve care, increase efficiency, and enhance consumer appeal.

• State policymakers should develop approaches to promote the availability of PACE statewide. This can be achieved through partnerships with providers willing to sponsor PACE programs and a planned approach to determining the service areas that will be supported by each program. States such as Pennsylvania, Virginia, and North Carolina can serve as models for promoting statewide access to PACE services.

• State Medicaid budgets can promote PACE as a cost effective care option through comprehensive, multi-year budget allocations for LTSS, rather than single year allocations targeted to specific provider types, e.g., nursing homes, day care, home care.

• States should consider PACE as a health home option. PACE organizations, working with community-based networks of primary care physicians, could serve as health homes to better manage care for a chronically ill population. Through this support, PACE could expand coverage to those who are at risk of needing a nursing home level of care, including persons under age 55. This expansion of services would require a change in the current requirement that PACE serve only those over age 55 and the nursing home eligible requirement for PACE participants, as well as expedited enrollment processes. North Carolina has tested a similar approach that could serve as a model.
3. Payment

- State and federal grant programs for PACE start-up costs would expedite PACE development and expansion, providing greater access to PACE services.

- In some cases, states’ confidence in the cost-effectiveness of PACE might be enhanced by risk adjusted payment systems for Medicaid beneficiaries. Such systems would link prospective payment rates to the health status and specific needs of individual enrollees.

- PACE could propose payment alternatives that make PACE more attractive for beneficiaries from various income levels.

4. PACE Operations and Communications

- If PACE organizations choose to expand and serve different populations, they would need to assure staff competencies related to the care of these individuals, such as those with intellectual disabilities or mental health needs. PACE organizations also would want to establish effective partnerships with community organizations, such as residential care facilities and vocational rehabilitation programs, and health professionals with expertise in caring for these populations. Existing PACE organizations should pursue linkages with community service providers that can support their current capacity to maintain people in the community. These may include senior centers, transportation providers, meals on wheels, and exercise programs.

- PACE organizations should explore the application of home health monitoring and care delivery technology to increase the quality of care and cost effectiveness of PACE services. PACE programs also need advanced electronic health records to gather data needed for monitoring program performance and demonstrating outcomes.

- PACE organizations could encourage their sponsoring entities to include key components of the PACE model in their broader health care delivery systems and emerging care coordination programs, e.g., accountable care organizations.

5. Research

- Research is needed to identify the relative importance of key elements of the PACE model, such as the composition and role of the interdisciplinary team and the use of PACE center services, on outcomes and overall effectiveness. This research would inform the development and implementation of variations on the PACE model.

- Research is needed to identify reliable and appropriate outcome measures for PACE that can be used to compare PACE organizations’ performance over time and to one another, as well as to compare PACE performance with alternative care options. This will support policy and payment actions related to PACE expansion.

- Research is needed to examine the cost effectiveness of PACE organizations relative to other care options, particularly capturing the longitudinal costs of care for the population PACE
serves and the comprehensive costs of that care, across all payers and service settings. Cost effectiveness research will need to incorporate accurate comparisons of PACE costs to different service delivery program options.

- Research is needed to understand how PACE could support older adults living in low-income housing. These data would be used to develop appropriate co-location strategies, outreach, and services for this population.

**Renewing an Innovation**

Health care reform presents a unique opportunity for PACE to renew itself through innovation and lead other organizations interested in developing care coordination models. PACE can build on its origins as an innovative model and its subsequent track record of achieving outstanding results for the people in its care. As one summit participant noted, “PACE is tangible, real and not theoretical . . . and it can be for all populations.” Policymakers and stakeholders should look to PACE and its core competencies as they seek to promote care coordination and integration across the entire health system.

**PACE Policy Summit Participants**

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The National PACE Association works to advance the efforts of Programs of All-inclusive Care for the Elderly (PACE) to support, maintain, safeguard and promote the provision of quality, comprehensive and cost-effective health care services for frail older adults. More information on NPA and PACE is available at www.npaonline.org.