Program of All-Inclusive Care for the Elderly

Country: USA
Partner Institute: Johns Hopkins Bloomberg School of Public Health, Department of Health Policy and Management
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Health Policy Issues: Benefit Basket, Funding / Pooling, Long term care, Quality Improvement, Access, Remuneration / Payment, Role Private Sector

Current Process Stages

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<th>Idea</th>
<th>Pilot</th>
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1. Abstract

The Program of All-Inclusive Care for the Elderly (PACE) is an integrated, acute and long-term care model for frail, disabled adults living in the community. Evaluations have demonstrated the program's success in reducing costs by delaying nursing home care and shortening hospital stays. However, the growth of PACE has been much slower than expected.

2. Purpose of health policy or idea

The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare program that integrates the delivery and financing of services for older adults who require nursing home level care but are able to safely reside in community settings. PACE organizations provide and coordinate a continuum of medical and social services including primary care, occupational and recreation therapy, home health care, and hospital and nursing home care. PACE enrollees attend an adult day health center where they receive most services from a multidisciplinary care team. Programs often contract out for specialty care, but services continue to be managed and coordinated by the care team. PACE providers receive a capitated payment per enrollee from both Medicare and Medicaid, and assume the full financial risk for all services including hospitalizations and nursing home stays. Providers are required to offer all services in the Medicare and Medicaid programs, but most provide additional services (Eng, 1997).

The overarching goal of the PACE program is to enable frail older adults to live in the community for as long as possible. Evaluations of the program have consistently shown that PACE enrollees have lower rates of nursing home admissions, shorter hospital stays, lower mortality rates, and better self-reported health and quality of life compared to non-PACE populations (Chatterji et al, 1998). In addition, costs for PACE enrollees are 16-38 percent lower than Medicare fee-for-service costs for a frail elderly population, and 5-15 percent lower than costs for comparable Medicaid beneficiaries (White 1998, Bodeheimer 1999).

Despite the success of this model of care, the growth of PACE has been much slower than expected. The 1997 Balanced Budget Act established PACE as a permanent program within Medicare, and authorized 40 new programs that year, and 20 programs each year thereafter. However, by 2008, only 61 PACE programs were operating in 29 states (NPA). While several million adults are potentially eligible for PACE, only 17,000 are enrolled. Lynch et al (2008) reviewed the existing literature on PACE and interviewed PACE program directors, financial officers, and researchers to understand why the program has not expanded and enrollment in existing programs remains limited.
They categorized their findings as follows:

1. **PACE is not appealing to many older adults** - The PACE model requires frequent attendance at an adult day care center. Many potential enrollees would prefer to receive their services at home, or visit the day center as needed. PACE enrollees must also switch from their regular primary care physician to the care team at the adult day health center. Many individuals do not want to discontinue their provider relationships (Lynch, 2008; Gross 2008).

2. **Non-profit providers do not have adequate funding to develop new PACE sites or expand existing sites** - The development of a PACE site requires substantial upfront investment. The early PACE demonstration sites received approximately 70 percent of their funding through grants from large national foundations. Since PACE is no longer a demonstration project, these grants are no longer available. Smaller community organizations cannot afford the initial costs, and most sites are developed by existing non-profit hospital or health systems who want to expand their services (Lynch 2008; Bodenheimer 1999).

   Many existing PACE sites do not have adequate funding to expand their facilities in order to enroll more individuals. Labor shortages pose an additional barrier to enrollment. A PACE team can only care for 120 to 150 individuals, after which a new team must be developed to care for additional enrollees. Most PACE sites are unable to provide competitive benefit packages to attract new staff during a labor shortage (Lynch 2008; Gross 2004).

3. **For-profit providers have not entered the market** - For-profit providers have not developed PACE sites even though the 1997 BBA authorized 10 for-profit programs. The federal government did not develop final PACE regulations and payment mechanisms for a number of years after the enactment of the BBA. A revised risk-adjusted capitation rate was not developed by Medicare until 2003; this did not allow potential PACE providers to accurately predict their revenue. The uncertainty over Medicare capitation rates as well as the financial risk of caring for a nursing home-eligible population have discouraged for-profit providers from developing PACE sites (Lynch 2008).

4. **Lack of marketing** - Most older adults and their families are unaware of the PACE model. Non-profit PACE organizations do not have enough funds for advertising and marketing (Lynch, 2008).

5. **Lack of State support** - At the State level, Medicaid budget shortfalls have led some states to place enrollment caps at existing PACE sites. Some state officials are also hesitant to support PACE enrollment over concerns that Medicaid costs could increase if PACE enrolls individuals who would not have enrolled in Medicaid. In addition, PACE sites face competition from other state-funded home and community-based programs which target the same population as PACE. Other private organizations that offer services such as home care or assisted living also compete for PACE enrollees. This has resulted in a ‘service-rich’ environment; frail older adults can obtain many of the services included in the PACE model elsewhere (Lynch 2008; Gross 2004).

6. **PACE is unaffordable for middle income individuals** - Enrollees who are not eligible for Medicaid face high out-of-pocket costs. The Medicaid program contributes two-thirds of the capitated payment per enrollee. Individuals who do not qualify for Medicaid must pay this difference out-of-pocket. These costs deter many middle income individuals from enrolling in PACE because while they do not qualify for Medicaid, they cannot afford to pay the Medicaid contribution (Lynch 2008).

In addition to these reasons, states with large rural populations have found it difficult to develop PACE programs. Since PACE uses a day care model, states with low population densities face additional transportation and care coordination barriers (Gross 2004; Lynch 2008). Despite these barriers, the PACE model has influenced the development of community-based integrated care models for frail and disabled older adults.
Main objectives

To provide comprehensive and cost-effective care for frail older adults living in the community.

Type of incentives

Capitated Medicare and Medicaid payments to PACE organizations.

Groups affected

Center for Medicare and Medicaid Services, State Medicaid Programs, Older Adults; Private Insurers

3. Characteristics of this policy

<table>
<thead>
<tr>
<th>Degree of Innovation</th>
<th>traditional</th>
<th>innovative</th>
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<tbody>
<tr>
<td>Degree of Controversy</td>
<td>consensual</td>
<td>highly controversial</td>
</tr>
<tr>
<td>Structural or Systemic Impact</td>
<td>marginal</td>
<td>fundamental</td>
</tr>
<tr>
<td>Public Visibility</td>
<td>very low</td>
<td>very high</td>
</tr>
<tr>
<td>Transferability</td>
<td>strongly system-dependent</td>
<td>system-neutral</td>
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The organization and delivery of services in the U.S. is highly fragmented. PACE is a program which integrates acute and long-term services and coordinates the continuum of care for its enrollees.

4. Political and economic background

Approximately 10 million Americans require long-term care services and demand is projected to grow substantially with the aging of the population. Medicaid pays for a large portion of long term care. In 2008, Medicaid paid 40 percent of total long term care expenditures, and 43 percent of nursing home expenditures (KFF, 2009). During the 1980s, few states provided long-term care services in home and community-based settings. The 1990 Americans with Disabilities Act ruled that States must provide services for disabled individuals in community settings if appropriate. Since then, spending on home and community-based has increased. Medicaid spending on home and community-based services increased from 13 percent of total long-term care costs in 1990 to 41 percent in 2006 (NPA 2004; KFF, 2009).

Both the trend away from institutionalization as well as the need to contain long-term care costs has encouraged the development of innovative care models for disabled populations. PACE was the first program to successfully integrate the delivery of acute and long term care services, and has served as a model for subsequent efforts.

Complies with

Other - Rising long-term care costs and the need to care for frail older adults in the community.
5. Purpose and process analysis

Origins of health policy idea

The PACE model was developed in San Francisco’s Chinatown-North Beach neighborhood by On Lok Senior Health Services in 1973. On Lok administrators believed that a neighborhood adult day center was a more culturally appropriate alternative to nursing home care for its largely immigrant population, and could also potentially delay nursing home placement. In 1979, On Lok received a four year demonstration grant from the Centers for Medicare and Medicaid Services. In 1983, it received a waiver from Medicare to combine Medicare and Medicaid financing for its enrollees. In 1986, CMS, the Robert Wood Johnson Foundation, and the John A. Hartford Foundation provided On Lok with funds to replicate its model at 10 additional demonstration sites. The success of these demonstration projects led to its establishment as a permanent program within Medicare (Bodenheimer, 1999).

Initiators of idea/main actors

- Government: The Center for Medicare and Medicaid Services (CMS) has funded the development and evaluation of PACE through demonstration projects. PACE is now a permanent program within Medicare. Studies show that the cost of PACE enrollees are lower than Medicare and Medicaid costs for comparable populations.
- Payers: Although the private long-term care insurance market is small, PACE could potentially be added as a benefit in a long-term care product. Insurers are interested in programs that reduce expensive nursing home stays (Lynch 2008).
- Private Sector or Industry: For-profit providers have not developed PACE sites even though the BBA authorized 10 for-profit programs. Uncertainty over Medicare capitation rates and the risk of a nursing home-eligible population have discouraged for-profit providers (Lynch 2008).

Approach of idea

The approach of the idea is described as: renewed: The PACE model was first developed by On Lok Senior Health in San Francisco in 1973.

Innovation or pilot project

Local level - PACE organizations currently operate in 29 states.

Stakeholder positions

The PACE model was developed at On Lok Senior Health Services in California. Both the Centers for Medicare and Medicaid Services as well as national foundations played an instrumental role in funding and supporting early demonstration projects and evaluations of the On Lok model.
Actors and positions

Description of actors and their positions

Government
- Center for Medicare and Medicaid Services
- State Medicaid Programs

very supportive
strongly opposed

Payers
- Insurance companies

very supportive
strongly opposed

Private Sector or Industry
- For-profit provider organizations

very supportive
strongly opposed

Influences in policy making and legislation

The 1986 Omnibus Reconciliation Act authorized 10 demonstration programs based on the model developed at On Lok in California. These sites were evaluated by CMS in 1991, and in 1997, the Balanced Budget Act established PACE as a permanent part of the Medicare program (NPA 2004).

Legislative outcome

success

Actors and influence

Description of actors and their influence

Government
- Center for Medicare and Medicaid Services
- State Medicaid Programs

very strong
none

Payers
- Insurance companies

very strong
none

Private Sector or Industry
- For-profit provider organizations

very strong
none

Positions and Influences at a glance

Adoption and implementation

Regulations governing PACE organizations are set by the Centers for Medicare and Medicaid Services (CMS); applications to become a PACE organization must be approved by CMS. Although PACE became a permanent Medicare benefit, States can choose whether to include PACE in their Medicaid programs. According to regulations, however, PACE organizations must operate under both the Medicare and Medicaid programs in a state. Therefore, if states do not incorporate PACE into their Medicaid plans, providers cannot receive approval from CMS to operate as a PACE organization. After States add PACE as a Medicaid benefit, they are responsible for setting the Medicaid capitation rate, as well as monitoring and oversight of the PACE organization (CFR, 1999; NPA 2004).
Monitoring and evaluation

PACE organizations are required to submit monitoring data to CMS and the State. Clinical measures include requirements for personnel training, infection control, service delivery, and emergency care. Administrative measures include requirements for fiscal soundness, grievance and appeals processes, and enrollment and disenrollment (CMS, 2008). PACE organizations must also develop an internal quality improvement plan which is approved by CMS and the State (CMS 2008; NPA 2004).

Review mechanisms

Final evaluation (internal), Final evaluation (external)

Dimensions of evaluation

Structure, Process, Outcome

Results of evaluation

Evaluations have shown that PACE enrollees have lower rates of nursing home admissions, shorter hospital stays, lower mortality rates, and better self-reported health compared to non-PACE populations (Chatterji et al, 1998). In addition, costs for PACE enrollees are 16-38 percent lower than Medicare fee-for-service costs for a frail elderly population, and 5-15 percent lower than costs for comparable Medicaid beneficiaries (White 1998, Bodeheimer 1999). PACE enrollees are also more likely to die at home than other Medicare beneficiaries (Temkin-Greener, 2002)
6. Expected outcome

PACE has become a model for community-based programs that integrate acute and long-term services and provide an alternative to nursing home care for disabled populations. However, the number of PACE organizations has not grown as rapidly as expected. Experts agree that the program must be modified if it is to grow substantially.

- First, the program must be made affordable for middle income persons who do not qualify for Medicaid. Most frail older adults receive Medicare benefits, but are not eligible for Medicaid (Lynch 2008; Bodenheimer 1999).
- Second, programs should accommodate those who do not wish to receive their care at an adult day center or want to continue with their own providers (Lynch 2008; Bodenheimer 1999).
- Third, increase state-level support for PACE programs as well as coordination among the many state programs that serve this population (Lynch 2008).

Locally, several PACE sites have adapted their programs to address these barriers. For example, On Lok in California has developed a program for individuals who are only eligible for Medicare (Bodenheimer, 1999). On a national level, the 2005 Deficit Reduction Act created the Rural PACE Provider grant program, which provides funding and technical assistance to 15 providers to develop PACE in rural areas. These efforts may help the expansion of PACE in the future (NPA).

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<tr>
<th>Quality of Health Care Services</th>
<th>marginal</th>
<th>fundamental</th>
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<tr>
<td>Level of Equity</td>
<td>system less equitable</td>
<td>system more equitable</td>
</tr>
<tr>
<td>Cost Efficiency</td>
<td>very low</td>
<td>very high</td>
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PACE evaluations have shown the program reduces hospital and nursing home stays, and improves health status of its enrollees. Low disenrollment rates also show that participants are satisfied with the program (Chatterji et al, 1998).

7. References

Sources of Information

- Kaiser Family Foundation (2009). Medicaid and Long-Term Care and Social Supports. Fact Sheet #2186-06.
- 42 C.F.R §460.10 (1999)

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