

Accelerating  
State  
Access to  
PACE

ASAP

# MODEL STATE PRACTICES FOR PACE

REPORT ISSUED February 2004

*Developed by*  
The National PACE Association  
*with support from*  
The John A. Hartford Foundation



801 North Fairfax Street • Suite 309 • Alexandria, Virginia 22314  
Phone: 703-535-1565 • Fax: 703-535-1566 • [www.NPAonline.org](http://www.NPAonline.org)

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**List of Contributors for  
Report on Model State Practices for PACE**

**Deidre Albert**

National PACE Association

**Christine Allen**

Life/UPenn School of Nursing, Pennsylvania

**Judy Baskins**

Palmetto SeniorCare, South Carolina

**Shawn Bloom**

National PACE Association

**Lori Bowen**

Arkansas Division of Aging & Adult Services, Arkansas

**Adam Burrows, MD**

Upham's Elder Service Plan, Massachusetts

**Peter Fitzgerald**

National PACE Association

**Diane Flanders**

Massachusetts Division of Medical Services, Massachusetts

**Robert Greenwood**

National PACE Association

**Joan Haslett**

Vermont Department of Aging and Disabilities, Vermont

**Steven Landkamer**

Wisconsin Department Health & Family Services, Wisconsin

**Christine Klotz**

*Formerly* Senior Health Partners, New York

**Rob McCommons**

Community Care for the Elderly, Milwaukee

**Cindy Proper**

Pennsylvania Department of Public Welfare, Pennsylvania

**Jim Pezzuti**

Pennsylvania Department of Public Welfare, Pennsylvania

**Theresa Pratt**

Centers for Medicare and Medicaid Services, Maryland

**Gale Remington Smith**

Kansas Department of Aging, Kansas

**David Reyes**

Total Long Term Care, Colorado

**Kimberly Ruff**

National PACE Association

**Christine van Reenen**

National PACE Association

**Rosalie Wachsmuth**

Washington Department of Social and Health Services, Washington



## Report on Model State Practices for PACE

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### Purpose and Scope

With funding support from the John A. Hartford Foundation, the National PACE Association (NPA) organized and convened a workgroup to identify and develop model practices for state PACE managers. A select number of individuals with experience developing and operating PACE programs were invited to participate in a Model Practices Workgroup. Individuals were chosen to participate in this workgroup meeting based on one or more of the following criteria:

- participation and/or familiarity with the Accelerating State Access to PACE (ASAP) and PACE Expansion Initiative (PEI) projects;
- experience developing at least one PACE program;
- experience and/or familiarity with PACE in multiple states;
- number of years' and recent experience with PACE;
- familiarity with the chosen subject areas; and
- a demonstrated desire to understand and work through state level issues.

The workgroup included representatives from state agencies, PACE programs, NPA staff and technical experts from across the country. Nine states were represented in the workgroup: Arkansas, Colorado, Kansas, Massachusetts, New York, Pennsylvania, Vermont, Washington and Wisconsin.

The workgroup convened July 26-27, 2003, and its findings were compiled in this report. A draft version of this report was submitted to the workgroup for the purpose of securing additional input and to ensure accuracy. In addition, officials from the Centers for Medicare and Medicaid Services (CMS) were invited to comment on the draft before it was finalized.

In addition to drawing on their own professional experiences, workgroup members considered a wide range of current PACE state practices. This information was collected by NPA through a series of interviews and surveys of state administrators of PACE, conducted in 2002. The workgroup considered practices and materials from 18 states: California, Colorado, Florida, Hawaii, Illinois, Kansas, Maryland, Massachusetts, Michigan, Missouri, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Washington and Wisconsin.

The workgroup's primary goal was to identify model state practices relevant to the development of PACE, in order to encourage state efforts to develop or improve their PACE programs. For purposes of this workgroup, a model state practice is one that promotes and supports the growth, development and quality of the PACE model of care. The primary objectives of this workgroup included:

- describing those state practices (past, present or future) that serve as model practices;
- identifying or generating examples of each model practice;
- identifying the elements which are critical to the success of each model practice; and
- identifying potential challenges, concerns or trade-offs (those things that may be given up in exchange) for that practice.

This report, which is based on the findings of the Model Practice Workgroup, is divided into six sections:

- Developing an Operational State Infrastructure for PACE;
- Building and Responding to Provider Interest;
- Provider Application Process;
- Rate Setting;
- Eligibility Determination, Enrollment and Disenrollment Processes; and
- Monitoring Cost Effectiveness and Quality Outcomes for PACE.

Each model practice identified in the report is followed by a list of critical elements, a brief narrative, and specific state examples describing how that practice has been utilized. Where a trade-off has been identified by the workgroup, it is explained in the narrative section following the relevant model practice.

The National PACE Association and the Model Practice Workgroup recognize that each state is unique. States are subject to a diverse range of factors which affect the way they develop and manage their long term care programs. Therefore, this report and the underlying findings of the workgroup are not intended to promote one state practice over another or imply that all of the model practices are appropriate or effective in all state environments.

Rather, the intent of the workgroup and this report is to describe those state practices that have been proven to promote and support the growth, development and quality of the PACE model of care, in the settings where they have been applied. The usefulness of a particular model practice may vary across states, depending on whether a particular state already has an operational PACE program. States are encouraged to draw on the experiences of other states and take the ideas outlined in the report and tailor them in ways that meet their individual needs.

## Section 1: Developing an Operational State Infrastructure for PACE

### Summary

States need to establish an operational infrastructure for PACE very early in the development process. This infrastructure is guided by a vision of where PACE fits in a state's spectrum of long term care services and the election of PACE as a Medicaid state plan option. It requires sufficient planning and commitment to ensure adequate state support, funding and staffing resources for the development, management, oversight and growth of PACE. The Model Practices Workgroup identified three model practices that they found essential to establishing an operational state infrastructure for PACE:

- ensuring adequate resources and linkages (interrelationships) for PACE;
- providing clear and consistent policies and regulations that build on states' existing long term care policies/regulations; and
- building on federal CMS requirements and coordinating administrative activities with CMS.

### Model Practices

#### **A. Effective operational state infrastructures ensure adequate resources and linkages for PACE.**

##### *Critical elements:*

- Provide clear support for PACE as a valued resource in the array of long term care options;
- Designate a specific state agency with responsibility for the development and administration of PACE;
- Establish a single point of contact within the state and ensure regularly scheduled communication opportunities for prospective providers;
- Identify and allocate staffing and resources commensurate with the program's needs;
- Establish necessary adjustments to data systems, including, but not limited to, MMIS information and payment requirements for PACE;
- Establish and maintain internal linkages with related agencies, advisory boards and commissions;
- Coordinate community services and resources (e.g., housing);
- Facilitate and encourage external linkages between PACE and other key providers; and
- Provide for the ability to conduct due diligence, including monitoring and oversight.

Experience has demonstrated time and time again that PACE development thrives with a champion from within state government – someone who believes in the model of care and is committed to expanding long term care options for frail elders. PACE is a fairly new Medicaid option which has yet to develop in most communities. As a result, a state new to PACE development must engage in a process of education about the model of

care directed toward agency staff, insurance commissioners, legislators, governors, community organizations, potential funding sources, advocacy groups and a wide range of service providers. By allocating adequate state staff to PACE development in the early stages, states are more likely to prevent conflicts and problems that could require even more staffing resources to resolve later in the process.

In addition, PACE offers a comprehensive and broad range of medical and social services, which require innovative and collaborative partnerships. Linkages between the state administering agency and other state agencies are crucial. State administrators of PACE collaborate with state insurance commissioners; legislators; aging networks; quality assurance, monitoring or auditing agencies; Medicaid agencies; state actuaries; and case managers. Linkages between community support systems and a broad range of service providers are equally important because PACE providers offer a full range of medical and support services directly or through contracts. These include, but are not limited to: medical care, pharmacy, home health, personal care, adult day care, respite, end of life care, physical and occupational therapy, transportation, socialization, nursing home care, hospital care, dental care, podiatry, adaptive equipment and mental health services.

*Examples:*

**Kansas** Department of Aging, which is the state administering agency for PACE, recently took steps to transfer the Medicaid rate setting responsibilities from the state Medicaid agency to the Department of Aging in an effort to make data more accessible to the administering agency and expedite the rate setting process for PACE.

**Louisiana** organized a PACE team that includes representatives from a variety of state offices and divisions that have a role in PACE. The team was organized in the very early stages of PACE development and meets regularly. This approach encourages “ownership” of the PACE program and fosters communication and coordination among individuals and entities responsible for PACE development or management including: eligibility policy, medical and financial assessment policy, enrollment and disenrollment, payment methods, MMIS system modifications, rate setting, monitoring, and licensure.

**Pennsylvania and Washington** state staff maintain regular communication by meeting face-to-face with their PACE providers as a group on a quarterly basis. Pennsylvania utilizes an e-mail distribution list to ensure regular communication with providers.

In addition, Pennsylvania encourages linkages between PACE and housing providers, by educating housing providers about the advantages of collaborating with home and community based service (HCBS) providers. State staff develop and display exhibits during housing authority conferences. They provide PACE brochures, show photos of their co-locations and interact with conference attendees in an effort to educate housing staff about the availability (and benefit of) matching their affordable housing with home and community based services.

Pennsylvania state staff also provide letters of support for grants and other funding to support co-locations of PACE and senior housing. Additionally, state staff have included a representative from a PACE program on their state's Medical Assistance Advisory Committee (MAAC). This PACE representative currently chairs the MAAC Long Term Care Delivery System Sub-committee. (In Pennsylvania, Medicaid is called Medical Assistance.) MAAC is an external stakeholder group whose purpose is to advise the Department of Public Welfare (the state administering agency for Medicaid) on policy issues.

**B. Effective operational state infrastructures provide clear and consistent policies and regulations that build on states' existing long term care policies and regulations.**

*Critical elements:*

- Identify general internal operating requirements for developing, implementing and managing PACE, which are, to the extent possible, compatible with existing policies and regulations;
- Establish and record any new policies or regulations needed for the development, management, expansion or oversight of PACE;
- Evaluate and/or establish policies and regulations which avoid the unnecessary duplication of other state regulations; and
- Communicate with prospective PACE providers regarding state requirements and expectations.

The success of PACE programs is highly dependent on the policies and practices of state agencies. Many states learn during PACE development that they already have a number of long term care policies, regulations and practices which were initially developed for home and community based, nursing home, or managed care programs, that also are relevant to PACE. These policies, regulations and practices may cover areas such as: eligibility requirements, enrollment and disenrollment processes, grievances, appeals, data collection, licensing, oversight, monitoring, and reporting requirements.

Identifying and then building upon existing state policies, regulations and practices helps avoid duplication and relieves burden on limited state staffing resources, especially during the development phase of PACE. This approach also fosters more consistent application of policies, regulations and practices across long term care options. In addition, this approach reduces the amount of time needed to develop a separate operational infrastructure for PACE.

State administrators of PACE report challenges stemming from the development of policies or practices for PACE, which are not captured or clearly set forth in writing. This generally occurs in the early stages of PACE development, while the state is working on or responding to a provider application. During this phase of development, state administrators "learn as they go." They may adopt policies and practices that are never documented. As a result, it may be difficult to ensure that everyone involved in



PACE development understands the practices and policy approaches utilized. Important practices and policy positions may be lost with turnovers in state staff, and undocumented policies and practices may be difficult to apply consistently or uniformly. Clearly documenting policy enables each player (state, CMS, provider) to understand one another's roles and responsibilities. However, the trade off with recording and formalizing state policies and practices during the early stages of PACE development is that once a state has completed its first provider application process and has the benefit of this experience (and hindsight), state staff may discover the need to modify or streamline previously developed policies or practices. Once formally adopted, some policies and practices can be difficult to change.

Once a policy or practice is proven to be effective, it should be clearly documented to assure that it will be communicated, enforced and applied consistently and uniformly. Otherwise, when states experience turnovers in state personnel, new program specialists or managers will not be aware of key (existing and historical) PACE-related policies. For providers, clear, recorded policies and/or regulations avoid confusion and are easier to understand, respond to and comply with. For CMS, clearly recorded state policies are helpful as they review and approve state assurances and contracts.

*Examples:*

**Michigan** identified a need to educate PACE providers about state policies, practices and regulations. State staff developed a PowerPoint presentation and a training manual for PACE program staff which reviewed the contract requirements (including services, marketing, reporting and hearings). The training materials also review eligibility and enrollment systems, processes, and practices; medical fair hearing practices; and remittance advice.

While reviewing existing policies, practices and regulations, state staff learned that a number of their policies and practices were not documented in writing. They began identifying policies and practices that were being used but not documented, developed new policies and practices where needed, and documented these practices for future reference.

**Pennsylvania** supported a PACE provider's request to waive an adult day care regulation that would have required the PACE provider to acquire a second day care license in order to serve enrollees age 55-60. The state regulation required providers with three or more people under age 60 to acquire a second day care license from the Pennsylvania Department of Public Welfare. The regulation was intended for settings that are serving a significant number of younger adult physically disabled and/or mental retardation clients. But since individuals are eligible for PACE at age 55, the regulation technically would have applied to the PACE provider absent the waiver. This requirement would have been duplicative and increased burden on the provider.

**Texas** Department of Human Services facilitated the involvement of legal counsel, Medicaid personnel, consumer advocacy groups and provider organizations in a review of their PACE state rules. Texas Department of Human Services collaborated with these entities in revising state administrative rules (including, but not limited to,

sanctions, proof required for debarment and suspension, and causes for and conditions of suspension). The revisions included writing PACE rules in plain language to avoid confusion and promote clarity. Revisions also were made to ensure that the rules work in conjunction with federal legislation and correspond with their new state plan amendment.

### **C. Effective operational state infrastructures build on federal CMS requirements and coordinate administrative activities with CMS.**

#### *Critical Elements:*

- Cultivate relationship with CMS regional and central offices;
- Elect PACE as a state plan option;
- Collaborate with central office staff for new PACE programs;
- Review federal PACE regulations to ensure compliance;
- Compare state requirements to federal PACE regulations to identify areas which may result in duplication or conflict with each other; and
- Meet federal reporting requirements.

Building on federal requirements and coordinating administrative activities with CMS reduces state administrative burden. The coordination of federal and state activities also reduces administrative duplication and burden on state program staff and provider staff. Reducing administrative burden for state staff is particularly important in states experiencing budget shortfalls, staffing shortages and hiring freezes. Reducing administrative burden for providers is important because it generally results in more time for staff to devote to patient care.

State administrators have identified a number of areas where the existence of federal regulations may eliminate the need for additional, duplicative state policies, particularly with respect to requiring risk reserves for providers, site review, oversight, data collection and monitoring.

#### *Examples:*

**Massachusetts, Pennsylvania and Washington** reduce administrative burden and duplication by utilizing the CMS initial and annual site review process rather than conducting independent state site reviews.

**Missouri**, as well as a number of other states (including Illinois, Michigan, Ohio, Oregon, and Washington), has found federal requirements for PACE providers adequate and has chosen not to require any other health care licensing requirements (such as adult day, HMO, physician clinic and home health licenses).

## Section 2: Stimulating and Responding to Provider Interest

### Summary

Historically, PACE development has been primarily provider driven. This is due, in part, to the design of the original PACE demonstration project, which required provider organizations to submit applications for Medicaid 1115 and Medicare 222 demonstration waivers. The prospective providers were required to provide evidence of their state's willingness to participate in the demonstration in their proposals. As a result, PACE development was initiated by providers who then stimulated interest and secured a commitment from state policymakers.

Recently, states have started taking a more proactive role in PACE development. This is due, in part, to the design of the "Accelerating State Access to PACE (ASAP)" demonstration project. Under the ASAP project, states were required to respond to an RFP issued by NPA in order to qualify for funding for preliminary PACE planning and development efforts. Some states entered the project with viable interested providers. However, most states participating in the project needed to stimulate provider interest through education and outreach opportunities.

Given that PACE is a three-way partnership between a provider, a state and CMS, interest is needed from both the state and prospective provider before a provider application can be submitted to CMS. Regardless of how interest is driven, the state needs to communicate its long term commitment to PACE within state government, as well as to prospective providers, other health care and aging service providers, legislators, community organizations, and consumers about PACE in order to stimulate and respond to provider interest. If state staff do not believe there is a place for PACE in their long term care system, it is extremely difficult, if not impossible, to develop PACE in that state.

The Model Practices Workgroup identified six model practices relevant to stimulating and responding to provider interest. Effective practices for states stimulating and responding to provider interest include:

- taking a lead role in educating prospective providers, advocates and consumers about PACE to develop provider interest;
- communicating a long term commitment to PACE as an essential component of their long term care mission;
- promoting the viability of the program with skillfully developed rates and opportunities to build census;
- ensuring that consumers have equal access to PACE as a long term care service option with PACE service areas;
- supporting and monitoring PACE programs through start-up and operational phases; and
- providing a clear and fair process for provider selection that is receptive to the innovative PACE approaches designed to respond to community needs.

These practices build provider interest because they help ensure providers that they will have an opportunity to build a reasonable census and develop a viable program.

### Model Practices

#### **A. States that are effective in stimulating and responding to provider interest take a lead role in educating potential providers, advocates and consumers about PACE, and in building provider interest**

##### *Critical Elements:*

- Educating state staff about the PACE model of care;
- Developing meaningful ways to communicate the concept and benefits of the PACE model in terms that stakeholders, providers, consumers and advocates can understand; and
- Educating providers about how PACE may be compatible with their organizations' missions.

To be successful, state administrators must educate a wide range of individuals within state government about the PACE model of care. State administrators often need to build an understanding, interest and support among a wide range of state staff before they can adequately build or respond to provider interest. For example, a state that has not educated or involved the agency responsible for licensure about PACE has no way to respond to a provider question about the licensure requirements that would apply to a PACE program. Similarly, states need to educate staff internally about the PACE model before they can respond to a prospective provider's inquiry about who is eligible to participate in the program.

In addition, states must find clear and meaningful ways to communicate the concept and benefits of the PACE model to consumers, providers, funders and advocates. In some states, state administrators also find themselves educating prospective providers about how PACE may be compatible with their organizations' missions. This requires in depth knowledge of the PACE model of care.

##### *Examples:*

**Arkansas** developed an RFP process to identify interested, capable providers throughout the state. The state issued a request for proposals for feasibility studies from interested providers and awarded Real Choice Systems Change grant money to help fund the feasibility studies for two providers.

**Rhode Island** convened interested parties and stakeholders in a statewide orientation to PACE, bringing all of them to the same table at a very early stage in the development process. This approach gave the state an opportunity to educate a wide range of stakeholders at the same time, address any confusion, and avoid the potential for misinformation. The process also gave stakeholders an opportunity to voice their concerns, become involved at an early stage, better understand what their role would be, contribute to the development of PACE, and learn about how the PACE program is distinguishable but complimentary to other long term care service options.

**Vermont** transported interested parties and stakeholders by bus to Massachusetts, so they would have the benefit of experiencing and observing a PACE program in person as well as an opportunity to learn more about the model of care.

**B. States that are effective in stimulating and responding to provider interest have a long term commitment to PACE as an essential component of their long term care mission.**

*Critical Elements:*

- Recognizing the importance of the PACE model in integrating acute and long term care in a joint Medicare-Medicaid context for the frailest, most high-risk elders;
- Committing state staffing resources to PACE development, expansion and program management;
- Submitting a state plan amendment to request CMS approval to add PACE as an optional state plan service, in advance of provider recruitment; and
- Establishing PACE as a unique provider type

When a state is proactive in building and responding to provider interest, there is a designated state staff person responsible for developing, expanding and managing PACE. The amount of time that this designated person spends on PACE (versus other responsibilities) varies from state to state, but a number of states have recognized the value of having a full time PACE program manager or specialist. This sends a clear message to providers and other stakeholders that the state is committed to including PACE as a permanent option in its long term care delivery system.

States that submit a state plan amendment to include PACE as an optional state plan service send a clear message to providers that they are committed to incorporating PACE into their long term care delivery system. Submitting a state plan amendment requires serious consideration, as the state must address rate setting, eligibility, enrollment and disenrollment issues. A state's decision to submit a state plan amendment in advance of provider recruitment reflects a state's firm commitment to PACE. Some states are operating under a legislative mandate to develop PACE.

While this practice may encourage provider interest in PACE, some states experience difficulty securing scarce state resources to complete the submission of a state plan when there is no provider committed to moving forward with PACE. When the effective date of program implementation is some time in the distant future, it may be difficult for a state to generate a sense of urgency among other state staff to devote the necessary resources (i.e., time) to complete all of the steps necessary to finalize and submit a state plan amendment.

Establishing PACE as a unique provider type within the Medicaid payment system also stimulates provider interest. Efforts to fit PACE into various existing regulatory or licensing categories, such as home health, adult day health or physician clinic licensing

categories may cause confusion and uncertainty about the PACE model of care. PACE is distinguishable from programs in all of these categories, especially with respect to the responsibility prospective providers are taking on as well as the comprehensive and coordinated nature of the program.

States may roll out multiple PACE organizations simultaneously or elect to introduce them sequentially. The workgroup found advantages and tradeoffs with each approach. Simultaneous start-up (1) puts PACE organizations on the same reporting and monitoring schedule, (2) creates a community of PACE providers, (3) develops a stronger political constituency, and (4) establishes immediate visibility for PACE. In contrast, starting with a single organization allows the state to develop experience and benefit from lessons learned. Developing multiple PACE organizations simultaneously may create a greater demand on state resources, especially in the area of staffing.

*Examples:*

**Colorado** enacted state legislation in 2002 which called for a statewide feasibility study for PACE. (§ 26-4-124 (8.5)(c)(1), C.R.S.) The legislative mandate directed the Department of Health Care and Policy Financing to explore the feasibility of expanding the PACE program to counties throughout Colorado, conditioned upon grant or gift funding sources. Grant funding was awarded by the National PACE Association under the ASAP grant project, and matching federal funds were secured by the state.

**Pennsylvania** began developing PACE with four provider organizations in two counties at approximately the same time. This approach allowed them to build a critical mass. Now the state expands PACE one provider at a time as potential provider organizations come forward.

**Texas** passed legislation (SB 908) in 2001 to demonstrate its support for promoting PACE expansion. The bill states that “The state agency administering the program of all-inclusive care for the elderly (PACE) implemented under Section 32.053, Human Resources Code, as added by this Act, shall use its best efforts to have in operation six PACE program sites for the state fiscal year beginning September 1, 2001, 11 PACE program sites for the state fiscal year beginning September 1, 2002, and 16 PACE program sites for the state fiscal year beginning September 1, 2003.”

**C. States that are effective in stimulating and responding to provider interest address financial risk and promote the viability of the PACE program with adequate rates and opportunities to build census**

*Critical elements:*

- Work with prospective PACE providers and other stakeholders to perform a thorough feasibility and market analysis, and, whenever possible, define service areas and assignments to ensure start-up and ongoing financial viability;
- Ensure independence of any state long term care entry point(s)/gatekeeper(s) so that prospective PACE participants are not discouraged from enrolling;

- Follow the federal lead and allow alternatives to cash risk reserves for reputable and financially sound PACE providers; and
- Provide fair and adequate capitation which allows for the accumulation of a risk reserve, or alternative mechanism, to ensure ongoing viability.

As states try to build provider interest, one challenge is to help the potential provider understand and prepare appropriately for the financial responsibilities and risk it must assume for serving a frail elderly population, which unlike most managed care populations is entirely in service. The state can help address provider concerns about financial risk by developing Medicaid capitation rates that will, in combination with Medicare capitation rates, adequately compensate the provider, compare fairly with other long term care service models, and create opportunities for the provider to accumulate an adequate risk reserve or other mechanism to ensure financial stability. A rate setting approach that accurately defines a comparable population and the corresponding adequate rates is critical to ensuring the ability of any PACE program to accept the responsibility to safely care for its vulnerable enrollees. Realistically, because providers are hesitant to begin work on PACE without some idea about what their rates are going to be, states need to start working on rates early in the process.

PACE providers must assume financial and medical responsibility for their participants immediately upon initiating PACE operations. By federal law, financial reserve requirements specify that PACE providers must have “one month’s total capitation revenue to cover expenses the month before insolvency” and “one month’s average payment to all contractors, based on the prior quarter’s average payment, to cover expenses the month after the date it declares insolvency or ceases operations.” (42 CFR § 460.80) CMS and most states allow for a number of non-cash alternatives for risk reserves, including: insolvency insurance or reinsurance, hold harmless arrangements, letters of credit, guarantees, net worth, restricted state reserves or state law provisions.

Selecting and defining service areas should be a collaborative process for the state, key stakeholders and interested providers. Evaluating the potential target population for PACE is a dynamic process. Census data alone is not sufficient. States also must consider an organization’s potential to establish a strong network of services, referral sources and the availability of other competing long term care services within the proposed service. In addition, states must balance policies pertaining to consumer choice with policies ensuring a viable market for existing providers.

Even when the service area provides a substantial number of PACE eligibles, state long term care screening entities (i.e., single points of entry, gatekeepers, etc.) can directly affect census growth for a PACE program. If the screening clinician, for example, works for the same organization which operates a HCBS waiver program, the screener may direct potential PACE enrollees into HCBS and discourage the PACE option. This is why the state should set clear expectations that an objective screening will consistently be offered and frail elderly individuals will have an unbiased choice of available services.

*Examples:*

**Massachusetts** has allowed prospective PACE providers to propose their own service areas, with the assumption that they would know best how well they could staff, transport and safely serve the frail seniors in their particular neighborhoods. When a PACE provider asks to expand its service area, the state evaluates their service contracts to make sure coverage will be adequate, and makes recommendations to CMS as to whether the expansion should occur or not.

**Pennsylvania** state staff presented the PACE model to an interested bank. Their presentation resulted in favorable financing terms for a PACE provider, which enabled that provider to move forward with PACE expansion. The state also has contacted the Pennsylvania Department of Banking and the Pennsylvania Bankers Association to identify options for building interest and funding opportunities for PACE. State staff determined that community banks must participate in community investment programs under state law. Consequently, they are promoting investments in PACE development and expansion as one way that banks can fulfill that state requirement.

**Washington** state staff chose not to impose any risk reserve requirements for their PACE provider beyond those required by the federal PACE regulation.

**D. States that are effective in stimulating and responding to provider interest ensure consumers have equal access to PACE as a long term care service option.**

*Critical Elements:*

- Make system changes to ensure access to PACE is equal to all other long term care options, such as nursing home and other community based services;
- Uniform clinical eligibility tools for all long term care programs;
- Provide independent access points to long term care services that have no bias or conflict of interest;
- Develop state programmatic and funding approaches that do not disadvantage PACE; and
- Provide education and outreach to potential PACE clients.

Incorporating long term care programs into a single long term care continuum helps state officials and providers ensure they are providing a broad range of service options that meet the needs of consumers. It also helps states and providers identify ways in which the various options are complementary (rather than competitive) to one another. The opportunity to offer a unique and complementary service option, rather than a duplicative or competitive service option, may help build interest among prospective providers. When state long term care programs and budgets are not incorporated into a single long term care continuum, there is a tendency for programs to compete against one another for funding, state support and census. In addition, including all long term care programs in one comprehensive continuum helps state officials compare and contrast cost effectiveness and quality outcomes across programs. Many of the states participating in the ASAP grant project identified a need for information that compares



cost effectiveness and quality outcomes for PACE to other service options as they build support and interest in the model.

Because provider interest is stimulated by consumer demand and opportunities to reach a reasonable census, states need to ensure that consumers have prompt access to PACE as a long term care service option. If a state's eligibility and enrollment processes are such that it typically takes less time to access services in a nursing facility than it takes to access PACE (or any other home and community based services), then the consumer's choice is limited. In essence, there is a built-in institutional bias, and the PACE program's ability to offer a comprehensive community care package while building its census is compromised. Unfortunately, it still is not uncommon for consumers to have immediate access to nursing homes, when their access to PACE may take 30 days or more. For example, some states link PACE enrollment to the Medicare "first of the month" enrollment schedule, which delays the individuals' access to PACE until the first of the following month. With Olmstead, many states became aware of institutional biases, which were built into their eligibility and enrollment processes. Consequently, states are beginning to make much needed systems changes, particularly with respect to eligibility determination and enrollment processes. These systems changes help ensure that consumers truly have access to comprehensive community based care options, such as PACE, and they help stimulate provider interest in PACE.

Uniform clinical assessment tools and processes help states ensure that consumers have equal access to long term care options. Uniform assessment tools also help states compare and contrast the populations served by various programs in their long term care continuum. Similarly, independent access points for long term care services help remove bias and avoid conflicts of interest.

Referral sources are another important factor. State materials regarding long term care should include information about PACE as prominently as any other long term care option. This lends credibility to PACE, whether as a new or an ongoing program. This also instructs physicians and other health care providers, as well as housing and advocacy groups, how to make referrals for appropriate seniors. States that incorporate information about PACE in their various information sources detailing long term care service options, such as web sites, brochures, public presentations and mass mailings place PACE on more equal footing with other long term care service options. Most states that are successful in stimulating and responding to provider interest develop and distribute educational resources that help increase consumer awareness of the PACE option in their long term care service delivery system. The information is distributed to potential consumers, caregivers, advocates and a wide range of health care and aging service providers. Education and outreach helps providers build census and maintain program viability.

*Examples:*

**Pennsylvania** state staff developed a transportable wall display, which includes photographs and other materials describing PACE. They use this display to educate

consumers, advocates and providers at aging and housing conferences, as well as in other forums, about the PACE model of care.

**Washington** found census levels in their PACE program stagnant for over 18 months. After extensive analysis, state staff identified a number of barriers relating to their gatekeepers' enrollment and referral process. The state implemented a policy change regarding PACE referrals, mandating that case managers offer PACE to all eligible clients and use a "Financial Fast Track" for enrolling PACE applicants when appropriate. The "Fast Track" authorizes PACE enrollment for individuals who are clinically eligible and likely to be financially eligible for Medicaid but are awaiting financial eligibility determination. Without access to this "fast track," most clients must wait 45 days to receive services. The state also worked to streamline the intake process so that PACE referrals requiring immediate placement can be enrolled within three business days. The policy and process changes made by the state were successful in addressing the need for census growth in the PACE program. Within six months of the policy change, census had increased by nearly 50 participants. The policy changes reflected the state's commitment to PACE and stimulated the existing provider's interest in expanding to new service areas. In addition, now that the state has overcome barriers to building census, it feels better able to market PACE as a viable program to new, interested providers. Since making the policy changes, the state has identified three newly interested providers for PACE development.

In addition, Washington state staff send mass mailings to potential participants living within the existing PACE service area to educate them about the availability of PACE.

**Wisconsin** developed an independent access point to address a conflict of interest inherent in its Milwaukee County Department on Aging. In addition to being the aging unit charged with providing information and assistance to consumers, the department is also a direct provider of the Family Care managed care organization. In order to prevent the department from enrolling people directly into its own program without advising consumers of other options, the state has arranged for an independent options counselor or enrollment counselor to meet with individuals before they officially enroll in the program. This practice protects against a potential conflict of interest for the "gatekeeper" and ensures that consumers fully understand their options and the program they are entering into.

#### **E. States that are effective in stimulating and responding to provider interest support PACE programs from conception through start-up.**

##### *Critical Elements:*

- Assist with startup costs;
- Develop a clear timetable for the process of becoming a PACE provider;
- Develop a clear process for responding to provider interest from conception through start-up;
- Establish clear steps and incremental milestones;

- Establish clear requirements;
- Provide technical assistance directly or indirectly to potential providers; and
- Look beyond individual state borders for developments and resources relevant to PACE.

Start-up (pre-operational) costs for prospective PACE providers are substantial and may actually deter interested providers from developing PACE. These costs are related to demographic analyses, market assessments, financial estimates and actuarial analyses, regulatory approval, planning for service start-up, and initiation of service delivery. Fees for these services range from \$20,000-\$30,000 for assistance with developing a feasibility assessment, and from \$40,000-\$50,000 for preparation of required submittals to state/federal agencies. Support for service development and start-up in the first years of operation is generally in the range of \$40,000-\$55,000. A feasibility study typically costs around \$50,000. Total start-up expenses typically cost between one and two million dollars, depending on a provider's existing building and equipment assets. States have begun to adopt practices that help providers overcome the hurdle presented by start-up expenses. For example, states are securing and awarding grant funding for providers to pay for technical assistance needed to conduct feasibility studies. States also are providing education and building support among banks and other funding sources at the grassroots level.

In addition to responding to the financial concerns of interested providers, states help sustain provider interest by establishing clear timetables for major milestones, such as: submitting a state plan amendment; developing a rate; obtaining state certifications and assurances; signing the provider agreement; and submitting a provider application. For example, the length of time that it takes the state, CMS and provider to complete the provider application review process is one year. A clear process and timetable for responding to provider interest from conception to start-up helps ensure that providers do not become discouraged. In addition, clearly communicated expectations and requirements help avoid frustration resulting from lack of information or miscommunications.

As states become more proactive in PACE development, state administrators are providing more technical assistance to providers directly and indirectly. For example, states are facilitating educational presentations to prospective providers' boards, as well as securing and funding technical experts. States also are hiring consultants to educate and build support among state and local foundations, which may be potential grant funding sources for prospective providers. States are ensuring the public is educated about PACE as a long term care option. In addition, state administrators are looking outside their own state borders to learn more about other state practices and approaches relevant to the development of PACE.

Examples:

**Arkansas** helped secure funding for an "Exploring PACE" membership for prospective providers in order to ensure the provider had the necessary resources to complete a

feasibility study and awarded Real Choice Systems Change grant funding to help fund technical assistance for feasibility studies for prospective providers.

**Louisiana** Department of Health and Hospitals provided PACE Louisiana with \$443,000 in start-up funds and \$100,000 in capital outlay funds for remodeling a church to accommodate a PACE center.

**Pennsylvania** has furnished letters of support from grant proposals that fund PACE. The state currently is exploring opportunities to develop PACE with a prospective provider in New Jersey in a New Jersey community that would be close enough to serve some of Pennsylvania's Northern Tier Counties. The state is identifying areas that would require policy change within their department to enable the state of Pennsylvania to enroll an out-of-state long term care provider. The state also is identifying the type of cross-state collaboration and coordination that would be needed for eligibility and review processes.

**Rhode Island** invited the Director of Senior Care Options in Massachusetts to educate state employees, consumer advocacy groups and prospective providers about the PACE model of care and various strategies and approaches for PACE development.

**Vermont** issued a "Request for Proposals" to PACE Technical Assistance Centers and supplied funding to secure technical assistance for prospective providers to conduct feasibility studies and collaborate on a provider application. Vermont also hired a consultant to help educate local foundations and other grassroots organizations about PACE, in an effort to build support and interest in grant funding.

**Washington** state staff are exploring opportunities to offer PACE to clients living in Vancouver, through an existing PACE provider in neighboring Portland, Oregon.

**F. States that are effective in stimulating and responding to provider interest establish clear and fair processes for provider selection and are receptive to innovative approaches that respond holistically to community needs.**

*Critical elements:*

- Defined process and criteria for identifying qualified providers;
- Encourage the formation of coalitions that can join forces to become PACE providers;
- Clear definition of responsibilities, contractual requirements and quality expectations; and
- Plans for the implementation of PACE in viable areas where there is a willing and qualified provider

PACE provides a comprehensive and extensive range of social and health services. As a result, it often is difficult for smaller and highly specialized providers to develop PACE. States and providers are responding by creating innovative coalitions among a variety of health care providers and other organizations to develop PACE. These coalitions

partner with a variety of social support services, including medical care, veterans' health care and even housing providers. This practice helps consumers, states and providers. For example, co-locating a PACE center with senior housing provides seniors with easy access to health care and related services, allows frail elders to age in place, and avoids premature placement in nursing facilities. When states encourage these types of coalitions they stimulate provider interest by helping smaller providers overcome funding and other resource obstacles that may exist on an individual basis. In addition, this practice encourages providers to identify ways their services complement one another and ways they can collaborate to better serve their communities. This practice also allows states to respond to consumer demand for community based care alternatives and saves the state money over fee-for-service expenditures for nursing home placements.

States also can stimulate and sustain provider interest by developing a proactive plan for PACE development in viable service areas, which can support and maintain a PACE program. This plan should establish a clear process for identifying prospective PACE providers in those areas.

Additionally, when states clearly define and build an understanding of responsibilities, contractual requirements and quality expectations among prospective providers, these providers are better able to determine their level of interest and accurately assess their capabilities to develop PACE.

*Examples:*

**California** approved PACE expansion which involved a partnership between a PACE provider and a local development corporation. The partnership was created in order to access and combine Federal Emergency Management Agency rehabilitation grant funds with HUD 202 tax credits. This collaboration enabled them to rehabilitate a previously condemned building into low-income senior housing, with 144 affordable senior apartments and a PACE program.

**Colorado** supported the partnering of its PACE program with the Denver Veterans Medical Center to develop a collaborative and innovative model of care delivery within the PACE concept. Under this model, each respective organization assumes risk for specified services in order to most efficiently and effectively meet the needs of the enrolled veterans. The two organizations linked their medical record information systems in order to facilitate the exchange of information and request for services. Under this arrangement, nursing home eligible veterans now have access to PACE services while maintaining a relationship with the Veterans Medical Center for some services.

**Massachusetts** approved a coalition between an Area Agency on Aging and a Community Health Center that joined forces to become a PACE provider.

## Section 3: The Provider Application Process

### Summary

CMS and the state share the responsibility for approving an organization's application to become a PACE provider. The major responsibilities of the state in this process include:

- providing feedback and maintaining an open dialogue with prospective providers while reviewing and approving provider applications;
- submitting the state-approved provider application to CMS;
- conducting an onsite review of the applicant's operations; and
- signing the program agreement.

The prospective provider works closely with the state as it develops the provider application to ensure that its program meets CMS and state requirements and is integrated into the state's long term care delivery system. States are responsible for verifying the completeness of the provider applications they review and submit to CMS.

CMS requires the state to submit certain assurances along with the provider application. This verifies that the state is willing to enter into a PACE program agreement with the prospective provider and the organization is qualified to be a PACE provider. The state must submit the following information along with the provider application:

- An assurance that the state considers the applicant to be qualified as a PACE provider;
- A statement that the state is willing to enter into a program agreement with the applicant;
- The participant enrollment limit imposed by the state on the PACE organization (if any);
- A description of the state's enrollment process, including the criteria for deemed continued eligibility for PACE;
- A description of the state's process for overseeing the PACE organization's administration of the criteria for determining if a potential enrollee is safe to live in the community;
- A description of the information to be provided by the state to enrollees, including information on how to access the state's Fair Hearings process;
- A description of the state's disenrollment process;
- A description of the methodology used to establish the Medicaid capitation rate, and an assurance that the rate is less than the upper payment limit;
- A description of the state's procedures for the enrollment and disenrollment of participants in the state's system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based, and the actual number of participants in that month;

- A description of how Medicare benefits requirements are protected for dually eligible PACE participants; and
- A description of how Medicare's share of cost requirements is imposed.

Because some of these assurances are related to issues that must be worked through for the state plan amendment, states may expedite the provider application process by completing work on their state plan amendment in advance of the provider application.

The provider application process requires a close, collaborative working relationship between the state and prospective provider as the provider application is completed. The workgroup identified four model state practices that are important to the provider application process:

- working as partners with prospective providers throughout the provider application process;
- developing and facilitating three-way communication opportunities among CMS, the state and prospective provider early on and throughout the provider application process;
- enabling the timely completion of the PACE provider application process so that consumers may receive services as soon as possible; and
- adequately planning for the state resources needed to process the provider application.

In addition to working cooperatively with applicants, states need to establish strong working relationships with PACE application reviewers in the CMS Regional Office (RO) and Central Office (CO). States also need to understand the work schedules and timeframes under which the RO and CO operate. It is equally important for states to understand CO and RO preferences as to the formatting of information as well as any specific provider application requirements, including those outlined in the *PACE Application Desk Review Guide*. States should consult the CMS PACE web site and list serve regularly for updated documents and information. When states establish these relationships and complete this type of homework early on, the provider application process is more likely to run smoothly and less likely to become bogged down by unnecessary delays.

### Model Practices

#### **A. States are effective when they work as partners with prospective providers throughout the application process.**

##### *Critical Elements*

- Serving as a facilitator and an advocate with CMS on the provider's behalf;
- Helping providers access technical assistance or coaching from CMS or outside consultants when necessary;
- Collaborating with prospective provider(s); and
- Supporting experimentation and innovation as permitted with flexibility and waiver opportunities under the federal regulation.

States that are effective in processing provider applications view their relationship with a prospective provider as a partnership. Because PACE is a partnership between a state, provider and CMS, effective state administrators often find themselves facilitating dialogue between the provider and CMS (RO and CO), seeking clarification from CMS on behalf of the prospective provider, and even advocating on behalf of a provider on certain issues. These types of activities help ensure open lines of communication among the state, provider and CMS. In addition, this practice reduces the potential for misunderstandings and expedites the provider application process.

Another state practice that increases the likelihood of a successful provider application process is securing technical assistance for prospective providers and itself when needed. In addition to securing expertise to meet their own needs (as with statewide feasibility studies or actuarial analysis), states have secured technical assistance to help providers who may not otherwise have adequate resources to hire expert consultants complete the provider application. Whether states help secure technical expertise for themselves or prospective PACE providers, there is an increased likelihood that the provider application will be more accurate, more thorough and will meet the requirements of the state and CMS. Technical assistance also can expedite the process of completing a provider application.

Some states take a “hands off” approach while the prospective provider completes the provider application. These states may have little or no role in developing a vision for the prospective PACE program. They review the provider application when it is completed by the provider, generate the necessary state assurances and submit the application to CMS.

There are additional areas where prospective providers can use the support and guidance of state administrators. Prospective providers may need help identifying funding sources for start-up expenses and risk reserves. They may need assistance acquiring assets (such as vans, buildings, land or equipment). They may need state guidance when responding to requests for information from CMS or assistance building relationships with other community providers with whom they will contract for services. Those states that build relationships and collaborate with their prospective PACE providers are more likely to overcome challenges that could compromise their ability to offer this long term care option. A program developed through a collaborative relationship is more likely to meet the expectations of the state, CMS and community members. This type of collaboration also helps expedite the provider application process.

During this process, states need to exercise caution and avoid endorsing one provider over another. States need to find a balance between being objective about individual providers and offering support that will help ensure the viability of the PACE program as a whole. It is important for states to offer the same level of support to ensure the viability of their PACE program as they do to ensure the viability of their other long term care programs, such as nursing home and HCBS waiver programs.



One of the reasons PACE is so successful in improving quality outcomes for clients is because the model is flexible and encourages innovation. In fact, the entire PACE model of care is based on innovation. The innovation lies in: integrating Medicaid and Medicare funding streams; tailoring health care services to meet the individual needs of the consumer; the interdisciplinary team approach to care management; the preference of community based care options; and the emphasis on preventive health care.

In the November 24, 1999 interim final rule, CMS identified specific waiver opportunities that were intended to encourage development of PACE programs, particularly in rural and tribal areas. (42 CFR 413 (I)(C)). CMS recognized that many of the PACE programs developed during the demonstration phase adapted the model set forth in the original PACE Protocol in ways that would better meet the needs and utilize the resources of their communities. In the October 1, 2002 interim final rule, CMS offered an opportunity for additional conditional waivers and encouraged creative approaches to improving the PACE model that would responsibly balance the need of a PACE organization with protection of participant health and safety. (42 CFR 413(I)(E)(2)). Waivers are considered by CMS on a case-by-case basis and are specific to particular organizations and their operational policies.

State administrators that recognize opportunities for innovation and flexibility in the model are more empowered to develop a PACE program that truly will meet the needs of their communities. A few ideas recently discussed among states and providers participating in a Rural PACE Summit address shortages among a wide range of health care providers in any one rural community, which may require a PACE model that networks services across a number of rural communities, offers a traveling interdisciplinary team or portable PACE center, or a model that utilizes telemedicine. This flexibility and the waiver opportunities are available to all providers, not just those serving rural communities. These opportunities are intended to empower states and providers to design their PACE programs in ways that truly meet the unique needs of those living in the service areas.

*Examples:*

**Ohio's** first PACE provider agreement was drafted by a team consisting of staff from two prospective providers and the state. Since Ohio's provider agreements with the two providers were identical except for the payment rates, state staff felt that it made sense to collaborate with both providers on the applications as well. The state established a schedule for submission of drafts of each section of the application and meetings to review those drafts. Each site drafted their own application sections and submitted them to the state for review, and then the state and providers met to discuss the drafts. The state had a copy of the CMS review protocol and used it to ensure that all of the noted review points were well covered in the applications. The sites then would make any necessary revisions to their drafts. The state found that this level of information sharing was very helpful and resulted in a very smooth submission process. By the time the providers submitted the actual applications there was little need for further revision, and CMS had very few questions or concerns that required a response from either

provider. Because each provider had its own strengths and weaknesses, they were able to learn from each other's past mistakes and successes as well as any innovative ideas. The practice of ensuring that each section was completed on a schedule meant there was no last minute rush to get the applications done on time. If there were issues raised that required CMS contact, the state scheduled conference calls so that all parties could hear the same thing at the same time.

**Pennsylvania** state staff advocated on behalf of one of their providers when CMS requested separate financial reporting from each of the two centers operated by the PACE provider. Because the state needed and required consolidated reporting from their providers, the CMS request for separate reporting would have been duplicative and overly burdensome for the provider. For this reason, the state advocated successfully on behalf of the provider for CMS to accept the consolidated financial reporting already being submitted to the state.

**Vermont** hired a consultant to coordinate a coalition of providers for PACE development and funded technical assistance services to assist their providers with a feasibility study and provider application.

**B. States are effective when they facilitate opportunities for three-way communication among CMS, the state and the provider throughout the provider application process.**

*Critical Elements*

- Identifying key players and roles for each of the three parties and any external consultants/actors;
- Collaborating with the provider to develop a plan of action with milestones;
- Clearly explaining necessary action steps (i.e., action review, three-way agreement); and
- Determining who must complete CMS requirements.

PACE requires a three-way partnership among a provider, a state and CMS. Consequently, clearly defined roles, open communication and collaboration are absolutely critical to the provider application process. Identifying key staff within the state, CMS Regional Office, CMS Central Office and the prospective provider organization is the first step. The second step is to develop strategies for ensuring an open line of communication among those individuals. Regularly scheduled meetings or phone conferences help ensure that key players are informed and involved throughout the process. These practices help ensure that the provider application meets the needs and expectations of all of the parties involved in the process.

Roles and responsibilities assumed by each of the key players may vary by region. As a result, it is important that the parties build a shared understanding of what one another's roles and responsibilities will be during the provider application process. States need to pull the parties together early in the provider application process to build this understanding. Otherwise, there may be an unnecessary duplication of

responsibilities or the potential for a misunderstanding about roles. By bringing the parties together early in the process to define their roles and responsibilities, states can avoid frustration and conflicts that impede the provider application process.

Similarly, it is important for the state to explore each party's goals and expectations early in the provider application process. Ideally, the state and provider collaborate on a clearly defined plan of action, action steps and milestones. Each action step should be clearly explained. This information should be captured in writing for future reference, reviewed on a regular basis and adjusted as the need arises. This practice helps avoid confusion, misunderstandings, unrealistic expectations and delays during the provider application process.

### **C. States are effective when they facilitate a timely process that ensures consumer access to PACE.**

#### *Critical Elements:*

- Maintaining focus on the primary goal, which is to ensure consumer access to PACE;
- Collaborating with prospective providers to establish timeframes for action steps and milestones; and
- Developing strategies for resolving issues without delaying the process or revising the timetable.

During the provider application process, there are times when the parties lose sight of the primary goal, which is ensuring that frail elders have access to the PACE option. Small issues can shut down the provider application process completely if there is not a plan in place for proceeding with other issue areas, a plan to move forward with the timetable while working to resolve the more difficult issues. For example, while negotiating interests are an important part of the rate setting process, there are times when the parties get so caught up in defending their own positions that they are no longer able to consider the needs of all of the parties involved. As a result, they struggle to find the common ground that will enable them to establish a rate that balances and meets everyone's needs. Then, they stop negotiating. When this happens, the parties have lost sight of their common goal.

States that are effective during the provider application process facilitate a timely process. They move the process forward by keeping the parties focused on the primary goal, which is ensuring that frail elders have access to PACE. They overcome delays caused by difficult issues by asking, "How can we move this process along pending the resolution of this issue?" These states develop strategies for resolving difficult issues that do not hinder progress in other issue areas. For example, when rate setting is delayed pending actuarial analysis or additional data collection, these states work on eligibility, enrollment, appeals and grievances issues. When the state and prospective provider collaborate on timeframes for action steps and milestones and adhere to those timetables, then there is an increased likelihood that they will complete the provider application in good time.

*Example:*

**Vermont** developed a process for encouraging and securing provider commitment to PACE. The state organized and facilitated a prospective PACE provider meeting to collectively review feasibility studies, business plans and financial proforma scenarios completed by prospective providers. In addition, the state shared information with prospective providers about the state work plan, state plan amendment, eligibility criteria, state requests for CMS waivers, and a list of potential funding sources and proposals which could help offset startup expenses for the providers. Prior to the meeting, the state experienced difficulty securing a commitment from the prospective providers to submit a provider application. By the end of the meeting, prospective providers agreed to update and educate their respective boards and request a vote of commitment to PACE within a specified timeframe.

**D. States are effective during the provider application process when they adequately plan for needed resources.**

*Critical Elements*

- Ensuring timely access to appropriate staff (financial, legal, clinical, auditing);
- Ensuring that appropriate staff are updated throughout the process to avoid delays at the end of the process;
- Ensuring that state systems are prepared to implement PACE as a permanent provider type; and,
- Ensuring that all CMS requirements (state assurances, state certifications, three-way agreement) are prepared in advance of or in conjunction with the provider application.

In addition to collaboration, communication, and clear goals and expectations, the provider application process is dependent on the allocation of adequate resources. States that ensure sufficient staffing resources to develop PACE and oversee the provider application process are more likely to get through the provider application in a more timely manner. Devoting appropriate staffing resources in the early stages helps states ensure the thoroughness and adequacy of the provider application before it is submitted to CMS. This practice helps avoid additional delays at the end of the process that will result when CMS identifies missing or unclear information and issues requests for additional information (RAI). The need for adequate staffing resources expands beyond the need for a PACE program manager. The state needs to ensure that the PACE program manager has adequate and timely access to MMIS personnel, actuaries, legal counsel, clinical and auditing staff. As is true for many documents, it can take weeks and sometimes months to obtain the appropriate signature(s) on the three-way agreement or provider contract. State PACE program managers help ensure adequate and timely access to other state staff by building relationships with key individuals early in the provider application process. In addition, supportive and informed agency and departmental directors can help pull key staff together, ensure that the provider application is a priority, and expedite the process.

State administrators help expedite the provider application process by keeping key staff informed of progress, the completion of milestones, and any pending activities on a regular basis. This process helps keep the provider application on the “front burner” and avoids potential misunderstandings and unnecessary delays. In addition, compiling state assurances, certifications, the three-way agreement, and all CMS requirements in advance or in conjunction with the provider application also helps avoid delays in the process.

Similarly, state systems need to be prepared to implement PACE. MMIS modifications may be needed to process enrollments and disenrollments, prevent PACE participants from accessing fee-for-service benefits, and enable capitation payments to be made to PACE provider organizations. The state is required to ensure CMS that there is a process in place to provide for the dissemination of enrollment and disenrollment data between the state agency responsible for the data and the state administering agency for PACE. In addition, the state should ensure that connectivity requirements are met by the PACE provider organization (e.g., the provider needs to establish an account with AT&T Global Network and obtain CMS passwords to transmit enrollment and disenrollment data, and other data elements). This will enable them to meet reporting requirements and is necessary for monitoring through the Health Plan Management System (HPMS). The state and provider need to obtain HPMS training from CMS as well as any additional CMS and state computer systems training that may be needed. The state also can expedite the provider application and approval process by requesting that the state’s legal department review the program agreement early in the process. Ensuring that these preparations are made early in the process avoids the potential for delays in getting the provider application approved.

*Examples:*

**Louisiana** organized a PACE team that includes representatives from a number of government agencies, including: Department of Health and Hospitals (DHH) Division of Research and Development; DHH Bureau of Community Supports and Services; DHH Bureau of Health Services Financing; the Governor’s Office of Elderly Affairs; and the Department of Social Services. Representatives from these agencies meet periodically and sometimes as often as weekly. When needed, they include representatives from other agencies, such as the Bureau of Appeals. Representatives from these agencies collaborate with representatives from advocacy groups and the Olmstead Task Force on development, implementation and operational guidelines for PACE.

**New York** shares state-approved language for grievances and appeals with prospective PACE providers during the provider application process. This language combines state and federal requirements for grievances and appeals.

## Section 4: Rate Setting

### Summary

PACE is a fully capitated program in which CMS establishes and pays the Medicare capitation and each state establishes and pays the Medicaid capitation. The Medicaid capitation rate is subject to guidelines specified by CMS. Medicare and Medicaid capitation payments are combined with private pay premiums (for those not eligible for Medicaid) at the provider level, creating a flexible funding pool for all primary, acute and long term care services.

Regulations implementing the establishment of PACE as a permanent Medicare provider contain guidance for payment and rate setting. 42 CFR § 460.182(a)–(b) provides the following guidance:

- (a) Under a PACE program agreement, the State administering agency makes a prospective monthly payment to the PACE organization of a capitation amount for each Medicaid participant.
- (b) The monthly capitation payment amount is negotiated between the PACE organization and the State administering agency, and specified in the PACE program agreement. The amount represents the following:
  - (1) Is less than the amount that would otherwise have been paid under the State plan if the participants were not enrolled under the PACE program.
  - (2) Takes into account the comparative frailty of PACE participants.
  - (3) Is a fixed amount regardless of changes in the participant's health status.
  - (4) Can be renegotiated on an annual basis.

Federal regulation requires the Medicaid monthly capitation rate to be less than the amount that would otherwise have been paid under the state plan if the participants were not enrolled in the PACE program. This upper payment limit (UPL) must take into account the comparative frailty of PACE participants, and must be a fixed amount regardless of changes in the participant's health status.

The state's general methodology is approved with the state plan, and the specific calculations for the UPL and rate are approved as part of the provider application process by its CMS Regional Office. In the provider application, the state must set forth the UPL and capitated payment rates, describe the methodology used to compute the UPL and rates, specify that the rates do not exceed the UPL, and demonstrate that the rates are reasonable and predictable. If the general methodology changes, the state must submit a state plan amendment. In general, the state must engage in the following steps to establish a PACE rate:

- (1) Calculate the UPL for the PACE eligible population;
- (2) Choose from among the following rate setting options and make the appropriate calculations:
  - (a) open cooperative contracting
  - (b) separate rate calculation
  - (c) competitive procurement

The calculation of the upper payment limit is intended to be equal to the costs to the Medicaid program for a comparable population, and reflect a scope of services that PACE participants would receive if they were not enrolled in PACE. The capitated rate established by the state must be less than the UPL. In the past, states often have set rates as a percentage of the UPL, which they then update annually.

States are encouraged to review the step-by-step process provided in the *Financial Review Documentation for UPL and Rate Setting* document developed by CMS. States also are strongly encouraged to maintain a dialogue with their CMS Regional Offices and providers as they develop their UPL. It is important to ensure that the provider is educated about how the UPL will be set, so the provider can make an accurate assessment about the financial viability of moving forward as a PACE provider. The Regional Office also should be consulted to ensure that the state and CMS agree on the final outcome of the UPL and rate setting processes.

The capitated rates paid by the state to the PACE site must be less than this Upper Payment Limit. Historically, Medicaid capitation UPLs are derived from fee-for-service data trended forward using fee-for-service utilization and inflation assumptions. This computation method is designed to represent the likely cost to the Medicaid program of providing all services to PACE plan members if they were in the state's fee-for-service (FFS) program, and FFS was providing adequate access, which may not always be the case. The key to using an Upper Payment Limit is the accurate exclusion of non-covered Medicaid costs and the inclusion of covered Medicaid costs. If the appropriate costs are not included, the resulting capitated payment may be set too low. If inappropriate costs are included, the payment may be set too high. If the payment is too high, the program will not be cost effective because per capita expenditures for enrolled participants in PACE will be greater than they would have been under the fee-for-service program. If the capitated payment is too low, the ability of the PACE provider organization to offer a high quality, financially viable program may be in jeopardy.

The establishment of one or more UPLs and Medicaid capitation rates for PACE is a critical step in the development and implementation of PACE. A state may establish multiple UPLs and rates depending on the number of distinct rates established by the state for subgroups of the PACE enrollee population, (e.g., dual eligible, Medicaid-only, age 55-64, age 65 and over.) UPL and rate-setting methodologies are developed by

the state, and subject to CMS review and approval.<sup>1</sup> Initially, UPLs and payment rates are considered in the context of the PACE provider application process with approved rates included as an appendix of the PACE program agreement. Subsequent modifications to the rate result in updates to the appropriate appendix of the program agreement.

The UPL and rate setting methodologies developed by the state should derive monthly capitation rates that:

- 1) provide the PACE organization with adequate resources to deliver high quality services in response to the health and social service needs of its frail, elderly enrollees; and
- 2) provide the state cost savings relative to “the amount that would otherwise have been made under the state plan if the individuals were not so enrolled.”<sup>2</sup>

Although federal regulation does establish parameters for state UPL and rate setting methodologies, it does not specify a single, required approach to states’ development of Medicaid capitation rates for PACE. Consequently, the state has flexibility in developing a rate setting methodology that incorporates state-specific policy and budgetary objectives.

In those states that have implemented PACE to date, state eligibility criteria for nursing home level of care have significantly impacted UPL and rate setting methodologies and consequent UPLs and rates. The more these criteria result in substantial variance in the level of need and service utilization among individuals determined eligible for nursing home level of care, the greater the potential for difficulty in identifying a truly comparable population to that which enrolls in PACE. Characteristics of the state’s long term care delivery system also have a significant impact on UPL and rate setting methodologies and resulting UPLs and rates. For example, the extent to which community-based care exists as a viable alternative to nursing home care will affect the mix of the comparable population for PACE, which in turn may affect the methodology and resulting UPLs and rates. The state’s long term care eligibility criteria and the existing long term care service delivery system must be considered when establishing a rate. States need to make policy decisions on where PACE fits within the existing long term care system. The state also needs to consider long range plans for the expansion of community-based alternatives and incentives that will secure prospective providers.

As mentioned previously, the UPL establishes a ceiling which rates cannot exceed. Once the UPL (or multiple UPLs, as the case may be) is established, the rates can be set as a percentage of the UPLs or an entirely different rate setting calculation(s) can take place. Regardless of the approach, states must undertake four primary activities when establishing the UPL(s) and capitated Medicaid rate(s) for PACE:

- Define a general approach to UPL and rate-setting processes;

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<sup>1</sup> CMS regional offices take the lead in the review of the PACE UPL and rate setting methodologies, using a document titled, “CMS Financial Review Documentation for UPL and Ratesetting” to guide their analyses.

<sup>2</sup> §1934(d) of the Social Security Act.



- Define a comparable population within the state's long term care system for purposes of establishing the UPL(s);
- Calculate the comparison group's costs and an upper payment limit; and
- Establish the rate(s), either as a percentage of the UPL or by means of a separate calculation, ensuring cost effectiveness by ensuring the rate does not exceed the UPL.

UPL and rate setting processes are complicated, time consuming and require balancing both the providers' and state's needs to ensure long-term program viability. The workgroup identified four model practices that contribute positively to UPL and rate setting processes:

- Ensure the rate setting process is timely, transparent and predictable;
- Ensure the comparison population used to establish the UPL is indeed comparable to the expected PACE enrollee population;
- Develop a common understanding among ratesetters, actuaries, policymakers and providers of the PACE program and its enrollee population, and relevant pieces of the state Medicaid system; and
- Ensure providers have adequate resources to care for the PACE population and an opportunity for program growth.

### Model Practices

#### **A. Ensure the rate setting process is timely, transparent and predictable.**

##### *Critical Elements:*

- Allow for dialogue between state and provider;
- Establish a detailed work plan;
- Provide prospective providers with preliminary rates that enable them to make a preliminary assessment of financial viability;
- Build an understanding of the UPL and rate setting processes for all interested parties;
- Ensure the provider has access to information used in calculating the UPL(s) and rate(s);
- Develop a consistent upper payment limit (UPL) and rate setting approach that applies to all PACE programs within the state; and
- Determine in advance the timing and processes for annual updates of rates and periodic rebasing of UPL.

UPL and rate setting processes are complex and can take a significant length of time to complete. During this time, it may be difficult for states to retain interested providers who may become frustrated by the perceived lack of progress and question the state's commitment to the development of the program. In order to avoid these problems, states are encouraged to create opportunities for communicating the process, progress and developments with prospective providers. States also are encouraged to start their rate setting process early, even in advance of working with a particular provider.

Education and the development of a detailed work plan during the rate setting process can help prevent unreasonable expectations and unnecessary frustration. The work plan should include opportunities and forums for communicating with interested parties and obtaining feedback. The level of collaboration between state staff and providers during the UPL and rate setting process varies by state. However, all states should meet with potential providers to explain the process. When states communicate with interested parties on a regular basis throughout the UPL and rate setting processes, they make the process more transparent.

Predictability is established when the state educates all interested parties about how the UPL(s) and rate(s) will be set. When states build an understanding of the UPL and rate setting processes among interested parties, including state staff, providers, legislators and funders, there is less potential for confusion and misunderstandings. At a minimum, the parties need to understand what is identified as a Medicaid cost, adjustments for pharmacy rebates, third party liability and how member months are calculated. It is especially important to ensure that the provider is educated about how the UPL(s) will be set, so the provider can make an accurate assessment about the financial viability of moving forward as a PACE provider organization. CMS requires that all UPL(s) and rate(s) are reviewed and approved as part of the provider application process. Subsequent changes also must be reviewed and approved by CMS. Consequently, the state should consult with the Regional CMS Office during the rate setting process to ensure that the state and CMS agree on the approach and final outcome of the UPL and rate setting processes.

Ideally, all interested parties should be involved with establishing a work plan and milestones. This approach helps align expectations, builds trust among the parties and makes the process more predictable. The work plan should include a description of the UPL and rate setting processes and the MMIS changes needed to implement the rates. Although the work plan may require revision and may not be adhered to exactly, it is useful because it gives order to the process, identifies milestones so that parties have a sense of progress, and prevents delays to the best extent possible. With respect to the work plan, it is important for states to ensure that all parties that need to participate in the process are included and updated regularly on its progress.

States that share a preliminary analysis and rough estimate (or draft) of the rate with prospective providers early in the process help them make an accurate assessment about the financial viability of moving forward as a PACE provider organization. In addition, this practice may shorten the time needed to develop a PACE program, as a potential provider may be hesitant to acquire needed property, funding and contracts pending information about the rate. Sharing the information that the state uses to calculate the UPL and rate with the provider makes the process even more transparent and understandable.

States and providers share a common dilemma with this practice. A provider may be hesitant to move forward with a feasibility study or PACE development without information about a rate. At the same time, the state may be hesitant to put considerable effort into calculating UPL(s) and rate(s) unless the provider demonstrates a high level of commitment to developing the program. As a result, states need to find a balance. Putting enough effort into establishing a draft or preliminary rate may give the provider sufficient information to move forward with PACE development pending determination of a final rate.

States can make the UPL and rate setting process even more predictable by developing a consistent UPL and rate setting approach that applies to all PACE programs within the state.<sup>3</sup> In most states, this is the practice. This approach benefits prospective providers in states where PACE programs already operate because they can estimate their rates much more easily. In addition, states help ensure the process remains transparent and predictable by determining in advance the timing and processes for annual updates of rates and periodic rebasing of the UPL, and sharing that information with interested parties.

## **B. Ensuring the comparison population used to establish the UPL(s) and rate(s) is truly comparable to PACE enrollees helps states establish effective rates for PACE.**

### *Critical Elements:*

- Consider whether statewide or regional UPL(s) and rate(s) more appropriately account for differences in access, utilization and cost patterns;
- Consider and evaluate distinct UPL(s) and rate(s) to ensure they reflect significant differences in costs within the long term care (nursing home certifiable) population;
- Ensure there is a consistency in the relationship between the UPL and rate setting process, eligibility criteria, and enrollee characteristics;
- Evaluate the integrity of the UPL(s) and rate(s), and cost savings for the state, by analyzing the costs of serving PACE and comparable populations over time;
- Determine whether the rate reflects the known operating costs; and,
- Establish an ongoing evaluation process to ensure that the rate adequately compensates the provider for caring for the PACE population and ensures a cost savings to the state.

When developing PACE, states need to assess potential differences in the cost of serving their long term care population in various regions of their state. Differences may exist in access to services, utilization, individual characteristics and cost patterns. If there are no significant differences across the state for these three variables, then the model state practice would be to establish one (or more than one for states with multiple

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<sup>3</sup> The workgroup does not mean to suggest that all states should develop a single statewide UPL and rate; rather the workgroup is encouraging states to develop a consistent *approach* for establishing UPLs and rates across their states. This practice may result in a single or multiple rates, depending on variances in the costs of serving individuals in different regions across the state.

categories for dual eligible, Medicaid-only or other populations) capitated Medicaid rate per category that is uniformly applied to PACE programs statewide. If the state does identify significant differences in access, utilization and cost patterns, then the model state practice would be to establish regional rates that more accurately compensate their PACE providers for the costs of providing care in their regions.

Similarly, the state needs to consider and evaluate distinct UPLs and rates that reflect significant differences in costs within the long term care (nursing home certifiable) population. For example, states need to consider differences in costs based on age, gender, Medicare coverage and geographic region. The workgroup identified a few tradeoffs that may develop with this approach. First, it is more difficult for the provider to predict its reimbursement, because it is dependent on its case mix, which is somewhat unpredictable. Second, this practice may be more timely and complicated for the states' MMIS because more data is needed and will have to be extracted and analyzed in more ways.

Another critical element for effective rate setting is for states to establish a relationship between the UPL and rate setting processes, eligibility criteria and the characteristics of enrollees. State administrators can ask themselves, "Does the comparable population used to establish the UPL and rate truly reflect who will be (or is) eligible and enrolling in the program?" Currently, CMS allows states to adjust their rates to reflect higher acuity levels for PACE participants, but the resulting rate(s) cannot exceed the UPL, which is not typically adjusted to reflect higher acuity levels in the PACE population. If a UPL and rate are based on a population of people who are eligible but not enrolling in the program, the rate may not adequately compensate the provider for the costs of caring for the population it serves. For example, if a state factors a low cost but eligible population into the UPL, but that population is not enrolling in the program, the provider's ability to care for its clients may be compromised. Similarly, if the state factors in a high cost but eligible developmentally disabled population into the rate that is not enrolling in the program, then the program will not be cost effective for the state. For this reason, a model state practice in rate setting is comparing the population used to establish the UPL and rate to the population that is both eligible and enrolling in the PACE program. Any differences between the two populations then would be factored back into the UPL and rate setting methodologies.

When states evaluate the integrity of their UPL and rate setting processes, they need to consider analyzing the costs of serving the PACE participant and comparable populations over time in order to truly evaluate the appropriateness of their UPL(s) and rate(s) and cost savings to the state. Historically, states have not been equipped to undertake this type of analysis, because their information systems are not designed to do so. Consequently, this approach may require significant data systems development. However, the state may lack an accurate picture of the comparable population, PACE population, appropriateness of the rate, and Medicaid savings if it relies on a "snapshot" of enrollees at one point in time (i.e., at the time of enrollment).

For example, PACE enrollees may have relatively low care needs and may be easily served in the community for the first year or two of participation in the program. Not surprisingly, the expense of serving the PACE population with a capitated payment in the early years of enrollment are more likely to save Medicare than Medicaid money when compared to what would have been paid in the fee-for-service system. For this reason, some states may not consider PACE a viable option for saving Medicaid money, because they only have considered the expenses incurred by the PACE and comparable populations for the first year of enrollment. (See Abt Associates, Inc.'s evaluation of the PACE demonstration, entitled "A Comparison of the PACE Capitation Rates to Projected Costs in the First Year of Enrollment," which compares Medicaid and Medicare capitation rates paid to PACE programs with Medicaid and Medicare expenditures for a comparison group in the first year following enrollment in the program.) However, for the vast majority of PACE participants, the average length of enrollment is four years, and the primary reason for disenrollment is death. Consequently, that same population will more than likely require nursing home placement and/or an increased number of prescription drugs three or four years into the program. As a result, an analysis of the costs of serving the PACE and comparable population during the third and fourth year of enrollment is far more likely to reflect a cost savings for Medicaid. Without an analysis that considers the costs of serving these populations over time, states will have difficulty assessing the true cost savings that accrue to Medicaid and Medicare over the course of enrollees' stay in PACE. This, in turn, may impact a state's decision to develop or expand PACE.

The first rate that is developed for a PACE program may be the most difficult for a state, because it will have no program experience to consider as it defines a comparable population on which to base the rate. States often find the process of adjusting or establishing a subsequent rate much easier because they have a better sense of who is participating in the program and they can consider the known operating costs for serving the PACE population. States are more likely to establish adequate rates for PACE by assessing whether the rate reflects the known operating costs for the PACE program and allows a provider to recoup start-up expenses and grow the program. States engaging in this practice may be tempted to minimize or eliminate any surplus in the rate beyond the known operating costs. The state must be careful to recognize the usefulness of a surplus if the provider is to recoup start-up expenses, establish risk reserves, and grow the program. The critical element to this practice is the development of an ongoing evaluation process that will allow the state to assess the appropriateness of the UPL and rate setting approach and resulting UPL(s) and rate(s).

*Examples:*

**New York** develops regional rates by county to reflect the dramatic differences in care patterns and cost between New York City and the rest of the state.

**Washington** hired an independent actuary to help Medicaid rates staff develop a PACE rate. The rate for the state's current PACE provider is based on the population of PACE eligibles who reside in the provider's service area. State staff anticipate that as new

providers come on board, there will be regional rates that reflect the cost of serving clients in specific service areas.

**Colorado** hired the state Peer Review Organization to monitor a sample of PACE participants for a four-month period of time in an effort to determine the degree to which these participants would utilize nursing home versus waiver services in the absence of PACE. The study found that approximately 70 percent of those who were monitored would have, in the absence of PACE, been placed in a nursing home, and 30 percent could have sustained their community placement with the support of services provided in the HCBS program. As a consequence of this effort, the state increased its blend of nursing home and HCBS costs used to determine the Medicaid capitation rate from 60/40 to 70/30.

### **C. Educating rate setters and actuaries about the state Medicaid and MMIS systems, the PACE population, and the state's vision for PACE helps states establish effective rates for PACE.**

#### *Critical Elements:*

- Ensure that rate setters or actuaries understand the PACE model so they approach rate setting from a PACE perspective rather than a fee-for-service or managed care perspective;
- Develop methodologies that consider the unique characteristics of the PACE program;
- Arrange for rate-setters or actuaries to visit the PACE program if operational, to improve their understanding of the program;
- Maintain open and regular communication among policymakers and rate setters about the state's vision for PACE, the nature of the PACE program and characteristics of enrollees; and
- Ensure that rate setters or actuaries understand the MMIS system, how data is pulled, the availability of data, the timeframes involved, and any limitations of the system.

While CMS strongly encourages (but does not require) states to hire actuaries to set PACE Medicaid rates, it is important for states to realize that not all actuaries are familiar with the way the PACE model works. As many state administrators are aware, PACE manages costs significantly differently than providers in the fee-for-service system and other managed care programs. In addition, PACE programs serve a unique population, all of which are elderly and in-service. Consequently, states need to ensure that their actuaries avoid the use of methodologies based on other managed care programs for PACE unless those methodologies are relevant to and contain appropriate assumptions for a long term care population. It is in the best interest of the state, providers, CMS and consumers for states to secure an actuary that is experienced in developing PACE rates, or at least provide the necessary education about the PACE model to the actuary in the absence of that experience. Without that education and experience, there is a risk that the methodology and rate will not be appropriate for PACE and could compromise the viability of the program.

Involving the use of a well-qualified actuary may bring new expertise and objectivity into the rate setting process. However, actuaries can be expensive, so some states rely on internal rate setting staff to pull data from the MMIS and develop an initial rate setting approach, UPL and draft rate, which later can be reviewed by an actuary. With this approach, the state must educate internal rate setting staff and the actuary about the PACE model. One way that states provide this education is by arranging for rate setters or actuaries to visit an operational PACE program. This practice helps improve their understanding of the program and the population it serves because it helps actuaries and rate setters distinguish between the PACE population and the Medicare+Choice population or other Medicaid managed care populations that may include children or younger adults. These populations are distinguishable from the PACE population because a large percentage of the populations do not utilize services on a regular basis. As a result, they have much lower per member per month costs than PACE enrollees, all of whom receive extensive services and some of whom receive 24-hour care.

To ensure that rate setters and actuaries are on the right track and work in a timely manner, state policy staff should meet with them regularly throughout the process. More often than not, the methodology, UPL and rate will have to be assessed and reassessed a number of times by state administrators to ensure that the methodology truly captures the costs of a comparable population and ensure that all relevant data is being factored into the formula. In addition, states often need to educate rate setters or actuaries about the state's MMIS system, the process for pulling data from the system, the timeframes involved, and any limitations the system may have. Educating the rate setters or actuaries about these issues early in the process helps prevent misunderstandings and delays.

Some states find their rate setting policies are developed subsequent to the rate, in part to support the rate setters' or actuaries' approach. The model practices workgroup does not support or recommend this approach. States need to ensure that policy makers are driving the rate setting methodologies. Only then will the rate setters have the guidance they need for establishing a methodology and rate that truly meets the needs of states, CMS, prospective providers and consumers.

The workgroup found the practice of asking the PACE organization to affirm that the rate is sufficient to meet the needs of the enrollee population is important either as an alternative, or in addition to, confirming the rate is actuarially sound. This approach lends a "reality check" to the process by giving the provider an opportunity to assess whether that rate will allow it to offer a high quality, financially viable program that will meet the needs of the people it serves. The critical elements here are an ongoing dialogue between the state and providers during the rate setting process and a sufficient amount of time for a provider to react to a proposed state rate.

*Example:*

**Washington** asks the PACE provider to review the rate to verify whether it is sufficient to meet the needs of the enrollee population. If it is not sufficient, the PACE provider may submit cost and utilization data to demonstrate that it is not an adequate rate.

**D. Ensure providers have adequate resources to care for the PACE population and an opportunity for program growth.**

*Critical Elements:*

- Offset the higher costs associated with the first year of operation by establishing a rate that is a higher proportion of the UPL;
- Encourage providers to use net revenue to grow program census;
- Provide financial incentives for growth; and
- Develop monitoring and evaluation procedures for assessing PACE costs to the state.

When establishing an upper payment limit and rate setting methodology, states must balance their need to save money (over fee-for-service nursing home costs) with the need to ensure that providers have enough funds to adequately care for the people they serve. Finding this balance not only is critical to the success of the PACE program, but it is critical to ensuring that Medicaid clients receive the care they need. How these needs are balanced may be considerably different during the early years of the PACE program for a number of reasons.

During the initial years of a PACE organization's operations, operating losses are anticipated as the program builds its census to reach the break-even point. Also, during the first few years of operation, the provider must build a risk reserve. The PACE provider also may need to recover some of its start-up expenses during the first few years of operation.

These budget issues present serious challenges for providers and can easily threaten the viability of a new PACE program. During this time period, the state's interest in ensuring the ongoing viability of the program may outweigh the need for immediate and considerable cost savings to the state. Consequently, it may be necessary for states to establish Medicaid rates at a higher percentage of the UPL during the first few years of operation. During this time, the state maintains a minimal cost savings while helping its PACE provider(s) use net revenue to grow program census, recover start-up expenses, and build a risk reserve. When the program builds sufficient census to remain viable, has acquired an adequate risk reserve, and has recovered start-up expenses, the state may place greater emphasis on securing more significant cost savings through the rate setting process. As the state is further assured of the PACE program's viability, it may negotiate the Medicaid rate at a lower percentage of the UPL. Those states that do not set rates as a percentage of their UPL need to consider these factors when developing a rate. For example, states that base their rate on a "premium proposal" might evaluate costs more "liberally" in early years than later ones. This approach would maintain the incentive sites have as managed care providers to benefit from effective care



management, providing a means for these programs to establish a risk reserve, recoup start-up expenses and grow their programs.

Either in addition or as an alternative to this practice, states may allow providers to use net revenue growth or capital financing for the purposes of growing census or building risk reserves. Net revenue growth would be the result of more generous payments during the first year of operation. States also may provide financial incentives for program growth, such as paying the PACE provider an assessment fee for each applicant they assess, to help defray the costs of doing the different assessments by the team.

Finally, in order for a state to successfully balance the need for a cost savings with the need for program viability, the state must identify the criteria and process by which PACE costs and cost savings to the Medicaid program will be evaluated, reported to the necessary individuals, agencies and organizations, and factored into subsequent changes to the UPL and rate setting methodologies.

*Examples:*

**New York** allows for an administrative add-on in the rate for the first two years of operation to help support providers with the high costs of start-up.

**Pennsylvania** sets Medicaid rates for their pre-PACE sites at a higher percentage of the UPL than their fully operational PACE programs. Pre-PACE programs are paid 95 percent of the UPL, while PACE programs are paid 85 percent of the UPL. The higher payment for pre-PACE programs is intended to help those programs with start-up and administrative expenses as they build a census that can support the program and as they transition to a full PACE program.

## **Section 5: Eligibility Determination, Enrollment and Disenrollment Processes**

### **Summary**

In order to develop and offer PACE, states must establish a number of requirements, systems and processes relating to eligibility determination, as well as enrollment and disenrollment. In addition, states need to specify policies and procedures for initial assessment and periodic reassessment of clinical and financial eligibility.

With respect to eligibility, states need to establish both clinical and financial eligibility requirements for PACE services. Federal regulation requires that all PACE enrollees must be 55 years of age or older, reside in the PACE organization's geographic service area, and meet their state's Medicaid eligibility criteria for nursing home level of care. At the time of enrollment, an individual also must be able to live in a community setting without jeopardizing his or her health or safety. (See 42 CFR § 460.150)

States must establish clinical eligibility criteria for PACE that are consistent with the basic requirement that enrollees meet the state's eligibility criteria for nursing home level of care. States typically use the same criteria that are applied to nursing home residents or HCBS clients, who also must meet institutional level of care requirements. (See 42 CFR §460.150)

Federal regulation requires the state to conduct an annual recertification of PACE participants to ensure that they continue to need institutional level of care. The reassessment must be conducted for all participants, whether Medicaid eligible or not. The regulation provides that this annual reevaluation may be waived for those individuals for whom the state determines there is no reasonable expectation of improvement or significant change in condition. In general, individuals who have shown no significant improvement or change in condition during their first year of participation in the PACE program may be deemed PACE-eligible by the state. Under these conditions, CMS permits the state to grant a waiver from the annual recertification requirement for the life of the person. Additionally, federal regulation allows for the continued, or deemed, eligibility of individuals who are determined through the annual recertification process to no longer meet the nursing facility level of care requirement, if in the absence of continued coverage under PACE the individual would reasonably be expected to meet the nursing facility level of care within the next six months. The state may wish to consult with the PACE provider organization in its determination process, because the PACE provider has detailed knowledge of the day-to-day care and service requirements of individual participants and would, therefore, be better able to predict a participant's reaction to the loss of PACE services. (See 42 CFR §460.160)

Medicaid financial eligibility policies must address requirements pertaining to income and assets, post-eligibility treatment of income, and spousal impoverishment. States which choose to cover PACE participants under institutional eligibility rules have the option also to use the spousal impoverishment rules to determine eligibility of married individuals. Spousal impoverishment rules do not apply in determining eligibility for

those individuals eligible for PACE services under community groups or rules. Post-eligibility treatment of income rules determine the amount (if any) that an individual is liable to pay for the cost of PACE services. The amount of the liability is calculated based on the individual's income minus certain amounts. The calculation is made after the individual's eligibility has been established. The individual's liability, in turn, determines Medicaid's share of the cost of PACE services furnished to that individual. If a state covers HCBS recipients who would be eligible if in an institution, then the state may (but is not required to) apply the same post-eligibility rules to PACE participants who are eligible using institutional rules. If a state does not make HCBS recipients eligible using institutional rules and, therefore, does not use post-eligibility rules for HCBS recipients, the state is not permitted to apply post-eligibility rules nor impose post-eligibility share-of-cost expectations on PACE participants.

With respect to enrollment and disenrollment issues, CMS and 42 CFR §460.150 to 460.172 require states to develop procedures for the enrollment and disenrollment of PACE participants, as well as procedures for notifying the state of a PACE organization's denial of enrollment, and the state's review and approval of all involuntary disenrollments. The federal PACE regulation sets forth the reasons for which a PACE provider may involuntarily disenroll a PACE participant. PACE providers are required to use the most expedient process allowed by Medicare and Medicaid as specified in the program agreement while ensuring that the disenrollment date is coordinated between Medicare and Medicaid (for participants who are dually eligible), and reasonable advance notice is given to the participant. Federal regulation also requires that, until the enrollment is terminated, PACE participants must continue to use PACE services and remain liable for any premiums, and the PACE provider must continue to furnish all needed services.

Documentation by the PACE provider of involuntary disenrollments is subject to a timely review and final determination by the state prior to the proposed disenrollment becoming effective. During the review, the state must determine whether or not the PACE provider adequately documented acceptable grounds for disenrollment. The purpose of the state review is to protect participants who may need costly services from being "dumped" by the provider, and provide for the continuation of services until a final determination is made. States are encouraged to establish timely procedures for reviewing and processing involuntary terminations. (See 42 CFR §460.150-§460.172)

These procedures must be documented in the PACE provider application and the three-way program agreement. These policies are extremely important because they impact the ability of the elderly to access PACE services. In addition, these policies guide provider practices, shape the characteristics of the PACE participant population and affect opportunities to build census. For these reasons, states need to educate prospective PACE providers about these policies and procedures very early in the development process.

The model practices workgroup identified four model practices that are important to the PACE eligibility determination, enrollment and disenrollment processes:

- Design eligibility determination and enrollment processes that promote access to PACE;
- Ensure timely access to PACE services;
- Collaborate with the PACE providers on the development and simplification of eligibility determination, enrollment and disenrollment processes; and
- Establish clinical and financial eligibility criteria for PACE that place PACE on equal footing relative to other community based and institutional long term care programs

### Model Practices

#### **A. States' eligibility determination and enrollment processes are effective when they promote access to PACE.**

##### *Critical Elements:*

- Ensure that state financial and clinical eligibility criteria and enrollment and disenrollment practices maximize consumer choice;
- Ensure that eligibility determination is made independent of the availability of services;
- Implement public policies that encourage deinstitutionalization;
- Involve grassroots eligibility staff in establishing eligibility systems/processes and grassroots enrollment staff in establishing enrollment systems/processes for PACE at the policy level early in the development process;
- Work with insurance commissioners to explore options with insurers that will include PACE as a long term care insurance option; and
- Train state employees and/or contractors involved in the eligibility determination and enrollment processes about PACE and the program's characteristics.

PACE is a fairly new Medicaid option which most consumers are unfamiliar with. States promote access to PACE by ensuring that individuals who are eligible for PACE services are informed and educated about their options. States promote access to PACE by disseminating information about PACE wherever and whenever they distribute information about their other long term care programs. This may include mass mailings, informational packets or information on their long term care web site. Informational materials should clearly define the program, its benefits and eligibility criteria in layman's terms. This does not mean that states should promote PACE over their other long term care programs. Rather, the critical element to promoting access to PACE is to ensure that education and outreach materials distributed to consumers about long term care options include information about PACE.

Equally important, states need to educate eligibility workers or contractors, referral sources, and anyone involved in the enrollment process about PACE and its strategic position within the state's long term care system. The state can begin by involving eligibility and enrollment staff in establishing systems for PACE early in the development process. In addition, the state should provide training to eligibility and enrollment workers about the PACE model and ensure they have a clear understanding of who is eligible for PACE, so as not to restrict or target enrollment inappropriately. When eligibility and enrollment workers lack a clear

understanding about the program and who is eligible, it is all the more difficult for consumers to learn about and access PACE. The state can provide guidance to eligibility and enrollment workers by establishing clear policies and criteria for the workers to use in identifying individuals who would benefit from enrollment in a PACE program.

If the state contracts out for the assessments of initial clinical eligibility, information and referral services, or other gatekeeper functions, then the state needs to ensure that the contracted agency does not have a disincentive to refer to PACE. A disincentive to refer may exist if the certification agency also is a direct provider of case management or long term care services. States can help prevent conflicts of interest from developing by establishing a clear process for assessing initial clinical eligibility, implementing a conflict of interest policy, and conducting periodic reviews of a sample of individuals who are not enrolled in PACE to verify that the process is equitable.

In addition, state long term care administrators can maximize consumer choice by enacting policies and procedures that ensure that state financial and clinical eligibility criteria and accessibility to services are consistent across long term care options. States need to ensure that consumer choice is a reality. All too often, consumer choice is limited by caps on enrollment, limited slots, and long waiting lists for community based care. The reality is that the frail elderly and disabled often require immediate access to services when they apply for Medicaid. Built-in institutional biases make it easier for consumers to access services from nursing homes than from other alternatives. As a result, the individual has only one real option – to enter a nursing home. State administrators can improve access to PACE and other community based alternatives to nursing home care by implementing public policies that encourage deinstitutionalization.

States can promote access to PACE by establishing a process where eligibility determinations are made separate from the consideration of the availability of services. For example, financial and clinical eligibility should be determined regardless of limits on slots, caps on enrollment, or waiting lists. In addition, state long term care administrators can promote access to PACE and other home and community based long term care options by working with their insurance commissioners to explore options with insurers that will include PACE and other nursing home alternatives as a long term care insurance option. States also can promote access to PACE by identifying and removing barriers to enrollment of true private pay (neither Medicare nor Medicaid) individuals.

*Examples:*

**Arkansas** Division of Aging and Adult Services has approached the Arkansas Department of Insurance and the State Employee Benefits Division to foster the development of a group long term care insurance policy for state employees that would provide coverage for home and community based programs, including PACE.

**Washington** case managers who assess clients' eligibility for long term care services are required to mention the option to enroll in PACE. Long term care Medicaid clients residing in the PACE service area also are notified of their option to enroll in PACE via a letter sent by the state PACE program manager.

**Wisconsin's** Office of the Commissioner of Insurance issued an amended order of exemption for PACE to permit its provider (Community Care for the Elderly) to continue its program with the modifications required by CMS to enroll Medicare-only participants.

**B. States' eligibility determination and enrollment processes are effective when they ensure timely access to PACE.**

*Critical Elements:*

- Allow for presumptive financial eligibility;
- Develop a process for "fast tracking" eligibility; and
- Allow for rolling enrollment.

PACE provider organizations enroll very frail individuals, who often are in immediate need of services, due to a recent health or family crisis. Consequently, it is extremely important for the enrollment process to facilitate quick access to services. Unfortunately, access to PACE services all too often is delayed for consumers due to pending effective dates of enrollment and the time needed to process clinical and financial eligibility. These delays can result in nursing home placement for frail elderly requiring immediate assistance. Practices that delay access to community based care options while providing immediate access to nursing home care severely limit community based care options for frail elders, who are facing a health or family crisis.

For this reason, it is critical that states establish an enrollment process for PACE that will facilitate timely enrollment in the program. States can accomplish this goal by developing processes that expedite determinations related to Medicaid eligibility or allow retroactive enrollments in PACE for individuals awaiting Medicaid financial eligibility determinations.

For example, states may use a presumptive eligibility process which provides consumers with immediate access to services pending a financial eligibility determination. Under the presumptive eligibility process, the state is liable for the costs of that participant's care. With this approach, case managers or financial eligibility workers approve access to PACE for individuals who are clinically eligible for PACE and appear to qualify during a preliminary financial eligibility review, but are waiting for a full review and final determination of financial eligibility. While the state generally pays for the cost of care during the time period pending the financial eligibility determination, the PACE organization also can assume financial risk pending the outcome of the financial eligibility determination process. However, should the state require the provider to absorb these costs pending the financial eligibility determination, excessive delays in making those determinations may jeopardize the viability of the program.

At least one PACE state has been successful in facilitating timely access to PACE by using an eligibility process that involves a social worker, registered nurse and a runner to expedite the clinical and financial eligibility determination processes. These approaches are sometimes referred to as a "fast track." They are intended to streamline clinical eligibility processes, expedite financial eligibility processes and improve consumer access to services.

In addition, states may utilize a rolling enrollment process, which allows the PACE provider to enroll participants any day of the month (rather than coordinating with Medicare dates of enrollment). This approach is consistent with enrollment processes for other Medicaid options, such as HCBS and nursing homes. However, the workgroup identified three trade-offs with rolling enrollments that are important for states to consider:

- The state needs to obtain a waiver from CMS;
- The PACE program may need to bill Medicare Fee-for Service until Medicare enrollment is activated; and
- There will be discord between the Medicare and Medicaid enrollment dates.

While the workgroup found rolling enrollments to be a model practice for ensuring timely access to PACE, CMS prefers that states meet the requirement under 42 CFR § 460.158, which states, “A participant’s enrollment in the program is effective on the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement.” However, CMS has approved this practice in some states where extensive system changes would be required in order to comply with the regulatory requirements.

Each of these approaches (presumptive financial eligibility, financial fast tracking, and rolling enrollment) promotes timely access to PACE, so that consumers can access the care they need when they need it most. The state is more likely to save money when long term care clients are diverted from more costly institutional care. In addition, these practices may help states meet Olmstead requirements.

*Examples:*

**Pennsylvania** allows its long term care providers to enroll participants any day of the month. Consequently, the enrollment dates are not consistent with Medicare date of enrollment. The provider is required to give enrollment information to the state within two days of enrollment. The state processes the enrollments as they are received. This practice expedites the enrollment process for PACE.

**Washington** uses a presumptive eligibility approach to ensure timely access to PACE for consumers. Following the implementation of this expedited enrollment process, Washington experienced an 11 percent increase in census during a three-month period in fall 2002. During the preceding seven months, the state had seen virtually no increase in census for its PACE program. The census continued to increase throughout 2003. The expedited enrollment process allows individuals who are clinically eligible to access PACE services pending determination of financial eligibility. Before consumers are given access to this financial eligibility fast track, a financial worker reviews the preliminary paperwork and determines it is fairly certain that the client will be financially eligible for Medicaid. Without access to this “fast track,” most clients waited 45 days to receive services. The state will pay for up to 90 days of care during the period that the client is waiting for Medicaid approval. If after the 90-day period the client is determined not to be eligible for Medicaid, the provider does not have to absorb the costs. The state pays for it. This presumptive eligibility approach shortened the length of time it took consumers to access care and improved the viability of the PACE program in Washington.

**Wisconsin** created a web-based system for determining functional eligibility that could allow providers to assess and enroll participants (who are already Medicaid eligible) as early as the same day of referral. Staff at the provider organizations must be certified to use this tool. This system allows the state to review the enrollments in “real time.” In some cases, enrollment in PACE is even more rapid than enrollment in the HCBS program. This web-based system helps facilitate rapid enrollment and also is used to expedite the recertification process, as well. Because the state does not use a presumptive eligibility process, Medicaid eligibility still must be determined by the County Department of Human Services, Economic Support Unit, for individuals who are not already Medicaid eligible. Approximately 79 percent of enrollees are already Medicaid eligible when they turn to PACE.

### **C. Eligibility determination, enrollment, and disenrollment processes are more effective when they are simplified and developed collaboratively**

#### *Critical Elements:*

- Simplify clinical eligibility determination instrument to the greatest extent possible;
- Separate care planning from the eligibility determination process;
- Maximize continuous eligibility for PACE through the use of a federal “deeming” provision that allows for continued enrollment in the event a person would meet eligibility criteria within six months in absence of the program;
- Waive annual recertification requirement for PACE participants who are not expected to improve;
- Establish a collaborative process among the state, provider and consumers to define criteria for denials of enrollment and involuntary disenrollments at the policy making level and in consideration of individual circumstances;
- Strive for consistency and build a clear understanding as to how to apply “safety standards,” which may result in the denial of enrollment;
- Provide oversight and monitoring for the denial of enrollments and voluntary disenrollments as well as the review and authorization of involuntary disenrollments;
- Establish systems that will prevent disruptions in access to service when program participants are voluntarily or involuntarily disenrolled; and
- Create a feedback loop evaluating actual enrollment relative to the comparison group used for rate setting purposes.

Clinical eligibility tools vary significantly across states both in length and scope. Typically, clinical eligibility tools are three to six pages in length and cover a wide range of issues, including: vital statistics; referral information; cognitive patterns; communication and hearing patterns; vision patterns; mood and behavior patterns; social functioning; informal support services; physical functioning (including ADLs and IADLs); informal and formal support services; disease diagnosis; continence; health conditions; preventive health measures; nutrition; hydration; dental status; skin condition; abuse, neglect and exploitation; and home and living environments.

States are beginning to simplify and streamline clinical eligibility tools and processes whenever possible. State administrators can reduce the amount of time it takes consumers



to access long term care services by establishing a process where providers conduct the clinical assessment, which is then followed by a paper review by state staff who will determine clinical eligibility. This approach reduces demand on limited state staffing resources. It also reduces duplication and burden on the consumer, because in cases where the state conducts an initial clinical assessment to determine clinical eligibility, the consumer will have to participate in a subsequent and more comprehensive assessment by the provider for the development of a care plan. Establishing a protocol where the provider can make both assessments at once will streamline the process, reduce duplication, reduce demand on state resources, and is less burdensome on the consumer.

Some states that are utilizing a dual purpose assessment instrument for PACE that assesses clinical eligibility and establishes a care plan are conducting reviews to ensure that every question is truly needed and useful in determining eligibility. They consider whether the tool is being used for other purposes that are not necessarily relevant to eligibility determination, such as general data collection or care planning. Where possible, states are seeking alternative sources that may capture this general information in lieu of collecting it during the eligibility determination process. They also are evaluating the tools to determine whether the scope exceeds eligibility determination and is designed more as a care management planning tool. This type of dual purpose assessment instrument may be useful for other long term care programs for which eligibility determinations are made by the same entities that assume case/care management responsibilities. However, this is not the case for PACE. For PACE, the clinical eligibility determination instrument should not be used as a care management planning tool. Planning for care management is a function of the interdisciplinary team. Consequently, using the eligibility determination instrument for this purpose is duplicative and unnecessarily burdensome on consumers, PACE programs and state staff.

States also are turning to technology to simplify eligibility tools and processes by developing computerized assessment tools that can be saved and processed electronically. This approach can save time and reduce the risk of originals or copies being misplaced during processing. In addition, the tool is portable so the information can be collected at first entry and follow the consumer through the long term care system.

Federal regulation requires the state to conduct an annual recertification of PACE participants to ensure that they continue to need a nursing facility level of care. The reassessment must be conducted for all participants, whether Medicaid eligible or not. However, the federal regulation provides that the state may permanently waive the annual recertification requirement for a participant if it determines that there is no reasonable expectation of improvement or significant change in the participant's condition because of the severity of a chronic condition or the degree of impairment of functional capacity. (See 42 CFR §460.160) For example, individuals with advanced Dementia or Alzheimer's disease most often are considered to be very unlikely to improve. Individuals who have shown no significant improvement or change in condition during their first year of participation in the PACE program may be deemed by the state not to show significant enough improvement in the future to no longer need a nursing facility level of care. Under these conditions, CMS permits the state to grant a waiver from the annual recertification

requirement for the life of the person. States can simplify the clinical eligibility process for these individuals, who are not expected to improve, by exercising their option to waive the recertification requirement. However, this assessment must utilize safety criteria developed by the state and the state is responsible for oversight.

States are improving the clinical eligibility process by utilizing the federal “deeming” provision that allows an individual whose health status may improve with the support of the PACE program to the point where he/she may no longer be clinically eligible for nursing home level of care to continue to participate in PACE if his/her health condition would be expected to decline within six months (to the point of becoming clinically eligible) without the support of the PACE program. Absent “deeming,” these consumers will suffer sporadic access to health care. Their health will improve to the point of disqualifying them from the program and, in some cases, Medicaid eligibility. Without access to PACE, they may experience a decline in health status. They may then re-qualify for the program a few months later and be required to start the financial and clinical eligibility process again. Absent deeming, this process would repeat itself until the individual’s health status declined to a point beyond hope of improvement. This situation can be cruel and destructive to already frail elders. In addition, it is not in the best financial interest of the state, federal government or the provider to pay for the consequences of such sporadic and fragmented access to health care. “Deeming” not only improves the clinical eligibility process, but it provides an opportunity to achieve more sustainable outcomes and allows for a more preventive and effective approach to long term care.

Eligibility and enrollment processes are further simplified and made predictable when states strive for consistency across their long term care system. Simplification, predictability and consistency are particularly important when it comes to safety standards. An individual participating in PACE must be able to live in a community setting at the time of enrollment without jeopardizing his/her health or safety. The PACE provider is responsible for assessing the individual’s ability to live in a community setting. The state is responsible for establishing a process to oversee the PACE provider’s administration of the criteria for making this determination. As part of this process, the state may wish to develop model criteria for providers to use in evaluating an individual’s ability to live in a community setting. Absent a uniform approach and systems that provide education and assess understanding among providers, the state risks the arbitrary application of safety standards, which can lead to unfair practices for consumers and lawsuits for states and providers. A critical element to this practice is providing the necessary oversight and monitoring for the denial of enrollments, which will help identify inappropriate patterns.

Federal regulations set forth the possible reasons for denials of enrollment and disenrollment. In order to ensure that the eligibility, enrollment and disenrollment processes meet the needs of all parties involved, the model practices workgroup recommended states establish a collaborative process among the state, provider and consumers to assess the denials of enrollment and for involuntary disenrollments. This type of collaborative process also would be useful for establishing systems that will prevent disruptions in access to service when program participants voluntarily or involuntarily disenroll from PACE. The workgroup recommended that states use this type of collaboration both at the policy making

and individual client levels. This can be accomplished through the use of work groups, policy forums, advisory committees or focus groups.

In order to ensure that enrollment processes are consistent with what the state factored into the upper payment limit and capitated Medicaid rate, the model practices workgroup recommends that states create a feedback loop evaluating actual enrollments relative to the comparison group used for rate setting purposes. This practice is critical to ensuring that the rate adequately reflects (and empowers the provider to meet) the needs of those being enrolled in the program. This practice also helps ensure the enrollment process is working sufficiently to generate the mix of participants in the PACE program that was anticipated during rate setting. Without this feedback loop, there is no way for the state or the provider to ensure the rate truly balances the need to offer the highest quality of care with the need for a cost savings, and there is no way for the state to ensure that PACE is serving the population of people the state intended for it to serve.

*Examples:*

**New York** established a set of health and safety guidelines to help providers make consistent decisions regarding acceptance, denial of enrollment and disenrollment. The state collaborated with PACE organizations and Managed Long-Term Care Plans in the creation of these guidelines.

**Washington** is in the process of implementing a new comprehensive and automated assessment tool, which is designed to streamline the eligibility determination process. This tool determines whether a client is eligible for PACE. The assessment is completed by state case managers but is used by PACE intake staff to evaluate an individual for PACE enrollment.

**D. Establish clinical and financial eligibility criteria for PACE that place it on equal footing relative to other community based and institutional long term care programs**

*Critical Elements:*

- Utilize a clinical eligibility determination instrument that establishes a level playing field for all long term care programs;
- Develop a means for comparing beneficiaries across various community based and long term care options; and
- Ensure financial eligibility rules do not provide a disincentive to enroll in PACE relative to other long term care programs.

States that have successfully leveled the playing field for PACE to become a viable long term care option have created standardized clinical and financial assessment tools that are applied uniformly across all long term programs. In addition, these states strive for consistency among institutional and community based eligibility rules and PACE. For example, states that choose to cover PACE participants under institutional financial eligibility rules apply spousal impoverishment rules (to determine eligibility of individuals with a spouse) to PACE in the same way they apply them to nursing home programs. In much the

same way, the spend down and cost-share requirements are consistent across the spectrum of long term care service options in states committed to offering consumers an equal opportunity to access PACE.

Some states are developing criteria, policies, procedures and studies that monitor and evaluate quality of care, outcomes and the costs of PACE to the state. While an analysis of the program is important to ensuring that eligibility and enrollment practices do not disadvantage PACE, this approach is limited in its usefulness. This approach considers the effectiveness of PACE in a vacuum. There is no cross-program comparison being used to put the findings in perspective. Consequently, what a state will learn using this approach is the costs relating to the PACE program and the quality of care provided by a given program. This information has limited usefulness and will not necessarily meet the state's needs with respect to PACE development or assessing the effectiveness of eligibility and enrollment practices. In addition, this approach makes it difficult for a state to compare or contrast PACE with other long term care service options. Consequently, the information gathered from this type of evaluation will not be useful for state administrators trying to make the case for PACE in front of their legislators. The usefulness of the information will be somewhat limited as state administrators try to recruit prospective providers to develop PACE. In addition, the information may not be useful as state administrators jockey for funding from the state's long term care budget. There also is a danger that the results may be compared to an analysis of other long term care programs that may not be comparable in methodology, scope or approach. The model practices workgroup found it critical that states compare quality of care, outcomes and costs across all long term care programs. This approach is more likely to meet states' needs because it will help them assess the value and effectiveness of PACE compared to their other long term care options and it will help states assess trends in, and effectiveness of, eligibility and enrollment practices across all of their long term care programs. A potential trade-off for this practice is the additional data collection and reporting burden that would result for the state and providers.

*Examples:*

**California** requires all long term care program participants to meet the same Medi-Cal eligibility requirements. In addition, the state applies the same spend down and cost share requirements across all programs and extends spousal impoverishment rules to PACE.

**New York** is comparing PACE organizations and Managed Long-Term Care Plans in the areas of demographics, clinical effectiveness and financial performance.

**Washington** recently began collecting and analyzing data to compare demographics, acuity, average costs, mortality rates and a number of other factors for a sample of PACE clients with a comparable sample of COPES (home and community services waiver) clients from FY 1998 through FY 2003.

## **Section 6: Monitoring Cost Effectiveness and Quality Outcomes for PACE**

### Summary

CMS and the state share responsibility for monitoring the ongoing compliance of a PACE provider organization. If deficiencies are noted during monitoring reviews, the PACE provider organization is required to take action to correct the deficiencies. Pursuant to 42 CFR § 460.190 and 460.192, CMS and/or the state administering agency will ensure compliance with requirements and monitor the effectiveness of corrective actions.

The provider agreement outlines the clinical, financial and other data that the PACE provider organization must provide to CMS and the state in order to demonstrate compliance with the requirements of the PACE regulation. In addition to these data requirements, federal regulation requires CMS and the state to conduct comprehensive annual reviews of PACE provider organizations during their first three years of operation, referred to as the “trial period.” *Federal citation: 42 CFR §460.190-§460.196*

Most states that have been successful in expanding PACE extend their oversight and monitoring efforts beyond the scope of the federal regulation to include the monitoring of quality outcomes and cost-effectiveness. The Model Practices Workgroup identified two practices that serve as models in this area:

- Create an environment that supports continuous quality improvement by providers, within which the state’s quality measures can be applied; and
- Clearly define state expectations and priorities with respect to cost effectiveness and quality outcomes.

### Model Practices

**A. State monitoring should create a collaborative environment that supports continuous quality improvement for all provider types, within which the state’s quality measures can be applied.**

#### *Critical Elements:*

- Seek and utilize provider and consumer input in the design and development of quality measures and quality monitoring systems;
- Create opportunities for state administrators and providers to work together as partners;
- Utilize measures that are qualitative and quantitative;
- Design state monitoring systems so that they complement but do not duplicate federal and other state agency monitoring systems; and
- Develop quality improvement projects that involve multiple provider types.

Long term care consumers, state administrators and providers share a common goal: cost effective quality care. While they share this common goal, consumers, state administrators and providers may have different perspectives and strategies for

accomplishing this goal and measuring outcomes. Working independently, they lack the advantage of sharing their experiences. Consequently, they may miss opportunities for identifying effective strategies, practices and measures. Increased collaboration and the adoption of a common data set with common audit tools will foster the sharing of good ideas and best practices. For this reason, consumers, state administrators and providers will benefit from opportunities to work together as partners toward the accomplishment of this goal. This type of partnership will bring a broader range of experiences and perspectives to the process. It will help build support for these activities, and it will increase the likelihood that measures and monitoring systems are not overly burdensome for any of the parties involved. In addition to working collaboratively towards this common goal, consumers, state administrators and providers should serve as resources to one another on a regular (and an ad hoc) basis to achieve cost-effectiveness and quality outcomes in long term care.

There are a number of areas that would benefit from collaboration:

- building shared definitions and a broader understanding of quality outcomes and cost effectiveness;
- building a shared vision for long term care;
- identifying best practices that lead to quality outcomes and cost-effectiveness;
- developing new strategies for achieving quality outcomes and cost effectiveness;
- developing measures and monitoring systems that minimize burden for consumers, state staff and providers; and
- developing measures and monitoring systems that will help identify quality outcomes and cost effectiveness.

Shared definitions for quality outcomes and cost-effectiveness are required if there is to be any collaboration among consumers, state administrators and providers. It is extremely difficult to establish common vision, goals, strategies or methodologies if the parties are not talking about the same things.

The ability to manage and analyze complex threads of information is becoming increasingly important for states assessing and differentiating long term care programs and provider organizations. Qualitative measures are important to this process for two reasons. First, states may lack the historical data or experience from which to draw upon for quantitative data estimates. Second, a qualitative approach will more accurately measure some quality outcomes, such as consumer and informal caregiver experiences and quality of life. Quantitative measures are equally important to the process. A quantitative analysis will help states identify important trends in quality outcomes and cost effectiveness. For example, quantitative measures will help the state uncover cost drivers and identify areas for possible cost avoidance when historical data or experiences are available for comparison and analysis.

Measurable outcomes are needed to allow the state to accurately assess the long term care services states fund. In addition, there is a need to develop measures that are comparable across alternative long term care settings. For this reason, it is important for states to ensure that the tools they develop are capable of measuring cross-

sectional and longitudinal results. Unless the state considers the same variables across programs and time, it is difficult to draw comparisons or conclusions. Comparisons made through benchmarking of identical data sets and definitions can establish strong evidence. Strategies should include common ways of following patients through the health care system and linking the relevant health care databases. Without these types of measures and monitoring activities, states are hard pressed to produce a sufficient evidence base from which to make decisions on quality and cost effectiveness.

The process of implementing quality and cost-effective measures and monitoring systems can strain limited state staffing resources and subject a provider to additional administrative responsibilities that will in all likelihood take time away from patient care. As a result, it is important to design measures and state monitoring systems so that they complement but do not duplicate federal and other state agency measures and monitoring systems. This practice requires a thorough knowledge of existing measures and monitoring systems. With this knowledge, the state may identify existing resources for capturing the information it needs for assessing quality outcomes and cost-effectiveness, and avoiding duplication.

This practice also requires streamlining measures and monitoring systems so they minimize burden for the consumer, state staff and providers. The interest in capturing this information must be balanced with the needs of the consumer, the realities of limited state staffing resources, and the providers' responsibility to deliver patient care.

*Examples:*

**Massachusetts** schedules quarterly meetings with medical directors. The state collaborates with providers and consumers when designing quality outcomes projects for diabetes, congestive heart failure and depression.

**New York** worked with PACE and managed care organizations on assessing quality for diabetes and is beginning a new project to evaluate falls.

**Washington** uses CMS Health Plan Management System (HPMS) data elements for monitoring, thereby avoiding duplication of data collection efforts. Washington staff review the HPMS data on a quarterly basis and requests more specific quality measures when necessary. State staff review enrollment and reasons for disenrollment on a monthly basis to track client satisfaction.

**Wisconsin** has developed quality improvement projects for all PACE and Partnership sites, which has increased the statistical value of their available data.

**B. The state's monitoring of cost effectiveness and quality outcomes for PACE should reflect clear and defined state expectations, policies, and priorities relevant to the long term care population.**

*Critical Elements:*

- Establish a clear definition of quality outcomes and cost-effectiveness;
- Focus measures on a few key policy priorities;
- Ensure that measures support both quality improvement and oversight/monitoring; and
- Ensure that measures are appropriate for the population eligible to enroll in PACE.

States need to clearly define what they mean by “quality outcomes” and “cost-effectiveness.” Definitions are needed if comparisons are to be made either on a historical basis or across long term care programs. Definitions also are important if states are to avoid the classic mistake of “comparing apples to oranges.” In addition, these terms need to be defined so that the state can make sure its measures reflect and can feed back into its long term care policies and funding priorities. As mentioned in the preceding section, it is important for a state to work collaboratively with consumers and providers when establishing definitions of quality outcomes and cost-effectiveness. In addition, it is important for the state to disseminate this information and educate all involved with the state's long term care system about the definitions once they have been established.

Since conducting a cost and quality analysis for the entire long term care system is extremely complex and time consuming, it is important for states to focus their measures on a few key policy priorities. These priorities most likely will change from year to year. One year the policy priorities may require measuring prescription drug usage, hospitalizations, immunizations, diabetes and heart disease. The next year the policy priorities may require measuring nursing home utilization, slip and falls, cancer, Alzheimer's, and end stage renal disease. The state would most likely continue these measures in subsequent years to assess progress on a longitudinal basis. That progress then would be considered as states revisit their policies and priorities.

In order to avoid unnecessary duplication of efforts and an unnecessarily burdensome process, measures should be designed in ways that meet the policies and priorities of the state in the areas of quality improvement and oversight and monitoring. In addition, the measures should be appropriate for the PACE population. Measures intended to assess trends relevant to pediatrics, expectant mothers or young adults of child-bearing age may not be appropriate for the PACE population. Instead, the state should focus its efforts toward measuring variables which are common across the long term care population.

The workgroup identified administrative and patient burden as potential trade-offs to these practices. Some states are addressing this trade-off by asking provider



organizations to submit standardized data already required for another purpose, such as the upcoming Core Outcome and Comprehensive Assessment Data Set for PACE (COCOA). States then can analyze the data and provide feedback without adding to administrative burden. In addition, the state must weigh the need for specificity with

the need to be comprehensive. Similarly, the state will have to balance the need for quality data and comprehensiveness.

*Examples:*

**Massachusetts** has aligned quality improvement projects with oversight and monitoring measures for diabetes, immunizations, disenrollments and service utilization. In addition, Massachusetts has established chronic care measures for diabetes and congestive heart failure.

**Ohio** requires PACE and nursing home programs to use the long term care Minimum Data Set, a resident assessment instrument, for all participants. This approach helps the state lay the necessary foundation for an accurate evidence base which can be used to compare clinical practices across long term care programs. It also helps the state ensure that data collection is uniform and accurate. The state uses the information collected by this instrument to help plan for these programs.

**Wisconsin** is developing definitions of quality care and cost-effectiveness. The state uses the same functional eligibility screen across all programs, and is conducting member outcome interviews across four long term care programs. The member outcome interviews will be repeated every two years. In addition, Wisconsin has conducted a longitudinal comparison of PACE and HCBS costs.

## **Conclusions**

The intent of this report is to educate state administrators about those state practices that the Model Practices Workgroup found promote and support the growth, development and quality of the PACE model of care. This report explored the Model Practices Workgroup's findings in six key areas critical to the development of PACE:

- Developing an Operational State Infrastructure for PACE;
- Building and Responding to Provider Interest;
- Provider Application Process;
- Rate Setting;
- Eligibility Determination, Enrollment and Disenrollment Processes; and
- Monitoring Cost Effectiveness and Quality Outcomes for PACE.

As mentioned earlier in this report, the National PACE Association and the Model Practices Workgroup recognize that each state is unique. States are subject to a diverse range of factors which affect the way they develop and manage their long term care programs. Therefore, this report and the underlying findings of the workgroup are not intended to promote one state practice over another or imply that all of the model practices are appropriate or effective in all state environments. States are encouraged to draw on the experiences of other states, continue to seek innovative practices, and build upon the ideas generated from the workgroup and outlined in the report in ways that meet their individual state's needs. The National PACE Association extends its gratitude to those who served on the Model Practices Workgroup and to those who continue to serve as leaders in the development and expansion of PACE.