

Are CCRCs and PACE a Good Fit?

While Programs of All-inclusive Care for the Elderly (PACE) have been around since the early 1970s, the program is experiencing record growth and many CCRCs are jumping on board with this innovative skilled care product. More and more CCRCs are analyzing the merits of the PACE model as a viable option to serve a broader array of seniors and perhaps improve its bottom line along the way. In this article we will provide a brief summary and overview of the history of PACE while also discussing why CCRCs may be interested. In addition, we detail a visit with Alexian Brothers in Tennessee to provide a firsthand account of how PACE works both operationally and financially.

What is PACE?

PACE is a capitated managed care program that is innovative in that it focuses on allowing individuals eligible for nursing home care the ability to continue to live in the wider community (outside of a skilled nursing facility). PACE serves individuals who are age 55 or older and have been certified by their state to need nursing home care but who are able to live safely in the wider community at the time of enrollment. The core principal of PACE is modeled around the belief that it is better for the well-being of seniors with chronic care needs, and their families, to be served in the wider community whenever possible.

History of PACE

The PACE model of senior care originated in the early 1970s in an effort to help the Asian-American community in San Francisco care for its elders in their own homes. A group of community leaders felt nursing homes were not a culturally acceptable solution to care for the elderly and decided to form a non-profit corporation, On Lok Senior Services, to create a community-based system of care. Even though On Lok was successful, the growth of community-based care was slow and by the end of 1996 only 21 PACE programs existed in 15 states nationwide.

The catalyst for significant growth occurred with the passing of The Balanced Budget Act in 1997, which established the PACE model as a permanently-recognized provider type under both the Medicare and Medicaid programs. Today there are 75 PACE programs operational in 29 states and while this represents significant growth, assuming each program has 200

participants (a conservative assumption), PACE is currently only serving about 15,000 seniors today.

Why CCRCs and PACE?

PACE programs are a three-way partnership between a provider, the state and the federal government. PACE programs are sponsored by a variety of different non-profit organizations but primarily by healthcare systems, community health centers or long-term care providers.

It seems counterintuitive that an industry that is dependent on welcoming new residents into their facilities (CCRCs) would embrace a program that strives to keep older adults living in the wider community. While on the surface this might appear to be a conflict, there are several reasons CCRCs are often interested in being involved in a PACE program. The most apparent is the ability for a non-profit CCRC to grow, enhance and fulfill its mission of providing quality care to seniors in need. While there are no eligibility requirements to participate in PACE, most seniors utilizing the program are Medicaid eligible. This combined with the fundamental principal of PACE, which is to keep participants out of a nursing home (less than seven percent of PACE participants reside in a nursing home), would allow CCRCs to serve a population they would likely never be able to serve otherwise. Another attractive attribute of PACE is economic and a large majority of programs nationwide are financially successful. As CCRCs strive to find alternative revenue sources, they are increasingly looking out into the local community for ways to generate income. Home Health Agencies and PACE programs are two business lines that allow CCRCs to further their mission by providing services to a broader market while also improving their bottom line.

PACE Financial Model

The PACE program does not have a complicated financial model. PACE revenue consists of a monthly lump sum payment from Medicare combined with either Medicaid or a participant's private pay resources. PACE expenses include the costs to provide all healthcare needs as long as the participant is in the program. This care includes: primary care, hospital care, prescription drugs, nursing home care, emergency services, physical and occupational therapy, adult care, dentistry, social

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work counseling and transportation. PACE also includes all other services determined necessary to improve and maintain the participant's overall health. The financial goal of PACE providers is similar to that of any business in that the cost of providing care to participants is less than the capitated payment it receives.

In a unique way, the financial objectives of the PACE program and the care needs of the participants they serve are aligned. In the more common Medicare and Medicaid traditional fee-for-service programs, care providers are often limited to what services they provide based on whether or not they will be reimbursed for providing this care. In PACE if a participant is in need of a service that will eliminate or prevent an adverse health condition, the program is incented to provide this care and is not concerned or restricted about whether or not it will be reimbursable in the traditional fee-for-service system. For example, a Medicaid beneficiary shows up at a primary care center or emergency room every month to be treated for skin infections likely caused by insect bites. The traditional care delivery system would treat the condition, with no mandate to identify the root cause. For a PACE participant, the care team, with specific input from its social workers, home health aids and drivers who have been in their home, may decide to fumigate the home and provide treatment for their pets. The ability to not only treat the current condition but also eliminate the root cause allows for a more cost effective solution and a higher quality of life for the participant on a long-term basis.

PACE Enrollment and Disenrollment

Enrollment in the PACE program is voluntary. If a participant meets the eligibility requirements and chooses PACE, an Enrollment Agreement is signed. The eligibility requirements vary from state to state, but the typical profile of a PACE participant is: 80 years old (74% 75 or older), female (75% are female) and approximately eight existing medical conditions.

A participant's enrollment in the program is effective on the first day of the calendar month following the date the PACE organization receives the signed Enrollment Agreement. A PACE participant has the option for voluntary disenrollment at any time. A participant can also be involuntarily dis-enrolled. This is an infrequent occurrence and is generally related to

the participant either moving out the PACE service area, the participant not following the care plan provided or the participant engages in disruptive or abusive behavior.

How is PACE Care Delivered?

Perhaps the most intriguing aspect of PACE is the method for which it accomplishes its goals. Intuition would suggest that a successful PACE program would strive to admit the least care-intensive participants possible. However, many PACE providers argue that the key is not the health condition of participants at enrollment but rather the infrastructure, program and people in place to provide services. While difficult to comprehend the degree to which PACE can be effective, it was quickly apparent in touring Alexian Brothers Community Services PACE Center in Chattanooga, Tennessee with Dan Gray of Continuum Development Services (CDS).

Alexian Brothers is one of the largest and most successful PACE programs in the country and Mr. Gray is a leading PACE consultant. "We quickly found at Alexian Brothers that the key to our success would have little to do with financial metrics but rather utilizing PACE fundamentals to provide quality care," said Mr. Gray.

A key component of PACE is the PACE Center. PACE programs typically serve 150 participants and include an approximately 15,000 square foot center. Alexian Brothers provides services to 325 participants in a super-site (with two teams). PACE centers include a health clinic with an on-site physician and nurse practitioner. In addition, PACE sites include physical and occupational therapy programs and at least one common room for social and recreational activities. The typical PACE Center is open from 6:30 a.m. to 6:30 p.m. and is visited by participants an average of three times per week.

A typical day for a PACE participant starts with the arrival of transportation to the PACE center. While some PACE participants are dropped directly at the center by their primary care giver, many arrive via PACE transportation. Transportation for PACE participants is a covered benefit and is critically important to the overall care plan. Alexian Brothers has over 30 vans, each capable of holding up to 10 people per van. In addition to providing participants a means to get to and from the community to the care center, the transportation program

allows essential insight into the lives of participants. The driver of a PACE van is much more than simply a transporter. A driver has frequent access to the living conditions of a participant and is often the first to know of potential care issues.

In addition to being the hub of PACE activities for participants, PACE Centers also serve as the primary work area for the interdisciplinary team. The interdisciplinary team includes, but is not limited to, the center's director, as well as physicians, nurses, social workers, therapists and drivers. Every morning the team meets to discuss the day's events and programs.

Sitting in on the daily team meeting at Alexian Brothers was fascinating. It was startling to witness the input of so many different disciplines. For example, in general discussion the activities coordinator noticed that a participant's clothes had been extremely dirty the last couple of visits and that this was unusual for this participant. A social worker responded that she and the participant's PACE driver had both noticed this as well. The driver informed the group that he was concerned because the participant's dirty laundry was stacked higher than normal in his room and that there could be a potential problem with in-home care. The team decided that the social worker would visit the participant at home with his primary caregiver present to discuss the problem and see what, if anything, needed to be done.

In addition to discussing any immediate needs a participant may have, the daily team meeting also provides the forum for which to conduct routine reviews of each participant. On a periodic basis that varies for each participant, there is a complete review of the participant's health status. The doctor and nurse review specific health issues, the dietician reviews any weight changes and diet recommendations, the social worker reviews in home care issues and overall participant behavior, the driver discusses any issues they are aware of, and it continues to each member of the team.

Nursing Home Care

A frequent concern regarding PACE programs is what happens to a participant when he can no longer live independently. The principal goal of PACE is to allow participants to live independently in the wider community, but in some instances a participant needs more care than can be provided at the home.

In these cases, the interdisciplinary team discusses the care needs of the participant and determines whether or not a nursing home stay is needed. If the team believes the level of care needed cannot be provided by a combination of the PACE center and home services, the team meets with the participant and the primary care provider to discuss a transfer to a nursing home.

Should a participant need nursing home care, they do not disenroll from PACE. Typically a nursing home stay is preceded by a hospitalization, but whether or not it is related to a specific occurrence or gradual decline in health, it is the PACE program's responsibility to provide a viable nursing home option. All PACE programs have a relationship with a nursing home to provide this level of care but the team continues to follow the participant, whether in the hospital or nursing home. Some PACE programs, Alexian Village for example, actually employ caregivers at the nursing home specifically to meet the needs of its PACE participants.

As stated earlier, while PACE participants tend to be extremely frail, only seven percent live in nursing homes.

Are CCRCs and PACE a good fit? – ABSOLUTELY

Consider this: A multi-site senior living provider recently had to replace an existing 40-year old 60-bed nursing home. In keeping with industry trends and to meet market demands, the institutional nursing home is being replaced with three 20-bed residential style buildings. The cost of this project is approximately \$7.5 million. This same provider recently received approval by the state to develop PACE in four counties with two PACE Centers serving 350 participants. The projected cost to initiate PACE and cover start up losses is \$7 million. In addition to costing less and serving many more seniors, the estimated financial profits associated with PACE far exceed those expected by the nursing home.

While unique and unconventional in many respects, PACE is an effective way for a CCRC to expand its mission by serving a senior population in need with manageable upfront capital needs and significant income potential. ■