Program of All-Inclusive Care for the Elderly (PACE): Status of Administrative Financing Mechanisms

Aging and Adult Services Division

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Legislative Report

Minnesota Department of **Human Services**

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A Report to the Legislature

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Introduction

The Program of All-Inclusive Care for the Elderly (PACE) is a nationally recognized and supported community-based model of interdisciplinary care for frail older adults authorized by the federal Balanced Budget Act of 1997 (BBA). The BBA established the PACE model of care as a permanent entity within the Medicare program and enables States to provide PACE services to Medicaid beneficiaries as a State plan option. This capitated model of care fully integrates all Medicare and Medicaid services and all medically necessary services. Participation in PACE allows eligible consumers to receive a comprehensive service package that enables them to continue living at home in their community while receiving services rather than needing to move to a nursing home. Participants must be at least 55 years old, live in the community in the PACE site service area, and be certified by the State as eligible for nursing home level of care to be eligible. (Additional detail on PACE is available at the Centers for Medicare and Medicaid (CMS) PACE website: htttp://www.cms.gov/pace/)

In 2005, the Legislature authorized the Department of Human Services (DHS) to develop and implement PACE in Minnesota, if DHS could fund the administrative costs of the development through grant funding (2005 Minn. Laws, 1 Spl. Sess., Chap. 4, Art. 7, Sec. 46). DHS was unable to obtain grants which prevented implementation of PACE. In 2010, the Legislature appropriated administrative funding to DHS for two years to implement PACE, with the requirement that the Department report to the Legislature by January 15, 2011 on progress to develop more permanent financing mechanisms to support the ongoing actuarial and administrative costs (2010 Minn. Laws, 1 Spl. Sess., Chap. 1, Art. 25, Sec. 3, Subd. 9). This report, prepared by DHS Aging and Adult Services Division, provides an update on the status of implementation and progress to identify ongoing funding support for PACE in response to this requirement.

Status of Implementation

The PACE application to CMS is highly structured and many materials are available to assist state administrative agencies with the implementation of PACE. However, the complexities of the federal PACE regulations and how to interpret and apply these rules in Minnesota's mature managed care market, which requires that most seniors enroll in managed care programs, has proven to be more challenging than originally anticipated. To address these complexities, an expert team of state professional staff (primarily from DHS, but also including the Departments of Health and Commerce) was formed. Team members have expertise in aging and adult services, managed care special needs programs and systems, federal relations, health care eligibility, disability services, health care licensure and financing.

The PACE team has primarily focused on four tasks: 1. Clarifying and coordinating the technical details and other complexities of how to coordinate PACE with existing Minnesota programs and policies; 2. Working with the DHS contract actuary to develop the rate-setting methodology and proposed capitated rates for PACE in Minnesota; 3. Developing a Request for Proposals (RFP) including a timeline and process for selecting up to three groups to enter into a contractual agreement to develop a PACE program application and the associated modified Managed Care Contract, licensing, financial and programmatic elements; and 4. Engaging interested stakeholders and providing information to the public on PACE implementation; and 5. Developing processes for offering PACE as an alternative to enrollment in other managed care programs.

Over the past seven months, DHS staff has clarified technical details and other complex interactions related to existing Minnesota law with CMS officials. The PACE team has received clarification on modifying the State plan, eligibility determinations, development of Minnesota PACE Medicaid rates, identification of service areas, and the nature of the three-way the PACE agreement between the organization, state, and federal government. An additional bilateral contract between the state and the organization seeking to implement a PACE site is being developed to comply with Minnesota data privacy laws as well as licensing, quality assurance, and other Minnesota requirements.

Working with the DHS contract actuary, DHS Special Needs Purchasing staff has developed a general rate-setting methodology for PACE which complies with both the Federal Upper Payment Limit and State-mandated budget neutrality requirement. DHS has proposed a general rate-setting summary for PACE and submitted it to CMS. It is currently pending approval. The proposed methodology assumes two base rates: one for enrollees 65 and older and one for enrollees age 55 to 64. The 65 and older rate will be based on Minnesota State Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) managed care organization reported costs, and adjusted for the nursing home certified population and expanded nursing facility liability of PACE. MSHO and MSC+ provide similar services under different service models. Rates for enrollees 55 to 64 will be based on the total average fee-for-service cost for current Community Alternatives for Disabled Individuals (CADI) and Traumatic Brain Injury (TBI) home and community-based waiver enrollees with an adjustment for anticipated nursing facility liability.

The RFP will be used to select organizations to enter into a bilateral contract with the state of Minnesota and pursue a PACE application in cooperation with the state of Minnesota. The RFP process, from publication through award, is expected to take up to five months. Following the selection process, contract negotiations with the selected organizations must occur before final contracts can be awarded (1st quarter of fiscal year 2012). Contracts are expected to be completed by the end of the first quarter of State Fiscal Year 2012. DHS and the selected organizations will develop PACE provider applications for joint submission to CMS. The joint application is expected to take up to 6 months to complete. CMS review will take at least another 6 months. During the review period the state is required to complete a readiness review and must submit a State Plan Amendment to elect PACE as a state plan option.

Ongoing Administrative Funding

All implementation activities to date have included investigations of financing mechanisms or other opportunities to support the ongoing actuarial and administrative costs of PACE implementation. This task is complicated because PACE organizations cannot be charged a special provider fee or tax, and PACE will not generate additional federal financial participation (FFP) for the Medicaid services it provides. The staffing requirements to develop the initial PACE RFP and associated programmatic, contracting, licensing, financial, legal and contracting work have been greater than originally expected. The ongoing financial requirements for the administration and oversight of PACE include: actuarial costs; staff time necessary to issue RFPs, administer contracts, monitor and provide technical as required by CMS; and training staff involved in explaining this additional service choice to new and existing beneficiaries.

The actuarial cost to calculate and set PACE rates is expected to be $50,000 annually. This estimate is based on actual cost for the current fiscal year, as well as previous experience working with the DHS contract actuary setting other states' PACE rates.

The current staffing level (two state staff FTEs) appears to be adequate for future needs. Ongoing staffing needs and other costs are only projected and may be lower. Direct experience administering PACE and providing ongoing technical assistance required by federal law with the first PACE organizations will help DHS better understand the actual ongoing staff needs after initial implementation.

The National PACE Association has indicated there may be additional funding opportunities as part of the Patient Protection and Affordable Care Act (PPACA).

Conclusions

CMS requires the ongoing involvement of state staff for three years after the start of a PACE site as part of the three-way agreement. The need for this technical assistance will continue for at least three years after the current funding mechanism ends.

Actuarial costs will continue as long as PACE is a Medicaid state plan option.

In the absence of additional grant funding through the PPACA or another new source of ongoing funding, DHS will need to seek either a direct appropriation from the Legislature or legislative authority for the Commissioner of DHS to transfer funds from related grant accounts to cover these administrative costs. An appropriation from the Legislature would provide a permanent source of funding for PACE implementation. Transferring funds would not be a permanent solution and would reduce funding for developing home and community-based long-term care services and service systems necessary to slow the rate of growth of Medicaid spending in Minnesota.