McKnight's
Long-Term Care News & Assisted Living

Edo Banach and Jade Gong

November 30, 2015

PACE Innovation Act creates opportunities

When President Obama signed the Program of All-Inclusive Care for the Elderly Innovation Act into law on November 6, 2015, PACE received recognition as high-quality, cost-effective program. Assuming the Centers for Medicare & Medicaid Services moves swiftly to use this broad authority to create PACE pilots, a new world of possibilities is opening for existing PACE providers and other entities interested in improving the delivery of care to high cost, high needs populations.

Jade Gong

Where have we been?

Currently, enrollment in a PACE program is limited to individuals ages 55 and over who meet a nursing home level of care. Once enrolled, PACE provides for the entire continuum of Medicare and Medicaid services through an interdisciplinary team, person-centered planning, and a focus on providing long term support services in a community based setting. The heart of PACE and the key to success is the interdisciplinary care team that knows the patient and family and is responsible for care on a 24/7 basis. By design, the PACE program has great flexibility to meet individual needs which has enabled programs to achieve triple aim goals, including improving the patient experience of care for the frailest and most vulnerable population.

Operating under the current regulations, the PACE community has grown to encompass 116 programs serving approximately 32,000 enrollees in 32 states. While PACE initially began as a demonstration program in 1983, Congress authorized a permanent program as part of the Balanced Budget Act of 1997 after demonstrating sustained success as the first integrated and capitated model of care. Since that time, PACE has achieved several significant milestones:

- 2001 – CMS recognizes first permanent PACE provider
- 2006 – CMS publishes final regulation and CMS awards grants to 15 rural PACE programs
- 2015 – CMS allows for-profit PACE sponsors

Historically, PACE growth has been limited by the constraints of PACE statute, CMS regulations and operational protocols as

well as state policies. CMS is currently revising its PACE regulations, but CMS authority to make broader changes to the PACE model, and specifically to expand it to broader populations, is limited. At the same time, other types of entities, such as Financial Alignment Demonstrations, Medicare Special Needs Plans and ACOs have been pursuing a path of rapid growth and innovation in the post health care reform environment. The PACE Innovation Act can provide PACE providers, and others interested in integrated care, an opportunity to innovate with a provider-driven, community based model of care.

What does the PACE Innovation Act allow?

At a dynamic time for healthcare, the law provides CMS with the ability to expand a proven model of care to serve high cost and high need populations. The law also allows providers and other entities that are not current PACE providers to think about how to adapt the model to serve new populations in innovative ways. Using the approach undertaken by the Center for Medicare and Medicaid Innovation in implementing and adapting other new models of care (such as ACOs and Bundled Payments for Health Improvement, CMMI can now adapt PACE so that it can scale to serve to provide better and more integrated care to high cost and high need populations who require the most coordination and assistance.

Specifically, the PACE Innovation Act provides CMMI with the authority to waive Medicaid requirements— contained in section 1934 of the Social Security Act— that could not be waived without additional statutory authority. Those provisions include the age of the beneficiary to be served and nursing home eligibility as a condition for PACE enrollment. CMS already had authority through section 1115A of the Social Security Act to waive Medicare PACE provisions contained in section 1894 of the Social Security Act but did not have similar Medicaid authority until passage of the PACE Innovation Act.

What should you be doing now?

In anticipating this opportunity, the PACE community has been considering how to adapt the model to serve new populations, including:

- Persons under the age of 55 with disabilities, using a modified PACE model of care
- Persons over the age of 55 but who are not yet nursing home eligible, using a less intensive PACE model of care

In particular, there are tremendous benefits to persons who are Medicare-only and not yet Medicaid- eligible to enroll in a PACE program. These beneficiaries gain access to community based LSTSS and in turn states will be able to avoid or delay Medicaid spend down. Under current PACE regulations, these individuals were required to pay the full Medicaid rate in order to enroll in PACE, which resulted in very few Medicare-only enrollees in PACE.

At this time, all providers interested in serving high cost and high need populations with integrated models of care should actively consider the following questions:

- If you could organize care in a different way, what would it look like?
- What aspects of care are important to the population you wish to serve?
- What aspects of the current PACE regulation should be more flexible and should be waived?
- What aspects of the current PACE regulation are fundamental to PACE success and should remain in place?
- Who should my organization partner with to deliver this innovative PACE model of care and scale quickly and effectively?
- What quality measures are most relevant for our target populations and how should we measure success to all parties?

- How can the PACE expansion contribute to improving the delivery of LTSS to all persons needing care in our communities and lead to priority reinvestment in the community's infrastructure for LTSS delivery?

Stakeholders and providers serving these vulnerable populations should not wait until CMS/CMMI issues its formal request for proposals. As Dr. Seuss said, “[o]nly you can control your future”. So let's plan now so that we can shape this exciting opportunity.

Edo Banach is partner at Gallagher, Evelius & Jones. Jade Gong is principal at Jade Gong and Associates.