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**PACE**  
Association



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# Implementing Health Care Reform—What are the Opportunities for PACE<sup>®</sup>?

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Jade Gong, MBA, RN, Health Dimensions Group  
Brenda Sulick, Ph.D., National PACE Association

# Presentation Overview

- The Affordable Care Act and PACE
- PACE Involvement in New Health Care Policy Initiatives
- Examples of Relationships between PACE and Managed Care Plans/Dual Eligibles

# Federal Issues

- The Affordable Care Act (ACA)
- ACA Provisions Affecting PACE
- CMS Innovation Initiatives
- PACE Demonstration Ideas

# The Affordable Care Act (ACA)



## Goals

- Control rising health care costs
- Expand/improve health coverage
- Improve access to and quality of care



## Cost

- \$940 billion over 10 years
- Paid for by new taxes, health industry fees, and cuts in projected spending for existing govt. programs

# ACA Key Themes

- Delivery system reform
- Health insurance coverage expanded and improved
- Quality improvement and measurement
- Primary care and prevention

# ACA Major Provisions

- Requiring that most U.S. citizens and legal residents have health insurance by 2014
- Creating state-based exchanges through which individuals can purchase coverage, with subsidies available to lower-income individuals
- Expanding the Medicaid program for the nation's poorest individuals
- Requiring employers to cover their employees or pay penalties, with exceptions for small employers

# ACA Major Provisions (cont.)

- Creating new regulations on health plans in the private market requiring them to cover all individuals, regardless of health status
- Establishing a national, voluntary insurance program for purchasing community living assistance services
- Increasing payments for primary care services
- Providing greater support for prevention, wellness, and public health activities

# ACA Number of Provisions by Year

2010 -- (25)

2011-- (21)

2012 -- (10)

2013 -- (13)

2014 -- (20)

2015 -- (1)

2016 -- (1)

2018 -- (1)



# ACA and PACE

- Accountable Care Organizations (ACOs)
- Health Homes
- Community Based Transitions Program
- Independence at Home (IAH)
- NPA Testimony at the House Energy and Commerce, Subcommittee on Health Hearing on Dual Eligibles
- NPA Presentation on Dual Eligibles on Capitol Hill

# CMS Innovation Initiatives (established through ACA)

- **Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office)**
  - Charged with improving integration of Medicare & Medicaid
    - Encourage and support state innovations and demonstrations
    - Identify federal regulatory barriers to integration and alignment of Medicare and Medicaid

# CMS Innovation Initiatives (established through ACA)

- **Center for Medicare and Medicaid Innovation (CMMI)**
  - Charged with transforming Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) through improvements in the health care system
    - Ensure better health care, better health, and reduced costs for beneficiaries
    - Enhance the health care system for all Americans

# PACE Demonstration Ideas

## Expanding the PACE Population

- **Regulatory Modifications**
  - Reduce reliance on PACE center
  - Expand opportunities for use of contract providers and alternative care settings
  - Enhance flexibility in composition of IDT
  - Risk sharing options for new PACE organizations
  - Modify Part D
  - Expedite eligibility determination process
  - Make changes to encourage larger numbers of Medicare onlys in PACE

# PACE Demonstration Ideas Expanding to New Populations

- Working disabled under 55 years of age
- Individuals with multiple and complex chronic diseases (high cost and at risk beneficiaries)
- Nursing home residents

# Questions?????



# Opportunities for PACE Recognized by Policy Makers

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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”

# Opportunities for PACE to Support Reform

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## Opportunity 1

- Monetize PACE care management competencies as a product for health systems/health plans

## Opportunity 2

- Participate in health care reform initiatives (ACO, Independence at Home, Medicaid health home)

## Opportunity 3

- Secure state funding to develop innovative models of care for dual eligibles

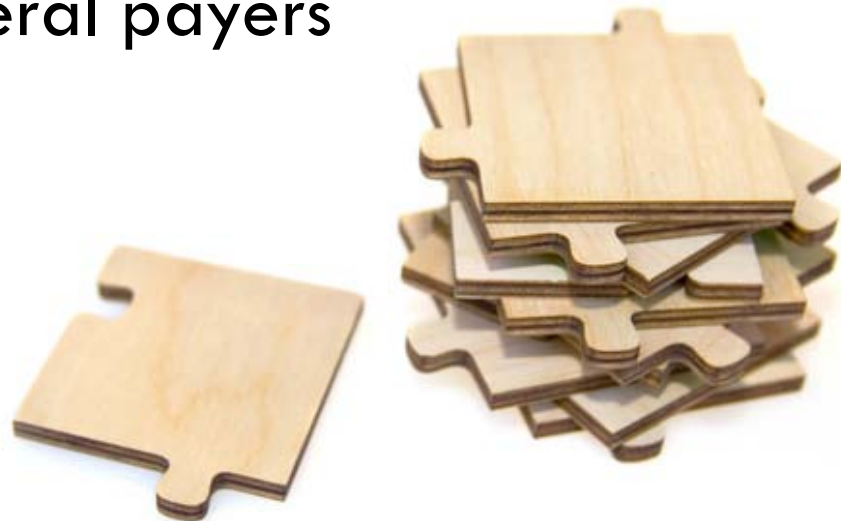
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# The PACE Value Proposition

# Constructing the Value Proposition

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- In order to successfully participate in these new opportunities, PACE organizations must present a compelling value proposition to potential partners
- Potential partners include health systems, health plans, new models of care post-health care reform, and state and federal payers



# Key Components of the Value Proposition

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- PACE serves a high-risk population with an effective model of care
  - Co-morbid, chronically ill elders with limited social support structure who are at high risk for readmissions
  - Dual eligibles who would benefit from a streamlined care delivery model
- PACE has data that demonstrated impact on population of care management interventions
  - PACE is the gold standard of care for nursing facility eligibles:
    - Reduce overall utilization of institutional-based long-term care, aligned with states' shift in funding toward home- and community-based services
    - High rates of patient and family satisfaction
    - Lower utilization of acute care as compared to comparable populations



# Key Components of the Value Proposition

(continued)

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- PACE can offer concrete proposals of how PACE services fit into:
  - ▣ Existing care management services of managed care organizations
  - ▣ Medical and social services provided by acute care hospitals who are looking to improve care management services through a partnership
  - ▣ Various initiatives within the ACA that require enhanced care management



# Opportunity #1

Monetizing PACE Care Management  
Competencies as a Product for Hospitals and  
Health Plans

# Health Plans and Hospitals Need Evidence-Based Care Management Programs

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- Hospitals
  - ▣ Hospitals are implementing evidence-based care management/care transition programs in response to readmission penalties and value-based purchasing requirements
- Medicare SNPs
  - ▣ SNPs needed stronger care management models
  - ▣ In 2012, all SNPs are now required to implement an evidence-based model of care

# Hospital Readmission Penalties

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## Program in Brief

- Hospitals in quartile with highest rate or lowest improvement in rate of 30-day readmissions for heart attack, heart failure, and pneumonia will lose a percentage of *total* Medicare payments
- Tracking begins on October 1, 2011, with penalty set at 1% in FY2013 and increases to 3% in FY2015
- More penalty conditions will be added, such as COPD, stents

## Quality Impact

- Focus on care transitions engages patients, families in care, promoting longer-term health care improvements
- Reduce patient volatility across care settings, minimize exposure to infections in hospital environment

## Financial Impact

- Likely to accrue significant savings to CMS; unnecessary 7, 15 and 30 day readmissions calculated to have cost Medicare \$25B in 2005
- Impact on hospital finances uncertain as readmissions a source of revenue; profitability of readmissions in contrast to penalties arbiter of impact

# Hospital Value-Based Purchasing

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## Program in Brief

- Moves Medicare's current pay-for-reporting system to pay-for-performance
- Begins 10/1/12 and impacts all short-term acute care hospitals
- Discharge payments reduced by 1%, and gradually reaching 2% by FY 2017
- Hospitals earn money back through Total Performance Score (TPS), determined through clinical care and outcome measures (70% weight) and patient experience of care survey (using HCAHPS) (30% weight)
- Proposed that on 10/1/13, hospitals responsible for Medicare costs for 90 days after hospital discharge (excessive costs = less Medicare payment)
- Proposed that in 2014, several additional measures be added, including 8 hospital acquired conditions

## Quality Impact

- Incentivizes hospitals to enhance quality and improve patient experience of care
- Establishes peer comparison
- Shifts health care system from one that rewards volumes, to one that rewards quality or provides **value**

## Financial Impact

- CMS budget neutrality due to payment redistribution
- Those hospitals that can really improve quality care and patient satisfaction will be winners in this initiative

# Care Management Requirements for Medicare SNPs

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- All SNPs required to implement evidence-based model of care having explicit components, including:
  1. Measureable goals specific to the target special needs individuals
  2. Adequate staff structure having care management roles
  3. Interdisciplinary care team for each beneficiary
  4. Provider network having specialized expertise pertinent to target special needs individuals
  5. Training on the model of care for plan personnel and contractors
  6. Comprehensive health risk assessment for each beneficiary
  7. Individualized plan of care having goals and measureable outcomes for each beneficiary
  8. Communication network that facilitates coordination of care
  9. Evaluation of effectiveness of the care model
- MA organization must design its model of care to accommodate most vulnerable members of its target population, i.e., frail, disabled, those near end of life, those having multiple medically complex chronic conditions, and those who develop end-stage disease after enrollment

# The Opportunity



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- PACE programs can establish a separate line of business that offers a care management product to a Medicare Plan or a health system that provides care management to a defined high-risk, high-cost population
- Payment could occur on a PMPM basis or a FFS basis



# Issues to Consider

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- What types of evidence-based care management/care transition services does our organization currently utilize?
  - ▣ Evidence-based patient selection and intervention strategy (CTI, Transitional Care Model, BOOST, GRACE)
  - ▣ Customized intervention models can be used if they demonstrate superior outcomes
- Are hospitals and/or health plans already using them?
- Are there obvious candidates to partner with? Are there opportunities for collaboration in our market and region?
- What are our current data tracking capabilities, and what investments would we need to make to successfully offer this program?

## Opportunity #2

Monetizing PACE Care Management  
Competencies with New Entities Created in  
Health Care Reform

# Monetizing PACE Core Competencies Through Reform Initiatives

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- ACA launches myriad demonstration projects to enhance care coordination for individuals at high risk for unnecessary hospitalization
- Effective care management outside of facility-based care providers essential to the success of these initiatives
- PACE offers an evidence-based value proposition that can support many of these initiatives

Source: <http://www.kff.org/healthreform/upload/8192.pdf>

# The New Models of Care

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# 1/1/2012—Accountable Care Organizations and Other Funded Options for System Change

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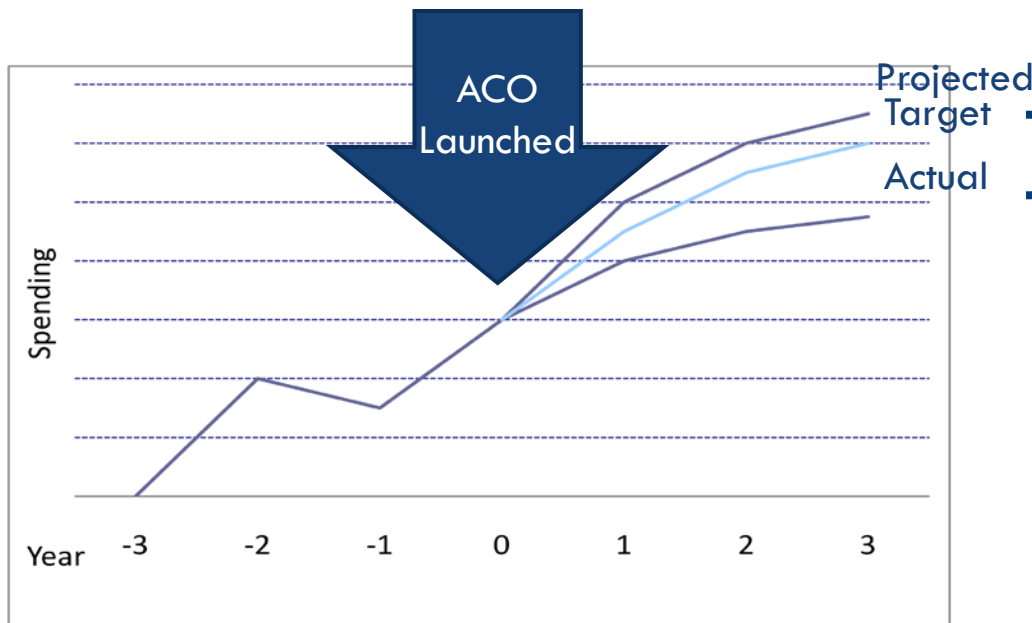


- Physician groups or physicians and hospitals share savings if reduce Medicare Part A and B costs
- Contract with select post-acute providers
- Serve 5,000+ Medicare fee-for-service beneficiaries
- Savings through primary care access, prevention, *avoiding institutions*

# How Shared Savings Works

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- 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**



Shared Savings...  
...to be distributed among  
ACO participants



# Pioneer ACOs—2011

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- 30 eligible participants\*, with experience in shared risk payments and robust HIT—begins Q4 2011
  - 15,000 Medicare; can be prospective alignment (via PCP)
  - 50%–75% shared savings
- By December 2013, majority of revenues must be from shared risk arrangements with other payers (insurers, Medicaid)
- Why virtually all major insurers are contracting with health systems on *shared savings* basis

\*

- ACO professionals in group practice arrangements
- Networks of individual practices of ACO professionals
- Hospitals employing ACO professionals
- Partnerships or joint venture arrangements between hospitals and ACO professionals
- Federally Qualified Health Centers (FQHCs)

# Pioneer ACO Applicants Partial List

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| Health System                        | Location        |
|--------------------------------------|-----------------|
| Tucson Medical Center                | Arizona         |
| HealthCare Partners                  | California      |
| Monarch HealthCare                   | California      |
| Scripps Health                       | California      |
| Advocate Health Care                 | Illinois        |
| Norton Healthcare                    | Kentucky        |
| Detroit Medical Center               | Michigan        |
| Henry Ford Health System             | Michigan        |
| University of Michigan Health System | Michigan        |
| Fairview Health Services             | Minnesota       |
| Park Nicollet                        | Minnesota       |
| Hackensack University Medical Center | New Jersey      |
| Crystal Run Healthcare               | New York        |
| Montefiore Medical Center            | New York        |
| IntegraNet                           | Texas           |
| North Texas Specialty Physicians     | Texas           |
| Texas Health Resources               | Texas           |
| Banner Health                        | Multiple States |
| Mountain States Health Alliance      | Multiple States |

Source: Kaiser Health News, 9/14/11; The Detroit News, 9/10/11; Hospitals & Health Networks Daily, 9/7/11

# Shared Savings Program/ACOs

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- Initiative under which hospital/health system or large physician practice assumes responsibility for patient population
- ACO leader reimbursed under fee-for-service system and eligible for bonus assuming quality and spending targets are met
- Care management and reduction of inpatient and institutional-based post-acute and long-term care essential to ACO success
- PACE programs with history of success in managing complex patients can be partners to ACOs

# Independence at Home Demonstration Program

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- 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 treat 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 the Independence at Home Demonstration (expected to be released in October 2011)

# Medicaid Health Homes

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

- 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

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

# Community Based Care Transitions Program

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- 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



# Expectations of Participant CBOs

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- Provide and coordinate services across continuum of care for targeted group of patients discharged from hospitals:
  - Deploy evidence-based patient selection and intervention strategy
    - Coleman, Naylor, BOOST model all acceptable
    - However, CBOs may use customized intervention models so long as they demonstrate superior outcomes
  - Build relationships and coordination mechanisms with key medical and social service providers
- Participate in collaborative learning and project redesign through robust data collection to ensure intervention success (improve care quality, generate savings)

# Demonstrating Success: Example from Community Based Transition of Care Program (CBTOC) Program

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## Outcome Measures

- 30-day risk-adjusted all-cause readmission rate (currently under development)
- 30-day unadjusted all cause readmission rate
- 30-day risk-adjusted AMI, heart failure, and pneumonia readmissions

## Process Measures

- PCP follow-up within 7 days of hospital discharge
- PCP follow-up within 30 days of hospital discharge

## Measures related to Hospital Consumer Assessment of Healthcare Providers and Systems

- Medication reconciliation, discharge planning
- Care Transitions Measure ([www.caretransitions.org](http://www.caretransitions.org))
- Patient Activation Measure (<http://www.insigniahealth.com/solutions/patient-activation-measure>)

# The Opportunity



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- PACE programs can establish separate line of business offering a care management product to a Medicare Plan or a health system that provides care management to a defined high-risk, high-cost population
- Payment could occur on PMPM basis or FFS basis

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## Opportunity #3

Secure Funding to Develop Innovative Care Models for Dual Eligibles

# CMMI Design Contracts to 15 States

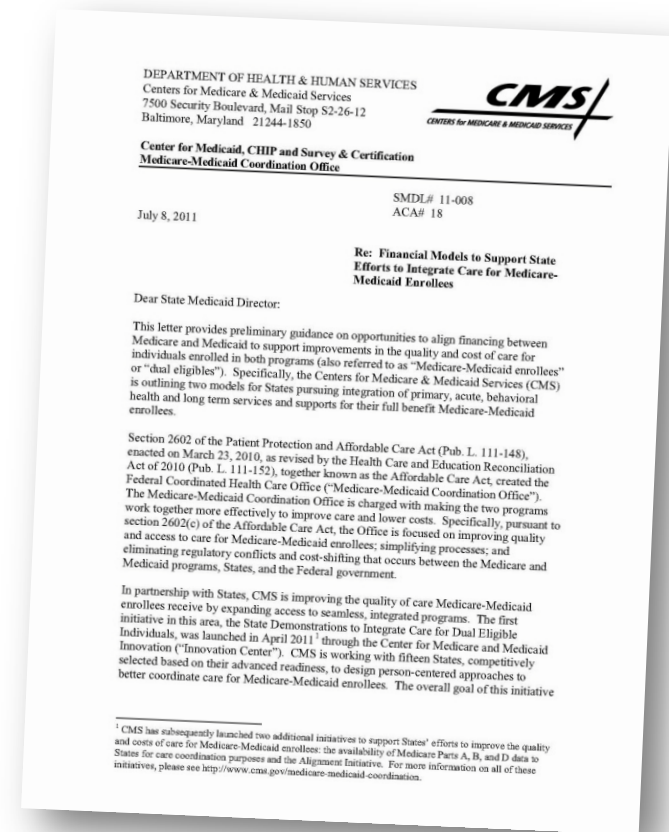
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- Federal Coordinated Health Care Office, in collaboration with CMMI, competitively awarded design contracts to states to test innovative care delivery models for dual eligible population
- In April 2011, up to \$1 million awarded to 15 states:
  - CA, CO, CT, MA, MI, MN, NY, NC, OK, OR, SC, TN, VT, WA, WI
  - NY, WI, OK specifically consider PACE as part of new delivery models for duals; OK has an explicit PACE strategy

# Expanding Innovation Opportunities to All States

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- In July 2011, CMS released a letter to state Medicaid directors announcing desire to test fee-for-service and capitated integrated care model in 15 design contract recipient states and any other interested states
- PACE organizations must be proactive in responding to such opportunities to provide services to broader populations of dual eligibles under these models



# Expanding Innovation Opportunities to All States (continued)

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## Capitated Model

- ❑ Three-way contract between CMS, the state, and participating health plans
- ❑ Plans receive blended rate for primary, acute, behavioral health, and LTC
- ❑ Rate less than sum of traditional fee-for-service components, with savings accruing to state and federal government

## Fee-for-Service Model

- ❑ State responsible for duals' care coordination and eligible for a retrospective bonus if a target level of Medicare savings, net of increased federal Medicaid costs, and specified quality thresholds are met
- ❑ Providers still reimbursed on a fee-for-service basis by CMS for Medicare services and the state for Medicaid services

# New York



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- Under the New York proposal, the state is considering a 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**



- Under Wisconsin's proposal, the state would provide coverage to high-cost, high-risk dual eligibles and Medicare beneficiaries through contracts with entities such as PACE/Partnership organizations, new entities composed of existing Family Care MCO in collaboration with acute/primary HMO or clinic, or other types of entities
- Goal is for one entity to be responsible for all acute, primary, and LTCS and provide care coordination

**Entirely new opportunities for PACE organizations**

# Michigan



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- Under Michigan's proposal, state Medicaid program would serve as designated entity assuming complete financial and administrative oversight for Medicare and Medicaid funds and services for duals
- State Medicaid program could then contract with entities to manage and coordinate care on local level—traditional MCOs, ACOs, SNPs, other capitated entities
- Delivery model would include robust care coordination program with health homes with single care coordinator and comprehensive provider network

**State would be a competitor to PACE**

# The Opportunity



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- PACE programs can participate in new state initiatives to serve dual eligibles through variations in the PACE model of care or new programs that utilize PACE core competencies

# Concluding Thoughts

- Among the opportunities, which are most aligned with your own organization's mission and population served?
- What is your initial assessment of how receptive other stakeholders—hospitals, post-acute providers, area agencies on aging, ADRCs, other new entities, state government officials—are to PACE playing an active role in developing new models of care for dual eligibles?
- What immediate next steps your organization could take to either:
  - Ascertain which opportunities are worth pursuing to expand utilization of PACE and PACE-like services; or
  - Pursue a specific opportunity that is aligned with our organization's goals and capabilities?



**“The only way I see it, if you want the rainbow, you gotta put up with the rain.”**

*Dolly Parton*

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# Discussion

# Contact Information

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Brenda Sulick  
Vice President,  
Congressional Affairs  
and Advocacy  
NPA

[brendas@npaonline.org](mailto:brendas@npaonline.org)

(703) 535-1521

Jade Gong  
Vice President,  
Strategic Initiatives  
Health Dimensions Group

[Jadeg@hdgi1.com](mailto:Jadeg@hdgi1.com)

(703) 243-7391 office

(703) 342-2615 cell