

Rapid PACE Responses in a Covid-19 Era

How PACE Providers Have Innovated and Adapted to Keep Enrollees Safe in Their Communities

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In the spring of 2020, the Covid-19 pandemic began rapidly reshaping long-term services and supports (LTSS). For frail elders, whose needs span both medical care and LTSS, the impact of the highly contagious virus has been catastrophic. High morbidity and mortality rates among those who are infected have been widely reported, with the most severe impact occurring in the nursing home resident population. Due to high death rates in congregate residential LTSS settings, such as nursing homes and assisted living facilities, interest in alternative LTSS models offering home and community-based services (HCBS) has been rising quickly.



PACE organizations responses during the initial Covid-19 outbreak were varied and ingenious.

Yet to date, little HCBS policy analysis has focused on arrangements that could serve the middle-class Medicare population in need of LTSS; rather, these discussions have mainly looked at lower-income individuals who already meet the clinical and financial eligibility requirements of state-administered Medicaid programs. This foreshortened perspective ignores important national policy strategies that could help to expand access to LTSS for tens of millions of “baby boomers” eligible just for Medicare. Surveys clearly demonstrate that this historically large cohort is hoping to avoid (or delay for as long as possible) “spending down” in order to qualify for Medicaid-funded LTSS which, although it provides a source of payment for services, also requires living with few choices, barely adequate services, and severe impoverishment.¹

Against this backdrop, the Program of All-Inclusive Care for the Elderly (PACE), which serves over 54,000 participants in 31 states (as of September 1, 2020), has emerged as a highly adaptable HCBS integrated care model that could help many more Medicare-only beneficiaries. PACE’s strength lies in the fact that it is deliberately designed to provide a comprehensive range of medical care and LTSS for disabled older adults who meet their state’s Medicaid criteria for nursing home care and

who are seeking highly coordinated, community-based care. In other words, the PACE model of care is designed to keep frail elders as well as possible, manage any medical crises at home, and reduce admissions to both hospital and residential LTSS settings, where transmission rates of Covid-19 have been high.

During the spring and summer of 2020, the responses of several PACE organizations during the initial Covid-19 outbreak were varied and ingenious.

Actions taken by PACE organizations included:

- ▲ 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.

Descriptions and accounts of these and other innovations deployed by PACE organizations during COVID-19 were described during a June 30, 2020 webinar presented by the National PACE Association and two PACE organizations based in North Carolina and Colorado, and through interviews with key staff in Michigan and Massachusetts.²

Background

PACE is a well-established financing and care delivery model for older adults (over age 55) who need a nursing home level of care. Originally conceived as a capitated model of care for dually eligible beneficiaries, PACE provides all necessary medical care, therapies, long term care and services, meals, socialization, transportation, day center services and activities. Today there are 135 PACE organizations in 31 states, with enrollment ranging from about 50 to over 3,000 participants, as of September 1, 2020.

Ninety percent of PACE participants are dually eligible for Medicare and Medicaid, 9 percent are eligible only for Medicaid, and less than 1 percent are eligible only for Medicare. Unfortunately, the Medicare-only census is very low due largely to exorbitant PACE Part D premiums for prescription drug coverage, as identified in internal research conducted by the National PACE Association (NPA).³ PACE participants are typically dependent in at least two activities of daily living (ADLs), and/or in need of constant supervision due to cognitive disability. To be accepted into the program, participants must be able to live safely in the community with the support of PACE services; many have family caregivers.

Unlike other LTSS options in the community, the PACE model of care addresses both medical and biopsychosocial needs, including some social determinants of health, e.g., transportation and nutrition services. PACE offers a comprehensive and integrated service array, starting with a

participant-centered care plan that includes substantial input from participants and families, and which is constructed in partnership with an interdisciplinary care team.

Although all PACE participants are certified as clinically eligible to receive nursing home care by their state, few do: Only about five percent of PACE participants actually reside in a nursing home. This low percentage is attributable to ongoing, careful monitoring of PACE participants, who on average have six chronic conditions (including 46 percent who have dementia and over 40 percent who have serious mental illness⁴) and to the financial incentives proffered by capitation, since PACE organizations bear full financial risk for all care and services. Capitated payments under Medicare motivate PACE organizations to try to keep participants as well as possible in order to keep inpatient hospital and skilled nursing facility costs down, and evidence shows PACE organizations generally have lower inpatient hospital use and shorter hospital lengths of stay. In addition, many PACE participants are motivated to stay in the community and they and their families are willing to exert themselves and possibly take some small risks to do so, with the supports provided by PACE. In 2020, the mean Medicaid capitation rate was \$3,981 and the mean Medicare capitated payment was \$2,797.

PACE organizations employ interdisciplinary care teams (IDT) comprised of primary care physicians, nurses, therapists, social workers, dietitians, home care professionals and others who work together to assess individual PACE participants needs, develop care plans and provide and coordinate all primary, acute and LTSS services. Typically organized in the PACE day center, the IDTs meet daily to discuss the emerging and ongoing care needs of the 150-200 individuals for whom they are responsible for caring. The IDT serves as the central hub of the PACE model of care and plays a vital role in the outcomes achieved by PACE.

Once enrolled, nearly all PACE participants remain in the program through the end of life, unless they move out of the geographic service area. In a 2018 survey conducted by NPA, 96 percent of family members reported overall satisfaction with the services and 97 percent said they would recommend PACE to a family in a similar situation.⁵ No similar programs of care come close to achieving this level of satisfaction. Further, 58 percent of family caregivers had a decrease in the level of burden felt after their loved one enrolled in PACE.⁶

Responses: PACE and the ‘New Normal’

Like other health care and LTSS providers, when Covid-19 surfaced in March 2020, PACE programs faced a crisis. Given their age, multiple morbidities and frailty, PACE participants are especially vulnerable to the virus. Living in the community, they are at risk of infection from both family members and staff, especially since most PACE participants regularly attended group activities in the PACE Center and received medical care and LTSS there as well. Many PACE programs did not have large stores of personal protective equipment (PPE) on hand when the pandemic surfaced and were not prioritized for either Covid-19 testing or PPE by public health officials. With regard to Covid-19, dually eligible beneficiaries are at higher risk to contract Covid-19 and be hospitalized than non-dually eligible Americans.⁷ Despite their frailty, dually eligible PACE participants have a lower hospitalization rate and, to date, only 1.6 percent of PACE participants from reporting programs were confirmed to have COVID-19 and died between April 27, 2020 and September 21, 2020.⁸ By comparison, 3.4 percent of the 2.1 million nursing home and assisted living residents had died from COVID-19.⁹



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Early in the pandemic, faced with Covid-infected and Covid-suspected participants—and operating with very little direct guidance from the federal and state governments—quick-thinking PACE programs took advantage of their flexibility to redesign service delivery rapidly. Information gathered by NPA indicated that most programs quickly adopted a greater use of telehealth, though use of video technology was limited to some degree by the capabilities and income level of participants and families. Others made a variety of rapid, effective adaptations to their care and support protocols to serve and protect their frail elders that are described here.

These adaptations reflect those put into place by other PACE organizations, and serves as successful examples for community-based providers serving a frail elderly population who are motivated to address the full spectrum of medical, LTSS and social needs during public health emergencies. These lessons learned will remain relevant for some time, since Covid-19 will continue to be prevalent in many communities until an effective vaccine is widely disseminated. Some may also be applicable to other situations, such as an influenza outbreak. Policymakers should take note of the merits of comprehensive, community-based service providers for frail and disabled elders.

Fallon Health’s Summit ElderCare, Worcester, Massachusetts

In March of 2020, Fallon Health’s Summit ElderCare PACE plan prepared for a worst-case scenario. Based in Worcester, Massachusetts, Summit ElderCare is the sixth-largest PACE plan in the country, with 1,312 participants enrolled at five sites in Massachusetts and one in New York as of August 1, 2020.

The dire situation of hospitals and widespread outbreaks of Covid-19 in skilled nursing facilities (SNFs) and assisted living facilities (ALFs) in the northeastern United States in the spring of 2020 convinced Fallon Health that, while its Summit ElderCare PACE Centers could remain open for limited services for the few elders who had medical and/or social needs to continue coming, the urgent need was for an infirmary for Covid-19 positive participants. Such a space did not exist—so Summit ElderCare went about creating one. On April 22, 2020, the PACE Center in Worcester, Massachusetts opened as a 22-bed skilled care unit with approval from the Massachusetts Executive Office of Health and Human Services.

According to Dr. Robert Schreiber, VP and Medical Director for Summit, “getting the infirmary up and running was a huge undertaking.” Among the required tasks were development of an operational

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readiness plan; and creation of training and staffing protocols for admissions, medications delivery, palliative care, therapy, food, family visiting and discharge from the infirmary. Budget, operational readiness and implementation plans had to be written, and staff had to be identified and rapidly trained. Personal protective equipment (PPE) had to be obtained, and protocols written for its use. Certain building code upgrades had to be made, including bringing the electrical system up to code for newly needed equipment.

The first participant was admitted on April 23, 2020, and the last was discharged on June 5, 2020. A total of 11 participants were served. Of these, three died, and their families were able to be with them on site. The infirmary allowed Summit ElderCare to “transform to meet the needs of frail older adults with Covid-19 in novel ways,” Schreiber said. For example, it provided a safe way for Covid-positive elders to be discharged from hospitals and to be cared for in a purpose-designed setting—including individuals with dementia and those needing end-of-life care. It also allowed families to be with their elders, which has typically not been the case for many ill elders cared for in hospitals and nursing homes during the pandemic. Further, PACE staff were able to care for Covid-positive participants in a controlled environment without the challenge of needing to go into their homes. Overall, the infirmary worked to “give families hope while also giving hospitals [discharge] options.”

Summit ElderCare’s rapidly created PACE infirmary provided a safe way for Covid-positive elders to be discharged from hospitals and to be cared for in a purpose-designed setting—including individuals with dementia and those needing end-of-life care.

More broadly, Schreiber observed that Fallon Health data during the pandemic showed that more elders and their families decided to return directly home after hospitalization, choosing to forgo potential skilled nursing facility stays. They were willing to wait for a needs assessment while living in the community—a core requirement for PACE enrollment. This required a repurposing of PACE providers and staff to do assessments and arrange for services quickly. Due to Covid-19, families expressed heightened interest in trying to figure out how to best support the clinical and LTSS needs of their elders at home in lieu of using a SNF or ALF. Changes in emergency department (ED) utilization are also surfacing, according to Schreiber, with a greater number of older adults being discharged from the ED who previously would have been admitted to the hospital. Additionally, more ill and injured frail elders are opting out of coming to a physicians’ office and are accepting home visits for treatment, rather than seeking care in the ED.

Huron Valley PACE, Ypsilanti, Michigan

In Ypsilanti, Michigan, Huron Valley PACE (HVP) took advantage of a recent major expansion of its PACE Center to provide round-the-clock care for participants testing positive for Covid-19, for those with symptoms and for those suspected of having the virus. Similar to Fallon Health, a Covid-19 inpatient unit was established, using dividers in the expanded PACE Center for 10 beds dedicated for Covid-19 care, and 10 beds for participants testing negative and who required respite care. “We did this, Executive Director Sonja Love Felton explained, because nursing homes and assisted living facilities were not taking people.” As of June 2020, 10 participants had used the Covid-19 or respite unit for round-the-clock care. With regard to families needing overnight respite care, “we’ve had two weekends of respite.”

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HVP adapted a flexible, innovative approach early in the pandemic: When a PACE participant was being discharged from a local hospital without a place to return to for 24-hour care, Huron Valley opted to rent a hotel room for the weekend, deploying two aides to assist the participant until the following Monday, when their PACE Center Covid-19 inpatient unit was ready.

During the pandemic, six to 10 participants have continued coming daily to the PACE Center. All are tested for the virus on a bi-weekly basis, with results generally being returned within 24 hours. Participants are given masks if they do not have one when they are picked up by the PACE van, and each must wear a mask during transit and at the Center. On arrival at the PACE Center, participants have their temperature taken and are assisted with maintaining physical distancing.

Beyond services provided in the PACE Center, Huron Valley is sending nurses, home care aides, and other IDT members to participants' homes to provide care, as needed, and the Center's physician is conducting home visits as well. Through mid-June, Huron Valley had reported 13 cases of Covid-19 among their 190 participants, with only one death.

Piedmont Health SeniorCare, Raleigh-Durham, North Carolina

When Covid-19 began taking hold in the Mid-Atlantic area, Piedmont Health SeniorCare made the decision to move from center-based services to a mix of home-based services and telehealth. This PACE program developed new service delivery platforms to meet existing care plan goals and adjusted planned interventions for the home environment.

To start, Piedmont also created new risk stratifications to help with virtual management of those with particularly high-risk conditions, e.g., high risk for hospitalization or exacerbation of chronic obstructive pulmonary disease, cardiac heart failure, diabetes; high risk for skin breakdown, foot ulcers, or pre-existing wounds; and nursing facility patients. These risk categories determined the intensity and nature of care and service interventions provided to the individual participant. For instance, the categories directed which participants would be contacted regularly by a physician, rather than another PACE staff member.

In addition, the IDT identified services gaps through online careful assessment of medical issues, caregiver support, behavioral concerns and social determinants, among others. Every morning and evening, the IDT would huddle via Zoom to coordinate care. At a minimum, every participant received a weekly call from staff, who conducted a comprehensive review via phone. Concerns identified were addressed with prompt home visits, clinic visits, emergency room referral or specialty consult. Acute medical visits were provided in the PACE Center, and others were met remotely or with services provided in participants' homes while meeting the infection control requirements required under Covid-19 guidelines.

Examples of new approaches in PACE's service delivery included:

- ▲ **Home monitoring and home care:** Piedmont Health SeniorCare was fortunate to acquire some telehealth equipment and technology including scales and blood pressure cuffs. With additional telehealth capacity, monitoring complex participants remotely proved challenging but successful. Piedmont also reallocated tablets not in use at the PACE Center to participants, who used them for tele-video visits. For caregivers and participants who were not interested or lacked the capacity to use Zoom, phone and in-person visits were substituted. In addition, North Carolina Governor Roy Cooper provided Piedmont with a temporary home care license to allow PACE staff to deliver many services at home (this was necessary because under North

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Carolina regulations, additional licensure was required for Piedmont to be able to deliver a higher volume of home care services than normal). To improve community service delivery, Piedmont converted one of its PACE vans into a mobile exam room, since some participants' homes lacked good lighting and other conditions needed to properly conduct exams and provide treatments.

- ▲ **Nutrition:** To mitigate food scarcity experienced by some participants, the PACE dietician arranged for mid-day meals to be delivered at home and for pantries to be restocked with groceries as needed.
- ▲ **Medication:** Medication adherence was encouraged through phone alarms, calendars, and encouraging routines.
- ▲ **Exercise:** To maximize participants' functional levels and prevent falls through exercise, PACE sponsored weekly videoconference calls for coaching and monitoring. Programs include pressure relief exercises, sitting and standing exercises, balance exercises and resistance exercises. PACE also provided materials needed to execute home exercise programs (e.g. resistance elastic "TheraBands") and virtual group exercise and dance classes were posted to YouTube.
- ▲ **Engagement:** To enhance cognitive stimulation and fine motor skills, PACE delivered weekly brain games, crafts and gardening kits to participants' homes. In addition, virtual classes on painting, book discussions, and cooking promoted brain health, education, independence and engagement. PACE staff helped participants tune into expanding online entertainment programs, such as PACE's weekly live bingo on the organization's Facebook page.
- ▲ **Mental health:** Simple low-tech interventions helped participants stay connected and prevented social isolation, anxiety, and depression. Examples include: conducting mid-day check-ins to participants at risk for increased anxiety or depression; delivering bouquets on Mother's Day; decorating front porches on birthdays; outside window visits to several participants residing in skilled nursing facilities that were closed to outside visitors; delivering helium balloons along with medications; and mailing personalized greeting cards to participants from members of the care teams to remind them that they are loved and missed. Social workers coordinated group Zoom visits for participants to connect those missing each other during the PACE Center closure. Gospel singalongs were held by phone, and the local Chaplain reached out to hold grief and virtual spiritual support groups.



Simple, personalized interventions can help prevent social isolation. Here, a Huron Valley PACE participant holds a handmade birthday card she received for her 90th birthday.

TRU Community Care/TRU PACE, Boulder, Colorado

At TRU PACE in Boulder, Colorado, 60 percent of enrollees live alone, and 37 percent have dementia. During the first part of the pandemic, many medical facilities closed, presenting challenges for keeping frail elders out of crisis. In addition to their chronic conditions, all TRU PACE participants have low incomes, and most have ongoing challenges maintaining affordable housing and nutritional security. Samantha Black, executive director of TRU PACE, observed that the program is "grounded

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in a social model, so creating inclusiveness and community is natural. Embedded in that is exquisite medical care and rehab.”

In an effort to avoid possible negative impacts associated with social isolation, Covid-19 prompted TRU PACE to increase its focus on social determinants. The organization devised a series of creative solutions, including a “trishaw” program—a concept popularized in Denmark—in which a local organization brings over rickshaws for elders to take them outside. The philosophy is to get older adults out and “let them get some wind in their hair,” according to Black. Rides last 10 minutes to an hour and can take place as often as three mornings a week. TRU PACE also launched an “Adopt a Grandparent” program that aims at developing intergenerational connections with teens, who are charged with developing relationships with “PACERs,” often through documenting their life stories. The organization is also launching a “Teen Tech” program for volunteers to help PACE participants learn more about online activities and offerings.

The program gave out tablets and smartphones to participants and helped them sign up on social network platforms. This in turn facilitated weekly “town halls” that participants and staff co-design. TRU PACE created a phone tree among participants to talk to each other. Throughout, Black stressed that PACE participants have made it clear they want to be active participants, not passive recipients in care—“venerable, not vulnerable.”

Covid-19 Points to the Need to Create More Community-Based Capacity for Older Adults

Taken together, these responses suggest that 2020 is a critical time to capture, document and analyze the full range of PACE “best practices” for dissemination to a wide audience, including policymakers, since these approaches have broad applicability to other vulnerable and at risk populations for contracting Covid-19. Such actions will improve our collective ability to devise ways of scaling, expanding and adapting the PACE model of care, which has demonstrated a remarkable ability to respond rapidly to unexpected and extremely challenging circumstances. As a model that is grounded in community culture and local circumstances serving vulnerable and marginalized populations, PACE organizations are now poised to become more visible and relevant to a larger public, which is deliberately seeking sources of comprehensive, community-based service alternatives to institutional care options.

The heart of the PACE model is the IDT, which, with the participant and family, assesses care needs, develops care plans and delivers the services in these plans. The IDT is based at a PACE center where many services are provided including primary care, physical and occupational therapies, adult day care, group activities and some meals. But the highly infectious nature of Covid-19 is shifting perceptions, which is evident in the fact that leading PACE organizations have significantly expanded the number and frequency of care and services provided beyond the walls of their PACE centers. Throughout the pandemic, PACE organizations have decreased their reliance on regular attendance in centers, while simultaneously repurposing and reconfiguring these centers for additional functions, e.g., providing overnight care (which no PACE organizations had ever provided before), and making parts of the PACE center an isolation area for Covid-19 infected participants.

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To better accommodate these shifts, PACE organizations are in the process of redefining staff roles as they move an increased amount of support into participants' homes. They are also providing post-hospital therapies in the PACE center and the home more often as an alternative to a skilled nursing facility stay for frail elders. Like many other Medicare and Medicaid providers, PACE has also further embraced telehealth—a development that is likely to accelerate. Traditionally, PACE has relied heavily on face-to-face interactions and interventions with participants. Now, PACE organizations are quickly transforming to best meet the evolving needs of their participants, whose own circumstances have changed due to Covid-19—both by figuring out how to field a more comprehensive array of services in participants' homes more frequently, and by adapting the PACE center itself for different uses.

The pandemic has dramatically highlighted the need for much more robust community-based, multi-disciplinary care options across the country. At this juncture, PACE has the potential to grow from being a highly regarded, small-scale program to one that could serve hundreds of thousands (and perhaps more) elders. As the Medicare population swells, many who are financially independent today will eventually (and in many cases quickly) spend down their life savings and other assets once they become functionally dependent, frail, or cognitively impaired.¹⁰ The U.S. economy is not healthy: A recent study found that nearly 700,000 older Americans, who ordinarily would not meet the income and asset eligibility limits for Medicaid, became eligible due to the costs of medical and other necessary care.¹ Compounding this is a high burden of chronic conditions among older adults, with 62 percent of those age 65 and older living with multiple chronic conditions, and 16 percent also reporting at least one self-care dependency.¹¹ Taken together, along with growing number of elderly, it stands to reason that many more older adults might rely on Medicaid as the payor for their long term services and supports.

While some states have statewide (or nearly statewide) PACE availability, too many restrict PACE to being offered only in certain areas or cap either the number of PACE organizations or number of participants per organization. These arbitrary limitations impede PACE organizations from easily expanding to meet consumer demand, not only within existing service areas, but also to new, unserved service areas. The need for PACE programs has never been greater, in part because many states are not allowing Adult Day Health Centers (ADHCs) to re-open quickly as Covid-19 continues to spread. Older adults who depend on ADHCs as their primary provider of social and nutritional supports may not fare well without access to these services. PACE programs are one option that can increase capacity quickly to help those most at risk and vulnerable for functional and medical decline.

PACE is a proven model for optimizing well-being during functional and cognitive declines among the dually-eligible population. Further, PACE is roughly half the cost of nursing home care. Therefore, deliberately expanding PACE to also serve the middle-class Medicare-only population would greatly reduce spend-down among those who can afford to pay for their own LTSS (the capitation rate that Medicaid would otherwise pay). A middle-class and wealthier Medicare-only population would also benefit medically from the program's focus on preventing functional decline and from reduced hospitalization. However, a major barrier stands in the way of PACE expansion to a middle-class Medicare population—the exorbitant cost of PACE Part D premiums, which arises because Medicare-only PACE participants do not benefit from government participation in Part D. Other obstacles include a federal prohibition on two-way agreements between PACE organizations and the Medicare program; if addressed, PACE could expand more readily in states where PACE is not part of the Medicaid program to serve Medicare-only beneficiaries. A third challenge is the current

requirement that PACE organizations charge Medicare-only participants an average rate, rather than one reflecting their individual care needs.

Analysts and stakeholders increasingly acknowledge that PACE is particularly well-suited and well-positioned to play a major role in addressing the needs of community-dwelling frail elders, whose needs range from light-touch daily living supports to high-touch continuous care with wraparound medical and social services. As noted in a recent analysis published by the Bipartisan Policy Center, PACE is an excellent, efficient model of care service delivery for full-benefit dually eligible beneficiaries.¹² In addition, PACE's tight care coordination, multi-disciplinary team-based approach and attention to social determinants of health of community-dwelling participants means that these organizations could be helpful partners to larger health care systems that are challenged by treating ever-rising numbers of frail elders. If PACE were to be offered in every state, it could work alongside more loosely integrated insurance-based models of care and emerging Alternative Payment Models to provide intensive supports for high-need frail elders whose needs for services span a wide range, and who require close monitoring to manage their multiple chronic conditions, functional limitations and/or cognitive impairment.



If PACE is offered across the country, it could work alongside more loosely integrated insurance models and value-based payment models to provide intensive supports and services for frail elders, who require close monitoring to manage multiple chronic conditions, functional limitations and/or cognitive impairments.

Looking Forward to 2021

The exogenous shock presented by Covid-19 to the U.S. health care system has brought into focus several concerns for older adults. First and foremost, the infection and death rates among nursing home residents from Covid-19 are high. A recent analysis of death rates from Covid-19 concluded that frail elderly individuals living in nursing homes and assisted living facilities (0.62% of the U.S. population) accounts for about 40% of all U.S. deaths to date from the virus.⁹ Second, the pandemic and its aftermath could bring about earlier onset of functional disability and complex medical needs in a cohort of vulnerable survivors, and these individuals' retirement savings may be eroded by a struggling economy. Few affordable options for LTSS are currently available to the middle class, burdening many older adults and their families with chaotic delivery choices and high out-of-pocket costs.¹ And if states tighten Medicaid eligibility rules for LTSS, many more older adults living with cognitive and functional limitations may struggle to access personal care in the future.

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Fallon Health's Summit ElderCare PACE participants enjoy a socially-distanced music performance at the Covid-19 infirmary.

Given these difficult scenarios, paying more attention to PACE makes sense. Peter Fitzgerald, NPA's Executive Vice President of Policy and Strategy, recently observed that "it's really the PACE IDT [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."² Among the priorities for 2021, he said, NPA will work with Congress and with the Centers for Medicare and Medicaid Services (CMS) on facilitating increased PACE

enrollment by expediting PACE enrollment assessments and permitting participants to join mid-month. Another goal will be to change currently inflexible and lengthy eligibility determinations along with the limitation to enrolling only on the first of the month that make it hard to convert a hospital discharge into PACE enrollment. NPA will also continue working to solve the Part D cost barrier that prevents all but a tiny number of Medicare beneficiaries from enrolling in PACE before they have spent down to Medicaid. Furthermore, NPA will continue to urge CMS to revisit earlier work on PACE-specific pilots.

Anne Tumlinson, a consultant with AT Strategies, recently commented that "never before have we so needed flexible community-based care options." At the June 30, 2020, webinar, she noted that "PACE is not just an adult day care program." PACE organizations "have really demonstrated what they are capable of" during Covid-19, she said, and are beginning to demonstrate "how we can deploy a very efficient workforce into the community" in a manner that is "agnostic as to time and space."

Today's fractious health policy environment is being deeply shaken by Covid-19—and the pandemic is putting into stark relief such observations as these: the need for much more regulatory flexibility that permits sensible adaptations to service delivery and design; and the imperative to encourage and lead deeper collaborations among medical and LTSS providers. In short, Covid-19 is a time of crisis, challenge and opportunity. The pandemic has also made it clear that PACE can respond quickly and that it is a suitable model for a time when staying in the community and away from congregate sites continues to be a priority.

Providing services successfully now and in the future will require thinking creatively about how to field innovative, flexible, highly coordinated care as circumstances change, emphasizing the use of existing resources and assets. Such systems must be cost-effective, integrated with medical and social supports, and readily accessible to large numbers of older adults living in the community. In short, the U.S. is being challenged to create on-ramps to comprehensive, safe community care that is scaled to handle the U.S. "age wave"—which has now arrived. PACE can be an important part of the answer.

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With additional thoughtful regulatory flexibility, PACE could expand rapidly in this decade to meet the much higher demands for eldercare services which, unless they are carefully designed, are likely to send health care costs soaring. Not only do PACE organizations have an IDT and community center designed to provide comprehensive care planning, primary medical care, supervision, therapies, and supportive services, but also they have dedicated transportation systems for participants, along with an ability to efficiently deploy services to their home as appropriate. PACE is also responsible for a defined geographic area and knows the challenges and resources of that area well, and PACE programs are fully responsible for their participants and have shown a remarkable willingness to stretch to ensure good service. If properly configured, these assets could be used and should be used by the larger community.

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