PACE Overview
An Integrated Model of Care

May 21, 2013

Clark County Commission on Aging
Program of All-inclusive Care for the Elderly (PACE)

An innovative program for serving seniors with complex care needs
Program of All-Inclusive Care for the Elderly (PACE)

The Program of All-Inclusive Care for the Elderly (PACE) provides comprehensive long term services and supports to Medicaid and Medicare enrollees. An interdisciplinary team of health professionals provides individuals with coordinated care. For most participants, the comprehensive service package enables them to receive care at home rather than receive care in a nursing home.

Financing for the program is capped, which allows providers to deliver all services participants need rather than limit them to those reimbursable under Medicare and Medicaid fee-for-service plans. The PACE model of care is established as a provider in the Medicare program and as enables states to provide PACE services to Medicaid beneficiaries as state option.
PACE Eligibility Criteria

• 55 years of age or older
• Live in a PACE service area
• Be certified as eligible to receive nursing home level of care
• Be able to live safely in the community at point of enrollment
• 95% dually eligible
Three-Way Partnership

- Provider Organization (PO)
- Centers for Medicare and Medicaid Services (CMS)
- State Administering Agency (SAA)

PACE
Balancing Services and Dollars

Use Dollars Sparingly
- Hospital
- Emergency Room
- Nursing Home

Use Dollars Generously
- PACE Team
- Home Health
- Day Center
PACE Nationally

- Currently 90 sponsoring organizations in 30 states
- Wyoming added 1/1/13
Examples of PACE in our area

• Providence ElderPlace in King County (WA)

• Providence ElderPlace in Multnomah County (OR)
• Payment features are unique compared to other health care payment models
• Capitated payment system (per member per month)
• Combines funding from multiple sources to meet all participant needs:
  – Medicare Part A & B
  – Medicare Part D
  – Medicaid
  – Private Pay
    (not common)
PACE Center

- On average, participants visit center 2.25 days/week
- Social interventions: meals, activities, exercise, community, spiritual services
- Personal care
- Observation and care environment
- Full-service clinic:
  - Primary care
    (PCP panel = 100)
  - Nursing
  - Rehab
  - Counseling
  - Diagnostics (labs, EKGs, X-rays)
  - Specialists (dental, optometry, podiatry, mental health, massage)
Interdisciplinary Team (IDT)

- Social Services
- Home Care
- Nutrition
- Personal Care
- OT/PT
- Transportation
- Primary Care
- Activities
- Pharmacy*

*Not required IDT member
PACE Critical Success Factors

- Sufficient demand
- Positive market factors
- Strong state support
- Adequate Medicaid payment
- Strong organizational capacity
- Adequate capitalization
Given the challenges with Medicaid reimbursement, meeting these benchmarks will require many partnerships and a great deal of creativity.
Why PACE Now?
Longer-term demographics favor PACE and other programs that support seniors.

<table>
<thead>
<tr>
<th>Geography</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
<th>2035</th>
<th>2040</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washington</td>
<td>827,677</td>
<td>989,124</td>
<td>1,210,895</td>
<td>1,449,119</td>
<td>1,654,289</td>
<td>1,774,401</td>
<td>1,857,527</td>
</tr>
<tr>
<td>Clark</td>
<td>48,710</td>
<td>60,822</td>
<td>76,033</td>
<td>91,612</td>
<td>106,363</td>
<td>116,716</td>
<td>125,863</td>
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<tr>
<td>Cowlitz</td>
<td>15,805</td>
<td>18,591</td>
<td>22,054</td>
<td>25,804</td>
<td>28,469</td>
<td>29,464</td>
<td>29,835</td>
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</tbody>
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The current model of resource allocation in healthcare is not sustainable.
Quality Care Leads to Longer Life Expectancy

“PACE clients have a significantly lower risk of dying, compared to similar clients who receive care in other home and community based service (HCBS) modalities. In the first 12 months after enrollment only 13 percent of PACE clients died, compared to 19 percent of HCBS clients. By year three, 29 percent of PACE enrollees had died, compared to 45 percent of HCBS clients”.

PACE (and similar programs) are the future.

Bottom Line:

- **PACE is the gold standard of care for nursing facility dual eligibles.**
- **PACE is fully accountable for the costs and quality of care.**
- **PACE supports consumers in their desire to remain at home.**
- **PACE allows a provider to meet individual needs without fee-for-service (FFS) restrictions.**
### High-Level Start-up & Implementation Timeline

**By Month**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Start Date</th>
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<tbody>
<tr>
<td>Go/No-go decision</td>
<td>13-Jun</td>
</tr>
<tr>
<td>Develop PACE application chapters</td>
<td>13-Jul</td>
</tr>
<tr>
<td>State review of PACE application</td>
<td>13-Oct</td>
</tr>
<tr>
<td>CMS review of PACE application</td>
<td>14-Jan</td>
</tr>
<tr>
<td>State readiness review</td>
<td>14-Apr</td>
</tr>
<tr>
<td>PACE program agreement executed; program opens</td>
<td>14-Jul</td>
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<tr>
<td>Program serves first participant</td>
<td>14-Aug</td>
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The first PACE participants will be enrolled in July 2014.
Thank You

Questions / Comments?