ISSUE BRIEF

What Role Can PACE Play in State and Federal Efforts to Reform Managed Long-Term Services and Supports?

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The Program of All-Inclusive Care for the Elderly (PACE®) fully integrates all Medicare and Medicaid services through capitated financing in order to provide primary, acute, specialty and long-term supports and services for frail older adults. PACE is a permanent provider under Medicare and a voluntary state option under Medicaid. PACE organizations receive a capitated, or per person, monthly payment to provide, directly or through contracted relationships, all necessary care. Under this capitated payment arrangement, PACE organizations assume full financial risk for all covered Medicare and Medicaid benefits, as well as for any other services required by an individual's care plan.

To be eligible for PACE services, individuals must be 55 years or older, reside in a PACE service area, be certified nursing home-eligible in their state, and be able to live safely in the community at the time of enrollment. The dual-eligible population, or those qualified for both Medicare and Medicaid benefits, represents 90% of PACE enrollees. There are more than 100 PACE organizations serving approximately 31,500 people in 31 states. From 2009 to 2014, there has been an 87% increase in enrollment. As of May 2014, there were 18 new PACE applications under review by the Centers for Medicare & Medicaid Services (CMS).

ISSUE

As state and federal policy-makers seek to expand the number of people enrolled in managed long-term services and supports (MLTSS), many have looked at an expanded role for PACE. Of the 9 million dual eligibles in the country, approximately 5.5 million are elderly, according to Kaiser Family Foundation estimates. About 1.35 million elderly duals need some level of long-term services and supports (LTSS). [i,ii]

States have identified large-scale, insurer-based health plans as one potential solution for enrolling these duals in an MLTSS model. Even as these plans are implemented and tested, state and federal policy-makers have indicated an interest in the potential for PACE organizations to offer a meaningful alternative that is widely available to duals. Unlike insurer-based health plans, which rely primarily on contracted provider networks, PACE organizations represent a provider-based model with an interdisciplinary team of health professionals who have a direct care relationship with the enrollee. PACE organizations also differ from most insurer-based MLTSS health plans in bearing full financial risk, without a capitation rate adjustment, for the enrollees who require a long-term nursing facility placement.

This issue brief addresses the potential for PACE organizations to offer broader access and to achieve larger-scale enrollment in order to play a significant role in statewide LTSS solutions. The brief presents examples from states that have promoted PACE as an MLTSS option and from PACE organizations that have achieved a high level of enrollment in their service areas.

PACE SERVICE AREAS

Enrollment in a PACE organization is limited to those who reside within its defined service area. The service area is defined in the PACE program agreement with the state Medicaid and federal Medicare programs. PACE organizations are required to provide access to one or more PACE centers within their service area. At the PACE center, participants are provided with meals, engage in activities, receive primary care, and participate in occupational, physical and speech therapy. Given the frailty of PACE participants, travel time to and from a PACE center is generally limited to 45 minutes or less. Many PACE organizations operate multiple centers to serve a larger geographic area.

In addition, PACE organizations may operate or contract with congregate care settings, such as adult day centers or senior meal locations, to provide timely and appropriate access to services. The size of a PACE service area is constrained by the ability of the PACE organization to provide access to PACE center services and to complement those services through community congregate care settings.
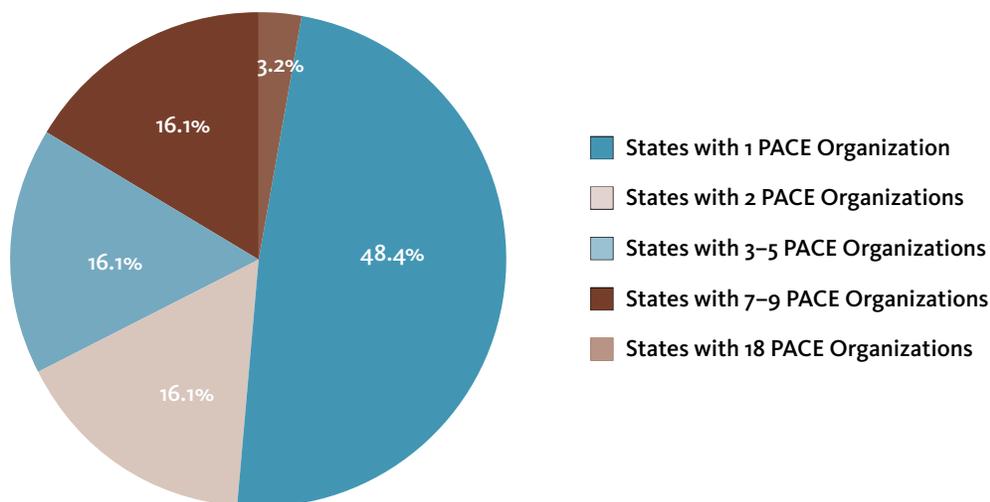
PROMOTING STATEWIDE ACCESS TO PACE

PACE organizations currently operate in 31 states. As indicated in Table 1 and Chart 1 below, there is a considerable range in the number of PACE organizations in each state and in the access that potentially eligible individuals have to a PACE program.

TABLE 1: NUMBER OF PACE ORGANIZATIONS IN STATES

States	PACE Organizations
AL, AR, DE, MD, MO, ND, NE, NM, OK, OR, RI, TN, WA, WI, WY	1
IA, KS, LA, OH, SC	2
CO (3), TX (3), FL (4), NJ (4), MI (5)	3-5
MA (7), VA (7), CA (8), NC (9), NY (9)	7-9
PA	18

CHART 1: DISTRIBUTION OF PACE ORGANIZATIONS

- States with 1 PACE Organization
- States with 2 PACE Organizations
- States with 3–5 PACE Organizations
- States with 7–9 PACE Organizations
- States with 18 PACE Organizations

Due to rounding, values do not equal 100%.

Across the 31 states that have one or more PACE programs, the percentage of dual eligibles who need a nursing home level of care and have access to PACE ranges from less than 12% in some states to as high as 100% in others, for an average of 30%.[iii] In most cases, states with the lowest levels of access have only one PACE program (AL, AR, OK, TN).

Several states with the highest levels of access, as illustrated in Chart 2, demonstrate the potential for PACE to make a significant contribution to achieving the objective of state and federal policy-makers to provide more integrated and better coordinated care to duals needing LTSS.

CHART 2: STATES ACHIEVING HIGH LEVELS OF ACCESS TO PACE
Percentage of Duals Needing LTSS with Access to PACE
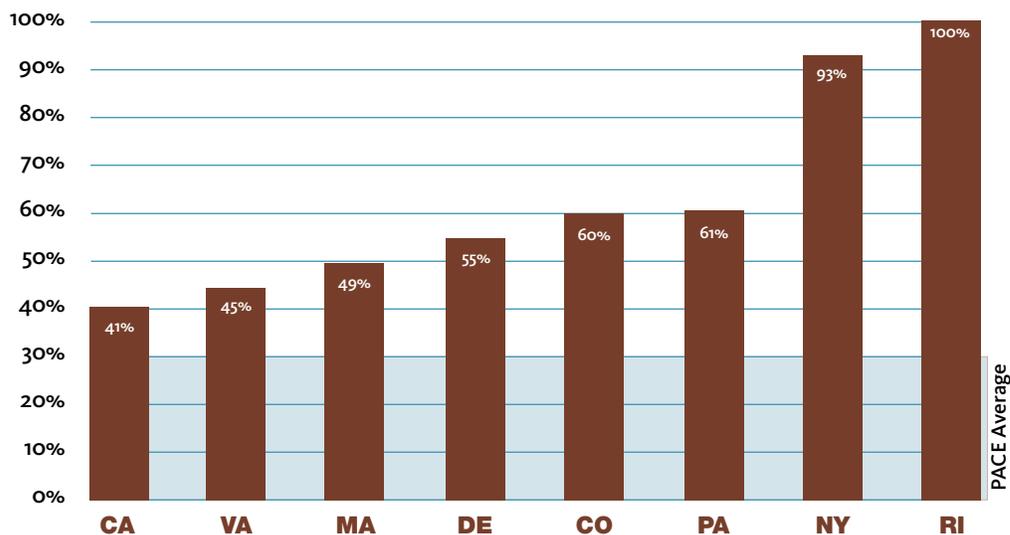
The level of access achieved by these states positions PACE to play a significant role in reforming their LTSS and illustrates how other states interested in offering PACE as a provider-based community alternative to large-scale insurance plans could achieve their goals.

Lessons from States with High Levels of Access to PACE

1. **Sustained State Support Achieves High Access Levels:** States that have sustained their support for PACE over time have achieved high levels of statewide access to the program. These states – including California, Colorado, Massachusetts, New York and Pennsylvania – have built on the early PACE programs that converted from demonstration to permanent provider status in 2000 and 2001 to steadily expand access to PACE.

2. **PACE Can Complement LTSS Managed Care Options:** States with a high level of access to PACE (CA, MA, NY, VA) are implementing MLTSS demonstrations as well. As an existing model that offers an alternative to large-scale, insurer-based health plans, PACE complements these demonstrations. PACE also can help to fill in service areas that are not covered by managed care, particularly rural areas. For example, two rural PACE organizations in Virginia provide access to services in areas that are not included in the state managed long-term care program.

3. **Geography Matters:** The size of the state plays a significant role in the level of access that can be achieved. For example, a single PACE organization in Rhode Island is able to provide 100% statewide access. Similarly, one PACE program in Delaware provides access to more than half of the state's dual-eligible population. In contrast, although California has eight PACE programs, only 41% of individuals eligible for PACE have access because of the size of the state.

4. **Population Density Matters:** PACE availability in high-population urban areas can have a disproportionate impact on the level of access to programs in a state. For instance, just two PACE organizations in the New York City metropolitan area contribute to an 84% statewide level of access. The two urban programs, along with seven other programs in the state, achieve a 93% total level of access statewide. Similarly, a large PACE program in Denver and two other programs in Colorado yield a 60% statewide level of access.

State Strategies for Promoting Access to PACE

The states with the highest levels of access to PACE display a number of common strategies:

- PACE is clearly positioned as a provider-based, community LTSS alternative to fee-for-service (CO, DE, NC, PA) and insurer-based (CA, MA, NY, RI, VA) MLTSS models. Clear policies that articulate the expected contribution of PACE to the overall LTSS plan of a state – such as when PACE is identified as a local complement to regional health plans in the Memorandum of Understanding between CMS and the state – offer PACE organizations a structured approach to growth even as states implement other new and alternative programs.

- State funding supports PACE growth in response to provider and consumer interest. State budgets are sufficient to support appropriate monthly PACE capitation rates and the enrollment growth of PACE programs (CA, CO, NC, NY, PA, VA).

- Sponsoring organizations that are operationally, organizationally and financially strong are able to build on their initial service areas to extend access to adjacent or nearby service areas (CA, CO, NY, PA, VA).

- States use requests for proposals (RFPs) to identify the interest of prospective PACE organizations in defined service areas with sufficient geographic size and populations to support financially viable operations (PA, VA). Applications for new PACE programs or PACE service area expansions are processed in a timely manner.

- Geographically large states rely on multiple PACE organizations to develop broad access to the program. These states combine large PACE organizations in urban areas with smaller PACE programs operating throughout the state to achieve high levels of access. Chart 3 depicts the relationship between the number of programs in a state and the overall statewide access level for the six states with the largest number of programs.

CHART 3: STATES WITH THE LARGEST NUMBER OF PACE PROGRAMS
PACE Access in States with the Most Programs
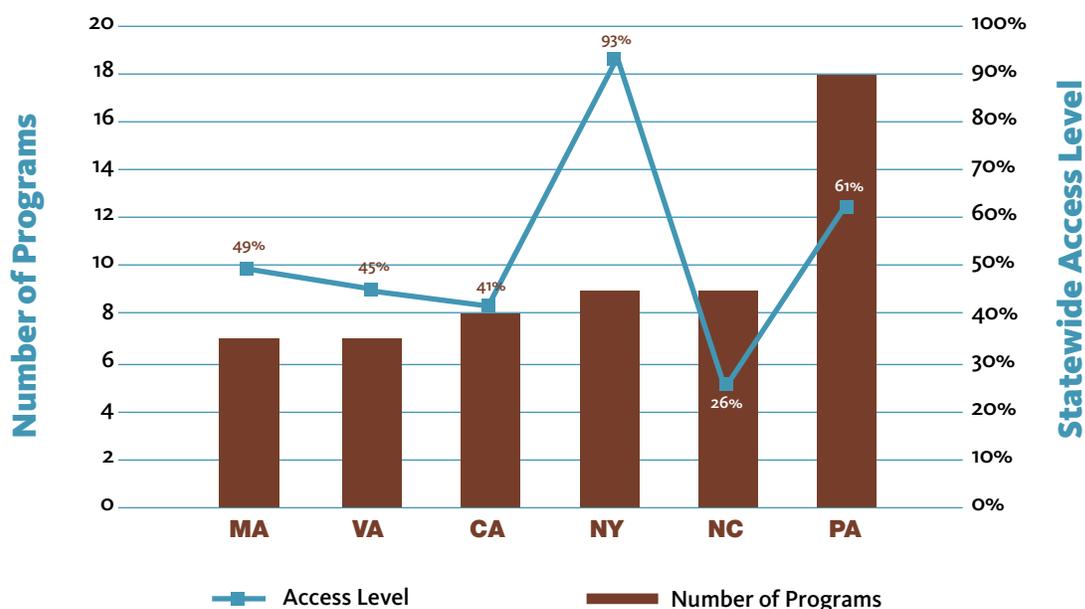
Enrollment in PACE: From Access to Service

Establishing access to PACE services through new programs and expanded service areas allows PACE organizations to offer their services to a larger number of those who need LTSS. Translating access into enrollment requires organizations to develop the operational capacity needed to serve individuals in their service areas as well as established outreach and enrollment practices that support equal access to PACE in the state.

A 2013 study of PACE organizations that opened prior to 2011 found that programs, on average, are enrolling and serving approximately 10% of individuals residing in their service areas who are dually eligible and need LTSS.[iv] The average enrollment in a PACE organization is 325 as of January 2014.

PACE organizations with the highest levels of enrollment exemplify the ability of the model to play a significant role in serving duals who need LTSS. The impact of PACE can be considered in terms of the percent of those needing LTSS who are served by the PACE organization, or market penetration, and the total number of those served, or the scale of the organization. In less densely populated service areas, market penetration is a useful measure of the impact a PACE organization has on those who need LTSS. In more densely populated areas, the total size or scale of the organization is often a better indicator of its impact, given the number of other options and providers available in these areas.

Two case study vignettes illustrate the potential impact of PACE enrollment in terms of market penetration and total scale:

1. Market Penetration: Senior CommUnity Care, Montrose, CO

Opened in August 2008, the Senior CommUnity Care PACE organization serves Montrose and Delta counties on the "Western Slope" of Colorado. Senior CommUnity Care was one of the 14 sites supported by the rural PACE demonstration authorized in the 2005 Budget Reconciliation Act. Its service area encompasses 3,382 square miles and a population of 71,462 people. Of that population, 13,982 individuals are over age 65, and approximately 1,000 are estimated to be Medicaid-eligible and in need of LTSS. With a current enrollment of 253 as of January 2014, Senior CommUnity Care is meeting the needs of 25.3% of these individuals. To achieve this level of market penetration, the organization developed a service delivery model that incorporates community physicians and community congregate care settings into the traditional PACE model. The organization has nurse practitioner liaisons to support the integration of community physicians into its interdisciplinary team. This relationship assures timely sharing of information, comprehensive assessment and care planning, and care delivery coordination.

2. Total Scale: On Lok Lifeways, San Francisco, CA

On Lok Lifeways, the originator of the PACE model, was founded in the early 1970s by a group of committed citizens to serve the Chinatown-North Beach community of San Francisco. Today, the organization provides services to more than 1,300 individuals across three counties throughout the Greater Bay Area in Northern California. To achieve its current scale, On Lok operates seven PACE centers. Six are directly under its own management, and one is managed through a subcontractor. In addition to its PACE centers, On Lok partners with community organizations to offer two alternative care settings (ACS) and owns and operates a third ACS site. These settings provide On Lok participants with the option to receive services and specialized programming in congregate settings outside of a PACE center. On Lok's capacity is extended even further through the use of up to 25 community physicians to supplement its own staff physicians in providing primary care. Collectively, its directly operated PACE centers, subcontracted PACE center, and ACS sites, with both staff and community-based physicians, have allowed On Lok to scale up as its service area has expanded.

While On Lok's enrollment is significantly larger than the average PACE organization, there are five organizations nationally with an enrollment greater than 1,000 participants as shown in Table 2

TABLE 2: LARGEST PACE ORGANIZATIONS

PACE Organization	City	State	Enrollment As of January 2014
CenterLight	New York	NY	3,813
InnovAge Greater Colorado	Denver	CO	2,056
AltaMed Health Services	Los Angeles	CA	1,592
On Lok Lifeways	San Francisco	CA	1,382
Providence ElderPlace	Portland	OR	1,055

Putting the Pieces Together: Access and Use of PACE Organizations

To establish access to PACE as a significant complement to other LTSS options, state and federal policy-makers need to do the following:

- design LTSS to offer Medicaid beneficiaries a range of meaningful options that clearly position PACE as an alternative to fee-for-service and MLTSS;

- establish adequate payment rates and sustained funding that support the development of new PACE organizations and the growth of existing PACE organizations;

- develop a systematic process for selecting the service areas of a PACE organization, enabling it to provide broad access; and

- foster the development of multiple PACE organizations to provide access across a broad range of communities for large states.

Beyond access, state policy-makers can support PACE enrollment in these ways:

- adequately budget for the expansion of PACE as organizations become available to serve more areas and people;

- ensure that options counseling for an individual's LTSS is conflict-free, knowledgeable about the PACE model, and offered on a timely basis as a person's needs change; and

- support the flexibility of PACE to serve more people by integrating community physicians and community congregate care settings into its care model.

Conclusion

As states achieving a high level of access to PACE illustrate, PACE can play a significant role in supporting the goals of state and federal policy-makers to serve dual eligibles who need LTSS in capitated and integrated care models. PACE offers consumers a provider-based alternative to larger, insurer-based managed care plans while helping policy-makers achieve their goals for more effective and efficient care. With support for growth, options counseling and model flexibility, PACE organizations can serve both a large proportion and a large number of those who need LTSS.

[i] Jacobson, G., Neuman, T., Damico, A. (2012). Medicare's role for dual eligible beneficiaries, a Kaiser Family Foundation issue brief, April.

[ii] Davenport, K., Markus Hodin, R., Feder, J. (2010). The dual eligible opportunity. Center for American Progress and Community Catalyst, December.

[iii] Sources: PACE service area data provided to NPA by PACE organizations and population data analysis by Health Dimensions Group

[iv] Fitzgerald, P., Higgins, C., Graziano, J. (2013). Rising to the challenge: What is the growth potential of PACE in your market and across the nation? Presentation at the Annual Conference of the National PACE Association, Miami, November.