Core Differences Between PACE and SNPs

Programs of All-Inclusive Care for the Elderly (PACE®) and Special Needs Plans (SNPs) share many common attributes. Both serve high-risk, high-need individuals who require significant care coordination. While PACE and SNPs both receive a capitated payment for program enrollees (set amounts that do not fluctuate with beneficiaries' utilization of health care services), there are important differences between these two models:

1. PACE programs are provider-sponsored and focus on the integration and delivery of care; SNPs are primarily sponsored by insurance companies, where networks of unrelated providers deliver care.
2. PACE fully integrates Medicare and Medicaid benefits and financing for dual eligibles; SNPs mostly cover Medicare benefits only, with the exception of a subset of Fully-Integrated Dual Eligible SNPs.
3. PACE organizations are at full financial risk for long-term care, while SNPs receive payment increases for enrollees who require nursing home care that is in excess of state-specified limits, typically more than 100 days.

PACE is a *provider*-based model of integrated care, with fully integrated Medicare and Medicaid financing. SNPs are insurance-based networks of care, for which only a small subset integrates Medicare and Medicaid financing.

- PACE is an intensive, provider-based model of care that features regular, sometimes daily, interaction between participants and a team of care providers. PACE organizations employ an interdisciplinary team of physicians, nurses, therapists, health care aides and others. Participants receive health care services (primary care, therapies, nutrition, durable medical equipment, prescriptions, etc.) and social supports (e.g., meals, recreation, personal care and transportation) in their homes and at locations such as a PACE center or an adult day health center. The PACE interdisciplinary team works with the participant and caregiver on assessment and care planning. While PACE participants receive the majority of their care through the program, PACE also contracts with specialists, hospitals, nursing homes and other providers to ensure that participants receive the services they need to stay healthy and independent. In PACE, the same providers are responsible for assessing the care needs of program participants, developing and updating care plans, providing care, and coordinating care with other providers.
- SNPs are specialized health insurance plans. They contract with physicians, hospitals and other health care providers that provide services in traditional settings. SNPs utilize a variety of methods for care coordination, from 24-hour hotlines to case managers to in-person meetings. There is greater variation among SNP plans in terms of network scope, care coordination services, delivery systems and quality measurement.

PACE and SNPs serve different types of beneficiaries.

- PACE enrolls the frailest Medicare beneficiaries – specifically, those who meet state eligibility criteria for nursing home level of care and require comprehensive, ongoing and intensive services to meet their chronic health and long-term care needs. The average risk score for a PACE enrollee is 2.57 [based on "CY2014 RAPS Compared to January 2015 Medicare Risk Scores and Payments (ESRD Enrollees Excluded)," National PACE Association]. PACE seeks to expand eligibility to others with significant care needs, such as younger adults with disabilities, and individuals who do not yet require a nursing home level of care but have multiple complex chronic conditions and some disability.

The National PACE Association is the voice of PACE providers across the country.
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- SNPs focus on specific subsets of Medicare beneficiaries, including dual eligible beneficiaries with both Medicare and Medicaid (D-SNPs), beneficiaries who meet institutional level-of-care requirements (I-SNPs), and beneficiaries with specific types of chronic illness (C-SNPs).
- Within the D-SNPs, 35 designated FIDE-SNPs provide fully integrated benefits similar to PACE (GAO Report to Congress, DISABLED DUAL-ELIGIBLE BENEFICIARIES: Integration of Medicare and Medicaid Benefits May Not Lead to Expected Medicare Savings). However, the average risk score for FIDE-SNP enrollees is 1.49 (2013 SNP Alliance Annual Profile & Advanced Practice Report, February 2014).

PACE is a fully integrated benefit.

- PACE provides *all* Medicare- and Medicaid-covered benefits, including all medical and long-term care services required to maximize the health and well-being of program participants. Comprehensive care coordination and effective use of outpatient and community-based services lead to significant reductions in participants' utilization of inpatient care. In turn, these inpatient savings are used to support care coordination and to expand both the range and intensity of community-based care.
- SNPs fall into several categories. Among SNPs that exclusively serve dual beneficiaries (D-SNPs), only 19 percent expressly provide for integrated Medicaid benefits, and of those, only 11 percent provide both community long-term support services and institutional care (FIDE-SNPs). (Report to the Congress: Medicare Payment Policy, March 2013).

PACE programs generally assume a greater level of risk than SNPs.

- PACE organizations assume financial risk if a participant ultimately requires a nursing home level of care. As a result, their financial incentives are strongly aligned to ensure that a patient receives appropriate preventive and acute services that can stave off a nursing home placement.
- Although some SNPs cover nursing home placements, such as Institutional SNPs, among FIDE SNPs (which are most comparable to PACE), several programs place limits on the amount or type of long-term care services that are covered. For example, in some states SNPs cap nursing home utilization at 100 days or provide only home and community-based long-term care, rather than nursing home care (*MedPAC Report to Congress: Aligning Incentives in Medicare,* June 2010).

There are differences in scope between PACE and SNPs

- The intensive nature of the PACE program requires significant capital investment. Currently, PACE programs must operate a PACE center and employ a full complement of health care professionals. As a result, PACE organizations are restrained by their physical and staff limitations. PACE programs average 334 participants per program and serve 34,000 individuals nationally. With additional flexibilities – such as greater use of alternative congregate care settings, greater use of community physicians, and more flexibility around the composition of the IDT – PACE could serve a larger proportion of dually eligible beneficiaries.
- The insurance-based model of SNPs, with its reliance on large networks of providers, allows for large-scale growth and streamlines administrative processes such as enrollment, marketing, quality measures and reporting. As a result, SNPs serve approximately 1.6 million dually eligible beneficiaries. However, FIDE-SNPs, which most closely resemble PACE in terms of beneficiary acuity, care integration and nature of the delivery model, enroll approximately 88,000 individuals – only 5 percent of all dual eligible beneficiaries. (Mathematica Policy Research Presentation, Medicaid Managed Long-Term Services and Supports (MLTSS): How Do Dual Eligibles Fit In? July 2014).