Coordinating care for dual-eligible beneficiaries through the PACE program

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September 15, 2011

MEDPAC

Overview of today's presentation

- Background on PACE
- Review key findings from site visits on:
  - Necessity of the day care center to the PACE model
  - Enrollment trends
  - Financial performance
- Discuss analysis of the Medicare payment system for PACE and availability of PACE quality data
- Review options for improving enrollment, Medicare payments to PACE, and quality data

Background: PACE

- Provider-based program
- Participants must be frail, over 55 yrs and nursing home certifiable
- Day care center & interdisciplinary care team
- Goal: keep beneficiaries in the community
- 77 PACE sites serving 21,000 enrollees
- Receive blended payment from Medicare and Medicaid for duals
- States pay a capitated Medicaid payment
- Flexibility to cover clinical and non-clinical services
- Study shows lower hospitalization, nursing home use and mortality among PACE participants compared to FFS

Lack of support among rural PACE providers for “PACE without walls”

- Methodology: site visits and phone interviews with 2 urban and 5 rural PACE providers
- Hypotheses:
  - Rural sites would rely less on the day care center because of challenges in transporting enrollees to the center
  - Rural staff would support “PACE without walls” - a conceptual model of PACE without the day care center
- Findings:
  - Enrollees attend rural sites 3 days/week on average
  - Staff not supportive of PACE without the day care center

Enrollment in PACE is generally slow

- Reaching enrollment targets helps sites break-even
- On average, PACE sites enroll between 2 to 5 beneficiaries each month
- Enrollment barriers include:
  - Characteristics of the PACE model
  - Competition from some local state agencies that make the nursing home certifiable determination
  - No pro-rated payments for partial-month enrollees

Permitting younger nursing home certifiable Medicare beneficiaries to enroll

- Enrolling Medicare beneficiaries under the age of 55 could:
  - Help PACE sites increase enrollment to break-even faster
  - Give access to beneficiaries that are not eligible

- PACE staff supportive; under 55 are a different population and providers may need to make changes
  - Schedule day care center attendance by age or condition
  - Add staff with competencies with this population
  - Offer separate activities or more behavioral therapy

Observations from PACE staff on their sites' financial performance

Start-up costs	Medicare payments	Financial performance
• Between $2-$3 million per site • Funds secured from sponsors or grants • Outlier protection was an incentive to open the site	• Average monthly PMPM between $1,700 and $2,600 • Flexibility to pay for non-clinical services • Ability to blend Medicare and Medicaid funds	• 4 of 7 sites reported operating above break-even • We observed sites in different stages in understanding they have to balance enrollees' needs with costs of services

Medicare payment methodology to PACE providers

- Based on Medicare Advantage (MA) payment system – capitated PMPM
- New HCC model in 2012 (includes dementia)
- Payment adjusted for frailty
- Rural PACE demo sites had access to outlier pool

Areas to improve the Medicare payment methodology to PACE providers

- Benchmarks: PACE payments are based on pre-PPACA benchmarks
  - PPACA changed MA county benchmarks to better align spending with FFS, but PACE was exempt
  - Payments to PACE providers are high relative to FFS in majority of counties PACE sites serve
  - In those counties, every Medicare beneficiary enrolled in PACE increases Medicare spending
- Risk-adjustment: Preliminary analyses suggest that current system under-predicts costs for complex patients – the type of patients that PACE enrolls

CMS monitors the quality of care in PACE sites but does not publish the data

Data elements for monitoring that are regularly reported to CMS:

- Readmissions
- Emergency care
- Routine immunizations
- Deaths
- Grievances and appeals
- Enrollments and disenrollments
- Prospective enrollees
- Unusual incidents

PACE does fully integrate care; however the program can be improved

Positive characteristics of PACE	• Evaluations show reductions in hospitalizations, mortality, and nursing home utilization • Fully integrates all Medicare and Medicaid benefits and PACE providers assume full-risk • Flexibility to blend Medicare and Medicaid funds and pay for clinical and non-clinical services
Areas for improvement	• Enrollment processes • Medicare payment methodology • Availability of quality data

Options to expand enrollment into PACE

- Concern: Nursing home certifiable beneficiaries under the age of 55 cannot enroll in PACE
- Option: Remove the age limit for eligibility for PACE
  - Allows PACE providers to enroll nursing home certifiable beneficiaries under the age of 55
  - Changes to PACE programs may be necessary to accommodate this population
  - Would allow Medicare payments for beneficiaries younger than 55, but Medicaid payments uncertain

Options to expand enrollment into PACE (continued)

- Concern: PACE sites lose some potential enrollees because they do not receive pro-rated capitation payments
- Option: Pro-rate Medicare capitation payments for partial-month enrollees
  - Enables PACE providers to receive Medicare payments for partial-month new enrollees
  - States would need to also make this change in order for PACE providers to receive full pro-rated capitation payments

Options to improve the Medicare payment methodology for PACE

- Concern: Medicare spending across all PACE enrollees is high relative to FFS because PACE is paid on pre-PPACA county benchmarks
- Option: Base Medicare payments to PACE providers on the PPACA-revised county benchmarks
  - Better aligns spending on PACE with FFS spending
  - Makes the benchmark payment methodologies consistent between PACE and other integrated care programs
- Note: Improvements to the risk-adjustment system, role of frailty adjuster to be discussed in the future

Options to improve the Medicare payment methodology for PACE (continued)

- Concern: New PACE providers will not have the benefit of an outlier protection
- Option: Create a temporary outlier protection for new PACE sites
  - Could help to persuade sponsors to open new PACE sites
  - Would only be available to new sites for a few years during start-up
  - Could only be used on acute-care costs for Medicare beneficiaries
  - Could be financed through a small reduction in Medicare payments across all MA plans or from the reductions in the PACE benchmarks
  - Size of the outlier pool likely to be small because of low enrollment in PACE

Options to improve the availability of quality data on PACE

- Concern: Quality data on PACE providers is not available to the public
- Option: CMS could publicly report the quality data that it collects from PACE providers
  - Enables beneficiaries, their caregivers, and the policy community to evaluate PACE providers' quality of care
  - CMS would have to determine how to accurately report the measures given the small sample sizes of PACE providers, such as by combining data from multiple years

Questions for Commissioners

- Is there more information needed for any of the options?
- Should the Commission consider any of these options as future recommendations?