Rural PACE

September 6, 2007
Burlington, Vermont

Presentation Overview

- Legislative history
  - PACE
  - Rural PACE
- Flexibility for PACE
- Status of Rural PACE organizations
- Challenges (and some solutions)
- AAA Experience in Virginia
- Financial Projections

PACE Statutory and Regulatory History

- 1997: PACE established as permanent Medicare and Medicaid provider in Balanced Budget Act; includes references to rural areas
- 11/24/1999: Initial interim final regulation published for PACE; inadequate flexibility
- 2000: Opportunities for flexibility in implementation of PACE clarified in statute
- 10/1/2002: 2nd interim final regulation published for PACE expanding opportunities for flexibility in program operations

PACE Provider Regulation

- Specifies requirements for all aspects of PACE organization administration and operations, e.g:
  - organizational structure and personnel
  - contracted services
  - patient care (IDT, assessments)
  - fiscal soundness
  - benefits and participant rights
  - Payment
  - QI
  - enrollment/disenrollment
  - data, etc.
- Refer to NPA Summary of the PACE Provider Regulation for more detail (on website)

Regulatory flexibility for rural PACE organizations

- The likelihood that PACE organizations serving rural areas will need flexibility in adapting the PACE model is recognized in both statute and regulation
- §460.26 and §460.28 define the process by which existing and prospective PACE organizations can request waivers of specific regulatory requirements
- Waiver requests can accompany a PACE provider application or be submitted independently

Requirements that CANNOT be waived without changing current law

- Focus on frail elderly who require nursing home level of care
- Delivery of comprehensive, integrated acute and long-term care services
- Interdisciplinary team approach to care management and service delivery
- Capitated, integrated financing
- Assumption of full financial risk

Additional provisions not subject to waiver

- Nonprofit or public status of PACE organization
- Elements of provider application process and PACE program agreement
- Availability of health care services at PACE Center
- Interdisciplinary team approach to care management
- Comprehensive assessment & reassessment of health care needs
- Participant rights

Types of flexibility that may be important in rural areas

- Use of non-staff, community-based primary care physicians
- Composition of PACE IDT
- Recognition that PACE Centers in rural areas may be different than those in urban settings and utilized less
- Use of alternative delivery settings
- Personnel requirements
- Requirements prohibiting governing body members' direct or indirect interest in contracts

How flexibility can be achieved

- By engaging State and CMS partners in development of PACE in rural areas
- By utilizing waiver process for regulatory flexibility
- By utilizing “new” opportunities for contracting for IDT members
- By pursuing statutory changes as necessary and appropriate

Deficit Reduction Act of 2005

- Provided start-up and development funding for 15 rural PACE providers
- Established cost-outlier protection for inpatient costs in a one-year period that exceed $50,000
  - 80% of costs above this will be reimbursed
  - Outlier payments limited to up to $100,000/participant
  - Total outlier payments to a provider, limited to $500K in a 12-month period
  - Available for first three years of operations, but not beyond September 30, 2010
- Requires selected providers to complete the application approval process by September 30, 2008

Examples of “grandfathered” and waivered practices from current urban PACE sites

- For use of community-based primary care physicians
- To waive specific personnel requirements
- To allow for involuntary disenrollment due to family member/caregiver behavior and nonpayment of Medicaid share of cost
- To allow for variation in interdisciplinary team composition

Who are the Rural PACE providers?

- 15 providers (see handout)
- Located in 13 states (VA and PA have 2 each)
- 2 large health systems (Geisinger, Billings)
- 4 involve AAAs (Mountain Empire, Appalachian Agency, CAMC, AllCare)
- 2 Hospice (Siouxland, Comm. Care of Western NY)
- 1 Regional Health Network (NHCA)
- 1 Community Health Center (Piedmont)
- Others are community-based LTC providers (includes home care, CCRC, housing/ALF)

Status of Rural Sites

- Provider applications at various stages of development and review
  - CMS desk review complete, on-site scheduled (2)
  - CMS desk review, request for additional info (5)
  - State desk review (5)
  - Application development (3)
- Sites that are furthest along starting to look at operational issues
- Needed to anticipate Part D, submit bid

Status of Applications into CMS – 7 Sites

- CMS Desk Review Complete, readiness review pending – 2 sites
  - Vermont
  - Geisinger
    - Both are service area expansions for existing PACE organizations
- CMS Desk Review in Process – 5 sites
  - AllCare of Arkansas (AAA, with hospital)
  - Appalachian Agency (AAA)
  - Methodist Oaks
  - Northland Health Care Alliance
  - Mountain Empire (AAA)

Status of Applications at State Agency – 5 Sites

- State Reviewing Complete Applications – 3 sites:
  - Charleston Area Medical Center (hospital system)
  - Hospice of Siouxland
  - Volunteers of America (Senior housing, ALF)
- State Reviewing Partial Applications – 2 sites:
  - Hale Makua (home care, senior care network)
  - Piedmont (Community Health Center)

Status of Applications in Development – 3 Sites

- Applications to be Submitted to State – 3 sites
  - Billings Clinic (health system)
  - Community Care of Western NY (hospice, home care)
  - Lutheran Social Services of South Central Pennsylvania
- Why: waiting to get state rate; finalizing location of PACE Center

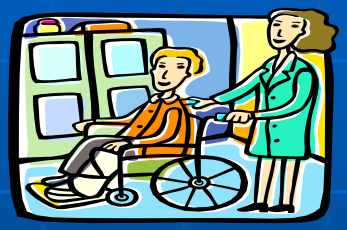
Rural PACE: Service Locations

Scope of Services

Full

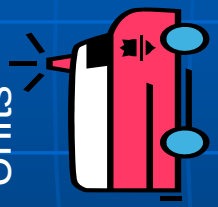
As Needed

PACE Center

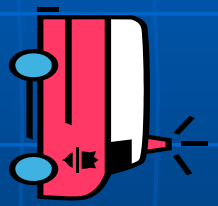


Alternative Delivery Sites

Mobile Health Units



Mobile Health Units



Congregate, Community Settings

Home

# of Participants

Many

Few

Challenges and Solutions

- Integrating care across diverse settings
  - IDT communication, coordination
- Distance
  - Transportation
  - Time
  - Access
- Emergency preparedness
- Enrollment – critical mass?
- Staffing (clinical, management)

- telecommunications, EMRs
- Telehealth, alternative delivery settings, congregate settings, lay caregivers
- Community partners, planning
- Serve all income levels
- leadership and IDT training

More Information

- www.npaonline.org
  - Regulations
  - Rural resources
- Peter Fitzgerald – 703/535-1521 or peterf@npaonline.org
- NPA – 703/535-1565

Financial Proforma Presentation and Discussion

PACE Financial Proforma

- Key assumptions: enrollment, capital, revenue, expense, and staffing
- Assumptions based on current utilization and cost experience of operational PACE programs; and
- Experience of Palmetto SeniorCare in developing PACE programs across the country; and
- Input from organization leadership re salaries, capital, current operational experience, etc.

Capital Assumptions

- PACE Center acquisition/development
- Fixed and movable equipment (clinic, PT, OT, furnishings, etc.)
- IT hardware (electronic medical record, care planning system, TPA, data submission, etc.)
- Transportation (vans)
- Working capital
- Risk reserve

Revenue Assumptions

- Baseline 2008 **Medicaid** monthly capitation rate **estimates**:

  dual eligibles: **$4,000 - $4,100**

- 2008 **Medicare (A&B)** monthly capitation rates (based on 2.39 frailty adjuster) for Vermont:

  Part A: $364.22
  Part B: $334.73

  Total: $1,670.49

- 2008 **Medicare (Part D)** capitation rate **estimate**: $400 - $550

- Case Mix (at maturity): 84% dual cap, 10% Medicaid only, 3% ESRD, 3% private pay

Typical Monthly Revenue Projection for a Dual Eligible Participant

Medicaid (state) capitation:	$4,100
Medicare (A&B) capitation:	$1,670
Medicare (Part D) capitation:	$450

Total Monthly Capitation: $6,220

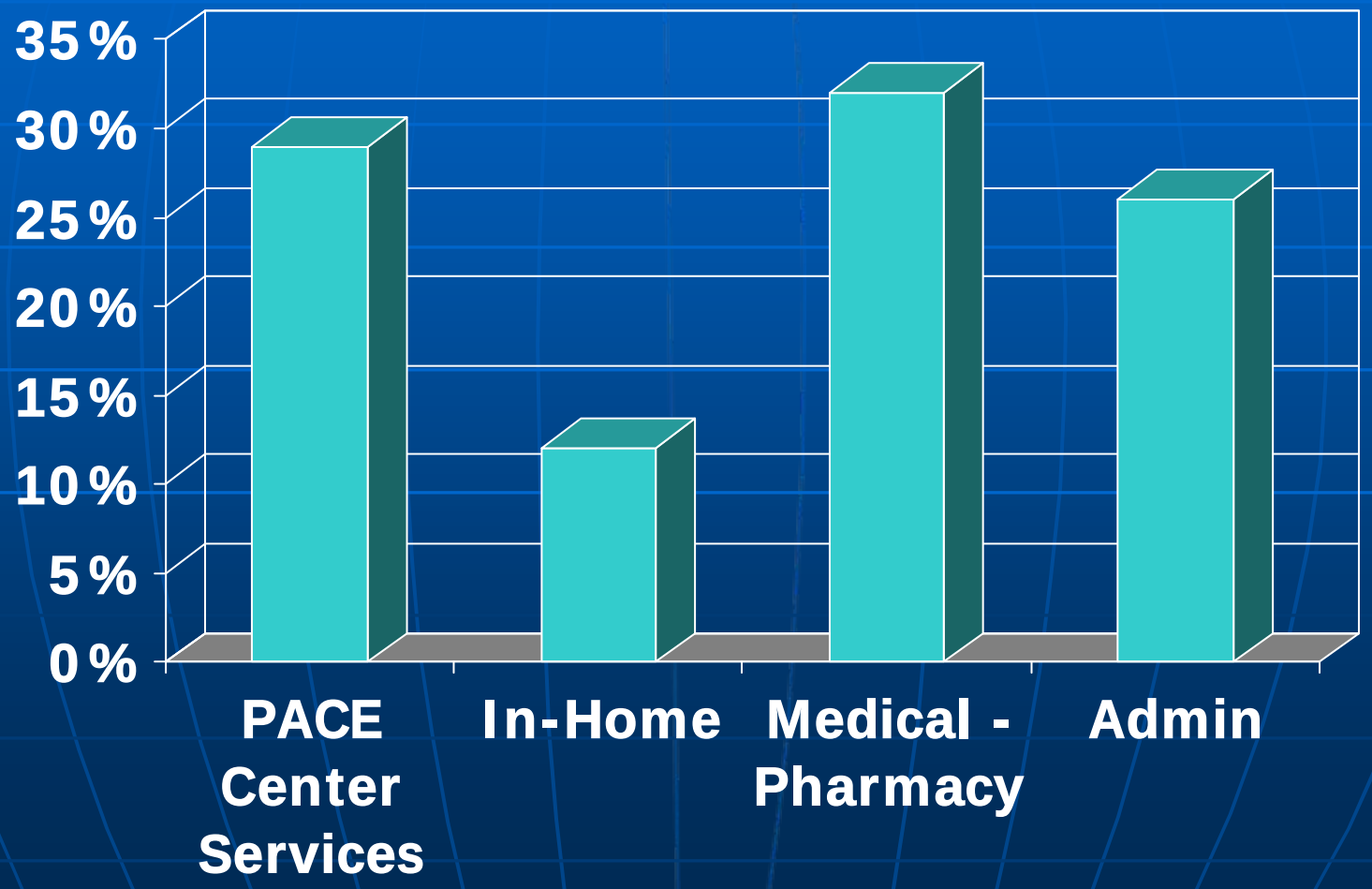
Expense Assumptions

- PACE Center – operations and staffing; primary care, transportation, meals, therapies, etc.;
- Acute Care – most important cost to control; good primary care key to success; projected to improve as program and IDT matures;
- Nursing Home – important to manage percentage of permanent placements; PACE average 10-13% at maturity;
- Pharmacy – contract service; could provide directly in the future; cost based reimbursement via Part D;
- Routine Specialist – Audiologist, Podiatrist, Dentist, Optometrist, Psychiatrist, Cardiologist, etc.;

Expense Assumptions

- Emergency Room, Ambulance, Lab, Outpatient, Radiology
- Supportive housing
- Dialysis
- Administration – Finance, HR, IT, support staff, medical records, claims processing
- Plant – maintenance, housekeeping

Expense Analysis (at maturity)



Staffing Assumptions

- Based on census, center attendance, and anticipated program needs
- Salary information, inflation, average fringe benefit rate
- Staffing ratios based on PACE experience and anticipated needs of PACE provider

Key Assumptions

- Census building is THE key factor for success; if census projections are not met, financial performance will be adversely affected
- Acute care utilization and cost must be controlled through strong and effective primary care and alternate strategies
- Projections **do not** take in to account unanticipated expenses or ‘catastrophic’ hospitalizations

Proforma “Risk Factors”

- Failure to enroll participants at the projected rates; program “handcuffed” by census capacity; strong rural PACE program should have a census of 100+
- Failure to develop a strong, functioning, Interdisciplinary Team dedicated to the PACE model
- Failure of primary care to embrace PACE philosophy
- Failure to control acute care and/or nursing home utilization

Financial Challenges for Rural Sites

- Upfront capital/working capital expenses may be overwhelming for organizations with limited liquid assets
- Census projections are more difficult to predict; more risk
- Maximum census in best of circumstances still may not be enough to maintain financial stability over the long term
- Administrative overhead and complexity of operating in the “health plan” arena often underestimated
- Meeting CMS risk reserve requirement more challenging

If you would like a sample proforma via hard copy, please contact me at:

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