2011 LeadingAge annual meeting & IAHSA global aging conference

C·E·L·E·B·R·A·T·E *Age*

OCTOBER 16 – 19, 2011 • **WASHINGTON, DC** • WASHINGTON CONVENTION CENTER

PACE in the Emerging Marketplace

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PACE in the Eyes of Policy Makers

PACE Policy Summit Participant, 2010

"PACE is the epitome of the medical home"

MedPAC, June 2011

"Fully integrated managed care plans and PACE providers offer the best opportunity to improve care coordination for dual-eligible beneficiaries across Medicare and Medicaid services"

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A New Era for PACE

1980s
Traditional PACE

2006
Rural PACE
Alternate Care Sites
Community-Based Physicians

2011
PACE in Health Care Reform

GOAL remains constant: *serving nursing home certified in home- and community-based system through an integrated financed care model*

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What's Changed?

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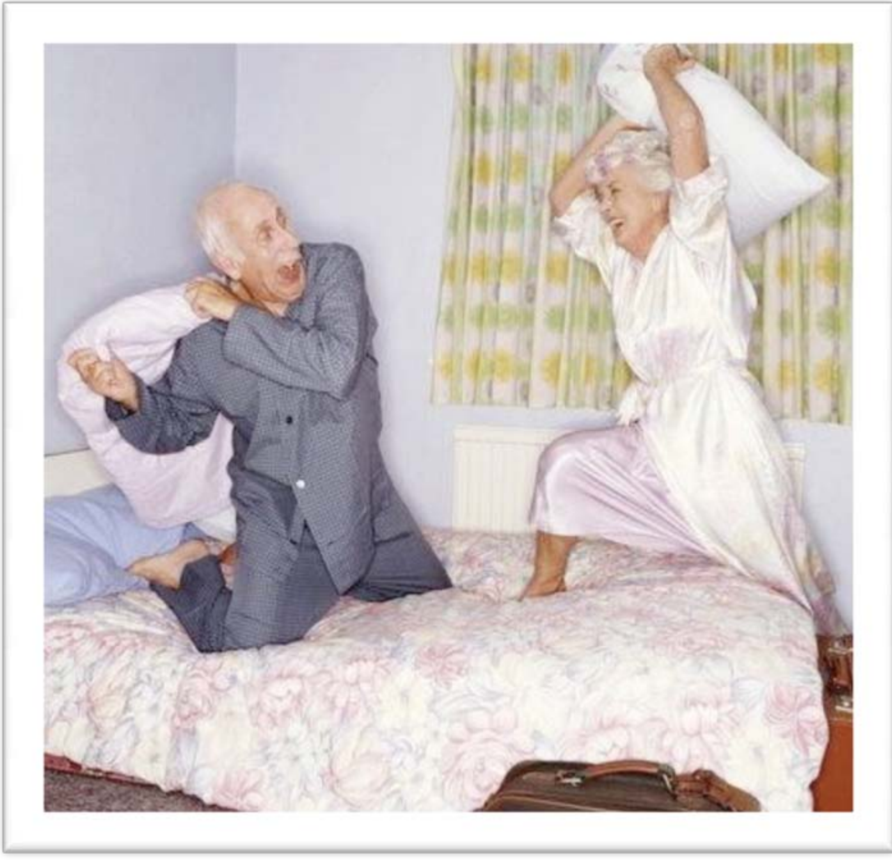
What's Changed: Consumer Advocacy



- Home is where boomers want to receive care
- Remain autonomous
- Self-directed care

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What's Changed: State & Federal Systems and Funding

- State Medicaid agencies looking to:
  - Reduce cost and improve care
  - Simplify administration or reduce number of options
- Centers for Medicare and Medicaid Services (CMS) looking to:
  - Reduce cost and improve care
  - Support State initiatives
  - Integrate financing

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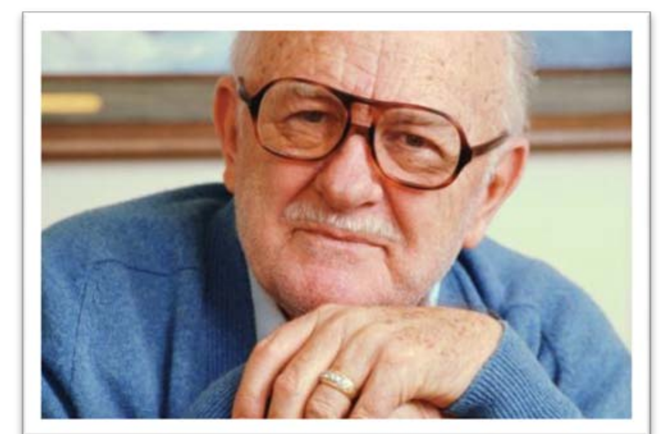
What's Changed: Growth of the Dual Eligibles 2008-2011

- Currently estimated 9 million dual eligible in United States[1]
  - 5.5M seniors and 3.4M disabled in 2010
- 18% of 50 million Medicare beneficiaries are dually eligible[1]
- New Medicaid beneficiaries grew 8% year from 2008 to 2010[2]
- Represent a diverse set of individuals:
  - SSI eligible non-frail seniors
  - Low-income frail seniors
  - Working age disabled
  - Individuals with intellectual disabilities



[1]*Kaiser Foundation Report 2011*
[2]*Health Affairs*

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What's Changed:
Cost of Care for Dual Eligibles

- Dual eligibles have nearly five times the per capita spending (Medicare and Medicaid) than non-duals ($20,902 versus $4,553)
  - 15% of Medicaid enrollees = 39% costs
  - 21% Medicare enrollees = 36% costs
  - Medicare costs are 60% higher than non-duals (MedPAC)
- Medicaid spending increases
  - 17% state spending in 2009 (excluding federal match)[1]
  - Expenditures grew 8.8% during 2010[1]

[1]*Kaiser Foundation Report 2011*

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Affordable Care Act (ACA):

Improving Care Coordination for Persons with Chronic Conditions

- “Federal Medicare/Medicaid Coordination Office” aka “Office of the Duals”
  - Align Medicare and Medicaid
  - Develop new models of care
  - Identify federal regulatory barriers to integration and align Medicare and Medicaid
  - Encourage and support state innovations and demonstrations
- https://www.cms.gov/medicare-medicaid-coordination/

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The New Models of Care

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Affordable Care Act: Accountable Care Organizations

Adapted from Premier, Inc.

- Patient-centered outcomes that deliver primary care and coordinate with other providers
- Aligned networks of specialists, ancillary providers, and hospitals focused on outcomes
- Explicit care integration and coordination mechanisms
- Payer provider partnership relationships and reimbursement models that facilitate and reward high-value—not high-volume—health care

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Affordable Care Act: Independence at Home Demonstration Program

- According to ACA, expected to launch January 1, 2012, for Medicare beneficiaries with chronic health conditions, including duals
- Provides funding to provider teams directed by PCP or NP who deliver in-home care to Medicare beneficiaries and available 24/7 to manage emergent situations, coordinating with other providers as needed
  - Bonus paid to teams whose costs are less than cost of care under traditional fee-for-service model
- PACE programs can evaluate participation in Independence at Home Demonstration (expected to be released October 2011)

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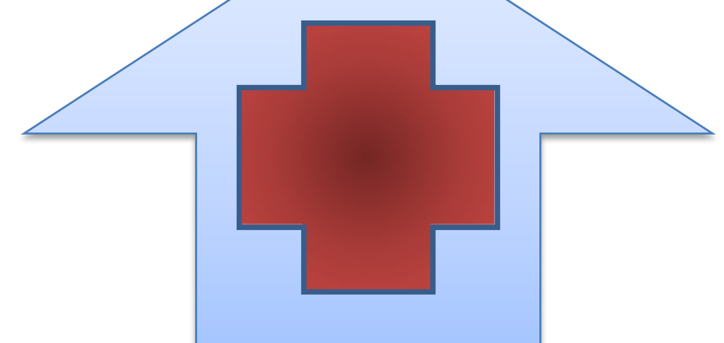
Affordable Care Act: Medical Home

- Program to serve Medicaid eligible, chronically ill individuals who can choose a qualified provider (single or coordinated team of providers) as their "health home"
- States attracted to enhanced match of Medicaid health homes; PACE providers may be eligible

Health Home: *Qualified provider responsible for providing in-home care and coordinating care with other providers as needed*



Source: http://www.kff.org/medicaid/upload/8136.pdf

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Affordable Care Act:
Community Based Care Transitions Program

- Section 3026 of the Affordable Care Act establishes Community Based Care Transitions Program (CBCTP)
- Provides $500 million in funding to community based organizations (CBOs)—either in partnership with hospitals or independently—to deploy evidence-based models to improve care transitions
- Goals:
  - Improve transitions from the inpatient hospital setting to other care settings or to the home
  - Reduce readmissions for high-risk individuals
  - Generate savings to Medicare

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Centers for Medicare and Medicaid Innovation

- 15 states awarded $1M each by CMS in April 2011 to develop new service and payment models for duals
  - CA, CO, CT, MA, MI, MN, NY, NC, OK, OR, SC,TN, WA, WI
  - Note: 13 of the 15 states (in red) have PACE programs already! OK explicitly stated PACE as part of strategy
  - Summaries available at http://www.cms.gov/medicare-medicaid-coordination/05_StateDesignContractSummries.asp#TopOfPage
  - Grantees have 12 months (until 4/12) to develop proposed designs
  - CMS will then determine which will be implemented and funded based upon approvals

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Centers for Medicare and Medicaid Innovation

- Goals:
  - Enhance linkages between health and long-term support services
  - Improve provision of primary care to persons with multiple chronic conditions
  - Smooth transitions from one care setting to another

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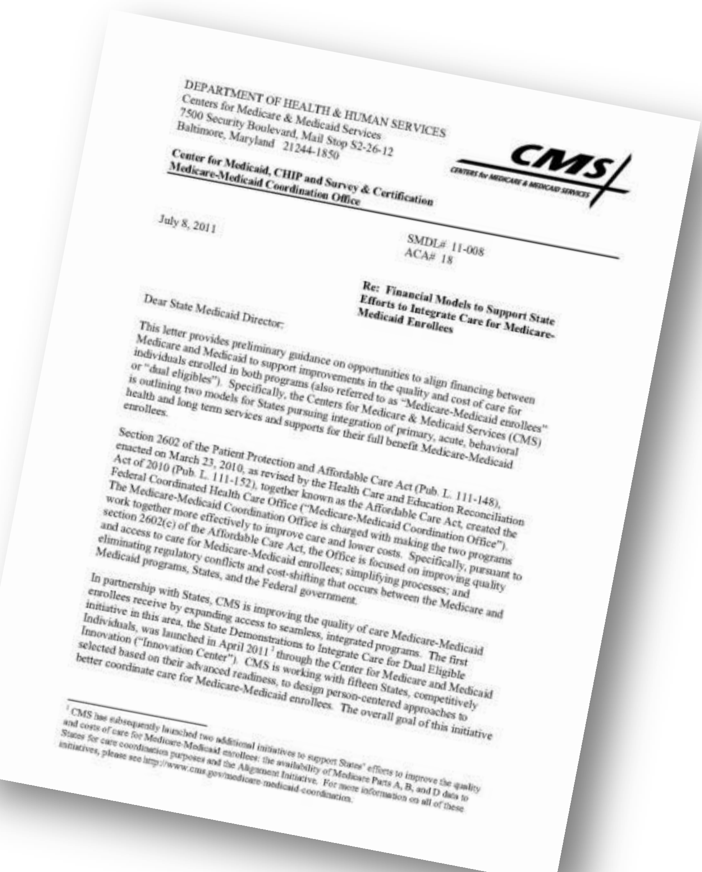
What About the Other States?

- Dear Medicaid letters offering opportunity to every state in the nation to redesign care
- 39 states have responded



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid, CHIP and Survey & Certification
Medicare-Medicaid Coordination Office

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

July 8, 2011

SMDL# 11-008
ACA# 18

Re: Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees

Dear State Medicaid Director:

This letter provides preliminary guidance on opportunities to align financing between Medicare and Medicaid to support improvements in the quality and cost of care for individuals enrolled in both programs (also referred to as "Medicare-Medicaid enrollees" or "dual eligibles"). Specifically, the Centers for Medicare & Medicaid Services (CMS) is outlining two models for States pursuing integration of primary, acute, behavioral health and long term services and supports for their full benefit Medicare-Medicaid enrollees.

Section 2602 of the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), together known as the Affordable Care Act, created the Federal Coordinated Health Care Office ("Medicare-Medicaid Coordination Office"). The Medicare-Medicaid Coordination Office is charged with making the two programs work together more effectively to improve care and lower costs. Specifically, pursuant to section 2602(c) of the Affordable Care Act, the Office is focused on improving quality and access to care for Medicare-Medicaid enrollees; simplifying processes; and eliminating regulatory conflicts and cost-shifting that occurs between the Medicare and Medicaid programs, States, and the Federal government.

In partnership with States, CMS is improving the quality of care Medicare-Medicaid enrollees receive by expanding access to seamless, integrated programs. The first initiative in this area, the State Demonstrations to Integrate Care for Dual Eligible Individuals, was launched in April 2011[1] through the Center for Medicare and Medicaid Innovation ("Innovation Center"). CMS is working with fifteen States, competitively selected based on their advanced readiness, to design person-centered approaches to better coordinate care for Medicare-Medicaid enrollees. The overall goal of this initiative

[1] CMS has subsequently launched two additional initiatives to support States' efforts to improve the quality and costs of care for Medicare-Medicaid enrollees: the availability of Medicare Parts A, B, and D data to States for care coordination purposes and the Alignment Initiative. For more information on all of these initiatives, please see http://www.cms.gov/medicare-medicaid-coordination.

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Where Does PACE Fit?

Opportunity

- Program expansion
- Favorable rates
- Examples: California, New York

Uncertainty

- Removing PACE as state option (Montana)
- Reduced rates (Pennsylvania)
- Enrollment caps (Texas)
- Structure (Massachusetts)

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Opportunity: California

- Elimination of adult day health benefit effective December 2011
- Authorize new legislation including provision that eligible individuals may select PACE plan as part of mandatory managed care
- State of California recognizes PACE as only fully integrated model of care that exists today
- Positive changes in state oversight agency with strong PACE advocacy

Entirely new opportunities for PACE organizations

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Opportunity: New York

- State considering wide array of options including proposals to expand PACE for under-55 population and PACE without walls
- Proposals include expanding existing managed long-term care programs (MLTC), PACE without walls, gain sharing demonstration, managed care for persons with developmental disabilities, and other models
- State already implementing mandatory enrollment of duals with long-term care needs into managed long-term care program, first in NYC and then across the state

More competition for PACE eligibles; PACE programs are developing feeder MLTC programs

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Uncertainty: Pennsylvania & Texas

- Pennsylvania had rate reductions for first time in 12 years with proposed enrollment caps
- Texas has enacted enrollment caps that prohibit expansion or growth of existing programs
  - Only new membership will be allotted based on attrition of existing membership

State limits growth and reduces reimbursement

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Uncertainty: Massachusetts

- 233,000 dual eligibles (2009)
  - 7% Medicare Benefits through MA SNP or PACE
  - Less than 1% through Medicaid Managed Care
  - 93% receive Medicare/Medicaid through FFS
- Proposed MassHealth operational responsibility for care, including admin, management, and oversight of all services
- Plan to target duals 21–64 @ 115K statewide
- Shared Savings Plan

State changes structure

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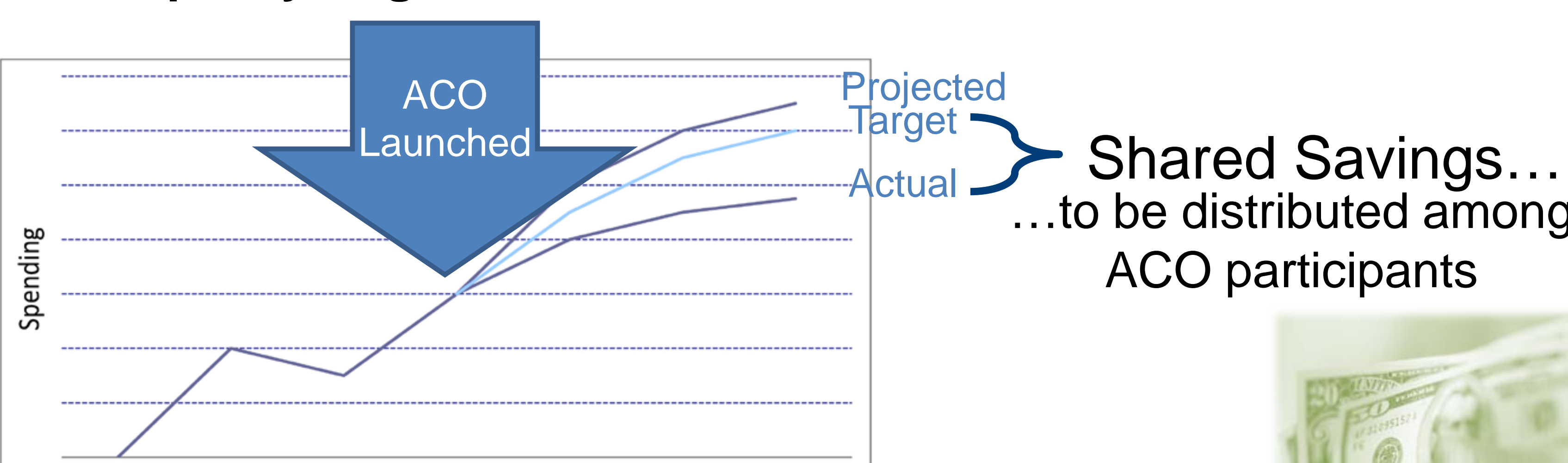
How Shared Savings Works

- Current average per-capita spending for Medicare patients in market area determined from claims for past three years
- Spending target is determined by CMS
- If actual spending lower than target, savings are shared—
- **IF quality targets are also achieved**



Adapted from Brookings Institute

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The Opportunity

- PACE programs can participate in new state initiatives to serve dual eligibles through variations in PACE model of care or new programs that utilize PACE core competencies
- PACE is a provider, not a health plan, which has daily and close contact with enrollees
- PACE integrates full range of Medicare and Medicaid care services, not just financing like health plans
- PACE serves exclusively the frail elderly—most costly and challenging subset of duals

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Concluding Thoughts

- PACE can operate successfully in a competitive marketplace
- Position PACE as a solution/resource:
  - PACE can provide budgetary "certainty" to the state through comprehensive Medicaid capitation
  - PACE is a fully integrated and accountable model of care that currently serves duals and has 20-year track record of success
- Review what's happening in your state—varies greatly across the nation and changing constantly

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More Concluding Thoughts

- Investigate opportunities to adjust the “traditional” model to meet the needs and current trends
- Be prepared to adapt to impending changes, even if unknown at the current time
- Reach out to known resources and experienced PACE experts to build competency

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Thank You

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