# PACE in Ohio: Coming Soon to a Community Near You

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# PACE Basics

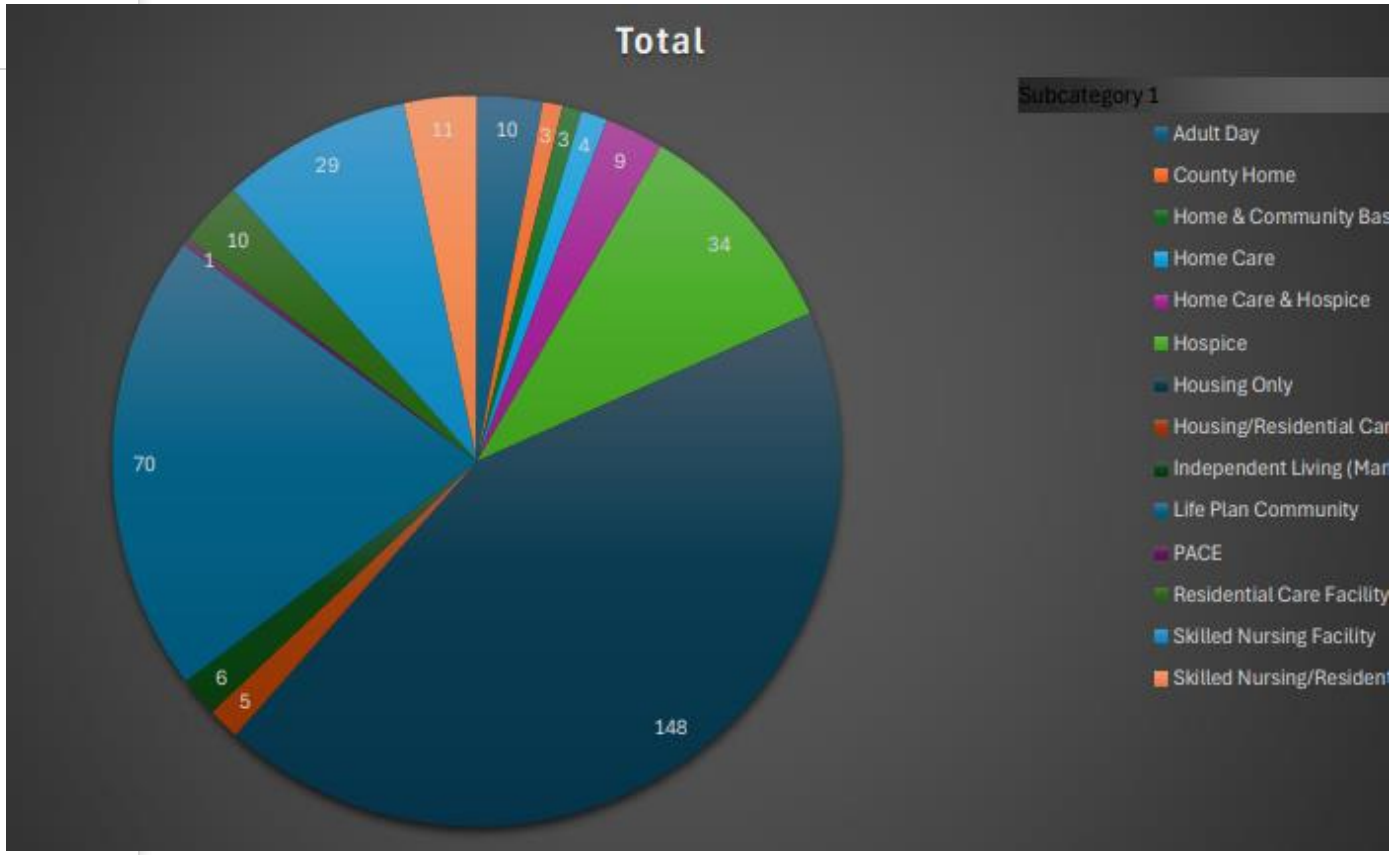
- Program for All-inclusive Care for the Elderly
- Founded early 1970's in Chinatown-North Beach community
- Medicare benefit: 1997
- Preventative / population health approach

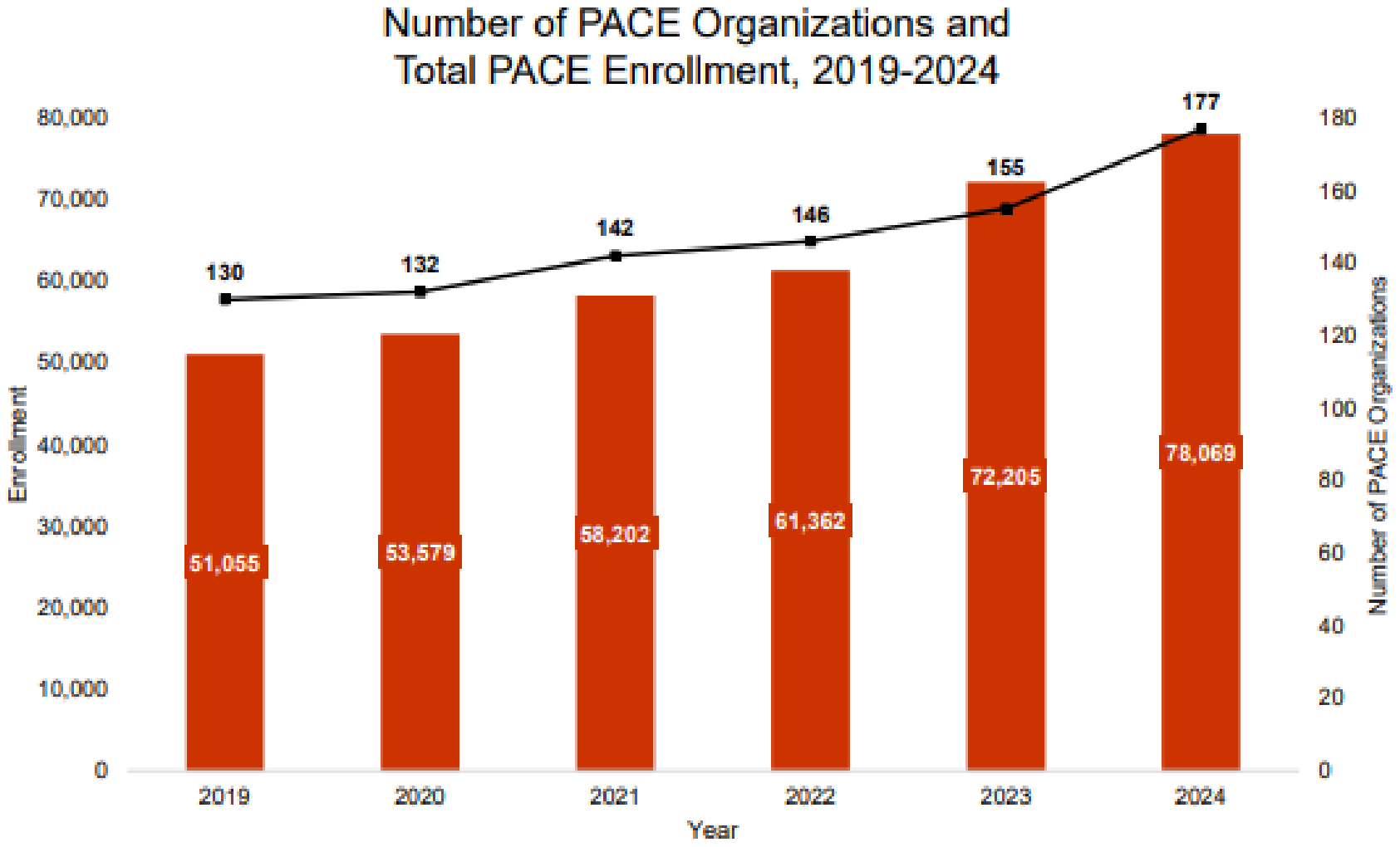
- PACE is an insurance model, not a provider type

LeadingAge Ohio

# Why LeadingAge Ohio?

- McGregor PACE
- LeadingAge Ohio members span the continuum
- Palliative approach
  - Populations with chronic illness
  - Holistic & interdisciplinary
  - Goals of care






# PACE organization and enrollment growth has increased over the last 5 years, now totaling over 78,000 participants.

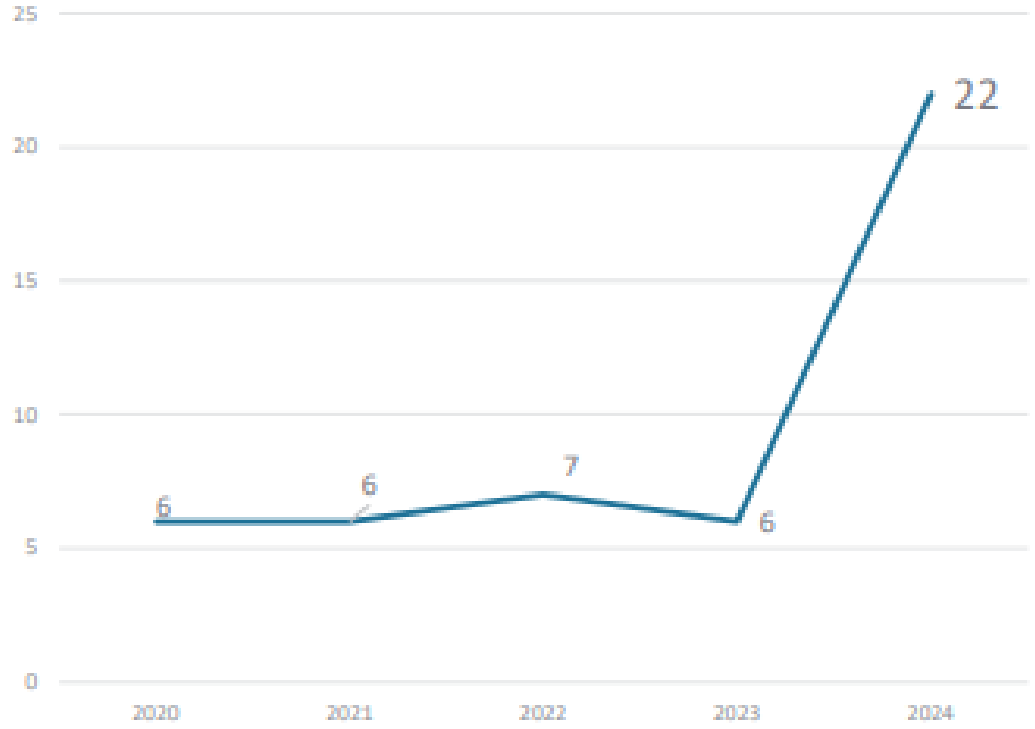
- Since 2019, the number of PACE Organizations has increased by **36 percent** and total PACE enrollment has increased by **53 percent**.
- Additional substantial growth anticipated in upcoming years reflecting new states and programs coming online.



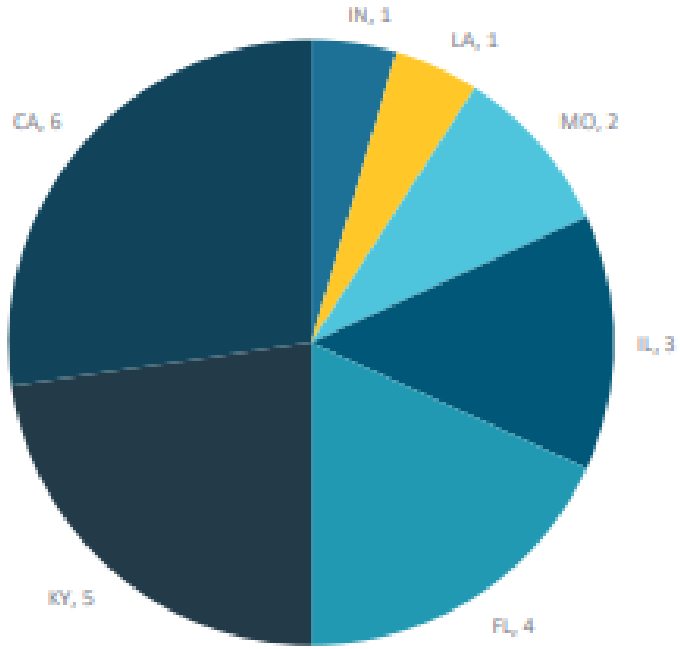
Source: National PACE Association data from September 2019, April 2020, December 2021, July 2022, December 2023, August 2024

# Growth in PACE Organizations

## New POs by Year, 2020 - 2024




## New POs in 2024, by State



# Why now?

- Transition of healthcare system from FFS to value-based payment
- Impact of pandemic
- Growing aging population

- Luck & opportunism

LeadingAge Ohio


Ohio Living
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McGregor


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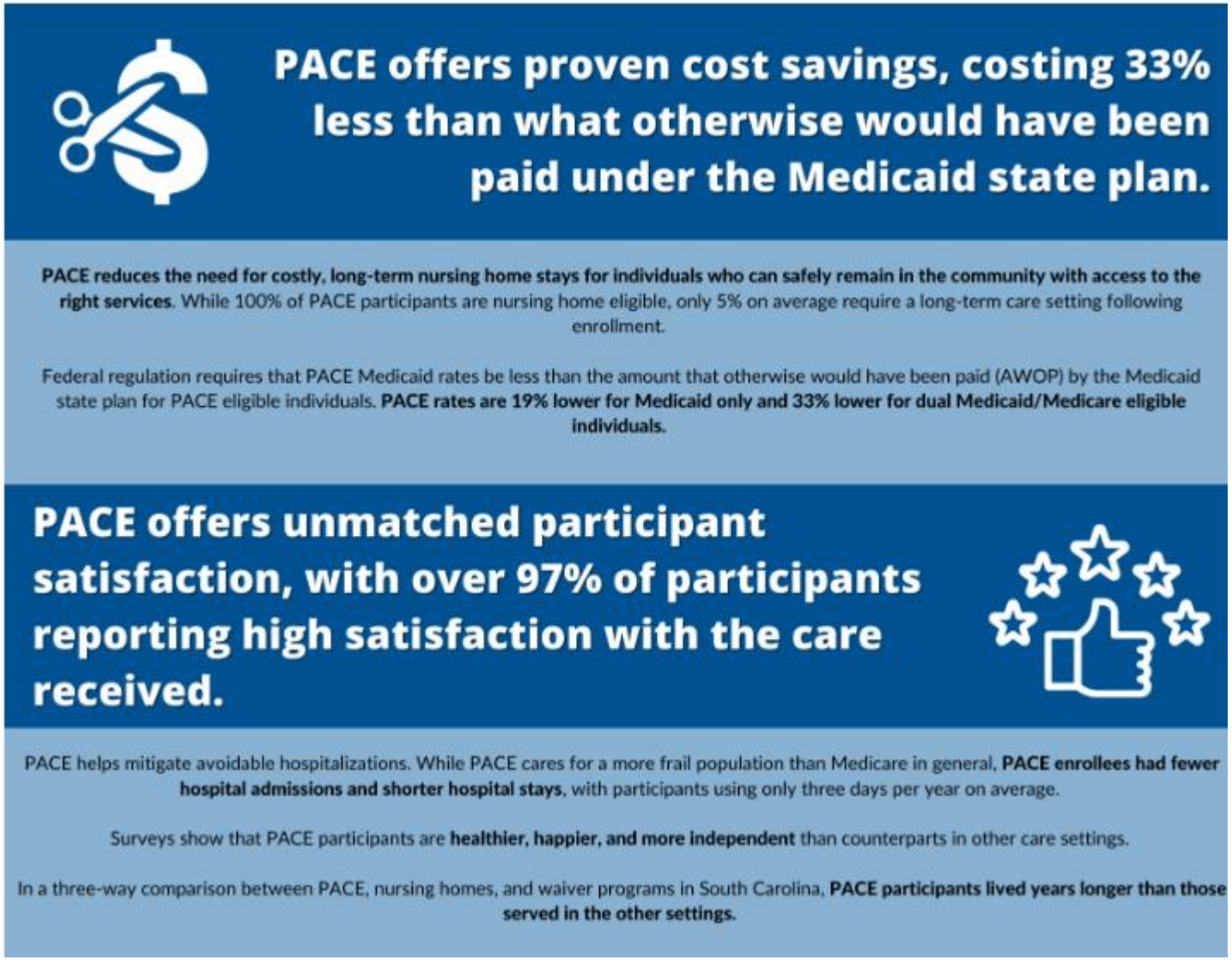
Ohio

# PACE Advocacy

- SFY 2022-23 Biennial Budget
  - Included in Senate version of the bill; removed in conference committee
- HB 45 (December 2022)
  - Expansion of Ohio's PACE programs
  - $50 million in ARPA funds to support start-up
- Awards announced December 2023




LeadingAge Ohio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# Opportunities for Ohio

- Learn from other states
- Leverage scape of nine (9) counties ramping up together
- Concurrent with NextGen MyCare (challenges and opportunities)


LeadingAge Ohio




Five locations in Northeast Ohio

525 employees

Supporting over 1,000 older adults a day

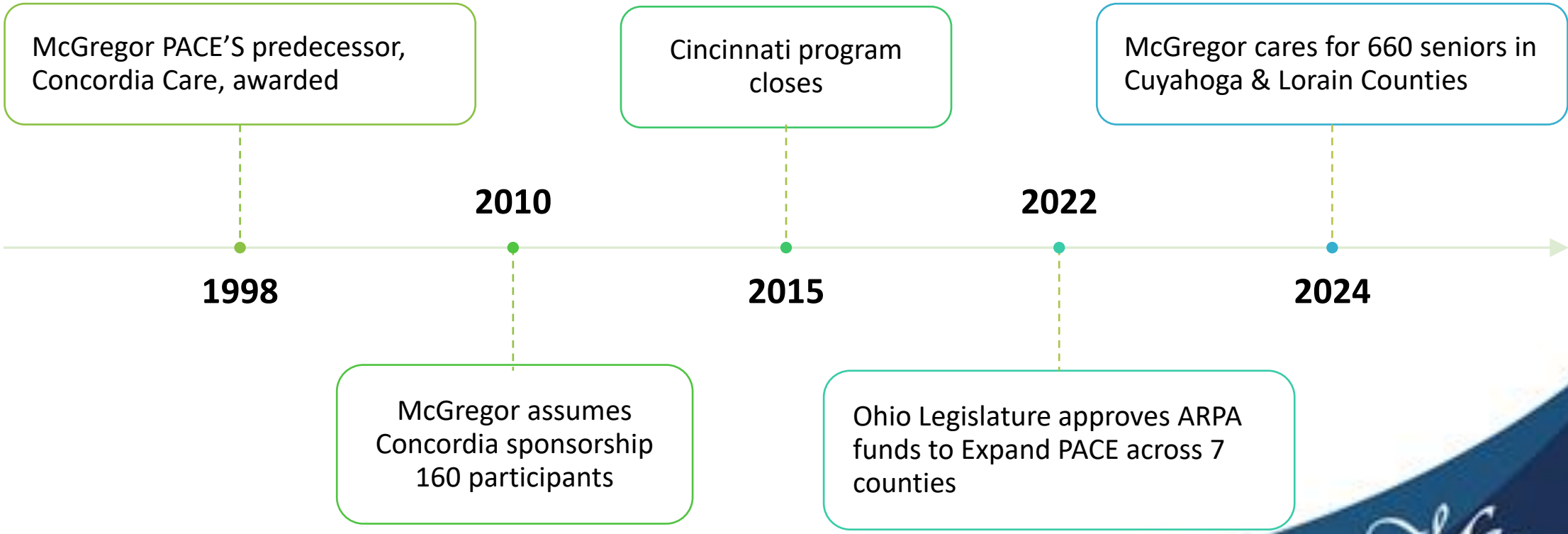
$90 million annual revenue


McGregor

# Agenda

- **PACE in Ohio**
  - History
  - Participant Eligibility
  - Services
- **What is PACE?**
  - Eligibility
  - Program Attributes
  - IDT
  - Day to day

# PACE History in Ohio



# PACE is a *PARTNERSHIP* between the Federal Government, the State Government, and a Local Sponsor

- 76,000 Participants
- 100% Need Nursing Home Level of Care
- 95% Live in the Community
- 5% Live in a Nursing Home
- 32 State Partners
- 163 Sponsoring Organizations
- 300 PACE Centers

# What is PACE?

"**P**rogram for the **All-inclusive C**are for the **E**lderly"

Coordinates and provides **all** preventive, primary, acute and long- term care services

Primary care delivered through onsite clinics

Interdisciplinary care management team meets daily

Regulated by Centers for Medicare and Medicaid Services (CMS) and Ohio Dept. of Aging (ODA)

# Enrollment Criteria

- PACE enrollment criteria:
  - Must meet nursing home level of care
  - 55 years or older
  - Live in the service area
  - Living safely in the community at the time of enrollment
    - Cannot be living in institutional setting

# Enrollment Criteria

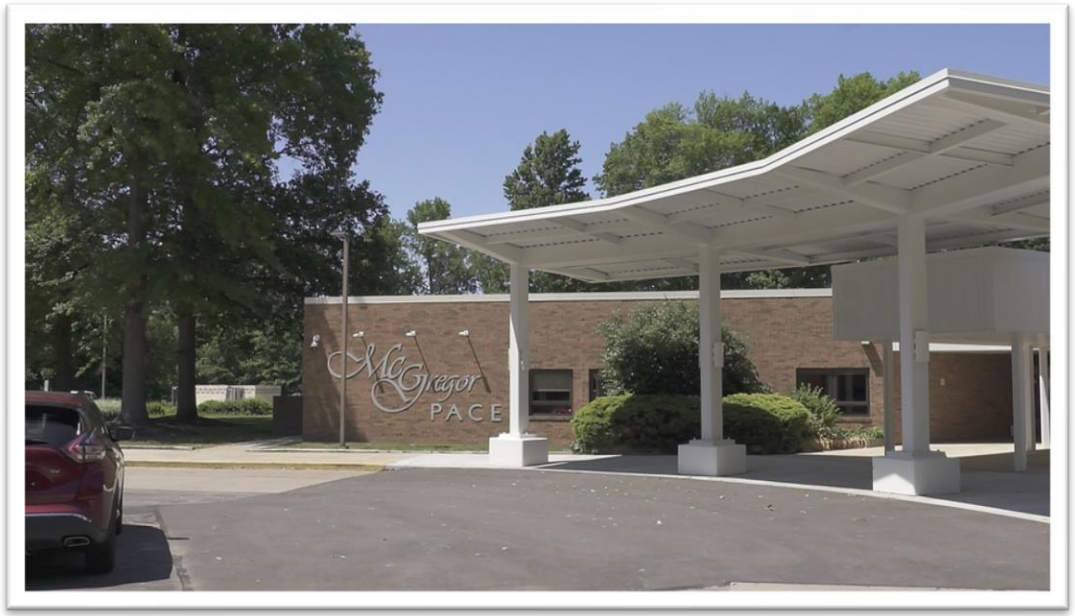
- Ohio nursing home level of care criteria:
  - Requires 24-hour supervision,
  - OR 2) dependent in IADLs plus assistance in 1 ADL plus medication management,
  - OR 3) dependent in IADLs plus assistance in 2 or more ADLs

*ADLs (Activities of Daily Living) includes eating, bathing, dressing, grooming, mobility (transfers), and toileting

*IADLS (Instrumental Activities of Daily Living) includes shopping, meal preparation, completing housework, maintain finances, and managing transportation

# McGregor PACE Services

- Adult day care
- Primary and specialty physician services
- Case management and social work
- Emergency room coverage
- Inpatient hospitalization
- Pharmacy (Medicare part D plan)
- Home support - homecare nursing; safety
- Cover all Medicare & Medicaid services

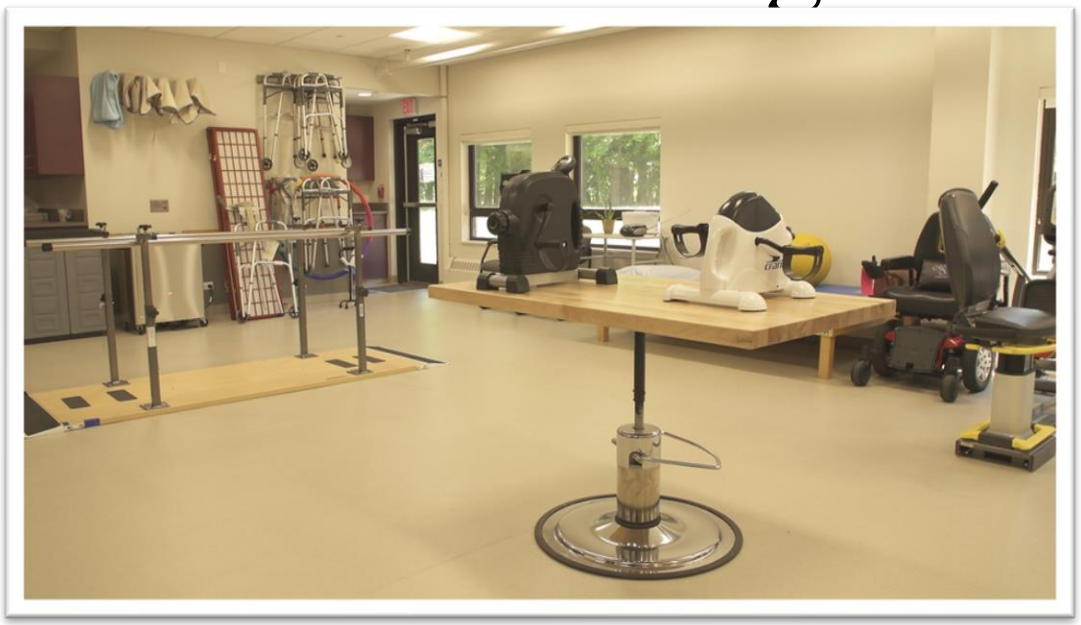


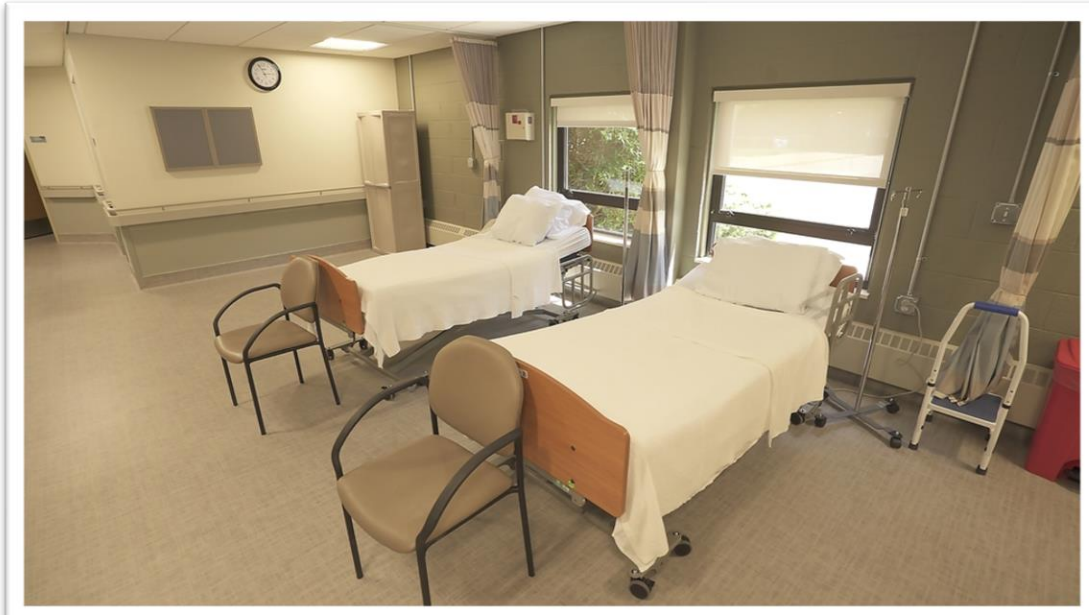

# McGregor PACE Center Locations in Cuyahoga County



# McGregor PACE in Lorain County

# McGregor PACE Centers






# Transportation is Critical

# IDT: Interdisciplinary Team


Each participant is assigned to a team that works closely with them.

The team meets regularly to review assessments, exchange information, and troubleshoot problems as conditions and needs of participants change.

# PACE in Action

Consider the example of a patient who has frequent ED visits to be treated for skin infections caused by flea bites.

The traditional, fragmented care delivery system would have trouble addressing the root cause of the condition and might just keep treating the patient's flea bites.

- In a PACE program, the IDT may decide that it is necessary to pay for pest extermination in the home to address to root cause of the problem.
- This flexibility can produce more cost-effective solutions and a higher quality of life than prescribing costly medications and continually providing hospital services.

# Day to Day for Our Participants

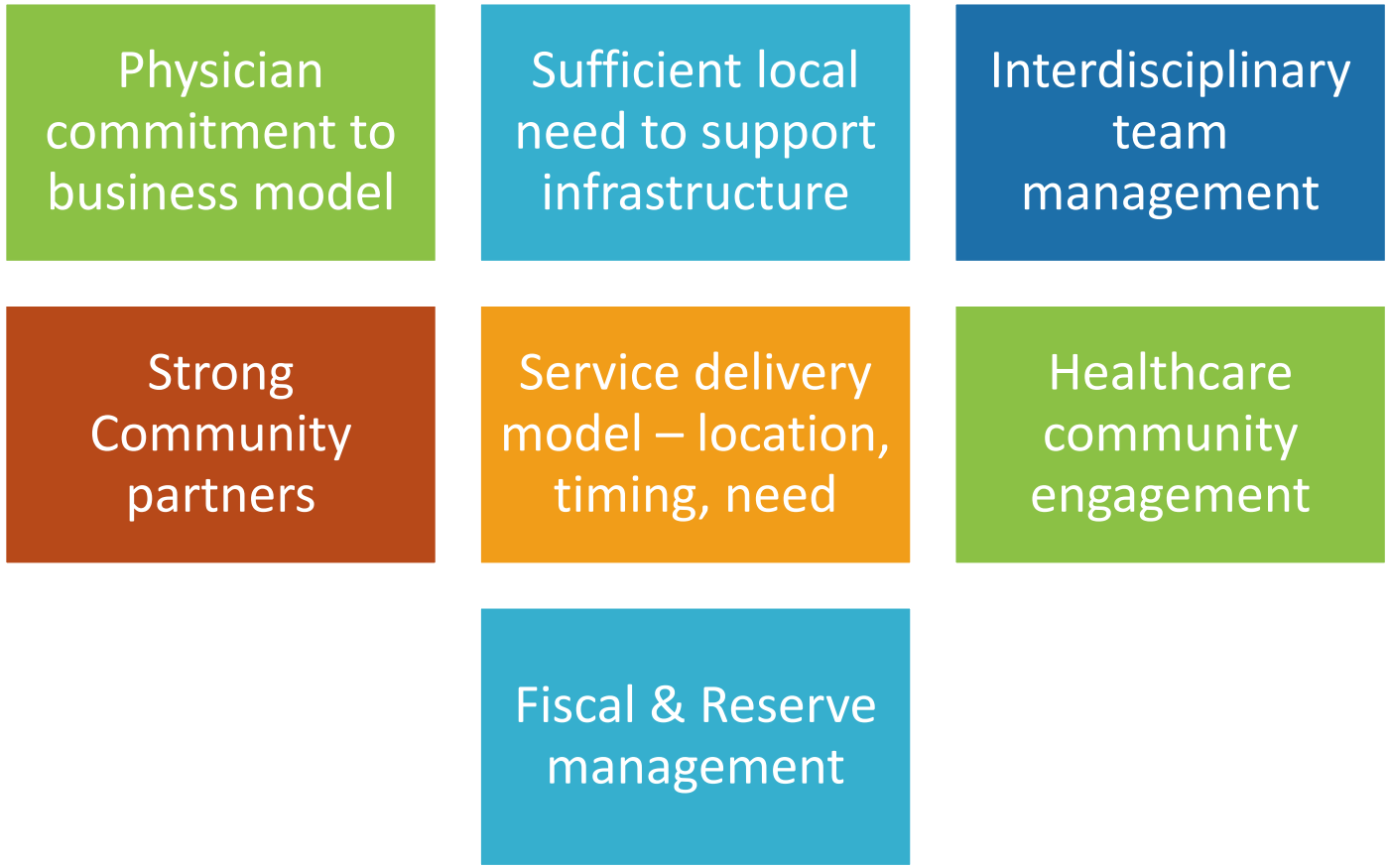
- Home Health Aide visits at home and assists with getting ready to Day Center, helps with egress. Linda, his daughter has already left for work.
- Transportation arrives to transport to Center
- At the Center, Rev. Preston:
  - Medical Visit (Provider has called Linda from the visit to coordinate care and discuss medication changes)
  - Participates in Activities
  - Exercises
  - Enjoys lunch
  - Social Worker checks in with him
  - Center staff may help w toileting/bathing
- Transportation returns him home, bringing along refill of incontinence supplies and delivery of supplement.
- His medications for the month have arrived by mail when he returns home
- Linda is home from work to resume caregiving duties.

# Day to Day Clinic

| |
|---|
| Morning meeting- info sharing including internal/external appointments, changes in condition, on call information, inpatient care/transitions, falls/incident reporting, and more. |
| Participants can be seen acutely in their residence or the PACE clinic in response to information shared in morning report or other sources. |
| Same day appointments with a provider are available Monday-Friday in our clinics at each day center. |
| Participants with chronic issues such as wounds, respiratory issues, pain management, etc. are seen routinely to prevent unnecessary ED visits/hospitalizations. |
| If the participant cannot be managed in the home or clinic setting due to worsening of condition or other factors, an admission to skilled nursing can be arranged at one of our contracted nursing facilities. |

# Participant Centered Care

- The participant care plan is individualized with the participant's goals at the forefront.
- The team communicates regularly with the participant and family and involves them in decision making processes.
- The team is knowledgeable about various cultural, religious and other considerations of participants and families.
- The team is informed and respectful of participant's end of life decisions and other issues affecting their care.
- Goals of care discussions are addressed at each assessment or significant change.




# Successful PACE Program Attributes

# The Path to PACE Partnership

# Began With

Otterbein SeniorLife

Area Office on Aging of Northwestern Ohio, Inc.

Brio LIVING SERVICES

National Church Residences

# The State's Response …

No Really

We Have

# Different Path to PACE Partnership

# New Neighbors

# Making Introductions

# Commitment to Objective Options Counseling

# Commitment to Smooth Care Transitions

# Additional Partnership Opportunities

# PACE of Cincinnati

- Hamilton County
- A partnership between TriHealth and Council on Aging

TriHealth

COA
Council on Aging

# Value Alignment with AAA

- Rapidly growing population – there is enough volume for everyone
- One size does not fit all – We need long term care choices
- No single model is going to work for everyone
- PACE is unique- each site is a small census with integrated health and long-term care services coordinated under one roof.

# Needed:
## Options counseling tool and staff education

Shared principles:

- Person centered tool that clearly outlines all of the individual options
- Identifying what differentiates MyCare from PACE- who is best suited for each option?
- Training and tools designed for case managers, ADRC staff, hospital discharge planners, etc.

# Pace and ADRC

- Over 72,000 inquires last year!
  - Most are phone calls
  - Professional referrals/website referrals
  - Website traffic, resource directory (not included in the 72,000)
- Staff training and tools will be needed.  How is PACE explained, available in some counties, but not others, defining next steps etc.?
- In person assessments, long term care consultations, waiver enrollment.
- Firewall from all other functions.

# PACE and Levy Programs

- Levies are payor of last resort.
- High demand, under resourced, large volume… this is where most older adults fall.  Motivated and required to enroll clients (when eligible) into PACE, PASSPORT or MyCare.
- There is overlap between MyCare and levies for dual eligibles who do not meet level of care requirements.  This is the “Community Well” population.
- Hamilton County Volume – 8,988 during 2023.  250 – 300 transitions to PASSPORT/MyCare annually.
- Avg age 80, 67% female, 60% living alone, avg annual income $21,468
- Bridge option for individuals enrolling into PACE or MyCare?

# Pace and Passport

**Migrating clients:**

- New dual eligibles - Median length of time is 4 months.  Mode = 3 months.
- Avg 37 migrations to MyCare each month in the Cincinnati region.
- Hamilton County: 509 PASSPORT, 109 Assisted Living
- 17% dual eligible PASSPORT
- 44% dual eligible Assisted Living

**Ongoing PASSPORT**

- Most are Medicaid only

# PACE and Mycare

- ODM controls the enrollment process an options.
- Mandatory auto-enrollment into MyCare.
- The letters sent by ODM for new dual eligibles do not include PACE.
- Members transition from community well to waiver within the health plan.
- It would not be appropriate for MyCare staff to offer PACE as an alternative option.

# Development of options counseling tool– Fall 2024

- Design thinking innovation to solve problems
- COA project to develop option counseling tools
- Will include:
  - Infusion of project resources and diverse expertise (ie- computer engineering)
  - National research for best practices, or adoption of models from other industries.
  - Process mapping
  - Stakeholder interviews
  - Feedback sessions, innovative thinking around pot