Understanding LIFE

A practical orientation for PACN-ACO practices

LIFE

Living Independence For the Elderly

LIFE is not Pennsylvania PACENET or PACE prescription assistance

LIFE

Pennsylvania's comprehensive program for eligible older adults. LIFE coordinates medical care, prescriptions, behavioral health, transportation, home-based services, social supports, and long-term care through one interdisciplinary team.

Pennsylvania PACE / PACENET

Pennsylvania prescription assistance programs that help eligible seniors with medication costs. They do not provide the comprehensive medical and social services included in LIFE.

LIFE is Pennsylvania's name for the Federal Program of All-Inclusive Care for the Elderly (PACE).

What this presentation covers

1 Define LIFE

- Model
- purpose

2 Eligibility

- Who may qualify

3 PCP role

Before and after LIFE enrollment

4 value-based care

- Why the model matters
- ACO Attribution Impact

Complex needs extend beyond the office visit

The challenge

Older adults increasingly live with multiple chronic conditions, functional limitations, social needs, and fragmented care. Standard access alone does not guarantee coordination, affordability, or support at home.

The opportunity

LIFE combines medical, social, pharmacy, prescriptions, transportation, home-based, and long-term support services around one individualized plan.

One program, comprehensive responsibility

LIFE

Living Independence For the Elderly

Who it serves

Adults age 55+ who meet nursing-facility level-of-care criteria and can live safely in the community with support.

What it covers

All Medicare and Medicaid services, prescriptions, plus additional care approved by the interdisciplinary team.

Federal terminology

LIFE is Pennsylvania's name for the federal Program of All-Inclusive Care for the Elderly (PACE).

ELIGIBILITY

Who may qualify for LIFE

- Age 55 or older
- Lives within a LIFE program service area
- Meets Pennsylvania nursing-facility level-of-care criteria
- Can live safely in the community with LIFE support
- Chooses to enroll voluntarily
- Cannot be enrolled in hospice

Important coverage note

Enrollment requires coordination of Medicare and Medicaid coverage through the LIFE organization. Confirm current plan and status during program assessment.

***The average PACE participant is 76 years old and has multiple complex medical conditions, cognitive and/or functional impairments, and significant health and long-term care needs. Approximately 90% are dually eligible for Medicare and Medicaid.**

LIFE CORE GOALS

Help eligible seniors remain safely in the community

1 INDEPENDENCE

Maximize function and autonomy

2 COORDINATION

Unify medical and support services

3 AVOIDABLE USE

Reduce preventable Emergency and hospital care

4 QUALITY OF LIFE

Support patients and caregivers

LIFE team: one care plan, coordinated services

1 Assess

- Clinical
- Functional
- Social
- home needs

2 Plan

Create and update an individualized plan of care

3 Coordinate

Arrange all covered services and transitions

4 Deliver

Provide care through LIFE centers, home services, and contracted providers

The LIFE participant is supported by a full team

- **Physician And Providers**
- **Nurse**
- **Social worker**
- **PT / OT / ST**
- **Dietitian**
- **Pharmacist**
- **Personal care aides**
- **Transportation staff**

Shared accountability

The LIFE team jointly assesses needs, establishes the plan of care, coordinates services, and responds as the participant’s condition changes.

COVERED SERVICES

A broad benefit package under one program

- Primary and specialty care
- Behavioral health and dementia care
- Labs and diagnostics
- Home care and personal support
- Hospital, emergency, nursing facility
- Therapy and rehabilitation and DME
- Adult day health services
- Transportation
- Dental, hearing, vision, podiatry
- Social work
- Prescription drugs
- Nutrition

A coordinated site for care, therapy, meals, and connection

1 Medical oversight

Routine care, immunizations, treatment of illness or injury, and specialty referrals.

2 Therapy

PT, OT, rehabilitation, exercise, and restorative support.

3 Daily supports

Meals, nutrition, recreation, and social connection.

4 Accessible services

On-site and coordinated access to additional clinical and social services.

More support at home, less fragmented care

1 HOME

Supports delay or avoid long-term institutional care

2 ONE TEAM

A single care team reduces fragmentation

3 TRANSPORTATION

Access barriers can be addressed directly

4 CAREGIVERS

Respite and a single point of contact can reduce burden

From inquiry to an individualized care plan

1 Identify

Potential candidates identified

2 Assessment

Clinical, functional, and social review by LIFE Center

3 Eligibility

PA DHS and LIFE program determination

4 Enrollment

Participant and Family voluntarily chooses LIFE Center

5 Care planning

LIFE Center Team Inter-disciplinary plan begins

When LIFE may not be the best fit

Safety

Cannot live safely in the community even with available supports

Preference

Does not prefer the LIFE model

Service area

Lives outside the program service area

Care alignment

Required arrangement does not align with needs or goals

Key principle

Inquiry and Exploration begin an evaluation process.
It does not predetermine eligibility or enrollment.

What changes after LIFE enrollment

1 LIFE team

Usually becomes the participant's primary medical provider and coordinates the full continuum of covered services.

2 Prior PCP

May provide records, clinical context, or specialty input, and may continue only if contracted by the LIFE organization.

3 Continuity

Clear communication during enrollment, hospitalization, transitions, and disenrollment remains important.

What changes after LIFE enrollment

Participant Attribution

- Per CMS and Federal Regulations, Patient can only be enrolled in one program
- When patient enrolls in LIFE, cannot also be a member of an ACO or other Program
- Attributed Costs are centered in the LIFE program
- Patient Utilization Costs for the current and future performance years are no longer counted against your practice
- Likewise, patient can no longer be a member in the PACN-ACO and those attributable ACO Costs are also shifted to the LIFE Center

LIFE puts aligned, team-based care into practice

PROACTIVE **PREVENTIVE** **TEAM-BASED**

Understanding LIFE helps practices identify appropriate candidates, connect patients with community resources, and align the intensity of support with clinical and social need.

Matching Complex and Unique Patient Needs
With
Comprehensive Patient Services

COMMON MISCONCEPTION

LIFE is not just adult day care

Much, much more Complete and Comprehensive Services

A comprehensive healthcare delivery model

LIFE integrates primary and specialty care, medications, behavioral health, home services, transportation, therapies, social supports, and long-term care through one accountable interdisciplinary team.

EVIDENCE

What the literature shows:

1 HOSPITAL USE

Reduced hospitalizations in multiple observational studies.

- Hospitalization rate 539 per 1000 person-years for LIFE versus 962 per 1000 for dually eligible waiver enrollees with 30-day readmission rates of 19.3% versus 22.9% annually.
- Significantly fewer hospitalizations (35.7 vs 52.8 per 1,000 patient-months) and fewer preventable ED visits.
- LIFE enrollees averaged 0.2 hospital days per month compared to 0.8 days for matched comparators (75% reduction)

2 NURSING FACILITY

Reduced or delayed long-term placement in several studies

3 PATIENT-CENTERED

Improvements in selected outcomes and unmet needs

Program of All-Inclusive Care for the Elderly (PACE) versus Other Programs: A Scoping Review of Health Outcomes – PMC

Effects of the Program of All-inclusive Care for the Elderly on hospital use – PubMed

Hospitalizations in the Program of All-Inclusive Care for the Elderly – PubMed

Comprehensive Primary Care for Older Patients With Multiple Chronic Conditions: “Nobody Rushes You Through” | Geriatrics | JAMA | JAMA Network

Reduced hospital use

0.2

hospital days / month

vs. 0.8 in matched comparators

Supporting findings

Studies cited in the original presentation reported lower hospitalization rates, lower 30-day readmission rates, and fewer preventable emergency department visits among federal-program participants than comparison groups.

Supporting community living

Long-term placement

A systematic review cited in the original deck found that three of four studies associated the federal program with a lower likelihood of long-term nursing home placement.

Functional independence

One program study reported that 46% of participants improved and 20% maintained functional independence over five years.

Patient-centered care

1 LESS UNMET NEED

Assistance with bathing, dressing, and mobility

2 PREVENTION

More hearing and vision screening and influenza vaccination

3 PLANNING

More participants with advance directives

4 EXPERIENCE

Generally positive consumer satisfaction across cited studies

Strongest signal: fewer inpatient hospitalizations

1 UTILIZATION

Participants have fewer inpatient hospitalizations than fee-for-service counterparts in the ASPE literature review.

2 QUALITY

The federal program improves selected aspects of care quality.

3 COSTS

The review found no significant effect on Medicare costs.

PRACTICE TAKEAWAY

Match the right patient with the right intensity of support

LIFE is an established, integrated model for adults who meet nursing-facility level-of-care criteria and want to remain in the community.

1 IDENTIFY

Patients with complex medical, functional, and social needs

2 ADVISE

Share clinical context and patient-specific concerns

3 CONNECT

Support voluntary evaluation by a local LIFE organization

RESOURCES

Learn more about LIFE

Questions? Contact the PA Clinical Network team.

John Pagan MD MBA
jpagan@PAClinicalNetwork.com
717-803-8063

Wendy York
wyork@paclinicalnetwork.com
(610) 310-9590

cms.gov/medicare/medicaid-coordination/about/pace

npaonline.org