D.C. MEDICAL CARE ADVISORY COMMITTEE (MCAC)
Sub-Committee Proposal Form

All MCAC sub-committee proposals must be submitted for consideration by the MCAC using this form. Proposals must come from the respective sub-committee chair to MCAC Liaison Trina Dutta (trina.dutta@dc.gov) at least two weeks in advance of the next scheduled MCAC meeting.

1. **Proposal Title**: Support FY 2019 funding of the Program of All-Inclusive Care for the Elderly (PACE)

2. **Submitting Sub-Committee** *(choose one)*

☒Long Term Services and Supports
☐Health Care Re-Design
☐Enrollment & Eligibility
☐Access

3. **Abstract**

In 100 words or less, explain the proposal being submitted for MCAC's consideration.
PACE organizations are person-centered, community-based alternatives to nursing home care. PACE offers an integrated care model that brings together the range of health care professionals and providers involved in supporting an individual's ability to live at home, with the highest possible quality of life. PACE is a financially capitated program, in which organizations receive a per member per month payment to deliver all the necessary care. This results in costs to the Medicaid program that are predictable and lower than the costs it would otherwise incur through its other funded services.

4. **Proposal**[1]

In 1000 words or less, explain the problem being addressed and propose a discrete and actionable solution for the MCAC's consideration. Include any scheduling and/or budget implications, along with risk and mitigation strategies of this proposal.
Click here to enter text.

Despite an array of home and community-based services available through the District's Medicaid program, seniors lack access to a truly coordinated and integrated model of care such as PACE. This was highlighted in the District's most recent community needs assessment in which seniors cited the lack of access to care management as one of their greatest challenges in maintaining their ability to live in the community.

[1] All supporting documents should be provided as attachments to this proposal.

PACE offers an integrated care model that brings together the range of health care professionals and providers involved in supporting an individual's ability to live at home, with the highest possible quality of life. PACE currently operates in 31 states and serves over 40,000 people. Notably, the District is the only metropolitan community in the region without a PACE program– with PACE programs located in Fairfax, Richmond, Philadelphia, Wilmington, Trenton, Jersey City, New York, Providence, Boston and many others. In each of these communities, PACE programs are enabling older adults (55 or older who meet nursing home level of care) to live more independently than they would be able to in an institutional setting by offering a comprehensive, community-based and highly integrated care system that has been cited as the gold standard of senior care.

PACE is able to support an individual's ability to live at home by truly being a person-centered, innovative care model. PACE provides a full range of preventive, primary, acute, and long-term care through the PACE program's interdisciplinary team (IDT) which consists of 11 different medical and paraprofessionals focused on the care of each individual enrolled in the program. The disciplines include: primary care physician, registered nurse, social worker, physical therapist, occupation therapist, recreational therapist, dietitian, PACE center manager, home care coordinator, personal care attendant, and a driver. The members of the IDT work in concert with one another, the PACE participant, and the participant's family to ensure that they assess and understand the unique needs of each individual and deliver comprehensive and appropriate care. Any care that is not provided by PACE staff, such as specialist and hospital care, is coordinated and closely monitored by the PACE team.

PACE is a proven and tested model, which participants rate highly. Ninety-three percent of PACE participants would recommend PACE and nationally PACE participants rate PACE 4.07 out of 5 in satisfaction. The model achieves superior health outcomes as well. A 2014 study published in the Journal of the American Geriatrics Society indicated that "PACE enrollees experienced lower rates of hospitalization, readmission, and PAH [potentially avoidable hospitalization] than similar populations." Furthermore, the PACE program is able to keep 95 percent of participants in the community.

In addition to the favorable health outcomes for participants, there are also significant financial benefits that the District could reap through PACE. PACE is a financially capitated program, in which organizations receive a per member per month payment to deliver all the necessary care. This results in costs to the Medicaid program that are predictable and lower than the costs it would otherwise incur through its other funded services. Nationally, PACE costs are estimated to be 16.5 percent less than what Medicaid would otherwise spend. About 90 percent of PACE participants are dually eligible for Medicaid and Medicare, 9 percent are Medicaid-only, while the remaining 1 percent are typically comprised of Medicare-only, private pay, or some other insurance arrangement.

A small amount of funding was included in the District's FY 2018 budget for PACE. The funds will be used to develop a state plan amendment and update rates for a future PACE organization. Since there are no service dollars included in the FY 2018 budget the District cannot move forward with submitting a state plan amendment, which would add PACE as a Medicaid benefit.

Submitting and getting the state plan amendment approved is a critical step to bringing PACE to the District.

As a result, it is essential that the FY 2019 include service dollars in the budget. Based on data from the National PACE Association, the estimated costs could range from $3.5 to $3.8 million for services that would begin in the second half of FY 2020 and extend through FY 2022, with a maximum enrollment of 200 participants.

5. Supporting Documentation

Any supporting documents should be provided as attachments to this proposal, and referenced in the Q4 Proposal above. List these below.

a. Segelman, Micah, Szydlowski, Jill (2014). Hospitalizations in the Program of All-Inclusive Care for the Elderly. *Journal of the American Geriatrics Society,* 62(2) 320-324.
b. D.C. PACE Cost Estimate, National PACE Association.
c. Click here to enter text.
d. Click here to enter text.
e. Click here to enter text.