Spectrum

Society for Healthcare Strategy and Market Development®

March/April 2013

POPULATION-BASED CARE

Photo credit: Deb Troell

Dr. Terence McCormally, Medical Director, InovaCares for Seniors, discusses patient care with a program participant.

PACE: Community-Based Model Still Leads the Way for Dual Eligibles

A tried-and-true program serves hospitals as a learning laboratory for new kinds of care delivery

Achieving the Triple Aim—improved experience of care, improved health of a population, and reduced costs—has become the mantra of healthcare reform, particularly among organizations that are focused on serving the so-called "dual eligibles," people who qualify for both Medicare and Medicaid. Our healthcare delivery system has failed to meet the complex and costly needs of this population, in particular the overwhelming consumer preference for community-based alternatives to institutional long-term care.

On the journey to value-based healthcare, providers of all types are embracing new Medicare models of care, including accountable care organizations and patient-centered medical homes. In addition, 25 states are moving towards implementing new managed care or financial alignment models specifically for dual eligibles, with the hope of stemming the rise in costs while improving outcomes of care.

However, long before the Affordable Care Act (ACA) spawned such intense interest in these population-based models of care, Programs of All-inclusive Care for the Elderly (PACE) were delivering the full spectrum of care in the community to frail seniors clinically assessed at the nursing facility level of care, 90 percent of them dual eligibles. PACE is recognized as the gold standard of care for this complex population precisely because it achieves the Triple Aim.

(Continued on next page)

Society for Healthcare Strategy and Market Development®

Spectrum is the bimonthly newsletter of and a membership benefit for members of the Society for Healthcare Strategy and Market Development®. SHSMD welcomes unsolicited manuscripts, which will be used on a content and space-available basis. Preferred article length is from 1,200 to 1,500 words, and graphics (figures, tables, photos) and suggestions for sidebars are welcome. Please e-mail articles to shsmd@aha.org.

The editorial office is located at:
155 North Wacker, Suite 400
Chicago, IL 60606
Phone: 312.422.3888
Fax: 312.278.0883
E-mail: shsmd@aha.org
Website: www.shsmd.org

Triple Aim and PACE Preconditions and Goals Comparison

Triple Aim	PACE
Preconditions	
Enrollment of an identified population	• PACE programs enroll nursing facility eligible populations
Commitment to universality for its members	• Total budget for care is the combined Medicare and Medicaid capitation
Existence of an integrator	• PACE serves the role of integrator and accepts full risk and responsibility for providing all services to PACE participants
Goals	
Improve the experience of care	• Participants prefer receiving care in their home rather than being placed in a nursing facility • Caregivers and participants rate PACE high in satisfaction • PACE programs experience low disenrollment rates
Improve the health of populations	• PACE is effective and efficient in treating individuals with multiple chronic conditions • PACE participants live longer than enrollees in a home- and community-based (HCBS) waiver program
Reduce per capita costs of care	• PACE reduces hospital utilization • PACE reduces the need for costly, permanent nursing facility placement • PACE produces savings to the Medicare program
Integrator Role	
Partnerships with individuals and families	• Support provided to individuals and families in order to achieve PACE objectives of community-based long-term care
Redesign of primary care	• Primary and preventative care is a focus of care delivery
Population health management	• PACE programs must consider the appropriate services needed to manage the health of the enrolled population over the duration of enrollment in the program
Financial management	• PACE programs receive one combined capitation per member per month and the costs of care are fully transparent
Macro system integration	• In order to manage a viable program, PACE sponsors utilize evidence-based approaches to care delivery

PACE

(continued from pg 1)

The PACE Model of Care

Beginning as a Medicare demonstration in 1983 and becoming a permanent program in 1997, PACE provides and manages all services needed by enrollees, including preventive, primary, acute, and long-term support services (LTSS), regardless of type or location—and without regard for what services Medicare and Medicaid will reimburse.

Three key features of PACE have led to its success:

- ***Capitated Financing:*** PACE programs receive fixed, combined, monthly payments from Medicare and Medicaid for individuals enrolled in the program, regardless of payer or services utilized. As a result, they have the flexibility to offer the care that is needed, no more and no less.
- ***Comprehensive and Coordinated Care:*** At the core of each program is a PACE

center, where primary care clinic services are provided, and an interdisciplinary team of physicians, nurses, therapists, social workers, pharmacists, van drivers, and others. PACE programs are responsible for meeting participant needs 24/7/365 in all settings in which the participant resides and in which care is delivered.

- ***Accountability:*** PACE programs are fully accountable for the quality and cost of the complete continuum of care provided both directly and through contracted providers. As such, they have the financial incentives to prevent prolonged hospital stays, unnecessary emergency room visits, and premature nursing facility placements.

The Case for PACE in a Health System

All PACE programs must be nonprofit organizations and, while there are a wide variety of PACE sponsors—including long-term care providers and community organizations—hospitals have always been the predominant sponsors. Two examples demonstrate why.

Inova Health System, Fairfax, VA

With five hospitals and more than 1,700 beds, Inova Health System is northern Virginia's leading not-for-profit provider, serving 2 million residents across northern Virginia and the Washington, DC, metro area. Inova sought and received state and Centers for Medicare and Medicaid (CMS) approval to operate InovaCares for Seniors, which opened in May 2012 with one center in Northern Virginia. Future plans call for expansion throughout the northern Virginia service area with multiple PACE centers and/or alternative care sites.

Why PACE?

- PACE targeted a population that accounted for more than its share of heavy service use and readmissions, which Inova knew it could manage better.
- Developing a PACE program provided Inova's first foray into risk-based payment and care management of a population.

How does PACE fit into the system's broader strategy?

- Inova is moving towards a risk-based, population-based health management approach across the system and new models of care for Medicare, Medicaid, and private payers.
- It has entered into partnership with Aetna to serve Medicare-covered lives through an entity called Innovation Health.
- It is applying to Medicaid to become a dual eligible plan in the state of Virginia.

What's next?

- Taking what it learns from PACE and other dual eligible programs, Inova intends to infuse care management throughout its non-PACE products, possibly by placing centers throughout the service area to serve seniors.

Cheyenne Regional Medical Center, Cheyenne, WY

Cheyenne Regional Medical Center (CRMC) is a regional healthcare system serving Cheyenne and southeastern Wyoming, western Nebraska, and northern Colorado. CRMC received state and CMS approval to open a PACE center on January 1, 2013.

Why PACE?

- The CEO sees the program as the ideal model for nursing facility eligible populations, as well as other high-risk populations, and saw PACE as an opportunity to learn more about population-based health.

How does PACE fit into the system's broader strategy?

- The PACE program is housed in a newly created Wyoming Institute for Population Health.
- The Institute is implementing a $14 million grant from the Center for Medicare and Medicaid Innovation to transform primary care across Wyoming through care redesign, care coordination, increased access to primary care, improved care transitions, and enhanced community-based, health-related social service delivery for the comprehensive care of vulnerable populations.

What's next?

- Once the first PACE center is established, the system will explore expansion into rural areas through satellites or other alternatives.

PACE Status Report

- 91 programs in 30 states, caring for more than 25,000 enrollees
- 20+ PACE programs in development
- 38 programs sponsored by hospitals or with hospital partners
- Average enrollment of 282 participants
- Average Medicaid capitation for dual eligibles of $3,343
- Average Medicare capitation of $2,000
- Average Part D payment of $658
- Average total capitation for dual eligibles of $6,000

Looking Ahead

Many hospitals, health systems, and not-for-profit providers along the continuum of care are embracing PACE as an effective, population-based model of care for nursing facility level dual eligibles—and as a learning laboratory for population-based models in general. The ability of healthcare organizations to serve as the integrator in caring for this population is well-established. But there is an opportunity and a need to do more, and healthcare providers and PACE are helping each other adapt to an increasingly complex marketplace.

Written by:

Jade Gong
Vice President of Strategic Initiatives
Health Dimensions Group
Arlington, VA
703.243.7391
jadeg@hdgi1.com
http://healthdimensionsgroup.com/

Anne Lewis
Manager, PACE Advisory Services
Health Dimensions Group
Billings, MT
406.669.3332
annel@hdgi1.com
http://healthdimensionsgroup.com/