

PACE: Managed Care for the Frail Elderly

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Managed care, contrary to current wisdom, is not a new concept in care for the frail elderly. As a pioneer in the provision of managed care and the integration of acute and long-term services, On Lok Senior Health Services, in San Francisco, has operated successfully for longer than 20 years. On Lok's model is the prototype for PACE, the Program of All-inclusive Care for the Elderly.

Overview of the Model

Both On Lok and PACE were established in response to the problems in the current system that affect the frail elderly—excessive cost, fragmentation, institutional bias, and lack of financing for community-based services. PACE enrolls the frail elderly exclusively and is the only model that completely integrates services and financing for both acute and long-term care. Currently, 56 organizations in 26 states are at some stage of PACE development—from exploring feasibility to operating fully.

Through the national PACE demonstration project, organizations throughout the United States are proving that the On Lok model of risk-based, long-term care can be replicated in many different communities. The On Lok-PACE model is a fully integrated managed care system for the frail elderly. The model's service delivery system is comprehensive, uses an interdisciplinary team for case management, and integrates primary and specialty medical care with long-term care services. Medicare and Medicaid waivers allow delivery of more services than the usual Medicare and Medicaid benefits.

PACE addresses the needs of long-term care consumers, payers, and providers. Consumers receive comprehensive, humane care and remain at home for as long as possible. Payers are able to control costs, rather than simply shift costs from one payment source to another. Providers can focus on the needs of the frail, older person without concern for traditional restrictions or the pressure to inflate coding in order to maximize reimbursement.

Where PACE Fits in the Continuum of Care

PACE manages the care of the nursing-home-certified segment of the elderly, a population group comprising people who require intensive, ongoing care that cuts across the boundaries of acute and long-term care. Although the PACE population—roughly 7 million individuals—is relatively small when compared with the general Medicare population, its use of expensive care is high. Consequently, serving these individuals effectively and efficiently requires an exceptional level of integration in services and financing.

In contrast, the well elderly comprise the vast majority of Medicare's 37 million beneficiaries. They do not have complex medical needs and can be served adequately through Medicare-risk health maintenance organizations (HMOs) or by other providers that integrate primary medical care but do not attempt to include long-term care.

A third group of older people, generally referred to as the "at-risk" population can be considered as ranked between the nursing-home-certified and the well elderly. These individuals have some impairment, need some supportive care, and may not thrive in the typical Medicare-risk HMO without additional attention. However, focused case management, which improves their access to services, generally can serve their care needs satisfactorily. The at-risk elderly are excellent candidates for healthcare delivery through a social health maintenance organization (S/HMO), which coordinates medical care and limited long-term care services.

From the National PACE Association, San Francisco, CA.

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History of PACE Model Development

The PACE model was developed during the early 1970s in the Chinatown/North Beach area of San Francisco. On Lok established a day health center with grant funding from the Administration on Aging and secured Medicaid funding for it from the state of California in 1973. Recognizing that participants required care after the center had closed for the day, On Lok began adding such services as home care, meals, and supportive housing. In 1978, On Lok began a Medicare demonstration to develop a comprehensive service program integrating acute and long-term care services. On Lok, along with Channeling and Nursing Home without Walls, was one of the original Medicare demonstrations to test community alternatives to nursing homes. The On Lok demonstration showed that participants would accept On Lok physicians, and that costs could be controlled.

In 1983, On Lok began a new demonstration, under Medicare and Medicaid waivers, that maintained the successful service approach, but that entailed the assumption of full financial risk through capitation financing. In 1985, On Lok received an indefinite extension of its waivers. Each year, On Lok not only has operated within the capitation rate but has been able to contribute to a risk reserve fund. In 1986, Congress authorized a demonstration to test the replicability of On Lok's approach at sites around the country. The model exported through the demonstration was named Program of All-inclusive Care for the Elderly (PACE).

Key Components of the PACE Model

PACE is designed to enable the frail elderly to remain in familiar surroundings; maintain their autonomy; and preserve maximum physical, social, and cognitive function. All PACE participants must be at least 55 years of age and certified by the state as requiring nursing home care. They also reside in a defined catchment area.

The comprehensive service package offered in the PACE demonstration includes all Medicare and Medicaid services as well as community long-term care services, with no copayments or deductibles. The integration of acute and long-term-care services enables a single organization to provide the full continuum of services needed for the care of multiple and complex problems. It also provides flexibility in developing a plan tailored to the needs of individual patients.

On enrollment in PACE, a participant is assessed systematically by an interdisciplinary team consisting of the primary care physician, nurse, social worker, rehabilitation therapist, home health workers, and

others. The team is responsible for decisions on service allocation and recognizes that social, emotional, and physical factors interact to affect the patient's healthcare needs. The team provides a continuous process of assessment, treatment planning, service provision, and monitoring and focuses on primary, secondary, and tertiary prevention.

The PACE model includes core services that the team manages (ie, primary care, day health, and home care) and contracted services, such as hospital, nursing home, and specialists. At the PACE center, primary medical care, nursing, social, rehabilitative, recreational, and personal care services are available. For most PACE sites, each PACE center serves 100 to 120 enrollees and has a daily attendance of 50 to 70.

Integrated Financing

PACE receives monthly capitation payments from Medicare, Medicaid, and individuals (ie, participants who are ineligible for Medicaid pay that portion of the monthly fee themselves). Medicare bases its payment on the adjusted average per capita cost (AAPCC) methodology used to reimburse HMOs with Medicare risk plans. For PACE, the AAPCC is multiplied by a single frailty-adjustment factor. In 1995, the monthly Medicare capitation ranged from \$737 to \$1,623 across the PACE sites. The Medicaid portion is negotiated state by state, with each state basing its reimbursement on what it pays for a comparable frail, long-term care population (either home and community-based or nursing home). Medicaid monthly capitation in 1995 ranged from \$1,486 to \$4,465 and provided savings to states of 5% to 15% relative to their costs outside PACE.

These funds are pooled by a PACE site and are used without regard to restrictions or benefits that exist in traditional Medicare and Medicaid systems. Like a Medicare-risk HMO, the site is financially at risk for the services provided. In return for its fixed monthly rate, however, the PACE site provides as much care as is necessary, for as long as is necessary, regardless of the ultimate cost of such care.

Because it cannot shift costs, PACE manages its financial risk by keeping each participant as healthy as possible through aggressive preventive health practices, frequent monitoring of the patient's status in the clinics and day health centers, and prudent use of the team's resources. In this all-inclusive system, built-in safeguards protect against withholding needed services to secure program cost savings. For example, a participant with delicately controlled congestive heart failure must receive appropriate care to prevent clinical exacerbation and a 3- to 5-day hospital stay. That

hospitalization would cost PACE \$5,000 to \$10,000—perhaps three times the individual's monthly capitation reimbursement.

Results to Date

As of the end of 1995, 11 PACE sites operated with waivers from both Medicare and Medicaid. They are located in San Francisco, Sacramento, and Oakland, California; Denver, Colorado; East Boston, Massachusetts; the Bronx and Rochester, New York; Portland, Oregon; Columbia, South Carolina; El Paso, Texas; and Milwaukee, Wisconsin. Their collective census was 2,709 in December 1995, with enrollment growing at an annual rate of about 18%. The 11-site PACE population includes all major ethnic groups (White, African American, Latino, Asian, and Native American). In addition to the 11 dual waiver sites, 8 newer sites operating with Medicaid waivers only had a census of 316.

Disenrollment for any reason other than death has been quite low (less than one person per month per site), indicating a high level of consumer satisfaction. Participants who disenroll usually give as a reason either a desire to return to the care of a private physician or a preference for home care services rather than for day health services. PACE requires enrollees to use the services of PACE physicians only and has emphasized center-based services.

PACE enrollees are frail. In 1995, their average age was 80 years, they had an average of 7.8 medical conditions (each), and 2.7 dependencies in Activities of Daily Living. More than half (55%) had bladder incontinence and 42% were diagnosed with dementia. More than one third (39%) were living alone in the community.

Despite these limitations, however, their hospital use has been low: On Lok's 1995 rate was only 1,200 days per 1,000 persons per year. In comparison, preliminary data indicate that the 1994 rate for the general Medicare population (which includes the well elderly), was 2,448 days. The average length of stay (ALOS) of hospitalized PACE participants in 1995 was 4.9 days compared to 7.6 for the general Medicare population. PACE also has reduced nursing home use. Although all enrollees are certified as eligible for nursing home placement, only 6% of PACE capitation days were nursing home days.

In 1995, 69% of service expenditures were for community services, broken down as follows: center services including primary care (31%), home care (24%), and other medical care (14%). Hospital and nursing home care accounted for 15%, and program administration, including plant operation, for 16%.

Opportunities and Challenges for the Future

The managed care model practiced by PACE is a proven way to meet the complex, changeable health-care needs of the frail older population. PACE is well positioned for the current healthcare environment and demographic trends. Having demonstrated success in managing care for a very difficult population, PACE is attracting the attention of policy makers and providers concerned about other groups, such as frail children, younger disabled people, and people with AIDS.

However, PACE is still far from being a major player even in the area of healthcare for the elderly.

PACE in Action: A Case Example

"Alice Brown," age 95, has outlived her husband and three children and dwells alone in senior housing. As a result of a previous stroke, she has a walking problem and falls often.

As a result of a fall in 1993, Mrs. Brown entered a nursing home for 2 months. She insisted on returning to her apartment but experienced a significant decline in cognitive function and became paranoid. Although a case management program authorized as many as 70 hours of home care weekly for her, she had difficulty keeping workers. Pots and pans left on a burning stove set off her building's fire alarms several times. With Mrs. Brown's eviction near in September 1994, her case manager referred her to On Lok, which she joined.

The On Lok team agreed that home safety had to be improved immediately. To keep Mrs. Brown from using the stove, On Lok provides all her meals and home care three times daily. Mrs. Brown refuses to come to the center as frequently as the team prefers for best oversight but attends once per week.

Recently, late at night, Mrs. Brown fell, fracturing two ribs. Rather than entering a nursing home, however, she spent 1 night in the hospital; under On Lok's care and supervision, she then returned to her home.

On Lok has been able to maintain Mrs. Brown in the community by providing a range of services through an on-call physician. The physician initiates hospital care as soon as it becomes necessary, physical therapy and nursing care in the center the following day, personal care in her home, medication management and monitoring, and delivery of all meals.

The small size of the demonstration has limited its policy significance. Furthermore, the vast majority of PACE enrollees are eligible for both Medicaid and Medicare. PACE has yet to solve the problem of financing long-term care for the middle-income elderly population and, therefore, to attract a sizable private-pay enrollment.

PACE is growing rapidly. Sites are beginning to experience some difficulty in recruiting a sufficient number of qualified physicians, therapists, and home care workers. Accordingly, considerable effort now is devoted to making PACE part of the delivery system.

Legislation has been introduced to move PACE from demonstration status to a provider type. An accreditation mechanism is under development for sites, with the assistance of the Robert Wood Johnson Foundation (Princeton, NJ), and the National PACE Association, the members of which are the PACE sites, has been formed to further the development of the model. Work also is underway to determine how best to link PACE with larger systems (eg, Medicare HMOs and the S/HMOs), and to adapt the model to reach the middle-income and nonurban, frail elderly populations.