

## PACE AS AN ACCOUNTABLE CARE STRATEGY

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The era of accountable care that has swept into existence with passage of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) has focused national attention on the failure of our health care delivery system to meet the complex needs of dual eligible individuals and of persons with multiple chronic conditions who require constant, intense, and coordinated care. New integrated models of care, including accountable care organizations (ACOs), are being created so providers have greater incentives to be accountable for the total care of their patients.

However, long before the recent interest in accountable care and patient-centered medical homes (PCMH), a provider-based managed care program known as the Program of All-inclusive Care for the Elderly (PACE) has been successfully delivering primary, acute, and long-term care to very frail dual eligible individuals in the community. This program has been operating since the 1980s, initially as a demonstration and later as a permanent Medicare program, and since 1997, as an optional Medicaid program. Today, nonprofit hospitals and health systems are a

major sponsor type for PACE. PACE is recognized as the gold standard of geriatric care. The newly created Center for Medicare and Medicaid Innovation (CMMI) recently awarded 15 grants to states to develop integrated delivery systems for dual eligibles. A number of states, including California, Oklahoma, New York, and Wisconsin, have existing PACE programs and are considering how to use grant funding to expand and innovate the PACE model to care for expanded numbers of dual eligibles.

While ACOs focus on delivering population-based outcomes to the Medicare population, PACE programs are fully accountable for population-based outcomes for the nursing facility-eligible population they enroll.

### *PACE in the States*

- *76 PACE programs*
- *29 states*
- *25 hospital-sponsored PACE programs nationwide*
- *Average Medicaid capitation: \$3,277.08*
- *Average Medicare Part C capitation: approx. \$1,950*
- *Average Medicare Part D capitation: approx. \$450*
- *271 average participants per program*

We believe that hospitals should examine the potential of developing a PACE program to meet the needs of the frailest nursing facility-eligible seniors who enter their hospitals and are cared for in their communities.

This article will explain the nuts and bolts of a PACE program and the reasons for its success as the gold standard of geriatric care and will outline the reasons why hospitals and health systems nationwide should consider developing PACE programs for effectively managing the frailest seniors at home.

### *What is PACE?*

PACE is a comprehensive, fully integrated health care delivery system for frail, older adults. Utilizing an interdisciplinary team approach, PACE organizations provide and manage a full spectrum of services, including preventative, primary, acute, and long-term support services (LTSS), regardless of the type or location of care.

To be eligible for PACE, individuals must be 55 or older; certified by the state as requiring nursing facility level of care; reside in a PACE service area; and be able to live in the community safely with the assistance of a PACE program at the point of enrollment.

For hospital providers that have built their practices around episodic payment, the new realities of readmission penalties and value-based health care will require some changes in the way care is provided. Hospitals and health systems can learn from the way PACE organizations are organized. From an outcomes perspective, the benefits of PACE in reducing hospital utilization and readmissions and, most important, averting permanent nursing facility placement are critical to hospital financial performance. Key to the success of PACE is a focus on the patient and his or her needs without regard for what specific care and services Medicare and Medicaid will reimburse. Focusing on individuals' needs—rather than reimbursable services as a means of treatment and care—not only improves care but lowers costs and enhances service flexibility and patient satisfaction.

PACE is an operational example of what many of the new models of care like ACOs and PCMHs are striving to become. Key features of PACE include:

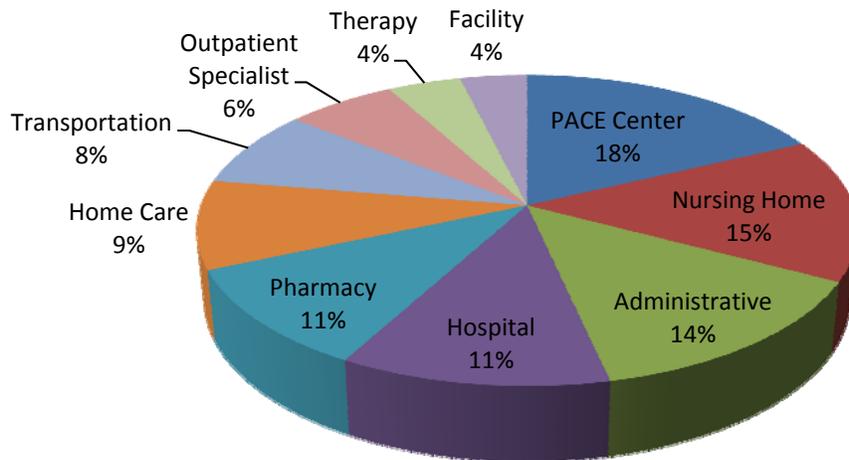
- **Comprehensive and Coordinated Care:** PACE organizations provide person-centered, comprehensive, integrated care using an interdisciplinary team (IDT). PACE IDT members—physicians, nurses, therapists, social workers, pharmacists, health care aides, and others—deliver much of the participants' health care directly, enabling them to monitor changes in participants' health status and respond in a timely manner. The PACE team also is responsible for managing services delivered by contract providers, such as hospital and nursing facility care and medical specialty services.
- **Integrated, Bundled Financing:** PACE programs receive fixed monthly payments from Medicare and Medicaid for individuals enrolled in the program.

These payments are pooled at the program level, providing PACE programs with the flexibility to consider all care options. PACE programs are not restricted by fee-for-service reimbursement requirements, and have strong incentives to proactively address each individual’s 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. PACE programs strive to provide less-expensive preventive and primary care in order to avoid more-expensive hospital and nursing facility care later. Because PACE is the payer for all needed care, including hospital and nursing facility care, the program is accountable for the care it provides throughout the continuum of care.

The chart in Figure 1 illustrates the top ten PACE expenses on a per member per month basis.

**Figure 1: PACE Service Expenses**



### *How Does PACE Achieve the Triple Aim?*

PACE programs have shown they can achieve the goals of the triple aim: improve the experience of care, improve the health of populations, and reduce the per capita costs of health care. The PACE IDT serves as the “integrator” and provides 24/7 care to enrollees and their families to safely and effectively maintain these individuals at home.

PACE participants match the profile of some of the costliest beneficiaries in both the Medicare and Medicaid programs. The comprehensive systems of care offered by PACE programs result in quality outcomes measures, greater independence, and improved functioning in the community, as well as far less need for hospital, emergency room, and long-term institutional care.

### *PACE by the Numbers*

- *PACE participants use fewer than four hospital days per year, on average*
- *Less than 10% permanently placed in nursing facilities*
- *PACE participants attend day center average of three days per week*
- *Disenrollments approx. 6% per year, compared to 9% for Medicare Advantage Plans<sup>i</sup>*

### *What Does the Future Hold?*

Although the PACE model is well-established, to date, PACE programs enroll just over 20,000 individuals. CMMI is seeking to remove some of the regulatory obstacles to PACE and allow PACE to come to scale and serve millions of participants.

Hospitals that have already embraced the strategy of population-based health for the senior population should look to PACE as a model for what both an ACO and patient-centered medical home for nursing facility-eligible seniors can accomplish.

More resources on how to move forward with developing a PACE program are available at [www.npaonline.org](http://www.npaonline.org)

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[www.advanceweb.com/executiveinsight](http://www.advanceweb.com/executiveinsight)

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<sup>i</sup> U.S. General Accounting Office, MEDICARE ADVANTAGE: Characteristics, Financial Risks, and Disenrollment Rates of Beneficiaries in Private Fee-for-Service Plans, 2008