McGregor PACE Program Demonstrates Success of Community-Based Alternative for Older Ohioans at Greater Risk of Contracting COVID-19

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Key Findings

- COVID-19 has wreaked havoc on Ohio's older adults living in skilled nursing and assisted living facilities; as of October 2020, deaths in these facilities accounted for 54% all coronavirus-related deaths in Ohio, underscoring the importance of increasing support for community-based services like McGregor's Program of All-Inclusive Care for the Elderly (PACE) that can keep older adults safe and at home.
- Among those who are at greatest risk from COVID-19 are dual eligibles, persons enrolled in both Medicare and Medicaid; this vulnerable population makes up the largest share of persons enrolled in McGregor PACE.
- McGregor PACE participants have fewer ER visits than their non-enrolled peers. PACE participants spend fewer days per member per month in the ER than their non-enrolled peers.
- Ninety-seven percent of PACE participants indicate a high level of satisfaction.
- While McGregor's PACE has demonstrated good outcomes and high customer satisfaction, too few policy makers understand the benefits of the PACE program or how it might complement Ohio's system of long-term services and supports.
- Independent of COVID-19, aging policy leaders now believe it's time for PACE to be expanded to other parts of the state, but expansion should be done thoughtfully and with carefully chosen partners.
- Aging experts believe that COVID-19 has "changed everything" and that it's important to provide the financial and policy support to expand PACE and other community-based services and supports to keep Ohio's elderly safe and, when at all possible, at home.

Introduction

The COVID-19 pandemic has been devastating to older adults and persons with disabilities who reside in Ohio's skilled nursing facilities. As of October, deaths in skilled nursing facilities accounted for 54% of all COVID-19-related deaths in Ohio, according to data from the Ohio Department of Health (ODH).[1] The rate of COVID-19 deaths in skilled nursing facilities in Ohio is 40% higher than the national rate. Nationally, deaths attributed to Alzheimer's disease and dementia rose more than 20% above normal during the summer months; the rise has been attributed in part to the isolation and stress of residing in facilities that, for the most part, have prohibited visitors or even the free movement of residents.[2] In response, national health and aging leaders have said that we must "accelerate effort to improve access to home and

[1] The New York Times, About 38% of U.S. Coronavirus Deaths Are Linked to Nursing Homes, October 20, 2020
[2] Tucker Doherty, "Summer wave of dementia deaths adds thousands to pandemic's deadly toll", Politico, September 16, 2020

community-based long-term services and supports"[3] One way to do that in Ohio would be to expand proven community-based programs like PACE. But PACE in Ohio, despite its successes, is not well known outside of a small group of aging advocates and state officials. This makes state leadership essential in any effort to expand PACE in Ohio.

Origins of PACE

The origins of PACE date back nearly 40 years, when a public health dentist and a public health social worker working in San Francisco's Chinatown neighborhood noticed that many of their elderly clients needed extra support to avoid placement in a skilled nursing facility. In response, they developed On Lok Senior Health Services as an alternative to institutional-based care. They noticed right away how often care became disjointed when clinicians failed to work with each other. Disjointed care resulted in medical complications that too often led to a skilled nursing facility admission or hospitalization. Their goal was to create a unified, team-based program that could allow their elderly to "age in place" in their own homes; *on lok* is Cantonese for "peaceful, happy abode."[4]

Description of PACE model

Today's PACE initiatives have maintained the original vision of the Lok Senior Health Services to deliver coordinated care outside of an institution for those who require a high level of medical and social care to maintain independence. PACE coverage includes all Medicaid- and Medicare-covered services, which are delivered by an interdisciplinary team of professionals. The team ensures the participants receive the benefits of a comprehensive system of care. All members of the team engage in regular communication regarding the patient's care plan. Physicians, adult day staff, social workers, therapists, nutritionists, aides, van drivers, nurses, nurse practitioners, and others are able to share information about the participant across settings to develop a full understanding of the social and medical needs of the individual and discuss how to best meet those needs as a team.

Individuals must qualify for PACE, both financially and clinically. PACE is an optional Medicaid benefit program that is currently operating in only one Ohio county. Applications are first screened by the Area Agency on Aging for clinical eligibility before being advanced to the local Ohio Department of Job and Family Services (ODJFS) office to determine financial eligibility. If an individual qualifies, they are able to enroll in PACE and begin receiving all-inclusive care. A key feature of all-inclusive care is the comprehensive coordination of services and payment of services provided by one entity: PACE. This comprehensive coordination sets PACE apart from other models of health care delivery for those dually eligible for Medicare and Medicaid insurances. Other models, such as MyCare Ohio, combine Medicare and Medicaid into one

[3] Bruce Chernof, M.D., Cindy Mann, Will Covid-19 Nursing Homes Tragedies Lead to Real Reform? Scan Foundation, Manatt, August 10,2020

[4] The Commonwealth Fund, Aging Gracefully: The PACE Approach to Caring for Frail Elders in the Community, August, 2016, Pages 2 and 3

insurance plan, but providers operate largely independently, billing the plan per service. When a client is enrolled in PACE, all medical and social services recommended by the interdisciplinary team are fully covered by PACE, including medications, transportation, therapies, and durable medical equipment. While many consumers find the all-inclusive features to be a benefit of the program, some people are reluctant to enroll in PACE, preferring to keep an existing primary care physician, specialist, or other provider.

PACE initiatives currently operate in 31 states with a total of 135 programs and over 54,000 participants. More than half of the states with PACE have more than one PACE initiative operating within the state. The National PACE Association has identified Texas, Florida, Ohio, Tennessee, and California as the states with the highest number of residents who are PACE eligible but lack access. The National PACE Association estimates that just 16.2% of PACE-eligible residents of Ohio have access to PACE. They believe 66,000 Ohioans could benefit from a PACE initiative but do not live in an area of the state with a program.

PACE-Covered Services

To be eligible for PACE, an individual must meet a nursing home level of care as determined by the Center for Medicare and Medicaid Services. Although receiving services in a skilled nursing facility is an option, PACE participants generally receive services in home or in a community-based setting. Services covered by PACE include the following:

- Adult day care
- Behavioral health services
- Durable medical equipment
- Emergency services
- Home care
- Hospital care
- Laboratory/x-ray services
- Meals
- Medical specialty services, including audiology, dentistry, podiatry, optometry
- Nursing home care
- Nursing services
- Nutritional counseling
- Prescription drugs
- Primary and preventive care
- Recreational therapy
- Rehabilitation therapy
- Social services, including caregiver training, support groups, and respite care
- Social work counseling
- Transportation

PACE Effectiveness

Research has shown that PACE participants receive high-quality care resulting in improved health outcomes. In a study reviewing models of care, researchers found PACE to be successful in providing quality care to patients with complex medical needs resulting from multiple chronic conditions. Dual eligibles, including those enrolled in PACE, often have a higher level of care need than their non-dual-eligible peers. Improved efficiencies and effectiveness in patient care were credited to comprehensive patient assessment; the creation and implementation of an evidenced-based plan of care; communication and coordination among an interdisciplinary team; facilitation of transition between care settings; facilitation of access to community supports such

as meal programs, adult day care, transportation, and support groups; and finally promotion of the patient's engagement in their own health care.[5]

The value of the interdisciplinary team approach is further supported by a study that examined the functional outcomes (mortality, changes in activities of daily living, and self-assessed health) of PACE participants across a number of factors. Findings from the study supported the practice of coordination of services for medically complex individuals through cohesive and effective teams. Participants with teams who effectively developed and implemented care plans across disciplines experienced better functional outcomes. Researchers also found that better functional outcomes were associated with larger and longer existing programs. It was hypothesized this finding reflected the programs learning curve on appropriate enrollee admissions and provision of services.[6]

Compared to their peers receiving services through a home- and community-based services (HCBS) waiver, PACE participants had a higher quality of care and better health outcomes as evidenced by a U.S. Department of Health and Human Services (HHS) study published in 2009. Participants in PACE appeared to have greater access to preventive care, including health screenings, flu shots, and pneumococcal vaccines. They also had fewer unmet needs, less pain, less likelihood of depression, and better management of health care.[7] A 2015 study provides further evidence of the positive impact of PACE on participants' mental health. Researchers found that nine months after enrollment, 80% of patients who had met the criteria for depression when entering the program no longer met the criteria.[8] High-quality care and positive health outcomes result in high consumer satisfaction and a low PACE disenrollment rate.[9]

In addition to providing high-quality care and high rates of customer satisfaction, evidence suggests PACE initiatives are a cost-effective model of care delivery. A 2017 study published in the *Gerontologist* found that PACE enrollees, when compared with 1915(C) waiver enrollees, had a 31% lower risk of long-term nursing home admission and that when they were admitted to a nursing home they were more likely to be suffering from severe cognitive impairment. The study authors say this suggests that PACE may do a better job of delaying nursing home admission because of the support that PACE initiatives provide to participants.[10] Delaying admissions to

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[5] Boult, C., Wieland, G.D. (2010). Comprehensive primary care for older patients with multiple chronic conditions: "Nobody rushes you through." JAMA, 304 (17): 1937-43.

[6] Mukamel, D. B., Peterson, D. R., TEMKIN-GREENER, H. E. L. E. N. A., Delavan, R., Gross, D., Kunitz, S. J., & Williams, T. F. (2007). Program Characteristics and Enrollees' Outcomes in the Program of All-Inclusive Care for the Elderly (PACE). *The Milbank Quarterly*, *85*(3), 499-531.

[7] Leavitt, M. (2009). Interim report to Congress. The quality and cost of the Program of All-Inclusive Care for the Elderly.

[8] Vouri, 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), 463-471.

[9] 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.

[10] Micah Segelman, MA, Xueya Cai, PhD, Christine van Reenen, PhD, Helena Temkin-Greener, PhD, Transitioning From Community-Based to Institutional Long-term Care: Comparing 1915(c) Waiver and PACE Enrollees, *The Gerontologist*, Volume 57, Issue 2, 1 April 2017, Pages 300–308

skilled nursing facilities reduces the cost of care per participant and overall costs for Medicaid and Medicare.

Evolution of the PACE Program in Ohio

While PACE has been operating in Ohio since 1997,[11] few legislators and/or policy makers understand or have any awareness of the program. One former director of the Ohio Department of Aging (ODA) said, "It's often overlooked, no one really knows about it." Another former director said, "No one is talking about PACE." ODA's State Plan 2019–2022 doesn't include any mention of PACE. The program also isn't mentioned in the Ohio's 2020–2022 State Health Improvement Plan. Encouragingly though, Ursel McElroy, the current ODA director describes "PACE as a valuable part of the long-term care continuum," and adds "I would like to see it expanded throughout the state."

Ohio's Medicaid directors have sometimes been less enthusiastic about the program, believing that PACE couldn't get to scale, was too expensive to establish, and that most of any program's savings were accruing to Medicare rather than to Medicaid. In fact, the program was nearly ended during the Kasich administration when the decision was made that an integrated care delivery waiver (MyCare Ohio) was the preferred approach for managing the care of dual eligibles in the state.

Efforts to start conversations with policy makers about PACE were always hampered by the fact that the program initially operated in just two counties. (Now it operates in just one). These factors made developing the political will needed to expand or support the program difficult. The small program size was likely one reason the state developed MyCare Ohio; its integrated care delivery Medicare/Medicaid demonstration, which uses private insurance companies, could be brought to scale much faster than establishing PACE in 29 counties. But despite this, almost every aging leader we interviewed for this issue brief said they thought PACE was important, believed it could serve key populations well, and thought that—in certain circumstances—the program had advantages over MyCare Ohio.

PACE is authorized in Ohio's state Medicaid plan through an agreement with the Centers on Medicare and Medicaid Services. Unlike PASSPORT or assisted living, PACE is not a Medicaid waiver but rather an optional benefit that Ohio has chosen to add to its Medicaid benefits. Both the State of Ohio and the federal government have a lot to say about how the program operates.

Initially, Ohio had two PACE sites; Tri-Health Senior Link in Cincinnati and Concordia Care located in Cleveland. At the time (before the creation of MyCare) the program was unique and was the only program in Ohio that sought to manage the care provided through both Medicare and Medicaid. The program grew quickly in its initial years, and soon both sites had waiting lists. Since State Fiscal Year (SFY) 2006, the ODA has served as the PACE state administering agency. The

[11] Shahla Mehdizadeh, Robert Applebaum, Suzanne Kunkel, Patricia Faust, Evaluation of Ohio's Program of All-Inclusive Care for the Elderly (PACE), Scripps Gerontology Center Miami University, August 2012

funding for the program (other than its administrative costs) continues to be provided within the Ohio Department of Medicaid's budget.

When the Ohio General Assembly passed the 2011–2012 operating budget, lawmakers included language allowing the director of ODA to expand PACE to regions outside of Cleveland and Cincinnati. But it prohibited the director from decreasing the number of participants at the Cleveland and Cincinnati sites to accommodate any PACE expansion elsewhere in the state. This budget also established a "Home First" provision in PACE, allowing persons on the waiting list for PASSPORT, assisted living, and RSS, and living in a nursing facility, to receive priority enrollment.

Over time, Concordia Care PACE encountered operational challenges, and in August 2010, they transferred operations of the program, with the approval of The Centers for Medicare and Medicaid Services (CMS) and ODA, to McGregor PACE. By the end of 2010, 556 participants were enrolled in the Cincinnati site, and only 166 were enrolled in the Cleveland site.

In 2011, the Ohio General Assembly passed an SFY 2012–2013 budget that included a 3% rate reduction for the PACE program as well as reductions in other parts of the ODA budget. The budget also included a requirement that the ODA contract with Miami University's Scripps Gerontology Center to evaluate PACE. The legislation somewhat limited the ODA director's authority to expand PACE to other portions of the state by requiring that funding be available, that ODA and ODJFS determine that the program is a cost-effective alternative to nursing home care, and that CMS agree to share any resulting Medicare savings with the State of Ohio.

In August 2012, The Scripps Gerontology Center at Miami University released its legislative mandated evaluation of Ohio's PACE. (McGregor had assumed control of the PACE program in 2010, so researchers were not able to fully evaluate their management of the program). The report contained several recommendations. First, clarify the programmatic goals of PACE: either "coordinating care for a medically complex population" or to "coordinate the health and long-term care costs for frail individuals at high risk of nursing home placement." They recommended that Ohio pursue an agreement with CSM to share Medicare savings, made suggestions about how payment rates should be calculated, and encouraged that an independent entity determine eligibility for the program. (Currently, ODA has contracted with the Western Reserve Area Agency on Aging, WRAAA, to review and approve every application for admission to McGregor PACE.) Finally, the report urged the state to "make a clear decision on how PACE fits in to the overall long-term services and integrated care plan for Ohio."

In 2013, the state created a separate state Medicaid agency; the Ohio Department of Medicaid, and funding for the PACE program was transferred into the new state department. Less than a year later Tri-Health Senior Link in Cincinnati would cease to operate, and its enrollees were moved into other waiver programs.

ODJFS announced in 2013 that the state had finally received three-year federal approval for a demonstration project called MyCare Ohio, an integrated care delivery system that utilized private insurance companies (e.g., managed care) to coordinate care for Medicaid enrollees who

were also enrolled in Medicare (e.g., dual eligibles). The demonstration was authorized under authority included in the 2010 Affordable Care Act (ACA). Those required to enroll were individuals 18 and older who met requirements to receive full Medicare Parts A, B, and D and full Medicaid benefits and who lived in one of the 29 demonstration counties. PACE participants were specifically excluded from the program. The rollout of MyCare Ohio has been described as "rocky" and "disruptive," with numerous complaints about enrollment, consumer education, and provider payments.[12]

With the involvement of Ohio's Area Agencies on Aging and others, many of the initial problems were resolved and or lessened. This led the Ohio Department of Medicaid to seek and receive federal approval to extend MyCare Ohio through June 2023. Whether current leadership at the Ohio Department of Medicaid will seek to extend the MyCare Ohio demonstration and/or whether they might seek to modify it are unclear. They have asked the Scripps Gerontology Center at Miami University to do an evaluation of MyCare Ohio to help guide future decisions. Finally, if the U.S. Supreme Court were to rule in California v. Texas that the entire ACA should be found invalid because the individual mandate is no longer constitutional and cannot be severed from the rest of the law, the legal underpinning for the MyCare Ohio program could disappear overnight.

DESCRIPTION OF MCGREGOR PACE

As an organization, McGregor has a long history, dating to 1877, of providing services to older adults in East Cleveland and Cleveland. The current McGregor suite of services includes assisted living, nursing care, hospice, independent living, senior housing, respite care, rehabilitation, and McGregor PACE. McGregor PACE generally has 625 participants enrolled in its program of all-inclusive care. Participants receive care in both their homes and in McGregor PACE facilities. Currently, McGregor PACE includes three locations in Cuyahoga County: Old Brooklyn, East Cleveland, and Warrensville Heights. Participants can receive transportation to the physical locations to attend appointments or the Adult Day Center.

The participant demographics of McGregor PACE are similar to those of programs across the country. The average age of a McGregor PACE participant in 2019 was 75, with 3.4 the average number of years a participant was enrolled in PACE. Females make up 75% of McGregor PACE enrollment. However, age group distribution has shifted to a younger population over the past three years. At the end of 2017, 82% of participants were 65 and over, and 18% were between the ages of 55 and 64. By the end of 2019, just 78% of participants were 65 and over, and 22% were between the ages of 55 and 64.[13]

McGregor PACE participants have fewer ER Visits, about the same rate of inpatient admissions, and more inpatient days than their non-enrolled peers, as defined by the National PACE

[12] Molly O'Malley Watts, Early Insights From Ohio's Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries, Kaiser Family Foundation, May 14, 2015

[13] DataPACE3 Benchmarking Report, McGregor PACE Q1 2019 to Q4 2019

Association. PACE participants spend fewer days per member per month than their non-enrolled peers in nursing facilities when stays are more than 89 days. The opposite is true for stays shorter than 90 days, with McGregor PACE participants having more days per member per month than their peers in nursing facilities. PACE participants experience fewer skilled-therapy and social-work encounters than their non-enrolled peers, slightly fewer specialist encounters, and about the same number of primary care encounters.[14]

When surveyed about satisfaction with the program, McGregor PACE participants indicate a high level of satisfaction, with 97% reporting overall satisfaction with the program. Ninety-six percent would select PACE again if they were to be in a position to make the decision to enroll, and 90% would recommend the program to a friend or relative. High levels of satisfaction with activities, the Day Center staff, and supporting social services drive the willingness of participants to recommend the program. Survey takers also reported a high level of satisfaction with nurse practitioners and physicians. Participants were least satisfied with dining services.[15]

Focus groups held in October 2020 support the findings of the customer satisfaction survey. Facilitated conversations included those with caregivers of PACE participants as well as with participants who were enrolled in and currently attending Adult Day programming. After having been away from the Adult Day Center as a result of the COVID-19 pandemic, the participants expressed much enthusiasm at being back in person. They expressed relief at having opportunities to socialize with each other, even if it meant sitting alone at a table and wearing a mask. When asked about the impact PACE had had on their health, both participants and caregivers shared moving stories. One woman had joined PACE shortly after her husband joined. He passed away a few months later, and she shared that the support provided by PACE staff after his passing helped her maintain her health during an incredibly difficult time. Another participant shared that after joining PACE and working with a nutritionist she was able to make changes to her diet that resulted in a 20-pound weight loss. Medication management was mentioned a number of times as having a positive impact on health. Multiple participants shared that, upon a medication review by the interdisciplinary team, medications were adjusted, eliminated, or added based on clinical need. These participants experienced improved feelings of physical well-being as well as a reduction in worrying about their health.

Caregivers who participated in the focus groups valued the all-inclusive nature of McGregor PACE. Having medical services and medical insurance provided by one entity eliminated a stressful part of caregiving: managing the financial side. Caregivers also appreciate other aspects of the program that make their lives more manageable. For instance, scheduling appointments is quick and easy, transportation is available, hours and locations are convenient, and the staff treats their care recipients well. All these individual benefits allow caregivers to worry less about the medical and social services delivered, reducing some of the stressors associated with caregiving. Multiple studies have shown that caregiving is a highly stressful endeavor that many

[14]DataPACE3 Benchmarking Report, McGregor PACE Q1 2019 to Q4 2019
[15] McGregor PACE Survey, September 2020

are not expecting, or prepared, to take on. Caregiving often involves complex and physically demanding tasks that are necessary to ensure the health, safety, and well-being of their care recipient. As one caregiver in the focus group stated, reduction of stress "keeps me calm, maintained and grounded." Although it is hard to measure empirically, the value of a calm and grounded caregiver is undeniable.

Ohio PACE Capitation Payments Lag National Average Payments

The capitation rates for McGregor PACE, while requiring review and approval by the federal government, are the result of a negotiation between McGregor and the Ohio Department of Medicaid and the ODA. Federal regulations, though, require that rates be in line with the following criteria:

- the capitation rate must be less than the amount Ohio Medicaid would have paid if the participants were not enrolled in PACE;
- the rate must account for the frailty of PACE participants;
- the rate is a fixed amount regardless of any changes in the participant's health status;
- the rate can be renegotiated on an annual basis.

When the rates are reviewed by the federal government, they confirm that Medicaid rates for PACE are no greater than the corresponding Upper Payment Limits (UPLs). Ohio Medicaid has one PACE rate for those who are dually eligible for Medicare and Medicaid and another rate for those with Medicaid-only coverage. Ohio bases its UPL calculations on fee-for-service data. This becomes more challenging as managed long-term services and support programs (MyCare Ohio) become more dominant. The encounter data provided by the Medicaid-managed care organizations to the state is not typically as robust as fee-for-service data, further complicating the process of UPL calculations.

McGregor's 2020 PACE rates for those who are dually eligible for Medicare and Medicaid and for Medicaid-only participants are approximately 26% and 25% (respectively) below the average rates paid nationally as calculated by the National PACE Association. While national rates for dual eligibles increased on average 1% and 2% for Medicaid-only participants, McGregor PACE rates were frozen in 2020.[16]

	National Average Rate	McGregor PACE Rates	Percentage Higher (Lower) than National Average
Dual Eligible PACE Medicaid Rates	$3,981 (1%)	$2,926	(26%)
Medicaid-Only Rates	$6,307 (2%)	$4,761	(25%)

Dual Eligibles at Greater Risk of Covid-19

[16] National PACE Association, Medicaid Capitation Rates and PACE Data for Calendar Year 2020

One group that is of increased risk are those individuals labeled dual eligible, meaning they are eligible for both Medicaid and Medicare. According to the Centers for Medicare and Medicaid Services, persons who are dual eligible have the second highest hospitalization rate among Medicare patients—with 473 hospitalizations per 100,000 beneficiaries.[17]

According to the Centers for Medicare and Medicaid Services Medicare-Medicaid Coordination Office over 12.2 million individuals are dually eligible for Medicare and Medicaid.[18] Seventy percent of dually eligible individuals have three or more chronic conditions. Forty-one percent have at least one mental health diagnosis, and nearly 39% are eligible for Medicare because of a disability. Nationally, 90% of PACE participants are dually eligible individuals. In Ohio, 81% of PACE participants are dually eligible.

Dual eligibles are considered at greater risk of COVID-19 infection; they are poorer, are disproportionately from communities of color, have higher rates of chronic conditions, are more likely to have limitation in activities of daily living (ADLs), and have more challenges related to the social determinants of health (e.g., housing, hunger, transportation).[19] According to the CMS, Black dually eligibles have the highest rate of COVID-19 cases and hospitalizations.[20] These facts have led many aging policy experts to call on the federal and state governments to dramatically expand community-based alternatives like PACE for dual eligibles. After all, while dual eligibles often have significant care needs, they have the same desire to live at home.

The PACE Integrated Care Model Offers One Solution

Melanie Bella, the chair of the Medicaid and CHIP Payment and Access Commission, says that "COVID-19 is exposing the lack of infrastructure to provide safe in-home care, coordinated transitions of care, food and housing security...ineffective coordination between physical and behavioral health care." She adds, "unless they have a very well-informed caregiver and/or are enrolled in an *integrated program* with someone checking in regularly to understand their needs and ensure they are getting met, they will face considerable difficulty with obtaining needed services."[21]

"In a COVID world, [PACE is] a bright shining light." That's how Bob Applebaum, the director of the Ohio Long-Term Care Research Project, Scripps Gerontology Center, Miami University, describes the benefits of PACE during the COVID-19 pandemic. A crucial ingredient, according to Applebaum, is PACE's interdisciplinary care team composed of physicians, nurse practitioners, nurses, social workers, therapists, van drivers, aides, and others, who meet regularly to exchange information and solve problems as the conditions and needs of PACE participants change.

[17] Centers for Medicare and Medicaid Services, Trump Administration Issues Call to Action Based on New Data Detailing COVID-19 Impacts on Medicare Beneficiaries, June 22, 2020
[18] Centers for Medicare and Medicaid Services, Medicare-Medicaid Coordination Office FY2019 Report to Congress, Page 3
[19] Medicaid and CHIP Payment and Access Commission, Report to Congress on Medicaid and CHIP, June 2020, Page 6
[20] Centers for Medicare and Medicaid Services, CMS Preliminary Medicare COVID Snapshot, September 2020
[21] Center for Health Care Strategies, Integrating Care for Dually Eligible Individuals Matters Even More in the Face of COVID-19, May 7, 2020

Because different disciplines are involved, the team has the benefit of information gained through interaction with the PACE participant over time and in multiple settings. Peter Fitzgerald, National PACE Association executive vice president of policy and strategy, commented during a presentation for the Better Care Playbook that "it's really the PACE [interdisciplinary care team], not the PACE Center, that is at the core of why PACE works so well and why it has worked quite well during COVID-19. What we have seen during the pandemic is that PACE can be brought to participants' homes, and good communication can be maintained with technology."[22]

Another advantage: in contrast to standalone fee-for-service providers, the capitated payment design of the PACE model allows providers greater flexibility to modify services to meet participant needs amidst COVID-19.

A report[23] from Altarum, Fall Health, and the National PACE Association identified a number actions that PACE programs across the country took in response to the COVID-19 pandemic:

- Reorienting care planning and close monitoring of enrolled participants by using telehealth technology in lieu of center-based face-to-face interactions;
- Reassigning of vans that are normally used to transport participants to and from their homes to the PACE Center to instead deliver home-based care and services, nutrition services, durable medical equipment, medications, and more;
- Repurposing of PACE Centers to be COVID-19-only infirmaries providing 24-hour care;
- Using PACE Centers to offer respite care (including overnight care) for families who need a safe place for their elderly loved ones to be while they are working or needing a break; and
- Inventing of new programming that combats social isolation.

The National PACE Association reports that, based on data collected from 107 PACE initiatives, 6.45 percent of PACE participants have had a positive test for COVID-19. They also report that 1.6% of all participants enrolled in PACE have died from the novel coronavirus nationwide. The Foundation for Research on Equal Opportunity estimates that the death rate for residents of nursing homes and residential care facilities is approximately 3.6%—a rate that is more than twice as high as those served by PACE.

The U.S. Centers for Medicare and Medicaid Services allowed PACE to make greater use of remote technology and telehealth for activities that would normally occur in person. They also allowed programs to relax "refill-too-soon" edits. (previously, claims payment systems would have refused refill requests before two-thirds of a prescription had been used) and provide maximum extended-day supply, provide home or mail delivery of Medicare Part D drugs, and

[22] Better Care Playbook, Caring for Older Adults with Complex Needs in the Covid019 Pandemic - Lessons From PACE Innovations, June 30,2020

[23] Altarum, Rapid PACE Responses in Covid-19 Era: How PACE Providers Have Innovated and Adapted to Keep Enrollees Safe in Their Communities, Page 2, October 2020

waive prior authorization requirements at any time that they otherwise would apply to Medicare Part D drugs used to treat or prevent COVID-19, if or when such drugs are identified.

In response to COVID-19, the National PACE Association has suggested that the PACE menu of services may need to evolve to include more respite and overnight care, as well as temporary shelter. They argue for retaining the ability of PACE providers to use telehealth for intake, assessments, care planning, and care delivery. They also urge a more expedited eligibility determination process and mid-month enrollment so that people who want to enroll in PACE can do it in a timely way.[24]

Arnold Ventures, a foundation that invests in evidenced-based solutions, says that in the face of COVID-19 and state budget constraints that are certain to follow "the integration of Medicare and Medicaid programs is exactly what state Medicaid agencies and departments of health and human services should be contemplating. Not only is integration good for dual-eligible individuals, by improving their experiences and outcomes, it also helps drive state and federal costs down over time."

POLICY RECOMENDATIONS OVERVIEW

We interviewed more than a dozen national and state long-term services and support experts prior to writing this paper. We found a general consensus that McGregor was a good operator of PACE and that any negative associations that resulted from the exiting of Tri-Health and Concordia Care had largely dissipated. When McGregor assumed control of PACE in Cleveland, 11 outstanding corrective action plans were in place. McGregor resolved all of them within six weeks of taking over the program. But these earlier experiences underscore the importance of finding the right program operators. One expert commented that "PACE programs don't belong under health systems, [hospitals] see them as strategic when times are good, but when hospitals aren't thriving, they see them as an expense. Applebaum, director of the Ohio Long-Term Care Research Project and Scripps Research Fellow, Miami University, cautioned against seeing PACE expansion as the only solution to our long-term care challenges. "We shouldn't oversell the model," he said.

The experts we interviewed also agreed COVID-19 was already changing and should further modify the way services are delivered to older adults, particularly those who experience high poverty and live in isolation. Mary McNamara, The City of Cleveland's Director of Aging, said that the ability to deliver community-based services during the pandemic has been hampered by lack of equipment and broadband access. Several experts mentioned that community-based services should be further prioritized and that PACE should be a part of that mix. Tangi McCoy, CEO, McGregor PACE, said that PACE was doing more telehealth. They provided loaner iPads, and if needed, aides stayed with patients to help them use the devices. When Adult Day was closed (it's

[24] Sheppard Mullin Richter & Hampton LLP, CMS Issues COVID-19 Prevention Guidance for PACE Organizations, April 7, 2020

now open) PACE increased home health, social services made daily calls, and nurses made home visits.

While MyCare Ohio was appreciated for its ability to bring care management for dual eligibles to scale, nearly everyone agreed that PACE brought additional elements that were valuable and weren't available via the MyCare model. Barb Riley, a former director of the ODA, and ODJFS said that PACE was "the opposite of scale; they are closer, know their clientele much better, and understand their special needs much better." Others commented that MyCare caseworkers had large caseloads and that care managers were more often working with managed care plans rather than with physicians and other health care providers. One person said, "The coordination just isn't there."

McElroy, director of ODH, took an even broader view and emphasized that quality-of-life measures should be considered in evaluating PACE. "For me [PACE] is a less restrictive level of care, maintained in the community, helping a family keep someone at home, increased quality of life, and providing peer support." Several individuals commented on the importance of adult day care—giving you "eyes on every day" of participants. They also believe this service could be particularly important for persons with dementia. "They are high need, hard to keep at home because of family pressures," they said. Director McElroy said adult day care "allows family members to continue to work and contribute, knowing that their loved one is being cared for." Lark Recchie, CEO, Ohio Association of Area Agencies in Aging, said that adult day programs might be one way to address the growing workforce shortage, since services can be provided in one location.

In terms of the future, Patrick Beatty, deputy director and chief policy office, Ohio Department of Medicaid, said that the state is already thinking about the future of Ohio's integrated care delivery system demonstration (MyCare Ohio), which expires in 2023. He indicated that the role and future of PACE should be a part of that conversation.

The National PACE Association has also developed a set of model PACE policies that are worth reviewing prior to the expansion of PACE in Ohio. One related to options counseling seems important since they can serve as the front door for individuals and families trying to navigate complicated systems often at a time of crisis. Currently, there are several options counseling providers, but they aren't uniform across the state. Having a statewide options counseling network could solve some of the inconsistencies in training and procedures that exist now with options programs and provide a standardized evaluation for options counselors. But any state system should acknowledge the existing options counseling programs and build off their successes and lessons learned. Another policy recommendation is the use of a streamlined clinical eligibility determination process. Currently McGregor PACE does a PACE eligibility "pre-screen" then sends the case to the WRAAA for an official determination of level of care eligibility, and then once they sign off on it, it is sent to the Cuyahoga County DJFS to determine their financial eligibility for Medicaid (if they aren't already enrolled). McGregor PACE reports that they can work within this system relatively well, but if they were to expand the program outside the

service area of the WRAAA, it might then involve dealing with additional agencies and the determination process could get bogged down. The goal should be to ensure that any eligible person seeking to enroll in PACE be able to get a decision quickly to reduce stress and uncertainty.

SPECIFIC POLICY PROPOSALS

The federal government should increase the federal share of Medicaid funding known as federal medical assistance percentage (FMAP) so that states have the funding they need to boost support for home- and community-based services provided via Medicaid. Without this additional funding, likely home- and community-based providers will experience rate cuts since—unlike skilled nursing facilities—their rates are not written into state law. A state budget provision to place PASSPORT and similar rates in state law was vetoed by Governor Mike DeWine in 2019.

The ODA and the Ohio Department of Medicaid should emphasize policies, services, and programs at every level that provide integrated long-term services and supports that help individuals remain in their home and community; PACE should be one of the programs emphasized and supported. It's hard to overestimate the tragedy that COVID-19 has been and continues to be for older adults in Ohio; the loss of life is almost impossible to comprehend. Too many eligible Ohioans, particularly dual eligibles, have no access to the kinds of integrated and personal support PACE provides, making them much more susceptible to being admitted to a skilled nursing facility or being readmitted to a hospital. In 2019, The National PACE Association—with the support of the John A Harford Foundation, the Commonwealth Fund, and West Health—researched which states had the largest number of PACE-eligible persons with no access to the program. The research identified Ohio as being the PACE state with the third highest number of individuals estimated to be clinically and financially eligible for PACE but without access to the program. They estimated that only 12,376 of 79,105 PACE-eligible Ohioans have access to the program.[25]

Programs for dually eligible individuals must place equity at the center of their response to the COVID-19 pandemic, collecting race and ethnicity data to better target outreach activities and services to people of color and to assess unmet need during the pandemic. COVID-19 has had a staggering disparate impact on dual-eligible enrollees. Nationally they are almost 4 times as likely to be infected and 4.5 times more likely to be hospitalized compared to Medicare-only enrollees. Poverty and racism exacerbate these rates. Black dually eligible individuals experience 1.25 times as many infections and almost 2 times as many hospitalizations as white dually eligible individuals.

The ODA and the Ohio Department of Medicaid should work with their partners at the U.S. Centers for Medicare and Medicaid Services to encourage the careful expansion of the Ohio's existing PACE program, and of new PACE programs in Ohio. We agree with McElroy, director of ODA, who described PACE as a "valuable part of the long-term care continuum" and said it should

[25] National PACE Association, Interactive Map of Potential PACE-Eligible Population, January, 2019

be "expanded throughout the state." Nearly every state and local aging expert we interviewed said that PACE could play an important role in providing better care for a very vulnerable population. If expansion does occur, we should keep in mind the recommendation of the 2012 Scripps report which said that any PACE expansion should "build on the expertise of current operators."[26]

The Ohio Department of Medicaid should fully incorporate the leadership of Ohio's PACE program, and home- and community-based waiver programs into the planning process for whether or how to extend Ohio's Integrated Care Delivery System 1915 (C) Waiver, MyCare Ohio, which expires June 2023. The Ohio Department of Medicaid went through an exhaustive consumer-, community-, and provider-focused planning process while preparing to issue its recent request for applications to operate its Medicaid-managed care program. A similar process should be undertaken prior to any waiver submission. This recommendation is like one made in the 2012 Scripps report, but recent consumer engagement efforts made by the Ohio Department of Medicaid have demonstrated how an extensive consumer and provider engagement process can produce a better plan.

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[26] Shahla Mehdizadeh, Robert Applebaum, Suzanne Kunkel, Patricia Faust, Evaluation of Ohio's Program of All-Inclusive Care for the Elderly (PACE), Scripps Gerontology Center Miami University, Page x, August 2012

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