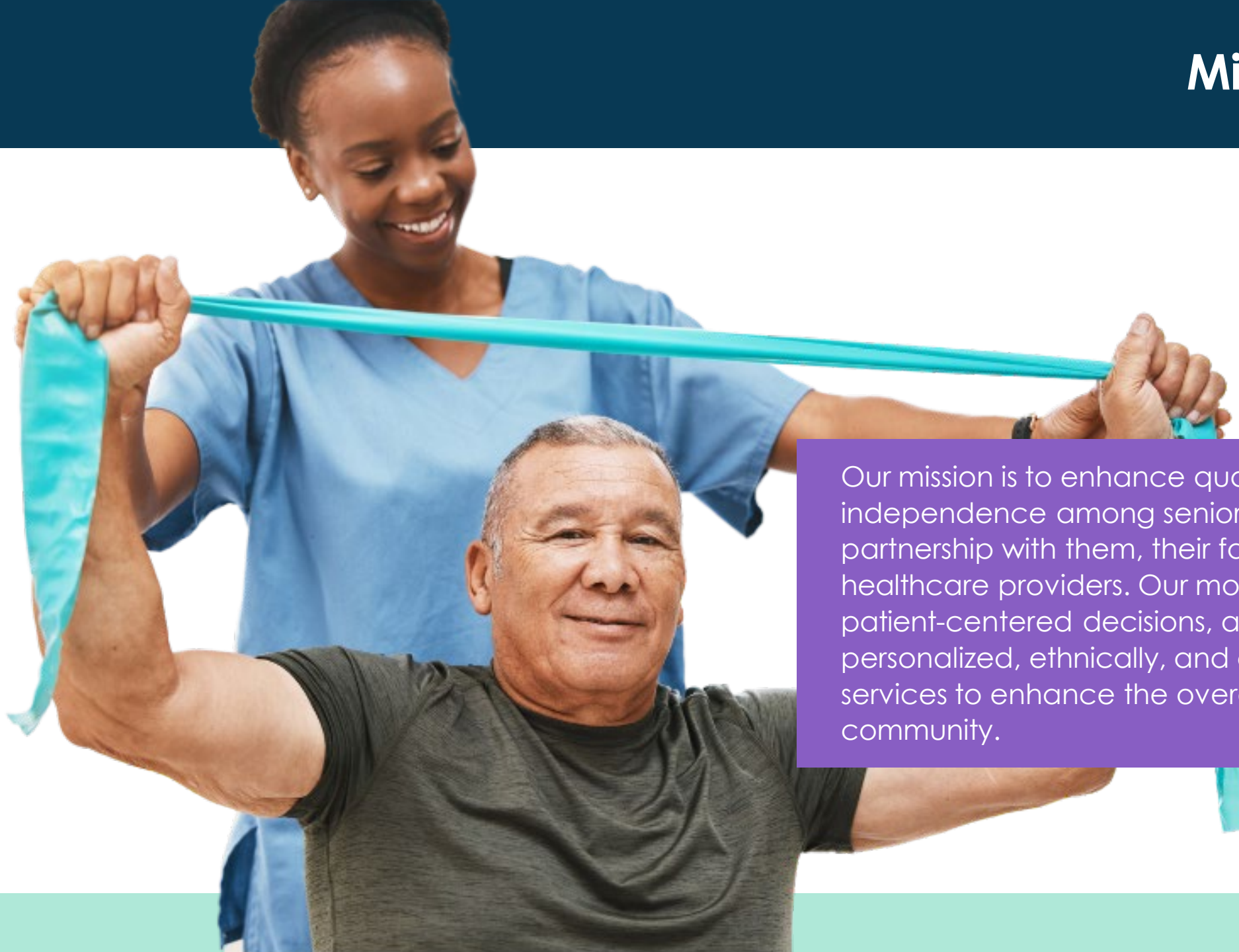
New Mexico

Senate Health & Public Affairs

November 28, 2023

PACE Program

Mission Statement



Our mission is to enhance quality of life and foster independence among seniors in the community through partnership with them, their families, caregivers, and healthcare providers. Our model of care prioritizes patient-centered decisions, along with high quality, personalized, ethnically, and culturally sensitive care and services to enhance the overall health of the community.

The Program of All-Inclusive Care for the Elderly (PACE)

- PACE, or the Program of All-Inclusive Care for the Elderly, is a fully-capitated healthcare program designed to help individuals whose health has deteriorated to the point of needing nursing home care remain in their home and age-in-place.
- The PACE model takes a holistic approach towards a participant's wellness, developing comprehensive care plans for some of the sickest and most vulnerable members of the community. PACE providers are responsible for ALL aspects of a participant's well-being, from medical to mental to social
- PACE is funded through a special federal statute whereby the PACE Organization, the State Administering Agency and CMS enter into a three-way agreement

Three-Way Agreement

To qualify for PACE, an individual must be:

- At least 55 years old
- Eligible for nursing facility level of care
- Ability to live safely in the community at home (or in assisted living / senior housing) at the time of enrollment
- Physically reside in location that is served by a PACE program

Most PACE participants pay little or no cost, dependent upon their financial condition and eligibility for Medicare and/or Medicaid Services

Participant is	Participant Cost
Eligible for Medicaid Only	No Cost*
Eligible for Medicaid and Medicare	No Cost*
Eligible for Medicare Only	Responsible for Medicaid portion, as well as monthly premium for prescriptions
Not Eligible for Medicaid or Medicare	Self-pay rate

The PACE Care Model

- The PACE care model is one of the most effective, innovative, accessible, and valuable models of care, promoting the highest possible level of independence for seniors with significant health-care needs.

- A successful PACE Program uses a holistic approach to meeting participant's healthcare and wellness needs in both social and medical settings, as determined by their interdisciplinary care team, allows them to age in the comfort of their own homes or other appropriate settings through a fully integrated person-centered approach to care.

Who We Serve & Benefits of PACE

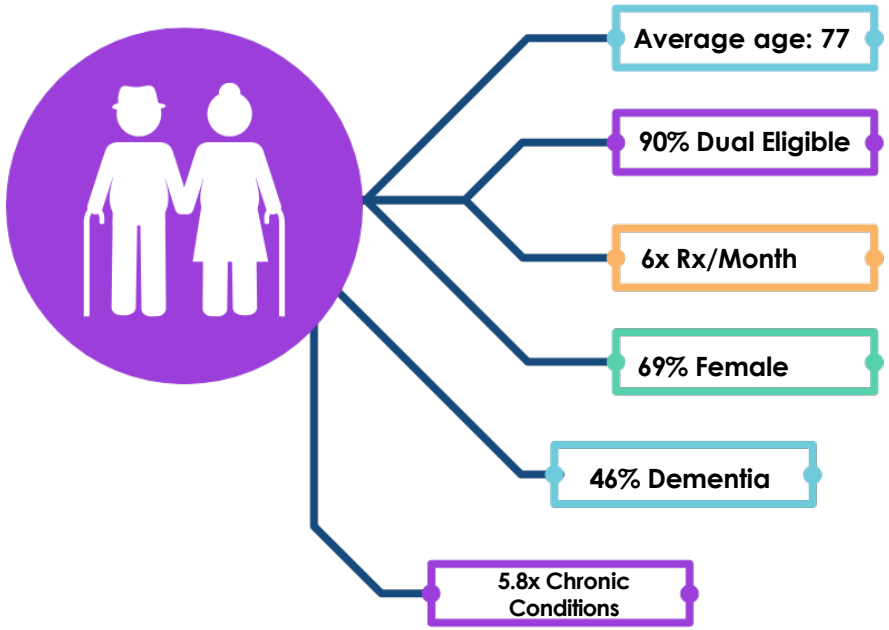
The PACE model provides for the one of the most advanced coordinated care models, incorporating primary care, support services (rehab, physical therapy, etc.) and wraps non-traditional care components such as transportation, specialty care, social care, social determinants of health, home care, pharmacy and others to provide a truly comprehensive care model

As the number of seniors continues to increase, so has demand for programs that will help individuals maintain their level of independence including aging in place as well as institutional settings based on their level of need.

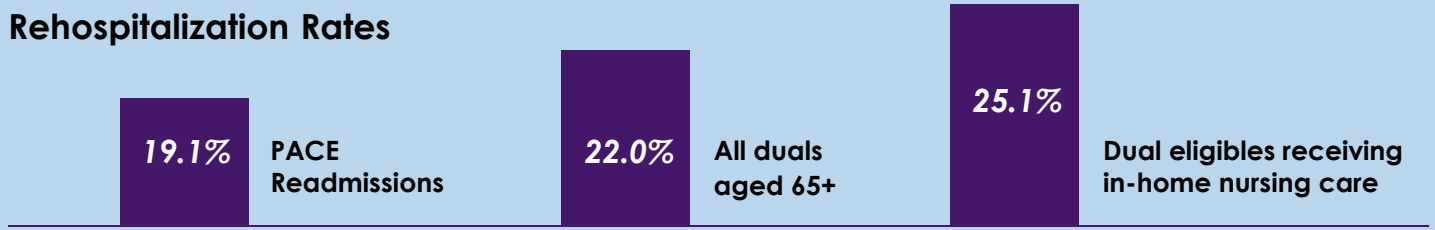
95% of PACE participants live in the community

97.5% of family caregivers would recommend PACE

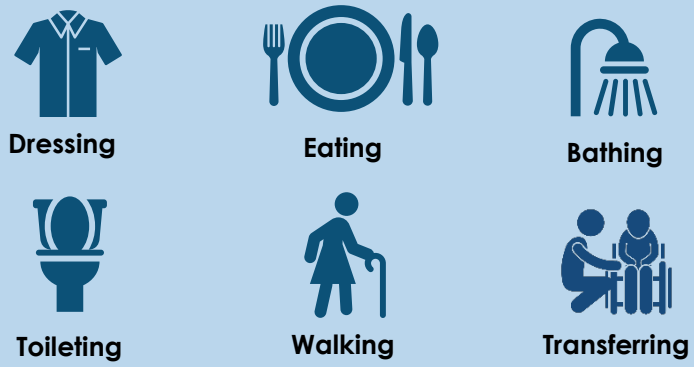
Snapshot of a Typical PACE Participant

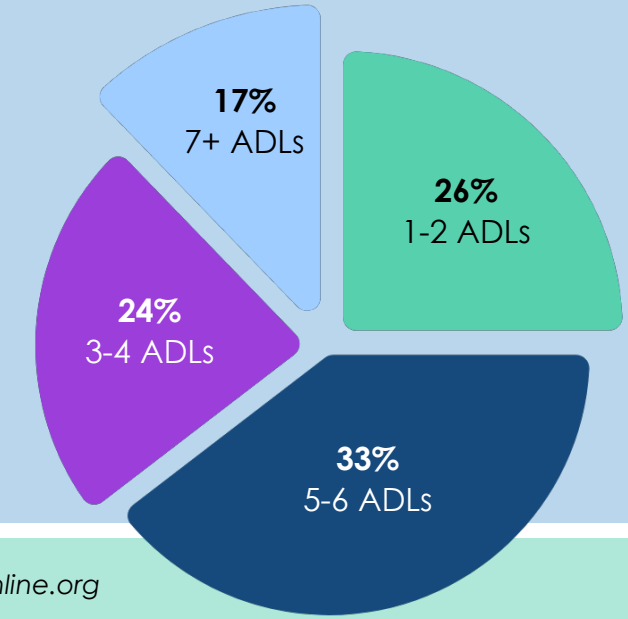


Rehospitalization Rates



Challenges with Activities of Daily Living





Source: NPAonline.org

Strengths & Core Values of a Successful PACE Program.

Trusted

Gaining support, trust of the community and our participants families are paramount to our success

Community

Improving a participant's surroundings and broader community drive improved quality of living

Commitment to Care

Commitment to treat all members, irrespective of Medicaid, Medicare, private pay with the highest quality care

Leadership

Our leadership team has extensive experience in PACE with track records for building world class PACE and other care programs for the elderly

Successful PACE program enable seniors to age gracefully, delivering high quality care at the right time in the right setting.

Service Coverage

PACE covers all Medicare and Medicaid services AND any other service as approved by the Interdisciplinary team. Services may include:

- Specialist
- Dialysis
- Home Delivered Meals
- Durable Medical Equipment
- Adult Day Center
- ER and Hospital
- Long Term Care / Skilled Nursing
- Transportation
- Dental / Vision / Hearing
- Pharmacy
- Pest Control
- Home Health – skilled and unskilled
- Homemaker services
- Home modifications
- Medication Administration
- Primary Care
- Physical / Occupational Therapy
- Case Management
- Behavioral Health / Counseling
- Medical Supplies
- OTC Medications

Claims and payment come directly to the PACE *program*. Medicare and Medicaid DO NOT get billed for PACE participants.

Participant-Centric, Integrated Care Model

IDT Assessment

- Initial and periodic assessments performed
- Review of prescriptions, dietary requirements, fall risk, home safety, etc.
- Preventative care to help keep participants in their home is the focus of the PACE Model

Plan of Care/Care Coordination

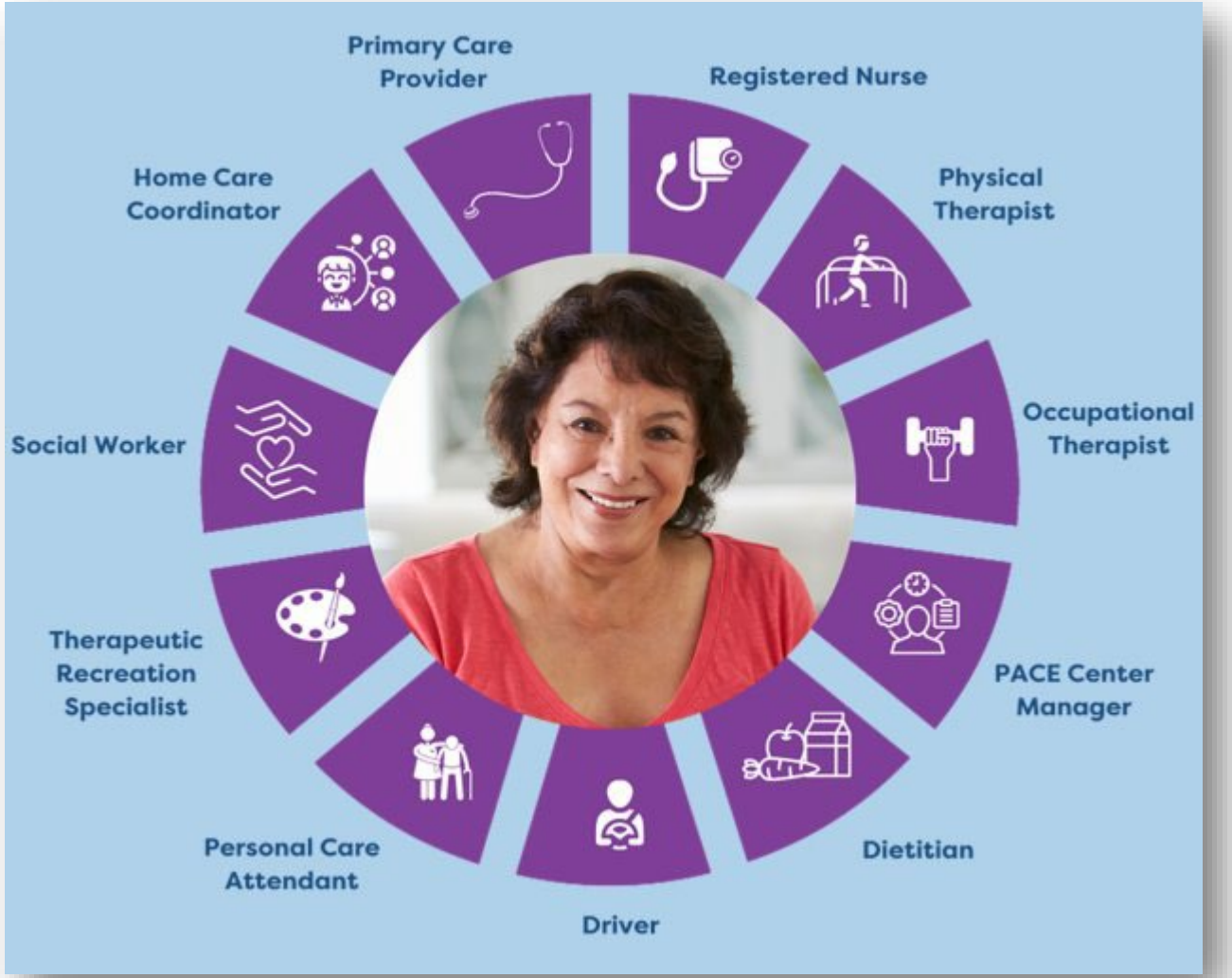
- Unique care plans created for new participants in collaboration with the participant and caregivers
- Update Care Plan for existing participants

IDT Daily Roundup

- Team meets daily to discuss participants
- Each member has an equal voice
- Upcoming participant events address concerns

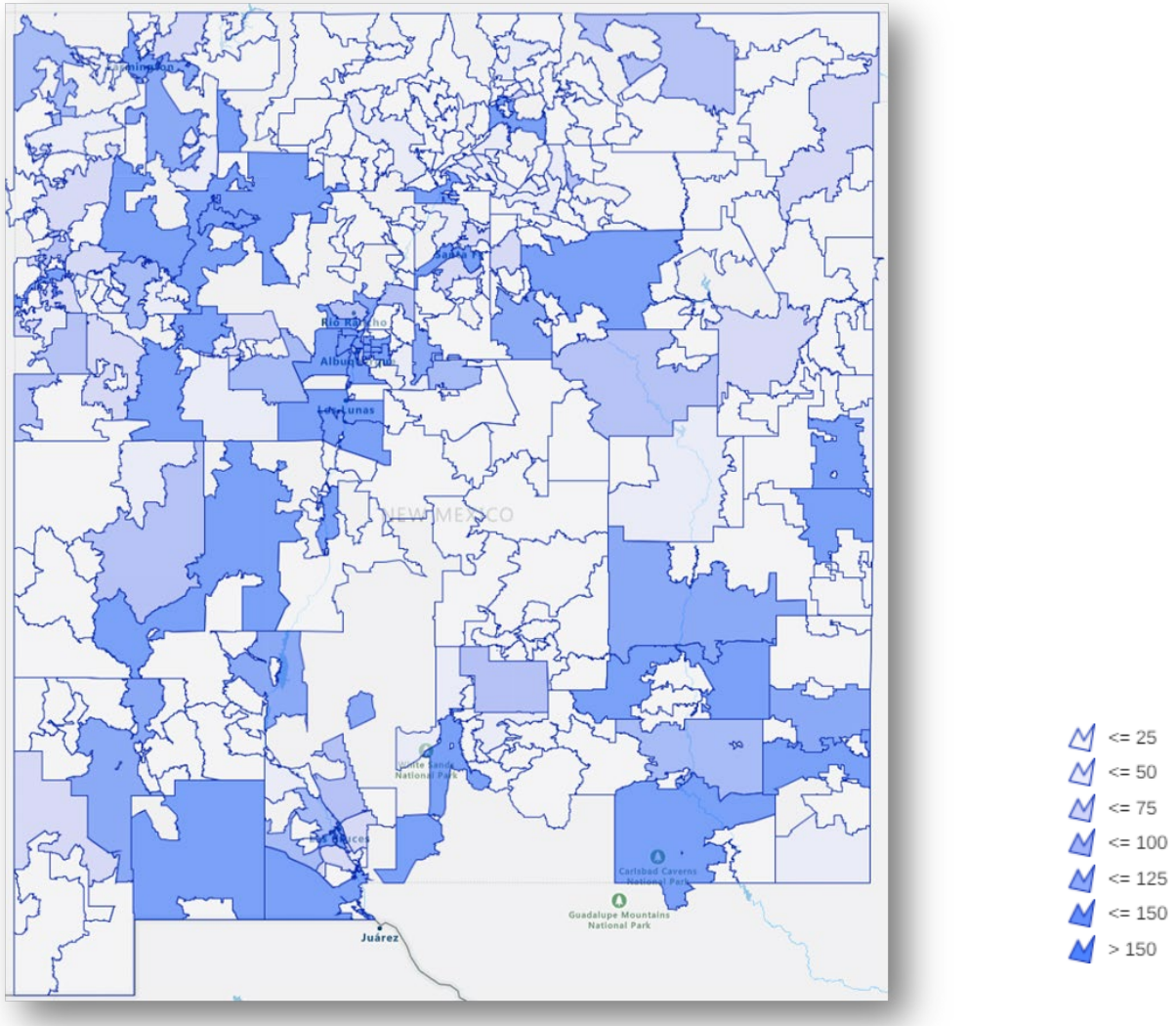
Primary Care Connect

- Coverage of all medically necessary care and services
- PCP responsible for utilization and communication with physician specialists



New Mexico – Heat Map of Potentially Eligible by Zip Code

- Approximately 18,000 New Mexico residents may be eligible for the program.



Thank you!

For more information, contact:

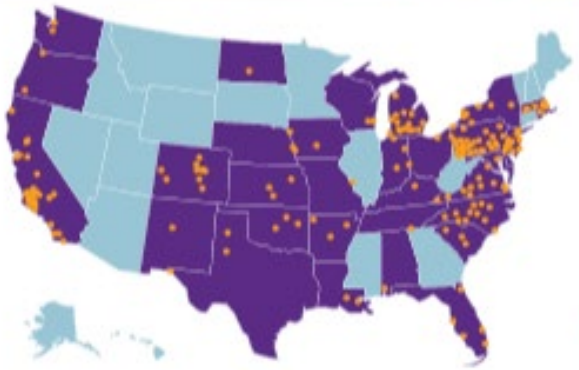
Judy Kohn, Chief Strategy Officer, jkohn@kinshiphs.com

Appendix – Background Information About PACE

PACE by the NUMBERS

Programs of All-Inclusive Care for the Elderly

PACE IS GROWING



PACE Programs currently exist in 32 States and the District of Columbia.[1]

154 PACE Organizations

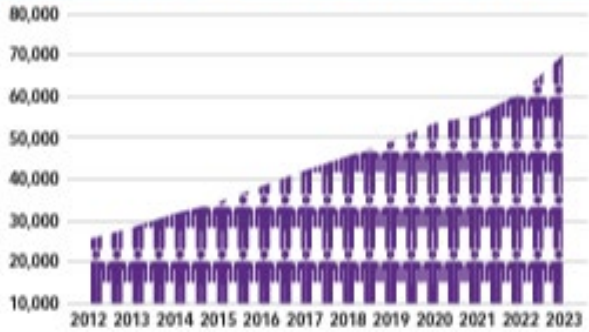
326 PACE Centers

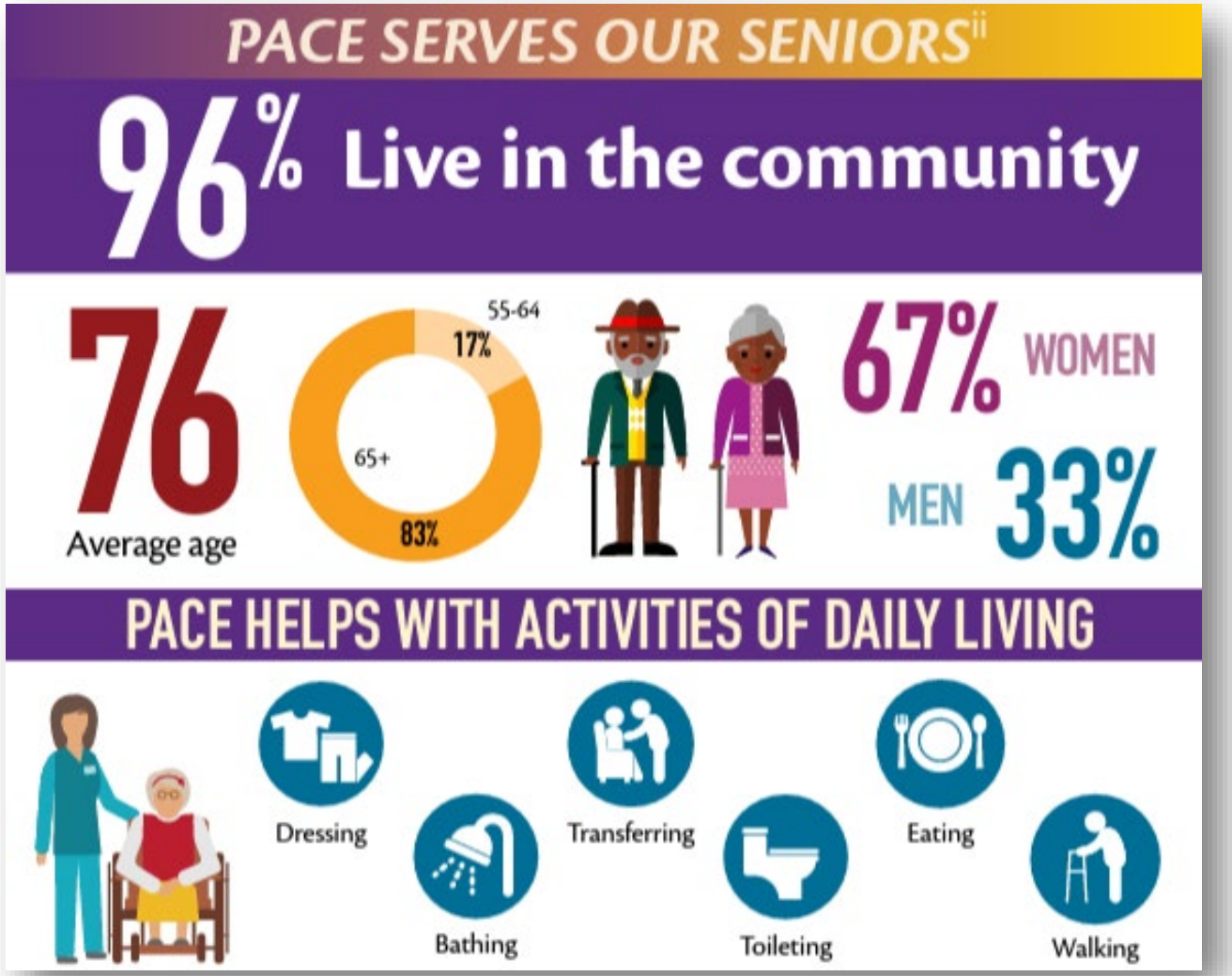
as of August 2023[1]

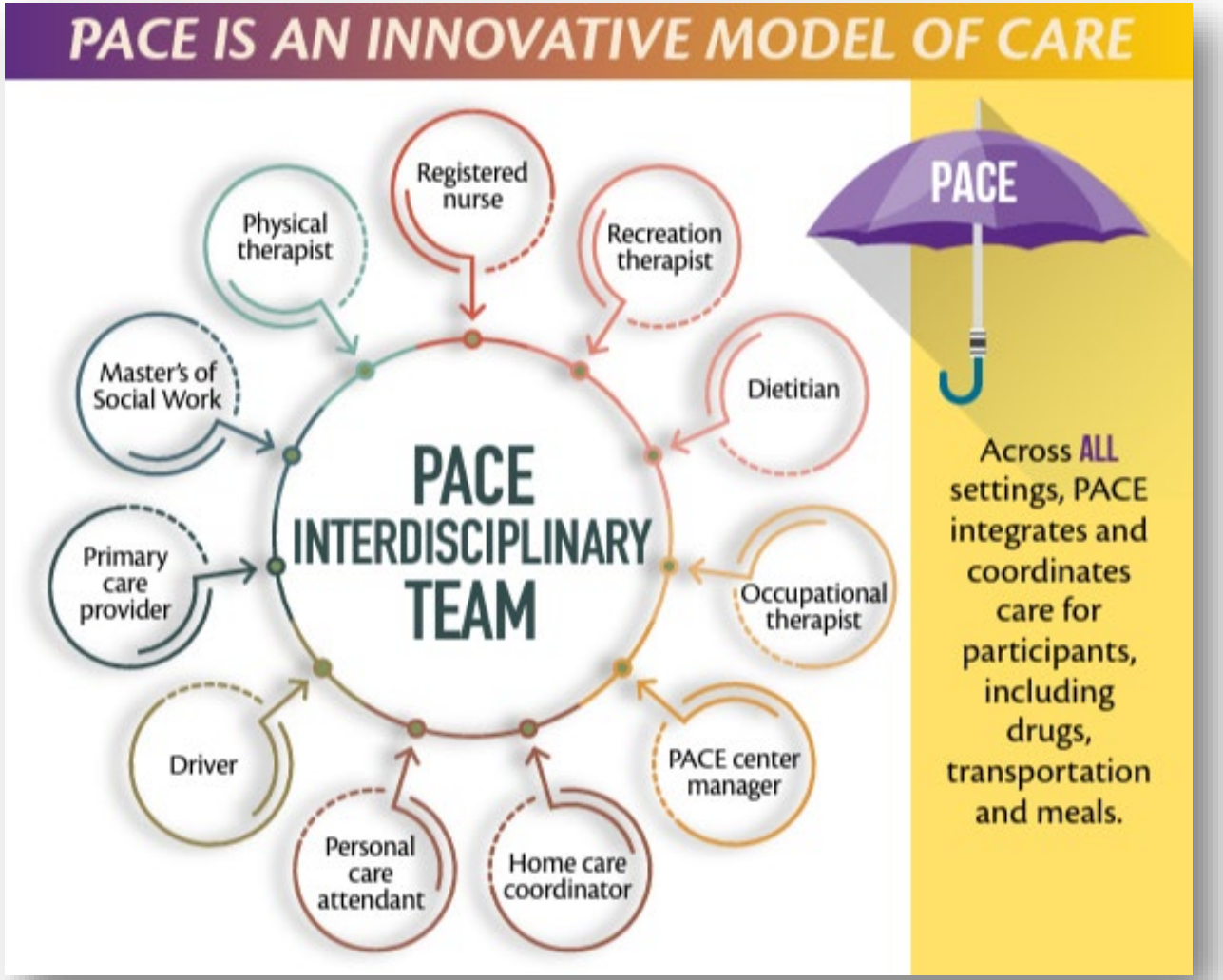
PACE ENROLLMENT ELIGIBILITY

- Age 55 and over
- Live in the PACE service area
- Certified to need nursing home care
- Able to live safely in the community with PACE support at time of enrollment

PACE ENROLLMENT OVER 70,000[1]




PACE SERVES OUR SENIORS[ii]
96% Live in the community
76
Average age
55-64
17%
65+
83%
67% WOMEN
MEN 33%
PACE HELPS WITH ACTIVITIES OF DAILY LIVING
Dressing
Bathing
Transferring
Toileting
Eating
Walking


PACE IS AN INNOVATIVE MODEL OF CARE
PACE INTERDISCIPLINARY TEAM
Registered nurse
Physical therapist
Recreation therapist
Master's of Social Work
Dietitian
Primary care provider
Occupational therapist
Driver
PACE center manager
Personal care attendant
Home care coordinator
PACE
Across ALL settings, PACE integrates and coordinates care for participants, including drugs, transportation and meals.

TOP 5 CHRONIC CONDITIONS OF PACE PARTICIPANTS[iii]

- Vascular Disease
- Major Depressive, Bipolar and Paranoid Disorders
- Diabetes with Chronic Complication
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease

6.1 Chronic Conditions[iii]

7 TRIPS[ii] **PER MONTH** PER PARTICIPANT

3 Visits to PACE Center per Month per Participant[ii]

IN AN AVERAGE MONTH

6 Prescriptions[xviii]

46% Dementia

PACE SERVES 23,564 MEALS A DAY[ii]

PACE PARTICIPANTS[iv]

81.76% Are dually eligible for Medicaid and Medicare

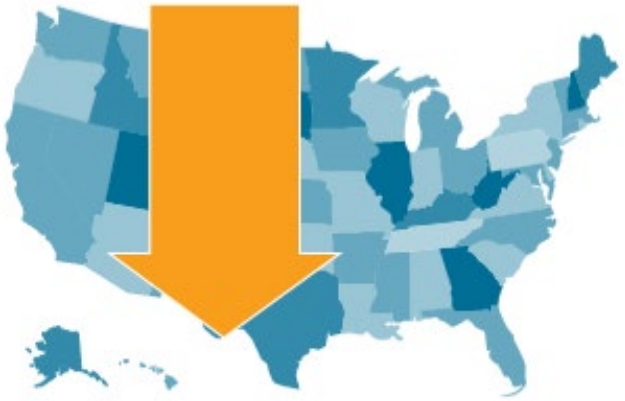
17.41% Are Medicaid-only

0.83% Pay a premium (Medicare-only and other)

NATIONAL PACE ASSOCIATION

PACE VALUE

PACE Saves Taxpayer Dollars



States pay PACE programs

12% LESS

than the cost of other Medicaid services

- States pay PACE programs on average 12 percent less than the cost of caring for a comparable population through other Medicaid services, including nursing homes and home and community-based waiver programs.[v]
- In Medicare, payments to PACE organizations are equivalent to the predicted costs for a comparable population to receive services through the fee-for-service program.[vi]


PACE Provides High-Quality Outcomes
LESS THAN 1 ER VISIT PER YEAR
• Lower Hospitalization Rate: A 24 percent lower hospitalization rate than dually-eligible beneficiaries who receive Medicaid nursing home services.[vii]
• Decreased Rehospitalizations: 16 percent less than the national rehospitalization rate of 22.9 percent for dually-eligible beneficiaries age 65 and over.[vii]
• Reduced ER Visits: Less than one emergency room visit per member per year.[viii, x]
ONLY
4.42%
of nursing home-eligible PACE participants currently reside in a nursing home[ii]
• Fewer Nursing Home Admissions: Despite being at nursing home level of care, PACE participants have a low risk of being admitted to a nursing home.[xi]
• PACE participants receive better preventive care, specifically with respect to hearing and vision screenings, flu shots and pneumococcal vaccines.[xii]
1/3
The rate of COVID Cases and Deaths as Compared to Nursing Homes
PACE Provides a High Quality of Life

Decreased Caregiver Burden Allows Family Members to Return to Work

58% reported decreased burden after PACE enrollment

Caregivers with high burden levels decreased from 48% before to 17% after PACE enrollment

The caregiver burden of family members is significantly reduced when a loved one is enrolled in a Program of All-Inclusive Care for the Elderly (PACE) according to a survey by the National PACE Association conducted by Vital Research

[i] National PACE Association. (2023). PACE in the States, August 2023.

[ii] National PACE Association. (2021). DataPACE3 2021 Benchmarking Report.

[iii] PDAC. (2023). HCC Report, July 2023.

[iv] National PACE Association. (2023). Medicaid Capitation and PACE Data Report.

[v] National PACE Association (2021). Analysis of PACE Upper Payment Limits and Capitation Rates.

[vi] Mathematica Policy Research. (2014). The Effect of PACE on Costs, Nursing Home Admissions and Mortality: 2006-2011. Evaluation prepared for U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy.

[vii] Segelman, M., Szydlowski, J., Kinosian, B., et al. (2014). Hospitalizations in the Program of All-Inclusive Care for the Elderly. *Journal of the American Geriatrics Society*, 62: 320-24.

[viii] Division of Health Care Finance and Policy, Executive Office of Elder Affairs. (2005). PACE Evaluation Summary. Accessed online on May 25, 2011.

[ix] Vital Research and CalPACE (2022). I-SAT.

[x] Kane, R.L., Homyak, P., Bershadsky, B., et al. (2006). Variations on a theme called PACE. *Journal of Gerontology Series A*, 61 (7): 689-93.

[xi] Friedman, S., Steinwachs, D., Rathouz, P., et al. (2005). Characteristics predicting nursing home admission in the Program of All-Inclusive Care for Elderly People. *Gerontologist* (2009). 45 (2): 157-66.

[xii] Leavitt, M. (2009). Interim report to Congress. The quality and cost of the Program of All-Inclusive Care for the Elderly. Mathematica Policy Research evaluation prepared for the Secretary of the U.S. Department of Health and Human Services for submission to Congress.

[xiii] Institute of Medicine. (2008). *Retooling for an Aging America: Building the Health Care Workforce.*

[xiv] Vourl, S.M., Crist, S.M., Sutcliffe, S., Austin, S. (2015). Changes in Mood in New Enrollees at a Program of All-Inclusive Care for the Elderly. *The Consultant Pharmacist*®, 30 (8): 463-71.

[xv] PACE Facts and Trends. (2016).

[xvi] Temkin-Greener, H., Bajorska, A., Mukamel, D.B. (2006). Disenrollment from an acute/long-term managed care program (PACE). *Medical Care*, 44 (1): 31-38.

[xvii] Government Accountability Office. Medicare Advantage: CMS should use data on disenrollment and beneficiary health status to strengthen oversight.

[xviii] National PACE Association. (2023) Part D Dashboard.

NATIONAL PACE ASSOCIATION

Support Innovate Lead

npaonline.org