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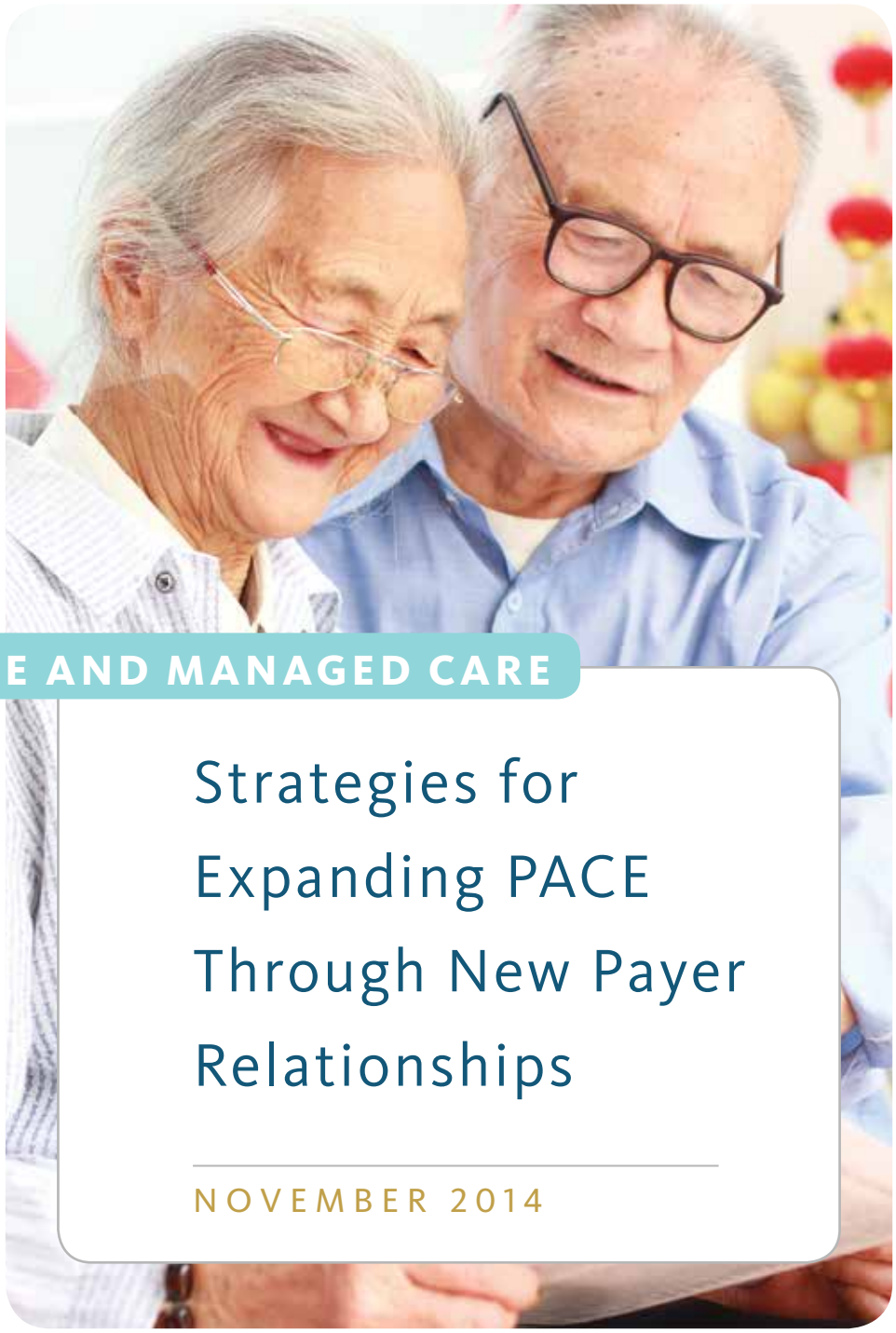

PACE AND MANAGED CARE

Strategies for Expanding PACE Through New Payer Relationships

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Introduction

State and federal initiatives expanding managed care and introducing delivery system changes for long-term services and supports (LTSS) may create new opportunities for Programs of All-inclusive Care for the Elderly (PACE®). The National PACE Association (NPA), with the support of The SCAN Foundation, asked PACE organizations, health plans and health systems to describe how they might form new relationships to explore these new opportunities. Their ideas were gathered through a series of presentations by PACE organizations at the forefront of considering these new relationships, site visits to gather more in-depth information, and discussions that brought PACE organizations, health plans and health systems together. NPA also spoke with thought leaders seeking to change LTSS delivery systems and financing.

This paper presents what PACE organizations and their prospective new partners have identified as the issues and approaches to forming new relationships. It addresses the following key questions:

- Beyond traditional government payers (Medicare, Medicaid), who are the potential "purchasers" of PACE services? What are their strengths and limitations?
- What are the potential benefits to PACE of working with new payers and delivery systems?
- What is the PACE "value proposition" for new payers or delivery systems? How can these value propositions be priced? What operational and administrative capacity will be required?
- What regulatory and statutory requirements will need to be addressed?
- How can PACE organizations approach new payers and delivery systems?

As PACE organizations and their new partners test and refine their arrangements, this experience will provide new insights and models that can be implemented more broadly.

This paper also includes case studies of three PACE organizations that are exploring new payer relationships. While primarily addressing PACE organizations, the ideas are relevant to the new payers and delivery systems PACE organizations may seek to engage. Given the relatively recent evolution of many of these new payers and delivery systems, coupled with a still evolving policy environment, this paper represents a preliminary assessment of the opportunities and issues. As PACE organizations and their new partners test and refine their arrangements, this experience will provide new insights and models that can be implemented more broadly.

Financing and Delivery System Reforms

For many years, federal and state policy-makers have been exploring ways to rein in costs for individuals who are dually eligible for Medicare and Medicaid ("duals"). Duals comprise 13 percent of the combined population of Medicare enrollees and aged, blind or disabled Medicaid enrollees; but they account for 34 percent of total spending for these programs.[1] Among the duals, costs are greatest for individuals who require significant LTSS. In 2008 69 percent of Medicaid expenditures for the dually eligible were for long-term care services such as nursing home care, institutional care, and home and personal care services.[2]

Policy-makers have been exploring large-scale models that can integrate the financing of the Medicare and Medicaid programs and the delivery of medical care with LTSS. PACE has a track record of achieving these aims.

With the total number of Americans in need of long-term care expected to rise to 27 million by 2050, policy-makers have been exploring large-scale models that can integrate the financing of the Medicare and Medicaid programs and the delivery of medical care with LTSS.[3] While PACE has a track record of achieving these aims, the scale of PACE to date is not sufficient to address the broader population of dual eligibles who might need LTSS. In 2010 PACE organizations served approximately 30,000 enrollees – less than 0.01 percent of the estimated 3.38 million dual eligibles who need LTSS. Significant efforts are under way to increase access to PACE and are starting to yield results. Nonetheless, new payers and delivery systems clearly will be needed to address the demand for LTSS services by dual eligibles.

New Payer Delivery System Types

The challenge of meeting the demand for LTSS through managed care and delivery system reforms is being addressed through a wide range of state and federal pilots and reforms. The Affordable Care Act (ACA) authorized the Centers for Medicare & Medicaid Services (CMS) to design and implement new models for integrating the benefits and financing of the Medicare and Medicaid programs. The law also introduced initiatives and built upon existing efforts to improve care coordination, quality and delivery. These new models include financial alignment demonstrations (FADs) offering managed care models for the dually eligible, Accountable Care Organizations (ACOs), expansion of Patient-Centered Medical Homes (PCMHs), bundled payments for acute and post-acute care, hospital readmission reduction incentives and other initiatives.

PACE organizations will need to become more familiar with this range of new payers and delivery systems in order to consider how best to partner with them.

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Financial Alignment Demonstration Health Plans for Dual Eligibles

Health plans participating in the CMS capitated FAD are responsible for the integration of all Medicare and Medicaid benefits. To date, Memoranda of Understanding (MOUs) have been signed with CMS and state governments to launch dual integration health plans in California, Illinois, Massachusetts, Michigan, New York, Ohio, South Carolina, Texas, Virginia and Washington. The FAD health plans represent the first time federal and state governments have authorized large insurers to offer widespread, fully integrated Medicare and Medicaid benefits, including both health care and LTSS for dual-eligible individuals.

Medicaid Managed Long-Term Services and Supports

In recent years the number of states offering managed long-term services and supports (MLTSS) to their Medicaid beneficiaries doubled from eight to 16, and by 2012 the number of persons receiving LTSS through Medicaid managed care rose to 389,000. By the end of 2014, that number is expected to triple to 1.17 million beneficiaries. The scope, benefits and arrangements of MLTSS plans vary considerably from state to state and reflect differing levels of coordination with Medicare plans.[4]

A state might offer the following:

- Capitation for Medicaid-Covered Benefits Linked with Capitation for Medicare Benefits: Health plans provide the full range of Medicaid-covered services, inclusive of LTSS. Plans are required to offer Medicare benefits through a linked health plan operated by the same sponsor. However, beneficiaries can choose to receive their Medicare services from a different plan or Medicare fee-for-service. For those who choose a linked Medicare plan, the combination with the Medicaid plan is similar to FAD plans, except for the separate and optional enrollment in the Medicare part of the benefit.
- Capitation Rates for Medicaid-Only Covered Benefits: Health plans provide the full range of Medicaid-covered services, including LTSS and health benefits.
- Capitation Rates for Limited Medicaid Benefits: Health plans provide some subsets of services but exclude one or more major Medicaid service categories, such as primary care, acute care, behavioral health, prescription drugs or LTSS.

Accountable Care Organizations

ACOs are groups of doctors, hospitals and other health care providers that collaborate to offer care to Medicare beneficiaries, with a focus on beneficiaries who have chronic illness. CMS is testing several payment methodologies with ACOs, including methods in which providers share in the savings generated (but not any losses), shared savings and risk where providers assume full risk, and advanced payment, which helps offset the start-up costs for developing an ACO.[5]

Patient-Centered Medical Homes

Based on the philosophy that primary care should be patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety, PCMHs are generally primary care practices that coordinate care for complex, chronically ill patients. The federal government promotes PCMHs through programs at the Agency for Healthcare Research and Quality, the Center for Medicare & Medicaid Innovation, the Health Resources and Services Administration, and other agencies. Some states provide Medicaid payments to PCMHs for their care coordination and management services.

Based on the philosophy that primary care should be patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety, PCMHs are generally primary care practices that coordinate care for complex, chronically ill patients.

Other Care Coordination Initiatives

The ACA established several initiatives to facilitate care coordination and health care transitions for individuals with significant care needs. Through payment reforms, these initiatives seek to address the gaps in care and perverse incentives present in the fee-for-service system.

- The Community-Based Care Transition Program aims to reduce hospital readmissions, test sustainable funding streams for care transition services, maintain or improve quality of care, and document measurable savings to the Medicare program by providing funding to community-based organizations (CBOs) – often in partnership with hospitals – to effectively manage transitions for Medicare patients and improve their quality of care. Under this model participating organizations receive an all-inclusive rate to manage the continuum of necessary services following a care transition. Interventions identified in this demonstration can be used by hospitals to reduce their readmissions.
- The Hospital Readmissions Reduction Program requires CMS to reduce payments to hospitals with excess readmissions for patients with acute myocardial infarction, pneumonia, congestive heart failure, chronic obstructive pulmonary disease, and total hip arthroplasty and/or total knee arthroplasty. Hospitals experiencing higher than expected readmissions for those diagnostic-related groups (DRGs) may experience reductions of up to 3 percent.
- The National Pilot Program on Payment Bundling allows hospitals and post-acute care providers to receive a single fixed payment for the 30-day period following a hospital discharge. By preventing costly readmissions, emergency room visits and post-acute care complications, these organizations can achieve savings while enhancing patient outcomes.

The goals of these initiatives – to provide more coordinated care, improve efficiency, and eliminate unnecessary care – are areas where PACE can lend significant expertise.

Collectively, these initiatives are designed to eliminate inefficiencies while improving quality and coordination of care. The goals of these initiatives – to provide more coordinated care, improve efficiency, and eliminate unnecessary care – are areas where PACE can lend significant expertise. Hospitals and CBOs participating in these initiatives may turn to PACE to help manage their more complex, challenging patients.

What Can PACE Organizations Gain?

Many PACE organizations are exploring relationships with new payers and emerging delivery systems to assess how their strengths can be applied to those needing LTSS. PACE organizations could benefit from these relationships in a number of ways:

- Referral Arrangements: These rely on payers or delivery systems to identify appropriate candidates for PACE and refer them to the local PACE program.
- Maximization of LTSS Services in a PACE Organization: PACE organizations could expand the provision of LTSS services as a growth strategy by offering the services to new payers' enrollees or individuals who are receiving care through another delivery system. This leads to better use of the existing service capacity of the PACE organization (e.g., PACE center, interdisciplinary team, in-house transportation and home care) and could create pathways to PACE enrollment as consumers and new payers gain experience with the PACE model.
- Experience with New Delivery System and Development of New Payment Models: PACE organizations could gain experience with new delivery systems to determine how those systems relate to PACE and how PACE might complement them. Working with new payers, PACE organizations could build on their experience with full capitation to understand other at-risk payment models, including post-acute bundles, partial capitation/partial risk arrangements, and full sub-capitation/risk.

What Will New Payers and Delivery Systems Need?

The delivery systems identified earlier may experience several challenges as they begin serving more complex, high-need beneficiaries. While challenges will vary depending on organizational, regional and policy-related factors, a number of trends are emerging:

- Newly launched dual integration plans sponsored by organizations that have historically served Medicaid populations may have little or no experience managing the acute and specialty care needs of frail, elderly populations.
- Similarly, newly launched dual integration plans sponsored by organizations that have focused on Medicare Advantage (MA) plans may lack familiarity with LTSS, including nursing facility care and home- and community-based services.

Most of the plans participating in managed care for the dual eligibles will lack experience integrating medical care and LTSS benefits.

- While some health plan sponsors for the duals have experience in either Medicare or Medicaid, few have experience in both. As a result, most of the plans participating in managed care for the dual eligibles will lack experience integrating medical care and LTSS benefits.
- Plans and providers might experience challenges with care coordination and transitions for the high-need, complex population needing LTSS.

- Plans and providers may not be accustomed to serving populations that experience high hospitalization and emergency room utilization
- There may be a shortage of qualified, trained health care and service delivery professionals.
- Health plans may experience challenges meeting network adequacy requirements, particularly with regard to LTSS providers and services.

PACE Value Propositions for New Payers and Delivery Systems

PACE organizations have significant experience managing short-, mid- and long-term care and financial risk. Additionally, the PACE infrastructure – notably the PACE center and interdisciplinary team – can be leveraged to help new payers assess patient needs, improve care coordination, and deliver services. As such, PACE organizations are well positioned to help managed care organizations, hospitals, health systems and other entities achieve the goals of new initiatives for dual eligibles needing LTSS.

Interviews with managed care executives and other thought leaders suggest that, especially in the case of MLTSS and FADs, plans would rather "buy it" than "build it." In other words, they are seeking to partner with entities that offer an array of services, have an established community presence, create unique approaches, and appeal to a broad spectrum of potential customers instead of developing these attributes in-house.

This finding was echoed in a recent study by the Advisory Board Company, which noted that three characteristics drive favorable terms for providers seeking to contract with managed care organizations:

- Scale: Sizeable operations, regional presence, full-service continuum, flexible workforce with diverse skill sets.
- Community Integration: Multilingual staff, strong community trust, culturally competent care.
- Operational Alignment: Streamlined billing and information exchange, communicative staff, consistent patient status updates.[6]

Keeping these general attributes in mind, the following are value propositions that PACE could present to prospective new partners.

Value Proposition 1

PACE has the infrastructure to assist payers and health delivery systems in assessing, coordinating, and providing access to LTSS.

- Assessment: As health plans absorb large numbers of new enrollees, they will need assistance assessing individuals and developing care plans. The PACE interdisciplinary team (IDT) can provide thorough assessments that identify the range of health and long-term care needs for an enrollee. Moreover, the PACE IDT can build on its expertise in geriatric care to develop comprehensive care plans that meet individual needs, focus on prevention, and help maintain individual function and independence.

The PACE interdisciplinary team (IDT) can provide thorough assessments that identify the range of health and long-term care needs for an enrollee.

- Care Coordination: PACE organizations are able to offer care coordination services that fill gaps in the existing, disparate system. By facilitating communication among enrollees, providers and administrators, PACE can ensure that enrollees receive high-quality care, are compliant with their care plans, and avoid unnecessary care.
- Long-Term Services and Support: Health plans will need to build their networks of long-term service providers. State and federal policies will require sufficient networks for home care, transportation, personal attendant services, and other services and supports. PACE organizations can leverage their existing infrastructure to meet this demand. Further, PACE services are designed and delivered with accessibility for people with disabilities in mind.

Value Proposition 2

PACE can help achieve high-quality outcomes to support payers and delivery systems in achieving their performance goals. These outcomes not only enhance the quality of care and life for beneficiaries, they contribute to the financial performance of the organization.

- Reduced Hospitalization and Re-Hospitalization Rates: PACE programs experience significantly lower hospitalization and readmission rates. A 2008 NPA analysis found that PACE participants experienced 15 percent fewer hospital days compared to the dually-eligible population. Likewise, PACE readmission rates were 17 percent lower compared to the national readmission rate for dual-eligible beneficiaries age 65 and over.

PACE programs experience significantly lower hospitalization and readmission rates.

- Longevity: A 2014 study by Mathematica Policy Research found that PACE enrollees had a lower mortality rate than comparable individuals either in nursing facilities or receiving home- and community-based services (HCBS) through waiver programs.[7]
- Disease Management: A 2009 U.S. Department of Health and Human Services study found higher quality of care and better outcomes among PACE participants compared to HCBS clients. PACE participants reported better self-rated health status; better preventive care with respect to hearing and vision screenings, flu shots and pneumococcal vaccines; fewer unmet needs, such as getting around and dressing; less pain interfering with normal daily functioning; less likelihood of depression; and better management of health care.[8]

Value Proposition 3

PACE enhances the quality and marketability of the provider networks for payers and delivery systems.

- Proven Quality: PACE has a long-standing, proven track record of providing the full continuum of Medicare and Medicaid services at the highest level of quality. In addition to low hospitalization and re-hospitalization rates, PACE has a low annual rate of disenrollment (7 percent), suggesting that enrollees have a high rate of satisfaction with the care they receive.

PACE organizations are visible, known quantities in their communities.

- Community Presence: PACE organizations are visible, known quantities in their communities. The PACE center and vans are physical reminders of the PACE model, and participants and their families offer outstanding word-of-mouth marketing opportunities.

Value Proposition 4

PACE is prepared to share in the financial risk that payers and health delivery systems face in providing benefits to dual eligibles needing LTSS.

- Experience with Capitated Medicare and Medicaid Benefits: PACE has experience assuming and successfully managing risk for the delivery of Medicare- and Medicaid-covered services.
- Experience Identifying and Using Cost-Effective Care Options and Settings: PACE organizations are adept at identifying goals of care, developing care plan options to meet those goals, and using services and resources efficiently.

Pricing PACE Value Propositions

While the above scenarios describe the range of services and potential benefits of a relationship, the "value" of the proposition to a purchaser will depend on its price. In order to be of value to a prospective partner, the price of a PACE organization's proposition needs to be less than the cost incurred if the proposed service were purchased elsewhere or delivered directly (by the purchaser itself). In pricing their value propositions, PACE organizations will need to consider the following:

1. Categories and volume of the services offered;
2. Quality and cost of competing service providers;
3. Budgets of the payer (e.g., capitation rates, DRGs, prospective payments to hospitals); and
4. Type of payer arrangement and level of risk assumed:
    - Fee-for-Service: The payer or health system pays the PACE organization a fee for each unit of service, which could be a health assessment, home inspection, PACE center attendance, transportation trip, in-home personal or skilled care, etc.;
    - Partial Capitation/Bundled Payment: PACE organizations would develop a product that offers some bundled array of services for a fixed per person/per month fee. In this scenario PACE organization can design bundles to meet the payer's needs, such as post-acute care, chronic illness management, in-home supports or needs assessment, and care management services; and
    - Full Sub-Capitation: Payers (most likely MCOs) would pay PACE organizations a fixed rate to assume full responsibility and risk for providing all required benefits to enrollees. For all practical purposes, a sub-capitated enrollee would enjoy the same benefits, services and providers as a traditional PACE participant.

NPA offers some tools to help PACE organization price their services:

- Voluntary NPA financial benchmarking services define cost categories for PACE services and enable PACE organizations to calculate these costs on a per member, per month (PMPM) basis. Using PMPM calculations, PACE organizations also can benchmark their costs relative to other PACE organizations.
- DataPACE2 is a Web-based reporting and benchmarking system supported and maintained by NPA that collects information in four main categories related to PACE: quality of care, number of participants served, service utilization and program growth/census data. PACE organizations can

use DataPACE2 to analyze their program's enrolled population, use of services, and outcomes. Participation in DataPACE2 is open to all PACE organizations.

- "Superbills" that were developed by NPA in response to state and federal efforts to collect encounter data can inform PACE organizations as they identify and quantify the range of products and services they offer and can be used to capture utilization, quality and process measurement data.

Administrative and Reporting Requirements: Finding an Operational Fit

There may be logistical challenges associated with PACE organizations establishing working relationships with new payers or delivery systems. They may be asked by these partners to develop internal systems to account for staff time, bill providers, and collect encounter and quality data. Furthermore, from a policy perspective, they may need to obtain additional licenses or become a Medicare-certified provider for Medicare-covered services. For example, some states exempt PACE organizations from licensure requirements for adult day, home health or similar services. If the program is serving non-PACE participants, however, they may be required to obtain such licenses.

Regulatory and Statutory Requirements

The PACE model of care is subject to significant federal and state regulations and policies. Part 460 of Title 42, Code of Federal Regulations (CFR), outlines the regulatory framework under which PACE organizations operate. Additionally, Part C of Title XVIII of the Social Security Act and Part 422 of Title 42, CFR, provides the legal, statutory and regulatory framework for the MA program. While the PACE regulation makes clear that PACE organizations can contract with other payers to provide services, there are certain statutory and regulatory requirements that may inhibit such arrangements.

The PACE statute makes clear that PACE organizations are unable to waive certain statutory provisions.

PACE organizations, their prospective partners and policy-makers will need to consider these key issues:

- The PACE statute makes clear that PACE organizations are unable to waive certain statutory provisions, including focus on frail elderly, delivery of a comprehensive benefit, and assumption of full risk. Some of the value proposition may not be structured in such a way as to comply with this requirement. Delivery of care or services by a PACE organization to a new payer therefore would have to exist outside of the sponsoring organizations' PACE program agreement. As a result, the statutory and regulatory framework applied to PACE would require organizations that operate a PACE program to develop separate and distinct corporate structures, provider numbers, licensures, etc.
- In accordance with 42 CFR 460.102 (d)(3), members of the IDT must primarily serve PACE participants. It is generally accepted, but not mandated in regulation or CMS guidance, that PACE IDT members spend 50 percent or more of their time serving PACE participants. If a PACE program comingles

individuals being served through an arrangement in which the individual is not enrolled in PACE, there must be fewer non-PACE individuals relative to PACE participants to comply with this requirement.

- PACE operates under a three-way contract with CMS and the state. It is the intent of Congress that PACE be a direct enrollment option (i.e., that beneficiaries enroll in PACE directly rather than accessing it through a larger health plan). While an organization operating a PACE program may wish to provide services through a sub-capitated arrangement, this arrangement would need to be established separately from the PACE program itself.
- To contract with an MA organization, a contractor, institutional contractor, practitioner, or supplier of services must be licensed to operate in the state, must comply with any applicable state or federal requirements, must be reviewed and approved by an accrediting body, must not be excluded from participation under the Medicare program, and must have in effect a provider agreement with CMS permitting the provider to furnish services under the original Medicare fee-for-service program.

Exploring New Payer and Delivery System Relationships: Taking the Next Step

While there is no single approach to developing new payer relationships, our research and conversations with experienced programs have identified a common set of questions, activities and tactics that can inform PACE organizations interested in pursuing a new payer relationship.

1. Who are your prospective partners?
    a. Identify the prospective new payers in your area.
    b. Determine their other plan offerings (e.g., Medicaid contracts, MA plans or commercial products). How can you complement or add to their current portfolio?
    c. Initiate discussions as soon as possible. These relationships take several months/years to establish.
    d. Be persistent. In this rapidly changing environment, plans are still "figuring it all out." They may not recognize or appreciate the value of PACE during the first go-round.
2. What is the role of other stakeholders in the development of partnerships? Can consumer organizations, state policy-makers or foundations be helpful in facilitating partnerships?
    a. Identify consumer organizations that are influential in the development and evaluation of new care models. In the case of MLTSS, what are their priorities and concerns (e.g., network adequacy, coverage limitations)? Explore how a PACE option can create a win-win-win for the primary payer, consumer and PACE organization.
    b. Work with policy-makers to ensure a supportive policy environment for PACE. Specifically, be sure to maintain policies that allow a direct enrollment option for PACE. This ensures that PACE organizations can continue to market to and enroll participants directly (i.e., not through a plan). By preserving the direct enrollment options, PACE organizations have more leverage with plans.

3. What do your prospective partners need? What can you offer that they can't do for themselves?
4. What is your goal for the new relationships? How do new payer relationships relate to the growth, financial sustainability, diversification or learning of your organization?
    a. What is your capacity? How will a new payer relationship affect your current operations? Will you need to hire new staff? Build new facilities?
    b. What are the risks associated with a new payer relationship? How can you insulate your program from those risks?
5. What are your value propositions?
    a. Identify the range of products and services you would be willing to offer. How can your organization meet the needs of the prospective payer? Would it require significant investment on your part to develop systems, hire and train staff, or administer?
    b. How can your organization distinguish itself from other service providers? Can you demonstrate (with data) your superior quality, efficiency and capabilities?
    c. Assess your marketplace. What other types of providers operate in your area? Do you have a competitive advantage over other providers? Use market data to articulate your value.
    d. Be flexible. As plans are identifying needs, they may change the scope and/or scale of the services they need.
6. How will you price your value propositions?
    a. Be thorough and precise in your assessment of the costs of delivering on the value propositions you have developed.
    b. In some cases PACE rates will exceed plan rates. However, plan costs for frail enrollees will likely exceed capitation rates. Can you negotiate prices that will cover your costs yet achieve cost-effectiveness for the plans? Do you have the data and information to help make that case?
7. What will you and the partner want to learn from the first phase of your relationship? How will you collect the information to support your learning objectives?

In some cases PACE rates will exceed plan rates. However, plan costs for frail enrollees will likely exceed capitation rates.

Conclusion

Discussions with PACE organizations and potential payers, along with the in-depth case studies of three organizations, reflect a range of potential relationships with different benefit designs and levels of financial risk. Across this range, new payer and PACE relationships are formed cautiously amid high levels of uncertainty. Nonetheless, some consistent patterns are beginning to emerge, as illustrated by the case studies and supported by the broader range of PACE organizations and potential payers who were interviewed for this project:

- The level and nature of new payer interest is market-specific. PACE organizations and new payers will need to define their fit through extensive interaction and relationship-building.
- Medicare-oriented plans (e.g., MA or MA plans) that are beginning to serve dual eligibles and integrating Medicaid benefits may be more interested in developing relationships with PACE organizations than plans with heavy Medicaid experience. This reflects their lack of experience with LTSS.
- Plans are taking a cautious approach to these new relationships. They might wish to start small. At the same time, plans struggle to reconcile the scale of their enrollment (large to very large) with the service capacity of PACE organizations (comparatively small).
- PACE should market its "boots on the ground" presence in communities. Plans are recognizing this as a significant need.
- PACE organizations will need to develop some organizational capacities and attributes to partner with new organizations, especially in the areas of billing, reporting, outcomes and accreditation.
- Partnerships will be slow to emerge. The changing landscape requires new relationships, but plans and PACE organizations will need time to sort out all the details.

There are a number of areas where future developments could help advance the potential for PACE and new payer relationships. Specifically, health plans expressed an interest in working with accredited organizations, which currently do not have programs directly applicable to PACE. The PACE community might explore whether an accreditation process would facilitate relationships with new payers.

Additionally, large multi-state plans have expressed an interest in developing contract templates and other tools that can be used by multiple local PACE organizations collectively in order to provide services and access to statewide or regional health plans. As PACE organizations gain experience and expertise in contracting, they can share their learnings and best practices with other PACE organizations.

New payer relationships will require significant time and investment, with both the payer and the PACE organization proceeding with considerable uncertainty. However, there is much to be gained from successful new payer relationships: service and payer diversity for PACE organizations; provider capacity and quality outcomes for payers; and effective care options for vulnerable, frail, elderly individuals who will continue to need the intensive services offered by PACE. Whether those services are covered by federal and state payers, managed care organizations through subcontracts, or partnerships with emerging delivery system models, PACE can offer significant value and high-quality care.

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ATTACHMENTS

Tools

Case Studies

What Payers and Delivery Systems Need to Know About PACE

In developing new relationships with payers or health delivery systems, it is important for these organizations to understand the unique elements of PACE. The following narratives can be used by PACE organizations to help educate new payers about the PACE model and can be used to develop "value propositions" or specific proposals. PACE organizations should feel free to tailor these narratives to include specific information about their programs (e.g., size, scope of operations, staffing).

Overview

PACE is a comprehensive, fully-integrated, provider-based health plan for those who require a nursing home level of care. PACE participants are medically and functionally complex. They have multiple chronic conditions and significant limitations in physical and cognitive functioning. Approximately 50 percent of PACE participants have a formal diagnosis of dementia, including Alzheimer's. Ninety percent of PACE participants are "dually eligible" for Medicare and Medicaid benefits.

PACE is responsible for providing all medical care: primary care, specialty care, nursing, prescription drugs, hospitalization and other medically necessary services. PACE also offers long-term services and supports (LTSS) such as home care, chore services, personal care, meal preparation, transportation, and other services that allow individuals to stay in their homes and communities. PACE receives monthly, capitated payments from both the Medicare and Medicaid programs to pay for this comprehensive range of services and bears full financial risk for participants' medical and LTSS needs.

Essential Elements of PACE

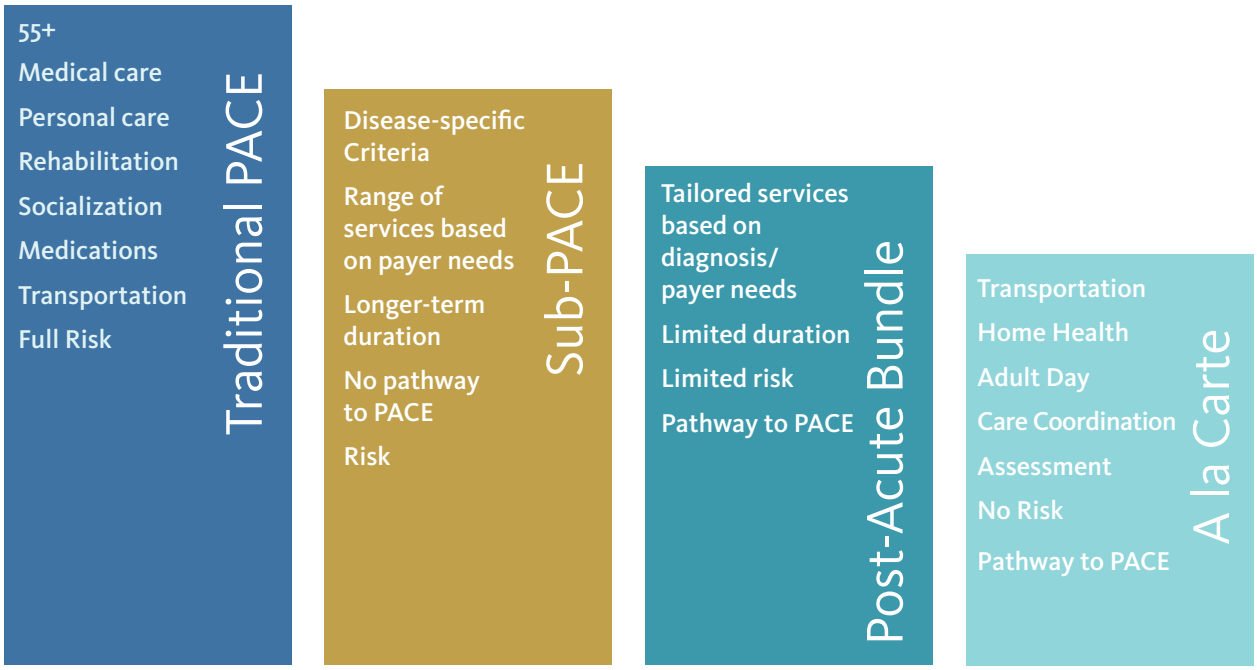
PACE organizations typically follow a highly structured, fully integrated model that includes these key elements:

- PACE IDT: Upon enrollment in PACE, participants' care is both organized and provided by an inter-disciplinary team that includes doctors, nurses, therapists, social workers, dietitians, personal care aides, transportation drivers and others. Their needs are assessed, and an individualized care plan is developed to respond to all of the participant's needs – 24 hours a day, seven days a week, 365 days a year.
- PACE Center: PACE participants receive comprehensive health and supportive services across a range of settings. At the PACE center they receive primary care, therapy, meals, recreation, socialization and personal care. In the home PACE offers skilled care, personal care supportive services, and supports such as ramps, grab bars and other tools that facilitate participant safety. In the community PACE offers access to specialists and other providers.
- Provider-Based Model: PACE combines the intensity and personal touch of a provider with the coordination and efficiency of a health plan. IDT members deliver much of the care directly, enabling them to personally monitor participants' health and respond rapidly with any necessary changes. The PACE team is also responsible for managing and paying for services delivered by contracted providers such as hospitals, nursing homes and specialists.

- Capitated Financing: PACE organizations receive fixed monthly payments that they can use to pay for all medically necessary care. The financial and clinical incentives are aligned to ensure that individuals receive appropriate, timely care that emphasizes prevention and functional independence.

Typically, these elements all work together to create a uniform, fully-integrated experience for PACE participants. As PACE organizations develop relationships with new payers, however, these individual elements may be disaggregated and reassembled into new products that address gaps in the new payers' service delivery and care coordination resources.

Possible Lines of Service



NPA Financial Benchmarking Service:

Per Member Per Month (PMPM) Cost Category Specifications

Functional Cost Categories

- Generally, costs are reported by function (e.g., PACE Center) rather than by input or resource (e.g., RN salaries).
- Each functional cost category should include all expenses directly associated with the function (e.g., salaries, supplies).
- General and administrative costs should be reported in the designated cost categories for these items (see Item Ref. #29–33 in Table 1) rather than allocated across all categories.

Allocation of Staff Expense

- Staff expenses should be allocated to one of the expense items as appropriate.
- For staff expenses, include the following: salary, benefits (health insurance, pension, workers' compensation, employee transportation assistance, parking, uniforms), taxes, employee recognition, professional development expenses, productive and nonproductive time, and professional licenses paid by the organization.
- An individual staff member's expense may be allocated across multiple cost categories if the individual contributes to multiple functions.

Complete Transmittal

In order to transmit a complete set of cost information, you must provide all of the required items. If you have incurred no expenses in a cost item, enter 0.

Cost Item Specifications

Table 1 provides specific information on the costs to be assigned to each of the Per Member Per Month cost categories. The Item Reference Number in the table refers to the item's number in the related data entry screen (the Excel spreadsheet).

Table 1. NPA Financial Benchmarking Service:
Per Member Per Month (PMPM) Cost Category Specifications

Item Ref. #	Item	Specification
1	Year-Ending Date for Data Transmitted	The Last Day of the Period for Which Income and Expenses Are Being Reported
2	Number of Days in Reported Period	Total Number of Days in the Period for Which Income and Expenses Are Being Reported
3	Enrollment	Total Number of Participants Enrolled in the PACE Program by the Year-Ending Date
4	Member Months – All	Total Number of Member Months for the Period Being Reported
5	Income – All	Total Income for the PACE Program
6	PACE – Medicare	Income Received from Medicare for the Provision of PACE Services
7	PACE – Medicaid	Income Received from Medicaid for the Provision of PACE Services
8	PACE – Other	Income Received from Sources Other Than Medicare or Medicaid (e.g., Private Pay) for the Provision of PACE Services
9	Income – Other	Income Not Related to the Delivery of PACE Services (e.g., Foundation Grants, Interest Income)
10	Expenses – All	Total of All Expenses Related to the PACE Program, As Detailed Below in Items 11–31 Below
11	PACE Center	Sum of Primary Care (Item #12) and Adult Day (#13) Below
12	Primary Care – PACE Center Based	Medical Director Primary Care Physician(s) in Clinic or Home Nurse Practitioner in Clinic or Home Nursing Staff in Clinic or Day Center Who Provide Primary Care (Note: Not Home Care Nursing)
13	Adult Day Care – PACE Center	PACE Day Center Staff – All PACE Day Center Staff – Assistants PACE Day Center Supervisor Recreational Therapy – Program Recreational Therapy – Contracted Laundry
14	Contracted, Off-Site Primary Care	Contracted, Primary Care Costs of Physicians, Nurse Practitioners and Nurses for Delivering Primary Care in a Location Other Than a PACE Center or Participant's Home
15	Contracted, Off-Site Adult Day Care	Contracted, Adult Day Care Costs for Services in a Location Other Than a PACE Center
16	Social Services	Social Work Staff – All
17	Therapy	Occupational Therapy – Program Occupational Therapy – Contracted Speech Therapy – Program Speech Therapy – Contracted Physical Therapy – Program Physical Therapy – Contracted Therapy Provided Under Contract – Other (Note: Do Not Include Recreational Therapy, See #12 Above) Therapy – Other

NPA Financial Benchmarking Service:
Per Member Per Month (PMPM) Cost Category Specifications

Item Ref. #	Item	Specification
18	Home Care	Home Care – Nursing Home Care – Personal Assistance Lifeline Monitoring Home Care – Other
19	Meals	Food Plates and Cutlery Staff Contracted Service Meals – Other
20	Transportation	Outsourced Transportation Costs (Including Ambulance for Non-Inpatient) Van Fleet: Van Leasing, Van Repairs, Van Maintenance, Auto Gas and Oil Transportation Staff: Drivers, Assistants, Other Other
21	Outpatient Specialist	Audiology Dentistry Optometry Podiatry Surgery Pathology Radiology Outpatient Dialysis Psychiatry/Psychology Other
22	Pharmacy	Prescription Drugs Over-the-Counter Drugs Dispensing/Administrative Pharmacist Other
23	DME and Supplies	Durable Medical Equipment Supplies: Clinic Supplies, Day Center Supplies, Therapy Supplies, Other Supplies Other
24	Labs and Diagnostics	Lab Costs Other Diagnostic Service Costs (e.g., X-Ray, Mri) Other
25	Nursing Home	Short Stay/Respite Long Stay/Permanent Placement Other
26	Hospital	Ambulance Emergency Room Intensive Care Unit Medical/Surgical Inpatient Rehabilitative (Acute Care Stay) Inpatient Dialysis Inpatient Psychiatric Other
27	Sub-Acute Rehabilitation	Skilled Nursing Facility – Sub-Acute Rehabilitative Care Hospital – Sub-Acute Rehabilitative Care Other

NPA Financial Benchmarking Service:
Per Member Per Month (PMPM) Cost Category Specifications

Item Ref. #	Item	Specification
28	Assisted Living/ Residential Care	PACE Housing Foster Care/Group Home Residential Care/Assisted Living ICF (over 30 Days) Other
29	Administrative	Admissions and Eligibility Staff Program Management Staff Travel Postage and Courier Photocopying and Printing Bank Charges Accounting Services Books and Subscriptions Management Support Services Information Systems Licensing Fees Legal Fees Translation Services Administrative Supplies Clinic Administrative Staff Medical Records Medical Records Staff Other
30	Marketing	Marketing Staff Marketing Expenses
31	Insurance	Insurance: Liability Insurance, Stop-Loss Insurance, Facility-Related Insurance
32	Depreciation	Equipment Building Vehicles Information Systems/Computers
33	Facility	PACE Center Rent/Mortgage PACE Center Utility Costs Facility Maintenance Equipment Maintenance Maintenance Staff Other
34	Other Expense	Expenses Not Specified Above
35	INCOME (LOSS) FROM OPERATIONS	Total Revenues Minus Total Expenses

Note:

1. Measures (Item Ref#) 11-28 are for expenses related to Participant Care.
2. Measures (Item Ref#) 29-34 are for expenses related to PACE Operations/Administration

Encounter Data Reporting

In 2013 CMS required PACE organizations (POs), MA Plans and Medicare Special Needs Plans to begin submitting service encounter data for use in calculating Medicare risk-adjusted payments. The data are required to assist in calculating risk-adjusted payments to adjust for inconsistencies among the diagnostic characteristics of individuals in these plans as opposed to beneficiaries in Medicare fee-for-service. In short, CMS is seeking alternative sources of data to more accurately calculate capitated payments to reflect spending in Medicare fee-for-service. New payers such as managed care organizations and institutional payers likely will also require encounter data from contract providers.

NPA has developed a series of superbills containing the common procedural terminology (CPT) codes most likely to be used by PACE health care professionals such as primary care, nursing, social work, therapy and nutrition. NPA also is developing superbills containing codes based on bundles of services, such as day center services, home care services and care coordination. These superbills will not only help PACE organizations to quantify their costs, identify potential inefficiencies, allocate resources, and improve quality of care, this information can inform the construction and pricing of a range of services (e.g., care coordination, day center, home care).

Quality

Encounter data can give payers a degree of confidence that they are receiving an appropriate quantity of goods and services, but the data alone do not capture the full PACE value proposition. Purchasers will more likely recognize the value of the PACE model if it can produce consistent quality outcomes. To encourage quality improvement among PACE organizations, NPA has developed a Common Data Set capable of generating PACE-specific outcomes measures. This standardized outcomes-based approach to evaluate PACE performance will allow programs to explore operational processes that generate better outcomes and will encourage the types of innovations necessary to enhance program efficiency.

Case Studies

PACE Relationships with New Payers: Palmetto SeniorCare Case Study

Palmetto SeniorCare is one of the original On Lok replication demonstrations and has been serving PACE participants since 1990. Currently, 290 enrollees are served by four centers throughout the Columbia, SC, metropolitan area. The program employs more than 120 full-time staff and has an annual operating budget of $17.75 million.

Palmetto SeniorCare is sponsored by Palmetto Health Systems, a large health system that includes several hospitals, physician practices, surgery centers and other services. While PACE is the centerpiece of its elderly care services, Palmetto has integrated elements of PACE into several of its service lines:

Palmetto has integrated elements of PACE into several of its service lines.

- Senior Primary Care Practice: This Medicare-only physician practice offers primary care/medical management, a patient-centered medical home, social work, pharmacy and nursing. The program was created in response to the demand for primary care for an elderly population at risk but not yet eligible for nursing home care, and it serves as a referral system for Palmetto SeniorCare. Like PACE, it uses a focused primary care physician and an interdisciplinary team and works closely with the patient and family on a comprehensive plan of care that is community-based.
- Acute Care for the Elderly (ACE) Unit: This unit provides specialized care for elderly acute care patients who are 65 and older and at high risk for complications. The ACE unit is focused on daily interdisciplinary rounds, the incorporation of patient preferences during hospitalization, early mobility, nutrition, and implementation of technology. The unit evolved because the typical acute care setting was not sensitive to the needs of a frailer at-risk patient. Like PACE, the ACE unit uses a team-based approach and is inclusive of the role of the family and the wishes of the patient. The nursing staff has been trained on the unique needs of this patient population, and Palmetto SeniorCare physicians are engaged in the day-to-day operation of the unit.
- Palmetto Health Quality Collaborative (PHQC): This physician-led organizational entity of Palmetto Health is focused on improving the quality and reducing the cost of patient populations. Similar to PACE, the PHQC employs interdisciplinary team care, a medical home and a narrow network and is based on the realignment of services necessary for population health and ultimately assumption of financial risk for other populations. Strong care management programs are now in place that support not only high-risk populations but other at-risk chronic disease patient populations. Linkages with post-acute care providers, especially nursing homes, around seamless transitions of care all have come from the "PACE playbook."

Though these programs have all been influenced by PACE, Palmetto SeniorCare has made a focused effort to stay true to the original PACE model. To date, they have not comingled staff or services at the

PACE center with services provided through other service lines. PACE serves as a training opportunity and model for interdisciplinary team care. As a hybrid of a provider and a payer, PACE prepares the Palmetto Health System to move into population health and ultimately accept financial risk. Understanding how to manage high-risk, high-cost patient populations will be critical to maintaining financial solvency for the health system as it evolves in a changing world of health care delivery.

The Policy Environment

Historically, South Carolina has not had a robust managed care marketplace. With regard to public programs, only a small percentage of Medicare beneficiaries is enrolled in MA plans, and Medicaid managed care has been limited to pregnant women, infants and children. In 2011, however, the state applied for and was approved to participate in the CMS FAD. Under this demonstration the state will begin enrolling eligible beneficiaries in integrated care plans in 2015.

The state intends to passively enroll individuals 65 and over who are not currently residing in a nursing home. Enrollment targets include both "at-risk" populations and the community well. These populations are underserved, racially and ethnically diverse, and endure high rates of chronic illness. While these individuals might not meet PACE eligibility criteria at this time, they may be expected to seek PACE services in the future as they experience declining health and reach a nursing home level of care.

Under the demonstration individuals who are determined to meet the state requirement for nursing home eligibility or are residing in a nursing home will be passively enrolled in a managed care plan that assumes responsibility for LTSS benefits. Plans are only responsible for 180 days of nursing facility coverage, after which enrollees revert to fee-for-service. Individuals who do not wish to remain in the plans can disenroll and opt to do one of the following:

- enroll in PACE,
- receive home- and community-based services under fee-for-service, or
- transition into a nursing facility under fee-for-service.

Enrollment initially was expected to begin in July 2014 but has been delayed to 2015. Four health plans have expressed interest and submitted preliminary readiness information. The plans that are moving forward typically have experience serving duals or operating Medicaid plans in other states.

Opportunities for Collaboration

Recognizing that this changing landscape could impact how PACE is accessed, Palmetto reached out to plans to initiate conversations. In anticipation of these meetings, Palmetto SeniorCare developed a core service package that would include care planning, day respite, home care, meals, medication therapy management and pharmacy, nutrition, occupational therapy, personal care services, physical therapy, primary care, recreation, social services, speech therapy and transportation.

Recognizing that this changing landscape could impact how PACE is accessed, Palmetto reached out to plans to initiate conversations.

Palmetto SeniorCare also would offer plans the use of its network of nursing home providers and manage the nursing home benefit for institutionalized enrollees. Palmetto SeniorCare is proposing to offer the range of PACE services with the exception of assuming risk for the cost of hospitalization or long-term nursing facility placement.

Because Palmetto SeniorCare is a firmly established PACE program and is also part of a larger health care system, the leadership believes the PACE program can develop these new relationships without compromising quality or diluting the PACE model for existing participants.

Pricing

With enrollment in the FAD health plans delayed until 2015, detailed arrangements and agreements on pricing have been slow to emerge. In general, plans seem receptive to conversations and are familiar with and impressed by the track record of PACE around hospitalization, emergency department utilization and pharmacy management. However, agreement on pricing and evaluation has not been reached yet.

Earlier this year, the state released its proposed rates for the plans, which fall into four rate cells:

- Community: $70.30
- HCBS Waiver: $1,093.59
- HCBS Waiver-Plus: $2,906.09
- Nursing Facility: $4,588.74

PACE rates in the state are comparable to the HCBS+ rate, at $2,605 per member per month. As Palmetto SeniorCare considers pricing tools, it is looking for bundles that can be compared to the rates that plans are paid by the state. Even as they appreciate the attributes of PACE, plans are uncertain if the proposed package is worth the cost. Palmetto SeniorCare anticipates that once plans experience the high cost of outlier patients, they will see the value of the comprehensive and preventive care offered in a PACE-like package of benefits.

Evaluation

With regard to quality and evaluation, plans are most interested in the Healthcare Effectiveness Data and Information Set (HEDIS) and encounter data. Quality bonuses might be offered for reaching certain benchmarks.

Top Takeaway

- The terms of the state contract with health plans will influence their arrangements with others. In the case of Palmetto SeniorCare, because the plans are only responsible for 180 days of nursing home care, they are not very interested in a full sub-capitation of PACE, which would include full risk of nursing home placement – short-term or long-term.
- PACE organizations should "master PACE" before taking on new arrangements. New arrangements can take time and resources to sort out. To ensure that new arrangements do not dilute the PACE model, programs should ensure that they can integrate these new payer relationships without compromising quality.

PACE Relationships with New Payers: Rhode Island Case Study

PACE Organization of Rhode Island (PACE Rhode Island) has been serving frail seniors for almost a decade. Since opening its first center in Providence in 2005, PACE Rhode Island has grown to serve almost 300 seniors at seven sites throughout the state. With a $25 million operating budget, PACE Rhode Island employs 79 full-time employees.

Policy Environment

In 2011 Rhode Island received a grant through the CMS initiative to support State Demonstrations to Integrate Care for Dual Eligible Individuals. The state submitted an application to participate in the FAD in 2012. While an MOU has not yet been signed with CMS, the state is moving forward with its Integrated Care Initiative (ICI) to better integrate health and LTSS for high-need populations such as those with intellectual and developmental disabilities, the frail elderly, and individuals with severe and persistent mental illness. Approximately 33,000 Rhodes Islanders are eligible for ICI benefits.

While an MOU has not yet been signed with CMS, the state is moving forward with its Integrated Care Initiative (ICI).

During Phase 1, plans will receive capitated payments to cover all LTSS benefits, and individuals will be offered a coordinated Medicare plan. During Phase 2, the state hopes to sign a three-way agreement with CMS and plans that allows for individuals to be enrolled in fully integrated plans.

The ICI relies on three models to coordinate primary care, behavioral health services, and home- and community-based services:

- Rhody Health Options (RHO) is a health plan option (operated through a contract with Neighborhood Health Plan) that offers MLTSS and coordinates other health services. Dually eligible beneficiaries receive Medicare-covered benefits through the traditional Medicare program or the MA plan of their choice. The state has not yet set a rate but will offer plans a fixed monthly rate to provide all LTSS services.
- Connect Care Choice Community Partners (4CP) is a Primary Care Case Management model (operated under contract with CareLink). Individuals who choose this option receive services from 4CP primary care sites and doctors. CareLink employs Community Health Teams – consisting of RNs, social workers, care managers and peer navigators – to provide support and education to members, ultimately increasing the members' ability to access and utilize health care services. Payment is based on a per member per month system for 10 categories based on clinical and service utilization. CareLink does not assume risk for services not covered in the bundle.
- PACE is a fully integrated, provider-based care plan for individuals 55 and over who require a nursing home level of care. Under PACE, beneficiaries receive all Medicare and Medicaid benefits through the PACE program.

Beginning in November 2013, eligible individuals received information about each of these option, along with notification that they would be automatically enrolled in either RHO or 4CP. Individuals had 60 days to "opt out," remain in the fee-for-service model, or select another option. At the end of Phase I, 18,000 individuals were enrolled in RHO, 4,900 were offered services under 4CP, eight were referred to PACE, and 4,669 opted out of the initiative.

As noted above, during Phase 1, ICI plans are only responsible for Medicaid-funded LTSS. Individuals continue to receive Medicare benefits through either fee-for-service or the MA plan of their choosing. During Phase II, which begins in 2015, the RHO model will be responsible for both Medicare and Medicaid. As 4CP does not authorize or pay for member services, the Phase 2 work of 4CP remains the same. 4CP will continue to receive a capitated rate from the state to provide community care management services to enrolled individuals.

Opportunities for Collaboration

Although PACE is available as a direct enrollment option for qualifying dually eligible beneficiaries, individuals being served through RHO or 4CP also might benefit from the PACE model. Because 4CP is a case management model (i.e., CareLink does not bear risk for all services) and because their operations share resources and staff, PACE Rhode Island focused its outreach efforts on Neighborhood Health Plans, which administers RHO. Conversations began in 2012, but the evolving nature of the initiative and delays in implementation caused conversations to continue throughout 2013 and into 2014.

Given this explosive growth and its relatively recent entry into the managed long-term care marketplace, Neighborhood needed to rapidly ramp up its capacity.

Neighborhood Health Plans was receptive to these conversations, given the rapidly growing population it serves. The statewide plan has more than 20 years of experience serving Medicaid populations. Due to its recent involvement with the Affordable Care Act – both the state's efforts to expand Medicaid and the development of products for health insurance exchanges – Neighborhood has added 51,000 new members since November 2013.

Given this explosive growth and its relatively recent entry into the managed long-term care marketplace, Neighborhood needed to rapidly ramp up its capacity. The plan leadership was a receptive and willing partner with PACE Rhode Island as both entities explored the potential value and structure of a collaboration.

Following many months of dialogue, PACE Rhode Island has proposed that, for a fixed monthly fee, PACE would provide full-care coordination across all settings and delivery of Medicaid-only community-based services, including transportation, adult day care services, home modifications and personal care.

Furthermore, PACE would provide and bill Medicare directly for all primary care, rehabilitation services, social work, primary care nursing, and nutrition and dietary consultation.

PACE Rhode Island and Neighborhood continue to discuss opportunities for PACE to assume full financial risk for hospitalizations and nursing home utilization.

Pricing

To appropriately price this product, PACE Rhode Island developed an exhaustive list of the types of services that would be offered. The list included significant detail about the number and intensity of services. PACE Rhode Island then priced this package, taking into account the following:

- Actual costs (based on PACE financial benchmark reports and utilization data);

- Medicaid and Medicare budgets for current benefits;
- Competitors' costs; and
- RHO capitation rates.

At the time of this analysis, PACE Rhode Island and Neighborhood have not yet agreed upon a rate but are close to agreement.

Evaluation

PACE Rhode Island and Neighborhood have yet to agree on an evaluation tool. Historically, plans have relied on National Committee for Quality Assurance (NCQA) recognition, accreditation or other metrics to assess quality and effectiveness. Given the absence of such tools for LTSS, however, plans and programs have to devise new metrics and systems for gathering, reporting, and analyzing quality data.

Top Takeaways

- PACE programs need to identify the range of products/services they would be willing to offer. They need to be thorough and precise in their assessment of the costs of delivering such services.
- Plans are used to established measurements for provider quality and performance, but there is no standard tool for evaluating PACE. PACE programs need to think about how they will measure and report their quality.
- Depending on the policy environment in the state, PACE program arrangements may have to be unrolled in stages. PACE Rhode Island is starting small but hopes to grow its arrangement as plans are expected to move from LTSS to fully integrated benefits.

PACE Relationships with New Payers: St. Paul's PACE Case Study

St. Paul's PACE has been serving seniors in the San Diego area since 2008. The program serves more than 400 participants through two centers in San Diego and Chula Vista. St. Paul's PACE employs 131 full-time employees and has an additional 50 direct care contractors on site. Its sponsoring organization, St. Paul's Senior Homes and Services, also offers independent living, assisted living, memory care, skilled nursing and an inter-generational day care program.

CalPACE, an association of nine California PACE programs, worked with state policy-makers to position PACE as an option for dually eligible beneficiaries.

Policy Environment

California's Coordinated Care Initiative (CCI) aims to integrate all health, behavioral, long-term institutional, and home- and community-based care into a single health plan. One of the largest CMS-sponsored FADs under way, CCI will take place in eight counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara.

Implementation of the demonstration is under way in San Mateo, Riverside, San Bernardino, San Diego and Los Angeles counties. Individuals residing in these counties received information about the initiative, including information about the health plans in their area. Individuals who do not choose a plan within 90 days will be automatically enrolled in a plan (i.e., passive enrollment). Implementation in Alameda, Orange and Santa Clara counties is delayed until spring 2015.

To ensure a level competitive playing field, CalPACE, an association of nine California PACE programs, worked with state policy-makers to position PACE as an option for dually eligible beneficiaries. The following policies ensure that beneficiaries can directly access the PACE benefit:

- Enrollment: Individuals enrolled in PACE will be excluded from the CCI demonstration. PACE enrollees will not receive enrollment materials from the state, nor will they be passively enrolled into plans. While individuals can be passively enrolled into health plans, they cannot be passively enrolled into PACE. This policy allows plans a slight competitive advantage in that they receive a steady stream of new enrollees.
- Education/Options Counseling: Appropriate individuals (beneficiaries who meet PACE eligibility requirements and live in a PACE zip code) will receive information about PACE in their enrollment packet. Beneficiaries who choose PACE as an enrollment choice still must choose a back-up Medi-Cal managed care or Cal MediConnect health plan in case they do not meet the eligibility criteria for PACE or they decide not to enroll in PACE. The Department of Health Care Services also is working to ensure that options counselors include information about PACE in their enrollment assistance and beneficiary outreach efforts. If a beneficiary opts for PACE, the PACE program has 60 days to perform an eligibility assessment and submit to the state for eligibility determination. Following the eligibility determination, the beneficiary can either enroll in PACE, choose an integrated plan, or receive Medicaid benefits through MLTSS and Medicare through fee-for-service or an MA plan.

Opportunities for Collaboration

St. Paul's PACE began exploring opportunities to partner with plans to deliver services in 2013. Four commercial plans will be serving individuals in San Diego County: Molina, CareFirst, Community Health Group and Health Net. St. Paul's PACE approached each of these plans several times to determine their needs, concerns and approach to serving frail seniors. Several plans were interested in its services, but only one plan has continued with discussions.

Based on feedback from its partner, St. Paul's PACE has developed two targeted service populations: "high utilizers" and individuals in a post-acute (30-day) episode.

For a fixed monthly fee, St. Paul's PACE will offer both populations monthly case management services that include assessment, care planning, arranging authorized services, and communication with the client. Any additional LTSS services (respite, day center, transportation, home care) would be charged on a fee-for-service basis. The health plan would continue to arrange primary, specialty and acute care.

Pricing

The chief financial officer and controller used internal data systems to determine costs and price accordingly. Electronic medical records will allow them to track utilization under the service arrangement and assess their pricing assumptions.

Evaluation

Plans are not yet ready to do risk-based contracting, so St. Paul's PACE has not developed a product where it assumes risk for nursing home placement or hospitalizations. Further, plans have not developed quality metrics, evaluation tools or penalties that might affect reimbursement (e.g., quality withholds).

Key Takeaways

- This arrangement offers some benefits to St. Paul's PACE by allowing it to leverage its existing infrastructure to generate additional revenue. It also allows St. Paul's PACE and the plans to "get to know" each other to see if additional opportunities arise. Looking forward, St. Paul's PACE anticipates:
  - the plans may realize that PACE offers better value when it assumes responsibility (and risk) for the full range of medical care and LTSS, and
  - a shortage of quality nursing homes in the region may pressure plans to consider PACE as an alternative.
- Partnering with managed care is only one way to diversify the payer base of PACE organizations. Other strategies include the following:
  - engaging in a robust marketing campaign to sustain demand for PACE services as a direct enrollment option;
  - exploring opportunities to market PACE and other services to individuals who can privately pay; and
  - engaging with the local Veterans Affairs Medical Center to consider serving veterans.
- Workforce issues are important. PACE staff members are well trained and adept at managing the needs of high-risk populations. Plans will need to build the capacity to manage high-risk populations in the community. The skills developed by PACE staff will be in high demand by these plans.

This arrangement offers some benefits to St. Paul's PACE by allowing it to leverage its existing infrastructure to generate additional revenue.

The National PACE Association consulted many individuals to inform this effort. We extend a heartfelt thanks to the following individuals for their support of this work:

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PACE AND MANAGED CARE

Strategies for Expanding PACE Through New Payer Relationships

NOVEMBER 2014

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The National PACE Association works to advance the efforts of Programs of All-inclusive Care for the Elderly (PACE) to support, maintain, safeguard and promote the provision of quality, comprehensive and cost-effective health care services for frail older adults. More information on NPA and PACE is available at www.npaonline.org.

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