

INTERIM REPORT TO CONGRESS

**THE QUALITY AND COST OF THE
PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY
(PACE)**

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INTRODUCTION

Section 4804(b)(1) of the Balanced Budget Act (BBA) of 1997 requires the Secretary to report to Congress on the impact of the PACE program on quality and cost of services. This interim report responds to this statutory requirement. The report also requires the Secretary to include specific findings associated with the treatment of private, for-profit providers (see sec. 4804(b)(2)). Specific findings, however, of the private, for-profit providers are not yet available since the for-profit demonstration is still in process (the first site did not begin operations until July 2007). This demonstration will operate through July of 2010. The impact of the BBA amendments to the PACE program on quality and cost of services follows.

BACKGROUND OF PACE

In the 1970's the federal and state governments became increasingly interested in moving states' long-term care systems away from the reliance on institutional care and toward the development of community-based services. As a result, federal Medicaid waivers allowed state governments to experiment with fee-for-service programs for frail elderly and disabled beneficiaries. One such program was the Program of All-inclusive Care for the Elderly (PACE),

which was conceived and refined at On Lok in San Francisco. On Lok enrollees were among the frailest elderly in the community, those considered most at risk of otherwise needing institutional placement to receive long-term care services. A demonstration of the On Lok model was initiated in 1991. By 1992, there were ten PACE replication sites. The demonstration operated until PACE was established as a permanent Medicare program by the Balanced Budget Act (BBA) of 1997. The BBA authorized the coverage of PACE under the Medicare program and established PACE as a state plan option under Medicaid. As of November 30, 2008, there were 51 PACE plans in 18 states.

Most of the features of PACE continued from the demonstration into the permanent program, including the focus on the targeted population, the frail elderly, and the capitated funding mechanism. To be eligible for PACE services, a beneficiary must be at least 55 years of age, a resident in a PACE organization's geographic service area, and certified by the state Medicaid agency as being eligible for a nursing home level of care. Eligible beneficiaries who choose to enroll in PACE agree to forgo their usual sources of care and receive all their services through the PACE organization.

The key features of the PACE model include the following:

- As a Medicare program and a Medicaid state plan option, PACE organizations receive two capitation payments per month for dually eligible participants. In exchange, PACE organizations assume full financial risk for all the health care services enrollees use.
- PACE services are provided by interdisciplinary teams. Teams assess the needs of each PACE enrollee, coordinate the delivery of services, and meet frequently to review individual cases. PACE enrollees agree to receive all their care from the PACE team.

- The locus of PACE activity is the PACE center. PACE center attendance is meant to promote socialization on the part of participants, alleviate caregiver burden, and help the team monitor enrollee's health and functioning.

Interdisciplinary teams continually assess participants' needs for PACE-covered benefits, develop customized care plans, and provide all the benefits included therein, either directly or through contractors. Except for care delivered at home, in inpatient hospitals, in nursing facilities, and medical specialist offices, most benefits are provided in the adult day health centers run by PACE organizations. Day center attendance provides a social opportunity for enrollees while giving staff the opportunity to observe and address problems before complications develop.

IMPACT ON QUALITY

A survey of PACE demonstration enrollees in the mid 1990s found that 64 percent were very satisfied with PACE services (Chatterji, 1998). Consequently, the expectation for quality and satisfaction in the permanent program was very high. Key features of the PACE program are designed to be potentially quality-enhancing. PACE utilizes an interdisciplinary team, responsible for assessing, planning, and providing needed services, and PACE payments are entirely capitated, which allows sites flexibility in providing care. These features are intended to enable each PACE team to meet the needs of participants as it deems necessary. Each PACE program is required to continually monitor the health status of enrollees, such as when providing home care and when enrollees attend the PACE center.

PACE enrollees were compared to participants in programs that similarly strive to maintain the frail elderly, who are nursing home-certifiable, in the community. These programs are the Medicaid Home and Community-Based Services (HCBS) section 1915 waiver programs. Where available, HCBS programs are considered a viable alternative to PACE, except that HCBS programs do not include institutional long-term care services. HCBS programs are not identical to PACE in terms of services and treatment philosophies. Inter-disciplinary teams that manage and provide care, a hallmark of the PACE model, are not part of the HCBS delivery model. HCBS programs are paid for services on a claims basis; consequently, non-covered services cannot be provided. Because of the capitated payment structure, PACE organizations can support services not available to HCBS participants. Upon admission to a nursing facility for long-term care, HCBS participants must leave the program, whereas PACE enrollees continue in the PACE program. The requirement to provide long term institutional care results in an additional financial incentive for PACE organizations to maintain the health of their enrollees.

To compare outcomes of people enrolled in PACE and in the HCBS comparison group (located in states with PACE organizations), participants in each group were interviewed in two surveys in 2005 and 2006. Results of these surveys indicate that compared with HCBS enrollees:

- PACE enrollees had better health management outcomes – they were more likely to have end-of-life documents in place, reported less pain that interfered with normal daily functioning, and were less likely to report unmet needs in getting around and dressing, (two activities of daily living);
- PACE enrollees were more likely to have received hearing and vision screenings, a flu shot, and were more likely to have ever received a pneumococcal vaccination;

- PACE enrollees reported higher levels of health status and fewer indicators of depression during the first survey, but PACE respondents were more likely to have exhibited certain behavioral problems.

Most HCBS participants and PACE enrollees reported satisfaction with their quality of life and the quality of care they received over the study period. The financial incentives of a capitated payment system and the requirement to provide long term institutional care are consistent with the higher quality levels generally reported by PACE enrollees.

One limitation of these analyses is that differences attributed to PACE may reflect other unmeasured differences between the PACE and HCBS comparison groups that persist despite attempts to adjust for sources of selection bias. To determine if such differences influenced the findings, sensitivity analyses were used to confirm the robustness of the survey results. Another limitation is that the measures were limited to data that could be collected in participant surveys. Measures of clinical quality of care and caregiver outcomes, for example, could not be directly assessed as part of this report.

IMPACT ON COST

PACE organizations are required to accept monthly capitation payments from Medicare, Medicaid, and private sources. This type of financing is intended to allow providers the flexibility to deliver all health care-related needs of participants. A relevant policy question is how the capitation payment compares with what would have been paid in the absence of PACE, i.e., if the beneficiaries remained in the traditional fee-for-service (FFS) system.

A comparison of capitated payments was made to PACE organizations with expenditures projected as if their enrollees remained in traditional Medicare and Medicaid programs under a FFS arrangement. For Medicare, a comparison was made for the first 60 months after enrollment into PACE in 1999 or 2000; for Medicaid, the comparison could only be made for the first 24 months after entry because of data limitations.¹

We found little difference between the Medicare capitated payments to PACE and predicted Medicare expenditures that would have been incurred in the absence of PACE for the beneficiaries who entered PACE in 1999 or 2000 in nine study states. This suggests that the capitation payments for Medicare were set appropriately (at the projected FFS levels) over the 60 month review period.

The analyses also suggest that PACE was associated with higher Medicaid payments than would have been experienced in the absence of PACE over the 24 month review period. However, the abbreviated study period likely did not include long-term care nursing home and other institutionalization costs, costs that would be normally incurred by Medicaid later in a person's care trajectory. The difference between the Medicaid capitated rates and projected expenditures was \$926 per person per month in first 6 months, versus \$536 per person per month in the last six months of the review. This decline suggests that higher expenses, possibly long term nursing home care, were entering the analysis as participant's age. Thus, the adequacy of the Medicaid capitation rates cannot be measured reliably for periods that extend beyond the

¹ Note that the sample and timeframe in the cost evaluation (1999-2003/4) differs from that of the quality evaluation (2005-6) because of timing issues primarily involving access to Medicaid data.

24 month period.

While the HCBS comparison groups were chosen to be similar to PACE enrollees, there is no absolute guarantee that the expenditures of HCBS participants will accurately predict the costs for PACE enrollees. Unmeasured differences in factors such as functional and cognitive limitations between participants, the extent of home support available, and differences in enrollee motivation to remain in the community, may account for some of the unobserved differences in the programs.

CONCLUSION

Most HCBS participants and PACE enrollees reported satisfaction with their quality of life and the quality of care they received over the study period. Survey results indicate that compared with HCBS enrollees:

- PACE enrollees had better health management outcomes – they were more likely to have end-of-life documents in place, reported less pain that interfered with normal daily functioning, and were less likely to report unmet needs in getting around and dressing, (two activities of daily living);
- PACE enrollees were more likely to have received hearing and vision screenings, a flu shot, and were more likely to have ever received a pneumococcal vaccination;
- PACE enrollees reported higher levels of health status and fewer indicators of depression during the first survey, but PACE respondents were more likely to have exhibited certain behavioral problems.

These findings are subject to several limitations including the effect of unmeasured differences between the PACE and HCBS comparison groups and to the data that could be collected in participant surveys.

There was little difference between the Medicare capitated payments to PACE and the predicted Medicare expenditures that would have prevailed in the absence of PACE for the beneficiaries who entered PACE in 1999 or 2000 in the nine states studied for this report. This suggests that the capitation payments for Medicare were set appropriately at the projected FFS costs over the 60 month study period. Using a simple extrapolation approach, this finding should not change when the transition to a full capitated rate system is completed in 2008.

The analyses also suggest that PACE was associated with higher Medicaid payments than would have been experienced in the absence of PACE over the 24 month review period. However, the abbreviated period likely did not include long term care nursing home and other institutionalization costs, costs that would be normally incurred by Medicaid later in a person's care trajectory. The difference between the Medicaid capitated rates and projected expenditures was \$926 per person per month in first 6 months, versus \$536 per person per month in last 6 months of the study. This decline suggests that higher expenses, possibly long term nursing home care, were entering the analysis as participants' age. Thus, the adequacy of the Medicaid capitation rates cannot be measured reliably for periods that extend beyond the 24 month period reviewed for this report.

The cost impact of PACE depends on the assumptions made about alternative placements. If most enrollees would have otherwise have entered HCBS or other community-based programs, the results suggest that PACE may lead to higher Medicare and Medicaid spending, at least within the short time frame reviewed. If, however, most PACE enrollees

would have entered nursing homes in the absence of PACE, then PACE leads to Medicare and Medicaid savings.

While the selected comparison group was chosen to be similar to PACE enrollees in terms of measures that were available from administrative data sources, there is no absolute guarantee that the two groups are equivalent in terms of other factors, such as functional and cognitive limitations, extent of home support, and motivation to remain the community. To the extent that beneficiaries who enter PACE rather than HCBS differ in ways that could not be measured and are related to expenditures, the projection of PACE expenditures could be biased.

REFERENCE

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