PACE in Your Community

UNDERSTANDING PACE OPERATING EXPERIENCE AND THE CRITICAL SUCCESS FACTORS

NATIONAL PACE ASSOCIATION
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PACE® BACKGROUND

The Program of All-inclusive Care for the Elderly (PACE) is an innovative, fully integrated provider of care for the frailest and most costly members of our society. It allows program participants to stay in their homes and communities—and out of nursing facilities. At the core of each PACE program is a PACE center and the involvement of a comprehensive interdisciplinary team. PACE programs receive capitated payments to provide the full range of primary, acute, and long-term care services needed by an enrollee.

PACE programs can only enroll the following individuals:

- At least 55 years old
- Living in a PACE service area
- Certified by their state as needing nursing facility care
- Able to live safely in the community with PACE services at the time of enrollment

PACE began in 1983 as a demonstration program by On Lok Senior Health Services in San Francisco, CA, in order to enable the Chinese community to care for its elders without placing them in nursing facilities. With the success of On Lok and subsequent replication projects, Congress authorized PACE as a permanent Medicare provider and Medicaid state option in the Balanced Budget Act of 1997. In the Deficit Reduction Act (DRA) of 2005, Congress established a program to expand PACE to rural areas of the country.

As of March 2013, there are 91 PACE programs in 30 states caring for more than 26,000 participants, with additional PACE programs under development. In order to assist an organization in its understanding of PACE, the National PACE Association (NPA) has prepared this document to highlight the cumulative experience regarding the critical success factors and key considerations for the development of new PACE programs.

PACE® AS A MODEL OF CARE FOR NURSING FACILITY-ELIGIBLES

The passage of health care reform legislation has focused national attention on the failure of our health care delivery system to meet the complex needs of dual eligible individuals and persons with multiple chronic conditions who require intense coordinated care. However, long before the recent interest in accountable care organizations (ACOs) and patient centered medical homes (PCMHs), PACE programs have been delivering primary, acute, and long-term care to nursing home eligibles in the community.

The success of the PACE model of care has been described in a recent JAMA article. In that article PACE is identified as one of three models of chronic care that substantially improve the primary care of community-dwelling older adults with multiple chronic conditions.[i]

CURRENT SPONSORS OF PACE®

There are a wide variety of sponsors of PACE programs, including hospitals, organizations that partner with hospitals, health plans, and many different types of community organizations. All PACE programs must be nonprofit organizations that can meet the state and federal requirements for PACE programs.[ii]

Sponsorship of PACE Programs

Program Sponsor	Number of PACE Programs	Percentage by Sponsor Type
Hospital-Only	31	34%
Community Organization	16	18%
LTC	17	18%
Other	10	11%
Partnership, including Hospital	6	7%
Federally Qualified Health Center	6	7%
Hospice	4	4%
Health Plan	1	1%
Total PACE Programs	91	**100.0%**

CRITICAL SUCCESS FACTORS FOR PACE® PROGRAMS

This paper summarizes the cumulative body of experience regarding the six critical success factors for PACE and key considerations that should be evaluated in a market area. At the end of this process of information gathering, it is recommended that each prospective PACE sponsor undertake a full PACE market and financial feasibility study before beginning PACE development.

1. Sufficient Demand for PACE® Program Services

PACE programs thrive in markets with high demand for their services. PACE enrollment is largely a function of the size of the population that is nursing facility-eligible within a designated service area, and the availability of alternative programs and services. PACE programs have also been successful in serving veterans in selected geographic areas (through a partnership with the Veterans Administration), as well as serving rural communities. With sufficient demand, PACE programs that are well-integrated in the community are in the best position to achieve high levels of enrollment.

Since about 90 percent of PACE enrollees are dually eligible for Medicare and Medicaid, determining the demand for PACE services is focused on calculating the size of the dual eligible population. PACE demand is typically calculated utilizing census data, from which zip code or county-level data can be obtained to reflect income levels and disability levels. Important factors to consider include:

- When determining financial eligibility, it is important to determine the Medicaid income level specific to your state for PACE and home- and community-based services (HCBS) eligibility. Many states set eligibility levels for PACE at 300 percent of Supplemental Security Income (SSI) payment, but some states have other income thresholds, which can be much lower.
- When determining level of disability, it important to match the clinical eligibility criteria to the census variables, which are two or more disabilities, including self care, or two or more disabilities with any limitation. The more restrictive and conservative level of disability is two or more disabilities, including self care.

It is also worth noting that 11 operating rural PACE programs received start-up grants, and their enrollment as of January 2012 ranges from 44 to 216 enrollees. Experience has shown that while there may be fewer PACE eligibles in the service area for rural programs, there can be a higher enrollment (market share) into PACE

as there are fewer alternatives in the community that can effectively support a nursing facility-eligible individual in the community.

A number of PACE programs are now participating in a pilot project to serve veterans. These programs receive a capitation directly from the Veterans Administration. This opens up enrollment to veterans not eligible for Medicaid, who would not otherwise be able to obtain PACE services. As part of a feasibility study, the prospective PACE sponsor could also consider the enrollment potential of serving veterans if the pilot program can expand to new PACE programs.

As of January 2013, the enrollment of operating PACE programs ranged from an average of 295, to 2,992 for a multi-site program in a large metropolitan area. Many PACE programs operate more than one PACE center. The actual number of PACE enrollees needed to achieve profitability will vary by market and site-specific factors and should be assessed thoroughly.

Considerations include:

- What is the trend in the aging of the population, especially the age 75-and-older populations, over the next 5–10 years? What is the estimated size of the dual-eligible PACE population from which a PACE program can draw enrollment?
- Are there any unique factors affecting the potential enrollment in a service area, including rural market considerations, location, or other factors?

2. Positive Market Factors

After calculating the potential demand for PACE services, a prospective PACE sponsor must understand the competitors to PACE in their community for the broader dual-eligible population and nursing facility-eligible population. States are seeking to improve care for dual eligibles and to reduce the costs of that care. PACE-eligible populations are only one segment of the dual-eligible population.

PACE competitive reviews have typically focused on traditional competitors to PACE, including the following:

- Nursing facilities
- Home- and community-based waiver programs
- Assisted living programs, particularly those serving Medicaid beneficiaries
- Adult day health care programs

- Home care services

With the passage of the Affordable Care Act (ACA), many new competitors to PACE programs are emerging that did not previously exist, including the following:

- States such as Massachusetts were pioneers in developing fully integrated dual eligible programs that served nursing facility-eligible participants and offered a full range of benefits. These new managed care entities, known as Senior Care Organizations (SCOs), serve a population that is similar to PACE with a different model of care.
- 15 states received grants from the Center for Medicare and Medicaid Innovation (CMMI) to develop innovative dual-eligible programs in their respective states. States such as Michigan are considering taking on direct risk for Medicare and Medicaid with the goal of enrolling large numbers of dual eligibles and having the opportunity to share in the Medicare savings directly.
- 22 states are seeking to participate in a new CMS opportunity to provide integrated care to dual eligibles that may offer competition for PACE dual-eligible enrollees, 18 have pending Memorandums of Understanding and four have signed Memorandums of Understanding and are beginning implementation.[i]
- The ACA has spawned many new demonstrations that also seek to serve chronically ill populations, such as the Independence at Home Demonstration.

Once a PACE-eligible population has been identified, consideration must be given to the referral sources. In some states, the local Area Agency on Aging (AAA) may affect the volume of referrals or the speed in which clinical eligibility determinations are made, particularly if the AAA is a direct provider of home- and community-based waiver services to the same nursing facility-eligible population as PACE.

The actual location of the PACE center, including distance and drive times, will also affect enrollment in the PACE program.

Considerations include:

- Who are the competitors to PACE in your community?
- Will a PACE program compete with the local Area Agency on Aging or other referral entities?
- What is the availability of alternatives, especially in rural communities?
- How attractive is the location of your proposed PACE center (if known)?
- Will you have exclusive rights to your service area, or will the state allow another PACE program to compete for enrollees?
- What is the historical penetration rate of PACE in your state and in comparable communities?
- Given the availability of alternatives, what is the likely PACE penetration for your program?
- Can partnerships be explored to increase the success and viability of the PACE program?

3. Strong State Support

A state's support for PACE is another critical success factor. Overall, it is important to understand how PACE fits into the state's strategy for providing long-term care services. Given the flexibility that is being granted to state Medicaid agencies in serving dual eligibles with innovative models of care, a number of states are moving aggressively towards managed care approaches to meet the needs of dual eligibles with improved quality and reduced costs.

Several states that have supported PACE in the past are looking for programs and models of care that can serve larger numbers of dual eligibles and achieve good outcomes while reducing costs. At the same time, other states such as New York and California are including PACE as one strategy for achieving the desired outcomes for the dual-eligible and nursing facility-eligible population.

In conclusion, it may be easier to grow PACE in states with existing PACE programs. Without existing PACE programs, states may face challenges due to budget and staffing shortfalls.

Considerations include:

- If PACE currently operates in your state, what is your state's history of commitment to PACE? Does legislation need to be enacted specifically to allow new PACE programs to develop, and does funding have to be allocated specifically for PACE program growth?
- What is your state's strategy for serving dual eligibles and/or achieving a greater proportion of HCBS versus institutional long-term care?
- Has your state applied for either of the CMS models to serve dual eligibles under a capitated or fee-for-service (FFS) approach?

4. Adequate Payment for PACE® Services

PACE programs receive payment from Medicare and Medicaid for all dual eligibles, which represent about 90 percent of enrollment.

Medicaid PACE rates are negotiated between each PACE program and the State Administering Agency (SAA). Federal regulations specify that each state must set a prospectively monthly capitation that meets the following requirements[iii]:

- Must be less than the amount that would have been paid by the state plan if the participant was not enrolled in the PACE program;
- Must take into account the comparative frailty of the PACE participant;
- Must be a fixed amount regardless of the changes in the participant's health status during the contract period; and,
- Can be renegotiated on an annual basis.

Given the variability in the underlying utilization of Medicaid-funded services and Medicaid rate-setting approaches, PACE rates vary widely across states. For example, dual-eligible rates vary from a low of about $1,420 in Florida to a high of $4,800 in New Jersey.

Medicare capitation rates and Medicare Part D payment for prescription drugs are set by federal statute and regulations. As a result of the ACA, there are now significant differences in how PACE and Medicare Advantage payments are calculated. Going forward, prospective PACE sponsors must remain aware of future changes in Medicare payment affecting PACE programs.

Considerations include:

- What is the state's approach to determine the Medicaid PACE capitation?
- How will the growth of managed care programs in your state affect the Medicaid PACE payment rate?
- What is your state's Medicaid capitation rate, and is your prospective program financially viable given the projected enrollment at this payment level?
- What is the Medicare capitation amount in the counties you plan to serve? How will future changes in Medicare payment policy affect your program?

5. Sustained Organizational Capacity and Commitment to PACE®

There are a wide variety of PACE sponsors who have been successful in developing and growing PACE programs in their community. No one type of sponsor is universally successful. The most important factors for success are the organization's long-term commitment to PACE as a model of care for the nursing facility-eligible population, access to the capital required to start up and sustain a PACE program, and the availability of an internal champion to secure sufficient resources for the program to be successful. PACE programs that start up today are likely to face greater competition and pressures to achieve cost efficiency with the continued Medicare and Medicaid budget challenges.

Organizations should also be willing to invest in operating multiple PACE centers if the market supports the need, and to invest in PACE as a viable alternative to nursing facility placement.

Considerations include:

- What is your organization's history with serving Medicaid beneficiaries and vulnerable populations?
- Does your organization have a long-term commitment to serving nursing facility-eligibles through a PACE model of care?
- Does your organization have strong internal referral sources, and can a PACE program be developed as one component of the care continuum?
- Does your organization have strong relationships with potential external referral sources, such as the Area Agency on Aging, Aging and Disability Resource Center, community physicians, or other entities?

6. Adequate Capitalization

Overall, the capital investments for PACE programs vary widely and typically range from $1.5 million to $5 million. Experience to date has shown that payback occurs in 48 to 72 months.

The following are the major components of the capital needs:

- PACE center building
- PACE center equipment
- Vans
- IT hardware and software
- Start-up expenses
- Funding of initial operating losses
- Funding of required federal or state risk reserves

Undertaking a complete assessment of capital needs is a critical aspect of a market and financial feasibility study.

Considerations include:

- Does your organization have sufficient capital to start up the PACE program?
- Have you considered less-than-optimal financial performance, such as lower-than-expected enrollment, higher-than-expected expenses, and future Medicaid or Medicare rate reductions?
- What strategies can be utilized to reduce capital needs, such as using existing staff or using existing buildings?
- Can the PACE center be leased to reduce the start-up capital required?

FINANCIAL ANALYSIS

NPA has developed a high level financial proforma for developing a proforma analysis that can help prospective PACE organizations better understand the factors that contribute to the financial experience of a PACE program. This model provides a snapshot of the potential viability of PACE. However, this is not intended to be a substitute for a financial feasibility study.

The financial model will estimate the costs of operating a PACE program that is in compliance with current regulatory requirements from the Centers for Medicare and Medicaid Services (CMS). These requirements include the start-up time prior to having a signed program agreement as well as specific regulatory requirements, such as the provision of required services and staffing of the multidisciplinary team.

The use of this model is not a substitute for undertaking a full financial and market feasibility study. However, this will allow prospective sponsors to assess high-level parameters of future success.

NPA RESOURCES FOR MOVING FORWARD

NPA offers numerous resources and tools for a provider to understand the PACE model, assess its organization's commitment and capacity, assess its community's needs, and move forward with development or expansion of a PACE program. The following resources are available on the Developing PACE section of NPA's web site (www.npaonline.org).

Understanding the PACE® Model

Developing an understanding of the PACE model's program and service requirements, their flexibility, and the stages of development across a team of management and clinical leaders will form a foundation for moving forward within the organization.

- PACE Fact Sheet – provides one page overview of the PACE program
- PACE FAQs - frequently asked questions summarizes important opportunities and challenges faced in PACE development
- Profile of PACE – a summary of PACE history and purpose
- "The PACE Model" – The Center for Medicare Education's December 2001 issue brief on PACE
- PACE in the States – a list of PACE and pre-PACE providers by state, their open date and census
- PACE Site Map - a map indicating the location of PACE programs throughout the country
- Find a PACE Program - Locate a PACE provider by state or zip code
- New PACE Providers: The Path from Interest to Start-Up – a guide to the planning process for initiating a PACE program
- An Overview of Self-Assessment Considerations – summarizes key considerations in an organization's review of PACE
- Summary of the PACE Provider Regulation – summary of the PACE interim regulations released in 1999 and 2002 and final regulation released in 2006)

Assessment of Community Needs and an Organization's Commitment and Capacity

Assessing your community's needs will help to determine if there is adequate demand to support a new PACE program and will lay the foundation for establishing referral networks that will help the program build census, contract for services to meet PACE participant needs, and foster public support. In addition, consideration of internal and external factors that will determine a PACE program's

success is applied to the development of a business plan, which is the basis for the organization to make a formal decision on whether to move forward with development of a new program.

- Organizational and Market Self-Assessment for PACE – reviews, in detail, key factors in evaluating PACE for your community and organization
- Sources of Financing – a brief description of financing sources for start-up costs associated with PACE
- Program Start-up and Development Costs – reviews the start-up cost experiences of PACE programs
- Principles of Effective Design, Layout, and Furnishing of PACE Day Sites – contains recommendations from experts in architecture and interior design on applying best practices of environmental design for seniors to the various areas of PACE center design
- An Overview of PACE Site Selection and Center Development (available to NPA members only) – highlights the major considerations necessary for site selection and center development, and costs associated with each
- Service Area Demographic Report Request (available to NPA members only) – a request for a report of the population, income and health factors shaping the organization's PACE enrollment projections

Planning and Development/PACE® Provider Application

A decision to move forward with a new PACE program will require the completion of a Provider Application, access to start-up funds and development of the infrastructure needed to provide services. A prospective PACE sponsoring organization will need to work with state and federal agencies, internal and external funding sources, community organizations and healthcare providers to assemble an operational PACE program.

- Core Resource Set for PACE (CRSP) (available to NPA members only)– a compendium of PACE program operational resources to assist providers in PACE development, start-up and expansion including PACE operating resources, and a guide to preparing the PACE provider application
- PACE Financial Proforma Baseline Scenario (available to NPA members only) – a detailed financial scenario reflecting the cost and revenue experience of successful operating PACE programs
- PACE Financial Planning Tools (available to NPA members only) – The PACE Financial Planning Tools consist of detailed development case studies, a financial proforma model, a baseline scenario, and the PACE business planning checklist. These tools help organizations assess the viability of developing a PACE program and present their plans for PACE development to others, including

external investors. These tools will help expanding PACE organizations explain PACE from a financial planning point of view.

PACE® TECHNICAL ASSISTANCE CENTERS

Successful and efficient development of a PACE program requires access to in-depth knowledge about PACE program operations, marketing and financing. Prospective PACE providers can benefit from the expertise of existing organizations that have experience in the development and implementation of PACE. PACE Technical Assistance Centers (TACs) may provide such expertise and guidance. TACs are available to assist prospective providers in building successful PACE programs, taking into consideration a broad range of general as well as program-specific factors.

Across the country, TACs are available to provide support and guidance throughout each phase of the PACE development process. TAC resources and services vary by organization, but may include:

- Core Resource Set for PACE (CRSP) – NPA's set of operating practice resources for developing organizations.
- Assistance with preparation of the PACE Provider Application.
- Assistance with facility development - PACE center design, capacity assumptions, equipment needs, etc.
- Assistance with development of program policies and procedures.
- Assistance with development of efficient management structure - key staff roles, job descriptions, etc.
- Service integration training - interdisciplinary team training, service allocation and care planning.
- Consultation on marketing and census building.
- Consultation on development of QI program and implementation of QI plan.
- Assistance with establishment of financial reporting and monitoring systems.
- Consultation on data collection systems and data collection training.
- Onsite review of ongoing operations and recommendations regarding potential improvements.

NPA does not endorse or recommend any TAC. A list of TACs that are members of NPA is available on the Developing PACE section of NPA's web site.

[i] Boult, C. and G. Wieland, "Comprehensive Primary Care for Older Patients with Multiple Chronic Conditions", JAMA, November 3, 2010

[ii] Federal statute and regulations permitted a demonstration of for-profit PACE programs. As a result of the demonstration, there is one operating for-profit PACE program. The period for development of new for-profit demonstrations is closed.

[i] State Medicaid Director's Letter, Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Dual Eligibles, July 2011.

[iii] 42 CFR 460.182