The Program of All-Inclusive Care for the Elderly

LEADING THE WAY IN CARING FOR DUAL ELIGIBLE BENEFICIARIES

Medical Director Essentials Course 2017
Learning Objective

To provide context and an overview of the PACE model of care for Medical Directors new to the Program of All-Inclusive Care for the Elderly.
Historical Focus: The Patient & Interdisciplinary

The PACE Model of Care grew out of a community’s desire to care for their loved ones in a way that did not exist before.

On Lok: “peaceful, happy abode”

A response to the expressed needs of the community by the community

- Culturally sensitive
- Creative
- Interdisciplinary
A Brief Timeline
1970’s

1971 – William Gee, DDS, and 2 others form the Chinatown-North Beach Health Care Planning and Development Corporation.

They hired Marie-Louise Ansak, a social worker from San Francisco General Hospital, to do a feasibility study for building a nursing home in the community. She finds a nursing home to be financially infeasible and culturally inappropriate.

She obtains funds to train community health workers and outlines a comprehensive system of care based on the British Day Hospital model that incorporates housing, all necessary medical services, and social services.

Throughout the 1970’s On Lok develops its model of care.
A Brief Timeline

1980’s

1983 – On Lok is allowed to test a new financing system that pays the program a fixed amount each month for each person in the program.

1986 – Federal legislation extends On Lok’s new financing system and 10 PACE demonstration programs are allowed to replicate On Lok’s service delivery and financing model in other parts of the country.
A Brief Timeline 1990’s

1990 – First PACE programs receive Medicare and Medicaid waivers to operate the programs.

1994 – NPA is formed with On Lok’s assistance. 11 PACE programs in 9 states

1996 – 21 PACE programs in 15 states

1997 – The Balanced Budget Acts of 1997 establishes PACE as a permanently recognized provider type under both Medicare and Medicaid programs

1999 – Interim regulations are published in November. 30 PACE programs in 19 states
A Brief Timeline
2000 to present day

2001 – Alexian Brothers Community Services in St. Louis, MO., becomes the first PACE provider to become a full, permanently recognized part of Medicare and Medicaid programs.

2006 – Final regulations published in November. Congress awards a $500,000 grant to 15 organizations for rural PACE expansion.

Between 2007 and 2013, there is a growth in PACE organizations from 42 in 22 states to 94 in 31 states.

2015 – In June, there are now 113 programs in 32 states. New programs include San Diego PACE, CommUnity Care of Michigan, and Life Armstrong in PA.

2016 – 118 PACE programs are operational in 32 states serving an estimated 38,000 participants. For-profit PACE authorized.

2017 – As of April, 122 PACE programs are operating in 31 states serving over 40,000 participants.
**Medicare**
- Elderly and/or Disabled
- 46 million people
- Total spending: $424 billion
- Administered and financed by federal government alone

**Medicaid**
- Low-Income
- 60 million people
- Total Spending: $330 billion
- Administered and financed by state and federal governments

**Dual Eligibles**
- Low-Income and Elderly/Disabled
- 9 million people
- $261 Billion ($132 B Medicare, $129 B Medicaid)
Challenges of Managing Dual Eligibles

Managing patients with multiple co-morbidities across many health care providers and 2 payers

Fragmented care

Navigating access to care

Multiple care transitions and hand-offs

Care coordination
Challenges of a Broken Health Care System

Skewed financial incentives discourage health care providers and Medicare and Medicaid programs from coordinating their care.

◦ Fee-For-Service payment rewards for increasing volume of visits and procedures

Medicare and Medicaid insurance systems often work at cross purposes

◦ Each program has incentive to shift liability to the other to avoid costs
The 65 and Over Population Will More Than Double and the 85 and Over Population Will More Than Triple by 2050

Figure 1: People with Disabilities and Long-Term Care Needs

One of five Americans has some level of disability, including:

- 45.6 million people who do not require another person’s help with activities of daily living
- 8.8 million people who receive long-term care services in a home or community setting
- 1.5 million residents of a nursing home or other institution

Total US Population = 300 Million


Medicaid is the primary payer for long-term care services.

NOTE: Total LTC expenditures include spending on residential care facilities, nursing homes, home health services, and home and community-based waiver services. LTC expenditures also include spending on ambulance providers. All home and community-based waiver services are attributed to Medicaid.

SOURCE: KCMU estimates based on CMS National Health Expenditure Accounts data for 2011.

Medicaid Long-Term Services and Supports (LTSS) Users Accounted for Nearly Half of Medicaid Spending, FY 2010

NOTE: Individuals who used both institutional and community-based services in the same year are classified as using institutional services in this figure.

SOURCE: KCMU and Urban Institute estimates based on data from FY 2010 Medicaid Statistical Information System (MSIS) and Centers for Medicare & Medicaid Services (CMS)-64 reports. Because the 2010 data were unavailable, 2009 data were used for CO, ID, MO, NC, and WV, and then adjusted to 2010 CMS-64 spending levels.
Figure 6

States Are Pursuing Multiple Medicaid Home and Community-Based Services (HCBS) Options Provided or Enhanced by the Affordable Care Act, July 2014

NOTES: Included options – Money Follows the Person Demonstration, the Balancing Incentive Program, the Section 1915(i) HCBS state plan option, and the Section 1915(k) Community First Choice state plan option
SOURCE: Medicaid.gov and state websites.
State Initiatives to Integrate Medicare and Medicaid Services for Dual Eligibles

Duals are individuals eligible for both Medicare and Medicaid services, who are typically poorer and sicker than other beneficiaries and therefore account for a greater share of spending. Most states with these initiatives are turning to risk-based managed care.

- **Existing program (2012)**
- **Plan to implement in 2013**
- **No current plan**
- **Plan to implement, time uncertain**

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**Maps:**

- **States' Participation Rates for Medicare and Medicaid Managed Care and Application for CMS's Financial Alignment Demonstration**

  - **Participation Rate for Medicare Managed Care**
    - **High**
    - **Low**
    - **None**

  - **Participation Rate for Medicare Advantage**
    - **High**
    - **Low**

  - **Application for CMS's Financial Alignment Demonstration**
    - Predominantly Capitation Model
    - Predominantly Managed FFS Model

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Notes:

- "High" participation means that more than 20 percent of a state's eligible beneficiaries were enrolled in Medicare Advantage plans or Medicaid managed care plans; "low" participation means that 20 percent or fewer eligible beneficiaries were enrolled.

**Sources:**

- CMS = Centers for Medicare & Medicaid Services; FFS = fee for service.
- Three states (New York, Oklahoma, and Washington) proposed testing both the capitation model and the managed FFS model in their demonstration projects. For the purposes of this figure, those states are categorized by whichever model would be used for the larger population of beneficiaries.
Implement a team approach to care

“What we really need is more integration and team care, particularly for serious and chronic diseases. We have a health care system that is focused on episodic care, rather than how to deal with chronic care. As the baby boomers are aging, that’s going to be a huge problem.”

Susan Love, M.D., Surgeon
Susan Love Research Foundation
Quoted in the April, 2015 AARP Bulletin on “Ideas to improve our system of health care”
The Case of CB

62 year old woman, former polysubstance abuser with recurrent exacerbations of HFrEF and COPD

Lives with her 90 year old blind mother who is her primary caregiver, though an aunt manages her care “from a distance”. She does not have decision making capacity.

Referred to McGregor PACE by a major health system where she was labeled as a “super-utilizer” – 20 hospitalizations within the past year.

Established pattern of care: change in condition, call 911, and expect hospitalization

Attendance at PACE Center recommended daily, occurs only occasionally

On a cold winter day, the PACE transport driver picks up CB at home, notes she is wheezing, takes her back inside the home with instructions to call 911. Taken to closest ED. Medical Director supports NP’s decision to seek alternative placement. PACE NP successfully works with ED staff to transfer CB to in-network SNF where she is successfully managed and discharged home 3 days later.

First 90 days in the PACE program: 2 ED visits, 1 hospitalization, 2 direct SNF admission

Team members involved: Van driver, NP, SW, Medical Director
The PACE Model of Care: A Concept Ahead of its Time

The PACE Model of Care

• Addresses problems of a fragmented system focused on acute episodic care

• Integrates primary, comprehensive, coordinated care with community-based long term care services and support

• Employs team-based care

• Places the patient and/or caregiver on the care team

• Brings together Medicare and Medicaid insurance programs while aligning finances with clinical outcomes
Care Transitions within a PACE Program

*Most* care transitions do not occur from hospital to ...

- Caregiver transitions
- Respite transitions
- Housing transitions within the community
- Skilled nursing care transitions
- Long term care transitions
- ED and hospitalizations
- Discharges from ED or hospital to ...
  - PACE Center, Home, SNF, LTC, ALF, Group Home
Hospitalizations in PACE & Comparison Populations (rate/1000 person-Years)

Hospital rates: 539 for PACE YR 1, 547 for PACE YR 2, 352 for Medicare FFS, 719 for DE Medicaid NH, and 962 for 65+ DE HCBS.

30-Day Readmissions Rate (%) in PACE & Comparison Populations

Percent Readmissions within 30 days of discharge

- PACE YR 1: 19.3%
- PACE YR 2: 19.1%
- Medicare FFS: 19.6%
- 65+ HCBS: 22.9%

16%
Rates of Potentially Avoidable Hospitalizations (PAH) per 1,000 Person-Years

**PACE vs. 65+ HCBS**

60%

**PACE vs. DE Medicaid NH Residents**

44%
Factors associated with successful care transitions

1. The Interdisciplinary Team
2. Integrated Plan of Care
3. Communication
4. An engaged PACE Medical Director
Key Factors Associated with a Successful PACE Operation

1. Team-based care
2. Early recognition of a change in condition
3. Immediate access to care

The Medical Director can directly influence this!
References


Kaiser Family Foundation
Medicaid.gov