



Sustaining PACE Organizations' Delivery of Services to Frail Older Adults at Highest Risk of Contracting the Coronavirus

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Summary

The outbreak of the COVID-19 virus poses unique challenges to frail older adults and the health care programs serving them. This population is especially vulnerable to infection and at high risk for experiencing worse outcomes than others. Serving a population of entirely frail, older adults and people living with disabilities in their homes, Programs of All-Inclusive Care for the Elderly (PACE) face an unprecedented challenge as they respond to the COVID-19 pandemic. In order to continue serving our vulnerable, elderly, and chronically ill patients, we strongly urge Congress to take action immediately.

Urgent Action is Needed to Assure PACE Organizations Continue Serving Patients

Since the full extent of the COVID-19 pandemic's impact on PACE participants and organizations is not yet known, targeted, time limited, solutions that respond to the range of needs across PACE organizations is required now. The National PACE Association (NPA) calls on Congress to stabilize PACE revenues by accounting for COVID-19 related increases in the cost of care, increase access to telehealth funding and support the PACE workforce. These actions will ensure the sustainability of PACE organizations so that they can continue caring for medically complex, older adults and those living with disabilities in the community. NPA recommends Congress pursue the following remedies quickly:

- Provide reimbursement to PACE organizations when a PACE participant has an inpatient stay in a hospital with a related diagnosis of COVID-19 and receives Medicare Part A services in recognition that the inpatient and related services were not reflected in the baseline expenditures used to establish current PACE Medicare capitation rates. Cost support equal to the cost of the COVID-19 related, Part A covered services should be provided to the PACE organization as a supplemental payment outside of its capitated payment.
- Establish a PACE-specific risk corridor to protect PACE organizations from costs that exceed their total capitation payments (Medicare and Medicaid) by more than 5 percent. Recognizing that as provider led health plans, PACE organizations may experience increases in the costs of acute and post-acute episodes of care as well as long term services and supports over an extended period of time across the population they serve.
- Increase access to federal funding provided through the Federal Communications Commission and the Health Resources and Services Administration to support PACE organizations' investment in and application of technologies facilitating additional in-home assessments, services and supports.
- Provide PACE organizations with increased workforce supports including:

- Access to funds to support increased workforce costs related to hazards faced by direct care staff in the performing their jobs in participants' homes daily and the increased costs of contracted staff needed to provide increased levels of home care to PACE's high-risk population.
- Access to protective personal equipment for direct care staff to maintain their safety and the safety of the participants in their care.
- Inclusion of PACE as an eligible entity for Congressional efforts addressing increased, rapid access to COVID-19 testing for direct care staff and high risk populations in the community to increase the safety of the workforce environment and protect their health.

The reasoning behind these recommendations follows below.

A. Why PACE Organizations Face Unique Challenges Due to COVID-19

PACE organizations are capitated providers of care who operate at full financial risk for all Medicare and Medicaid benefits. Increasing COVID-19 infection rates have the potential to destabilize PACE organizations through a combination of increased costs of care occurring at a time when revenues and financial reserves may decline due to reduced census. As small, capitated programs with an average census of approximately 400 medically complex individuals being served, PACE organizations are particularly vulnerable to the financial upheaval COVID-19 may cause. In order to assure the continued ability of PACE organizations to care for their participants during and after the pandemic, PACE organizations need targeted Medicare and Medicaid support that strengthens their workforce, funds increased costs of care and stabilizes revenues.

PACE serves exclusively older adults and those living with disabilities, who are at least 55 years of age and at a nursing home level of care but wish to continue living in the community. The objective of PACE is to maintain the independence of program participants in their homes and communities for as long as possible. Fully integrated and coordinated, PACE organizations provide medically complex older adults with the entire continuum of Medicare and Medicaid covered services, including Medicare Parts A, B and D and long-term services and supports.

PACE organizations develop each individual participant's care plan, coordinate and provide that care, as determined by the plan, around the clock, seven days a week, across all settings. Most participants are dually eligible beneficiaries (90 percent), some are Medicaid only beneficiaries (9 percent) and a few are Medicare only beneficiaries, Department of Veterans Affairs beneficiaries or private pay (less than 1 percent combined). PACE organizations are capitated providers of care, at full financial risk for all services, with an average enrollment of approximately 400 people.

PACE organizations' short and long-term ability to sustain their operations may be at significant risk as COVID-19 infection rates climb for the following reasons:

- PACE participants (individuals enrolled in PACE) are on average 78 years old, with multiple chronic conditions and functional limitations-- individuals at the highest risk for COVID-19 infection and severe health consequences.
- Fifty percent of PACE participants have a cognitive impairment, that in combination with their health conditions and physical limitations, require extensive in-home support.

- While all PACE participants meet their state Medicaid program's criteria for needing a nursing home level of care, PACE organizations enable approximately 95% of the individuals in their care to remain living at home.
- PACE organizations rely on a direct care work force facing a high potential risk of infection as they provide care in the homes of the frail older adults and people with disabilities enrolled in the program, in hospitals, in nursing homes and at PACE centers' primary care practices.
- As a provider-based, capitated model, PACE organizations have a very small risk pool of entirely high risk, high need and high cost frail, older adults and those with disabilities. There is little or no opportunity to absorb any extraordinary, COVID-19 related costs associated with serving this high-risk population.
- In exchange for monthly capitated payments, PACE organizations assume all financial risk for the full range of community-based and, as needed, institutional services necessary, either directly or through contracts with other community-based providers, hospitals, nursing homes, and others.

B. Financial Impact of COVID-19 on PACE Organizations and Our Patients

As a fully risk bearing, financially capitated model of care, PACE organizations receive a per member, per month payment (PMPM) to deliver all necessary care and services regardless of setting. While the Medicare capitation is risk adjusted for participant acuity, Medicaid capitation risk adjustments generally are not, with limited exceptions (NY, WI). In 2019, the mean Medicare PMPM rate was \$2,574 and the mean Medicaid PMPM rate was \$3,933. Thus, for dually eligible PACE participants, PACE organizations received an average of \$6,607 per participant, per month to provide all necessary medical and other care 24/7, every day of the year.

On average 60 percent of each PACE organization's annual revenue comes from Medicaid, while 40 percent comes from Medicare. As PACE organizations respond to COVID-19, they may experience significant financial strain, undermining their ability to sustain services for the older adults and those with disabilities in their care in the short- and long-term. If COVID-19 infection rates accelerate for PACE participants, this will likely lead to significant declines in the census of PACE organizations. Given that many PACE organizations have a small census and that even the largest PACE organizations operate with limited financial reserves, the resulting decrease in Medicare and Medicaid payments paid to PACE organizations could threaten their risk reserves and financial solvency. These threats include, but are not limited to:

1. As PACE organizations devote their resources to caring for their currently enrolled participants, they may be limited in their ability to enroll new participants, which will reduce their census, further undermining their operating revenues and financial sustainability.
2. PACE organizations pay for the hospitalization costs associated with their participants' COVID-19 treatment out of their capitated payments from Medicare and/or Medicaid. These costs are not reflected in the Medicare or Medicaid expenditure baselines used to establish PACE capitation rates.

3. PACE organizations also are experiencing higher and unaccounted for costs related to staffing, protective personal equipment, diagnostic testing, medical supplies, durable medical equipment, and participant meals, among other items. PACE organizations are required to cover these costs as well as the costs of all other Medicare and Medicaid covered care and long term care services and supports out of their capitated payments. Again, the increased costs associated with COVID-19 are not reflected in the baselines used to set current PACE capitation rates. In fact, PACE programs are being economically challenged by the need for almost all participant care and services to be provided in the home, rather than having some medical care and other services being provided in PACE centers.
4. PACE organizations have relied on a high touch care model that is now being replaced with increased use of telehealth and telemedicine in order to maintain the safety of PACE participants and staff. PACE organizations will need to invest technology and training to enable the application of telehealth and telemedicine services to the care of PACE participants.

We look forward to discussing these recommendations with you as well as other concepts that may arise.