GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Program of All-Inclusive Care for the Elderly (PACE)

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Joseph Hood
Chief Operating Officer
Georgia Department of Community Health

Dean Burke
Chief Medical Officer
Georgia Department of Community Health

Brian Dowd
Deputy Executive Director, Medical Assistance Plans
Georgia Department of Community Health

Grant Thomas
Deputy Commissioner
Georgia Department of Community Health

Cody Whitlock
Chief Financial Officer
Georgia Department of Community Health

Jared Duzan, CFE
Principal
Myers and Stauffer LC

Vicki Bartlett, RN, BSHA, CCM, COC
Health Care Senior Manager
Myers and Stauffer LC

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Today's Agenda

1. PACE Overview
2. DCH Needs Assessment
3. Draft and Preliminary PACE Rates
4. Anticipated PACE Procurement
5. PACE Implementation Process

Our Mission

The mission of the Department of Community Health is to provide access to affordable, quality health care to Georgians through effective planning, purchasing, and oversight.

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Our Purpose

Shaping the future of *A Healthy Georgia* by improving access and ensuring quality to strengthen the communities we serve.

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PACE Overview

What is PACE?

- PACE is the **P**rogram of **A**ll-Inclusive **C**are for the **E**lderly
- An innovative health care delivery model with the goal of keeping seniors healthy and living in their own homes or communities as long as possible
- PACE provides comprehensive medical and social services to qualifying seniors – called participants
- Care is provided primarily in an adult day health center setting and supplemented by in-home and referral services. However, services are available 24/7, every day of the year based on a participant's needs.

What is the Purpose of PACE?

- PACE provides pre-paid, capitated, comprehensive health care services designed to meet these objectives:

Enhance the quality of life and autonomy for frail, older adults

Maximize the dignity of, and respect for, older adults

Enable frail, older adults to live in the community as long as medically and socially feasible

Preserve and support the older adult's family unit

Who Does PACE Serve?

- PACE serves individuals who are age 55 or over and who meet the state's nursing facility level of care
- The average PACE participant has multiple complex medical conditions, cognitive and/or functional impairments, and significant health and long-term care needs
- PACE participants must live in a PACE service region
- Participants must be able to live safely in the community with PACE services at the time of enrollment

What is the PACE Model of Care?

- Participant care is coordinated by an 11 member interdisciplinary team (IDT) responsible for assessments, plans of care, and coordination of 24-hour care delivery
- The PACE organization provides comprehensive medical, health, and social services that integrate primary care, acute care, and long-term care
- The place of service may be the PACE center, the home, inpatient facilities, and network provider office locations (e.g., specialists)
- Participants are provided transportation to and from home, the PACE center, specialists and other appointments

What Services are Covered Under PACE?

- All Medicare and Medicaid services are covered under PACE, including but not limited to the following:

Adult day care	Meals	Dentistry
Transportation	Nursing home care	Medical specialty services
Emergency services	Occupational therapy	Recreational Therapy
Home care	Physical therapy	Social Services
Hospital care	Prescription drugs	Social work counseling
Laboratory/x-ray services	Primary care (including doctor and nursing services)	Nutritional counseling

- PACE also includes all other services determined necessary by the Interdisciplinary Team (IDT) to improve and maintain a participant's health

What Services are Required ?

All participants, regardless of the source of payment must be provided the following benefit package:

1. All Medicare-covered services
2. All Medicaid-covered services, as specified in the State's Medicaid plan
3. Other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status*

*This determination is based on assessment of the participant's current medical, physical, emotional, and social needs consistent with the clinical practice guidelines and professional standards of care for the particular service

Who is on a PACE Interdisciplinary Team?

An interdisciplinary team, consisting of professional and paraprofessional staff, assesses an enrollee's needs, develops care plans, and delivers all services (including acute care services and when necessary, nursing facility services).

- Dietician
- Driver
- Home care liaison
- Nurse
- Occupational therapist
- PACE center supervisor
- Personal care attendants
- Physical therapist
- Primary care physician
- Recreational therapist or activity coordinator
- Social worker

Responsibilities of the Interdisciplinary Team

- Initial and periodic assessments of each participant at the PACE center
- Planning care for each participant
- Coordinating 24-hour care delivery
- Processing service determination requests (SDRs)
- Individually, each member of the IDT is responsible for:
  - Regularly informing the team of the medical, functional, and psychosocial condition of each participant
  - Remaining alert to pertinent input from other team members, participants, and caregivers
  - Documenting changes of a participant's condition in the medical record
  - Primarily serving PACE participants

Why PACE?

Over the almost 50-year history of PACE, dozens of research articles have been written on the PACE model of care. Results of these studies can be generalized as follows:

- Provides quality and cost-effective community-based care to older adults who would otherwise require a nursing home or other model of care.
- Good consumer and family member satisfaction.
- Reduces the use of institutional care.
- Better overall service utilization by PACE participants.

PACE Satisfaction Rate – Rhode Island

The PACE-RI Senior citizen programs have consistently shown improved health outcomes for older adults.

93%

- PACE-RI participants that rate their care very favorably (good, very good, excellent)

72%

- PACE-RI participants enrolled for at least a year that have not had an inpatient stay in the last three years.

>4 years

- Participants kept out of nursing homes over four years longer than a similar population not enrolled in PACE

11%

- Fewer visits to the emergency department made by PACE-RI participants than other Medicare recipients with similar health conditions

PACE Satisfaction Rate – New York

According to the New York Department of Health, PACE has led to reduced hospital admissions, better preventive care, high rates of community residence, and high caregiver satisfaction.

24%

- Lower hospitalization rate for PACE members than other dually-eligible who receive Medicaid nursing home services

95%

- PACE members who live in the community instead of a nursing home

96%

- Family members who are satisfied with PACE support

97.5%

- Caregivers who would recommend the PACE program

DCH Assessment of PACE

Needs Assessment

DCH conducted a PACE needs assessment during the 2023 legislative session. In 2024, House Bill 1078, which would permit DCH to establish and implement PACE in Georgia was passed and signed by the Governor.

- DCH staff contacted and met with the National Pace Association staff and asked them to do a viability check on the counties of Fulton, Dekalb, Chatham and Bibb.
- DCH contacted and met with interested providers. One provider had completed their industry assessment of viability for these same counties and other metro areas in Georgia.
- DCH contacted and met with representatives from North Carolina and South Carolina.
- DCH reviewed estimates of potential members who could be served.
- DCH reviewed the potential number of new nursing facility entrants versus eligibility for PACE for those members. DCH found that enrollment into PACE typically runs between 10 and 15 percent of those eligible.
- DCH contracted with Myers and Stauffer and developed 6 regions for initial PACE RFP.

Grant Program for Non-Profit Providers

The Amended Fiscal Year 2024 budget, signed by Governor Kemp on February 29,2024, included an appropriation for $2 million total in funding for DCH to provide grants to non-profit PACE providers.

“Increase funds for one-time grants up to $500,000 for the development of nonprofit Programs of All-Inclusive Care (PACE) to provide home and community-based services.”

DCH provided grants of $500,000 to 3 non-profit PACE providers.

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Draft and Preliminary PACE Rates

Medicaid Payments

- Under a PACE program agreement, the State Administering Agency (SAA) makes a prospective monthly payment to the PACE organization of a capitation amount for each Medicaid participant.
- The monthly capitation amount is set by the SAA and is:
  - Less than the amount that would otherwise have been paid under the State plan if the participants were not enrolled under the PACE program.
  - Take into account the comprehensive medical needs of the elderly when developing the overall capitation rate.
  - Is a fixed amount regardless of changes in the participant's health status.
  - Will be updated annually.
- The PACE organization must accept the capitation payment amount as payment in full for Medicaid participants.
- For Dual-eligible participants, the PACE organization will receive a capitation payment for the Medicaid portion and the Medicare portion (i.e., two payments).

PACE Amounts That Would Have Otherwise Been Paid (AWOP)

The state provides their actuarial vendor with the most recent statewide claims data and enrollment information for the state's nursing home certifiable population. This includes both the nursing home and home and community-based services (HCBS) populations. Once the nursing home certifiable population is identified, the PACE comparable population is identified by limiting claims and payments to members whom are at least 55 years of age. The PACE comparable population composes the base data, and the PACE AWOPs are developed by rating cohort based on the appropriate service regions and dual status.

The data adjustments made to arrive at the projected AWOPs include but are not limited to the following:

Incurred But Not Reported (IBNR)
Nursing Facility Reimbursement Adjustment
Prospective Trend
Any other program or fee schedule changes
Patient Liability
Administrative Loading
Regional Adjustments
Nursing home and HCBS setting of care distribution assumptions

Payment rates will be paid by service region and dual status, adjusted to remove patient liability by member, and discounted from the AWOP based on the methodology set forth by DCH. DCH establishes the Medicaid capitation rates at a percentage of the calculated AWOPs. The AWOPs will be updated annually.

Cost Proposal

For purposes of this RFP the following draft and preliminary rates at 97% of AWOP per month have been calculated.

Service Region	Rate Region	Medicaid only Rate/Month	Dual Eligible Rate/Month
Alpharetta	Atlanta	$ 6,742.86	$ 5,117.80
Columbus	Central	$ 7,388.21	$ 5,625.72
Decatur	Atlanta	$ 6,742.86	$ 5,117.80
East Point / College Park	Atlanta	$ 6,742.86	$ 5,117.80
Macon	Central	$ 7,388.21	$ 5,625.72
Savannah	Southeast	$ 6,741.59	$ 5,188.85

Notes:

1. The above are Medicaid rates for RFP purposes only. The rates will be determined as part of the PACE application and site approval process.
2. Please see the next slide for additional information regarding the draft and preliminary SFY 2025 PACE rates.

Cost Proposal Information

Notes:

1. The draft and preliminary SFY 2025 PACE rates in this presentation are for RFP purposes only and subject to review and revision.
2. Prior to implementation, AWOP PMPMs, NH/HCBS blending assumptions, and other rate considerations are subject to review and revision as DCH determines appropriate to reflect the anticipated contract period.
3. Rates shown in this exhibit are inclusive of estimated medical and administrative costs and are gross of patient liability.
4. Rates shown in this exhibit include the estimated Medicaid portion of members' costs only, and do not include estimated Medicare costs for PACE dual eligible members, which are determined separately.
5. Payment rates will be paid by service region and dual status, adjusted to remove patient liability by member, and discounted from the AWOP based on the methodology set forth by DCH.

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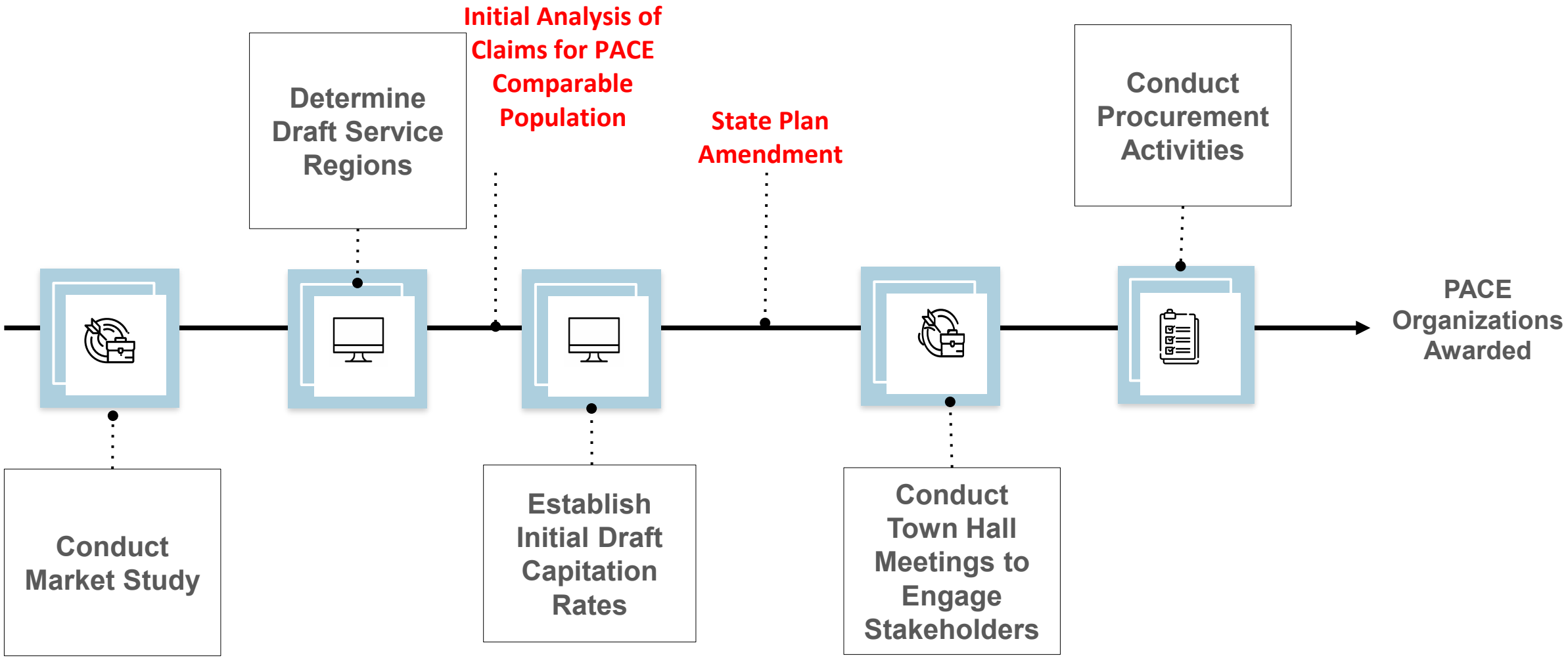
Anticipated PACE Procurement

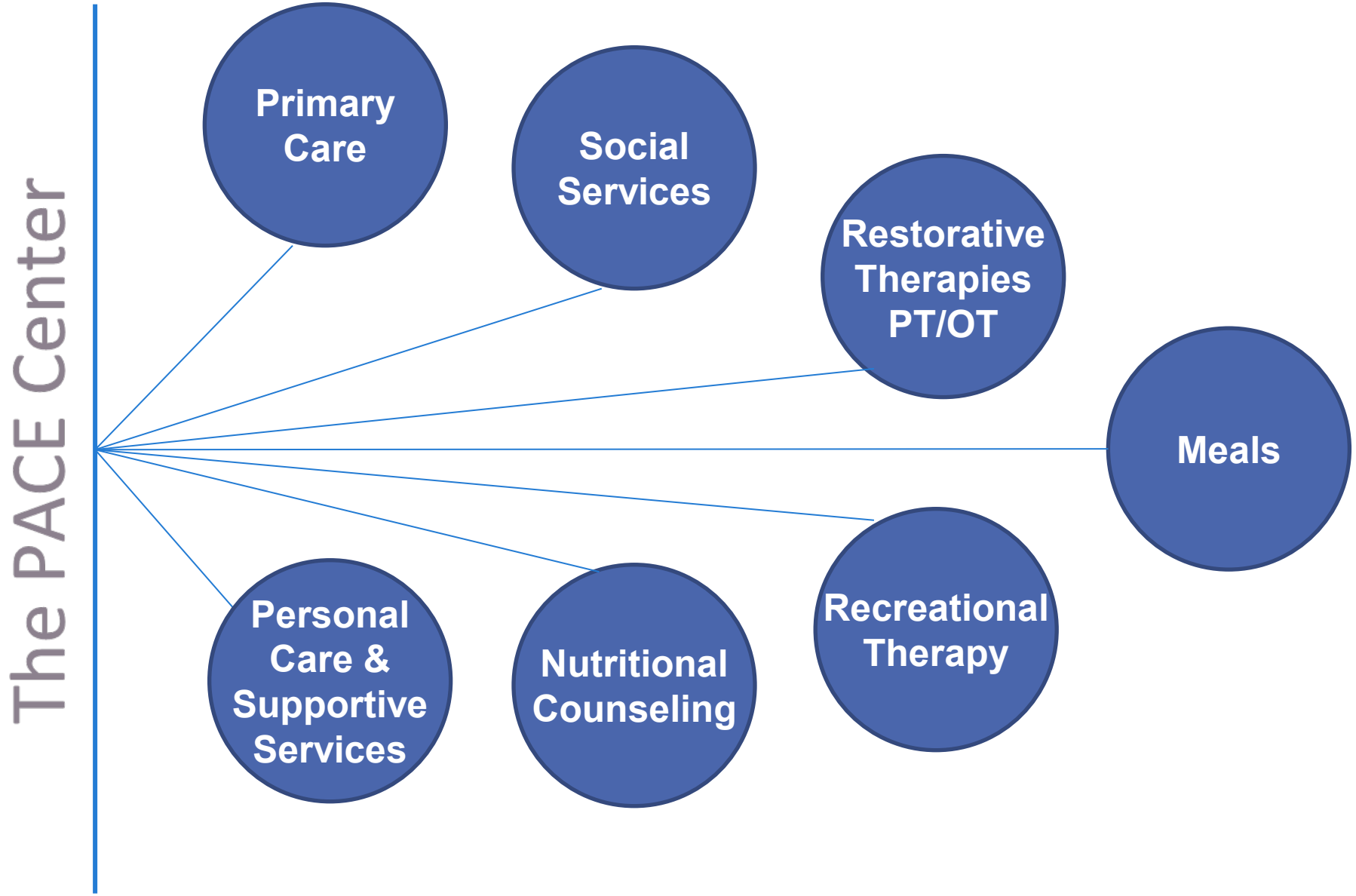
PACE Procurement Overview



Next Steps (RFP)

- DCH plans to issue a Request for Proposals (RFP) for the purpose of selecting qualified suppliers who will be awarded pre-established zip codes per service region via the RFP process.
- The first round will be based on six (6) regions of Georgia and potential Special Health Focus Service Areas.
- Each selected supplier will then be permitted to proceed to the application stage with the Centers for Medicare & Medicaid Services (CMS).
- Approved applicants will enter into three-way program agreement for PACE in Georgia.

The PACE Center



A PACE organization must:

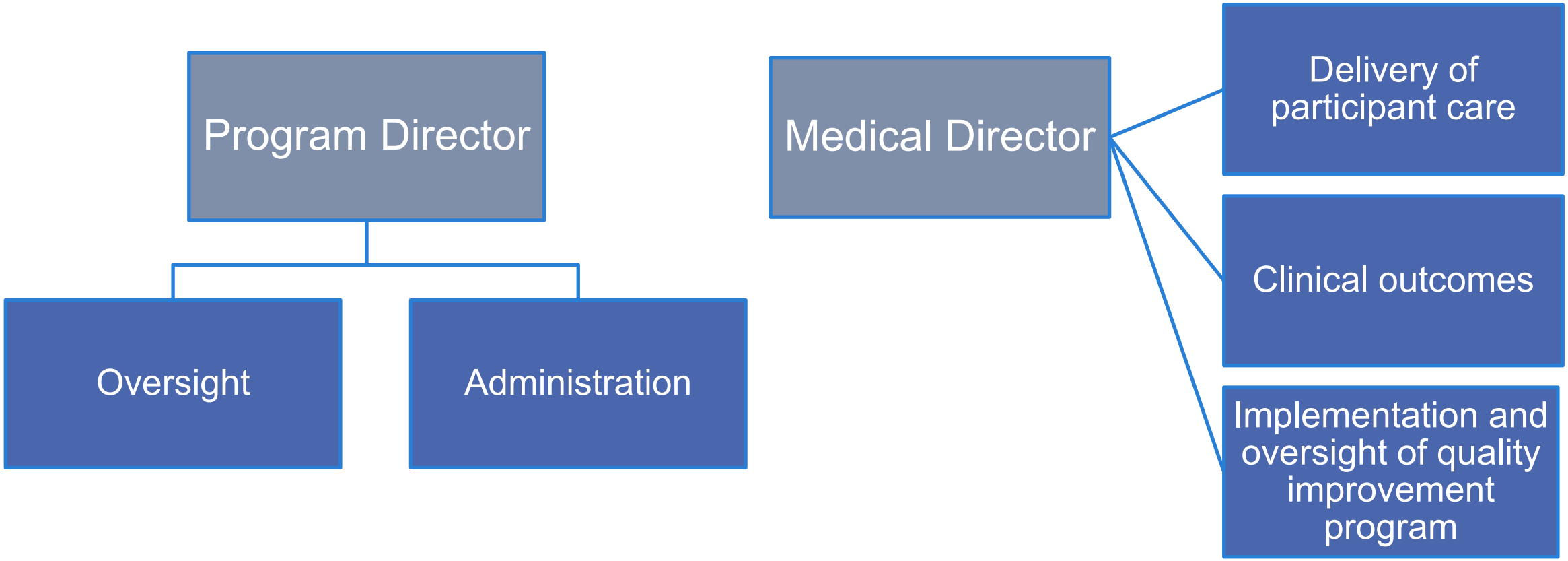
- operate at least one PACE center for its defined service region and
- ensure accessible and adequate services to meet the needs of its participants.

The frequency of a participant's attendance at a center is determined by the IDT, based on the needs and preferences of each participant.

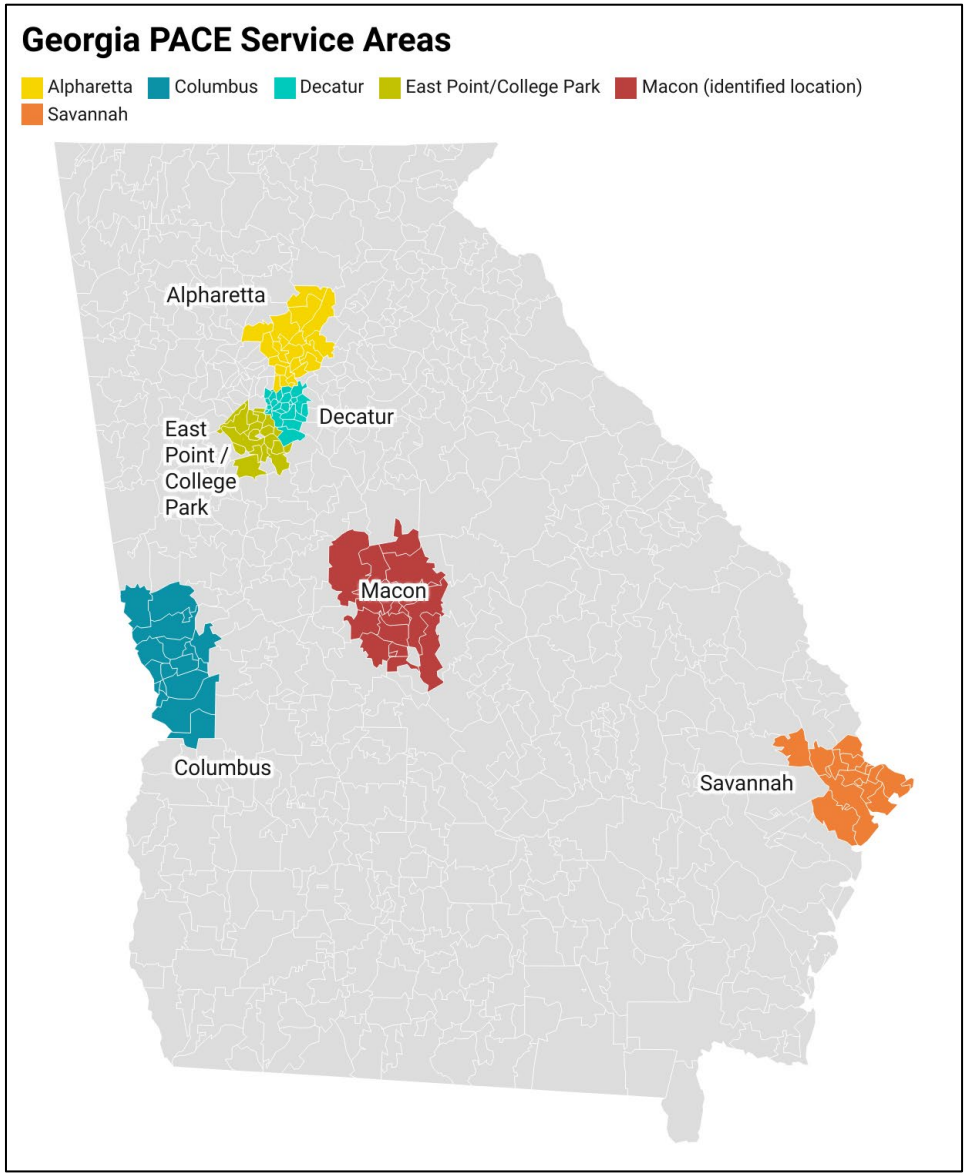
PACE Organization Requirements

- A PACE organization must complete an intensive application process, submit to CMS, and undergo state readiness reviews before being allowed to enroll participants
- A PACE organization must be a non-profit, private, or public entity that is primarily engaged in coordinating and providing all PACE health care services. Organizations must have the following:
  - A governing board that includes community representation
  - A physical site and a facility that is approximately 10,000-square feet to provide adult day services
  - A defined service
  - The ability to provide the complete service package regardless of frequency or duration of services
  - Safeguards against conflict of interest
  - Demonstrated fiscal soundness

PACE Organization Structure



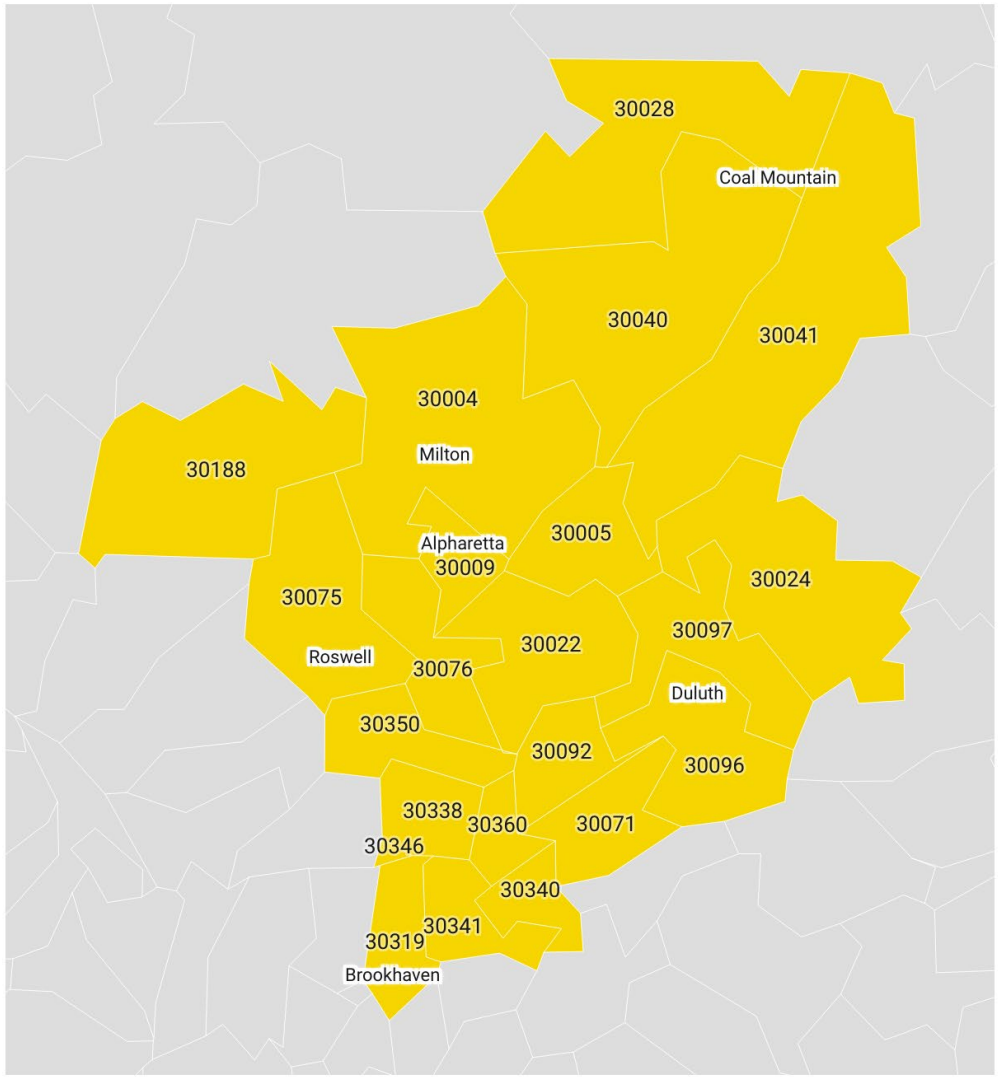
Draft Service Regions



Service Region Name	Number of Zip Codes
Alpharetta	22
Columbus	18
Decatur	29
East Point / College Park	19
Macon	19
Savannah	17

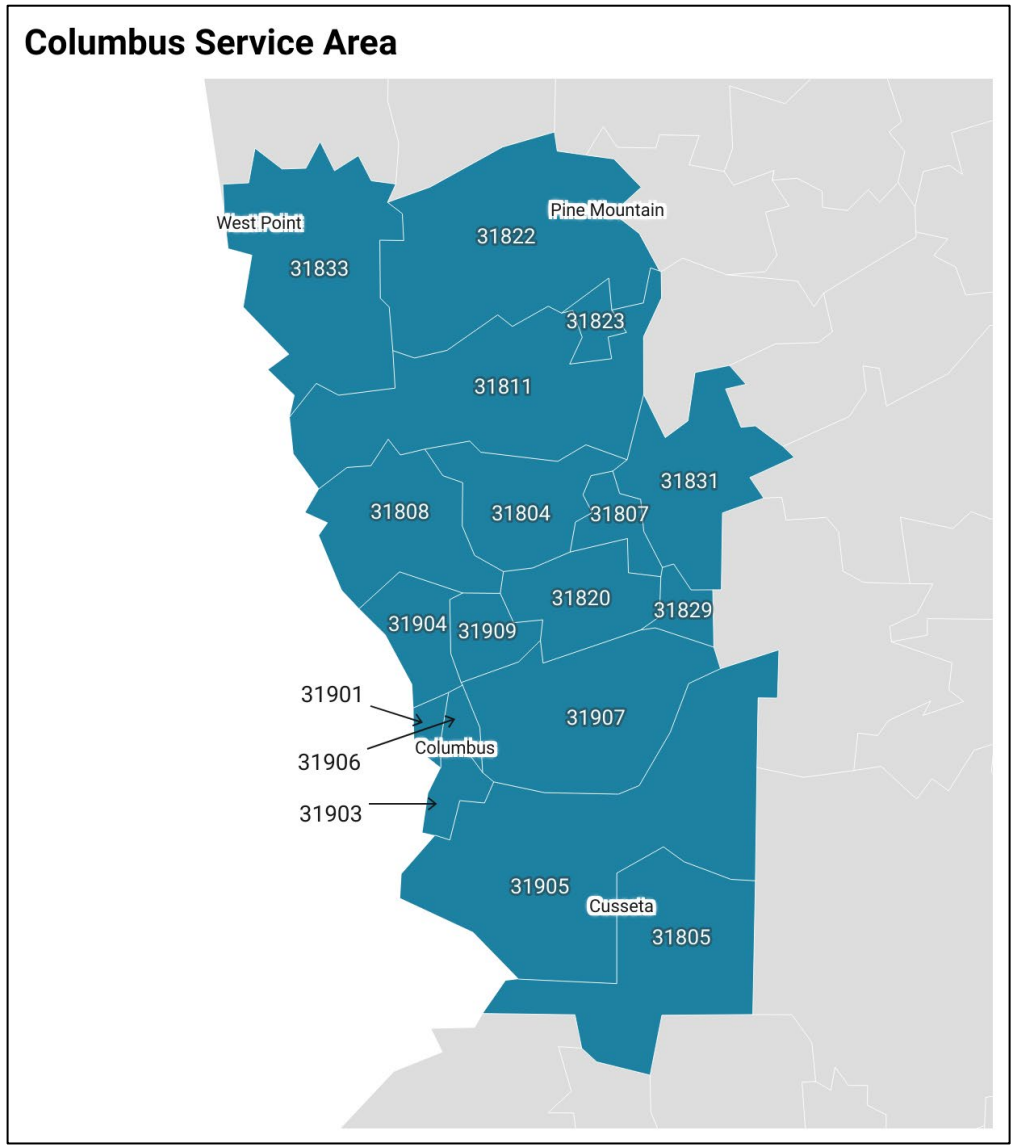
Draft Service Region - Alpharetta

Alpharetta Service Area



Zip Codes	
30004	30092
30005	30096
30009	30097
30022	30188
30024	30319
30028	30338
30040	30340
30041	30341
30071	30346
30075	30350
30076	30360

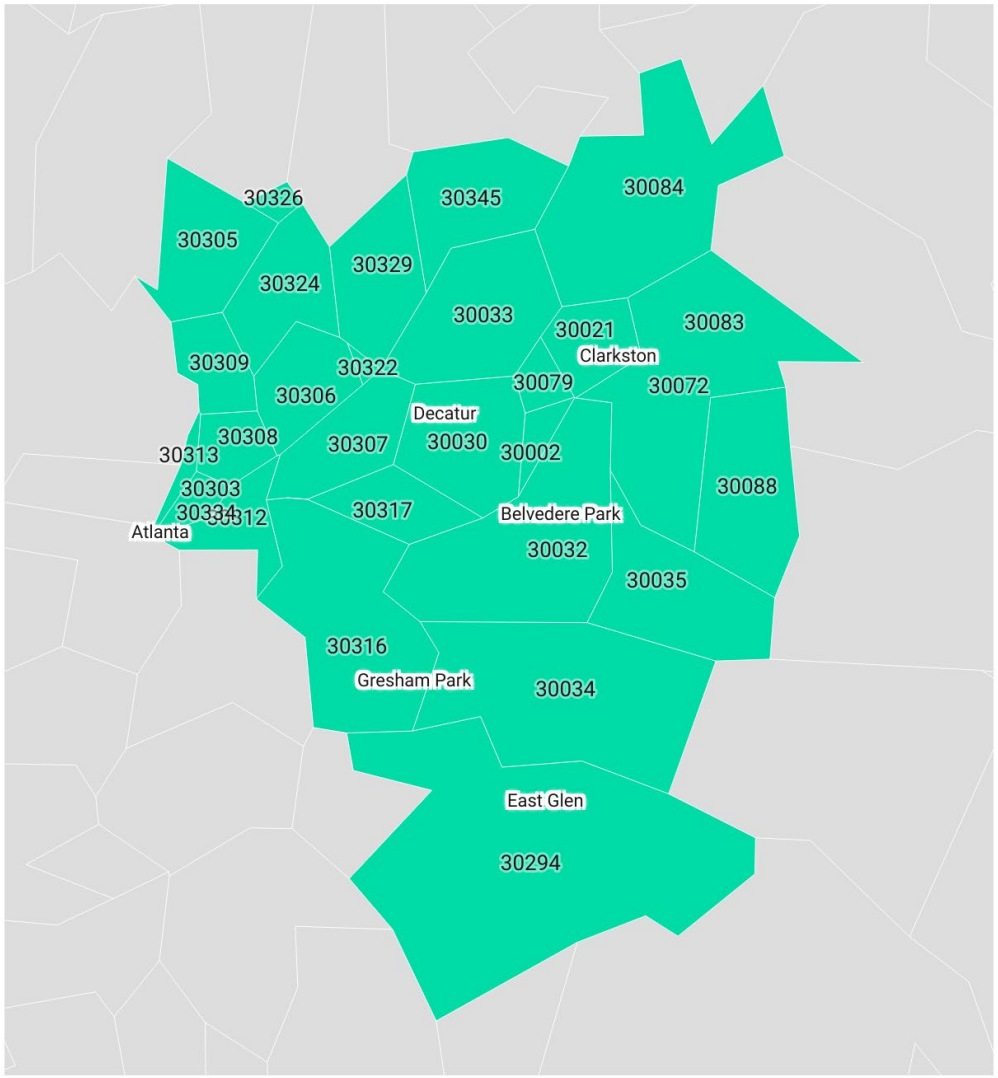
Draft Service Region - Columbus



Zip Codes	
31804	31831
31805	31833
31807	31901
31808	31903
31811	31904
31820	31905
31822	31906
31823	31907
31829	31909

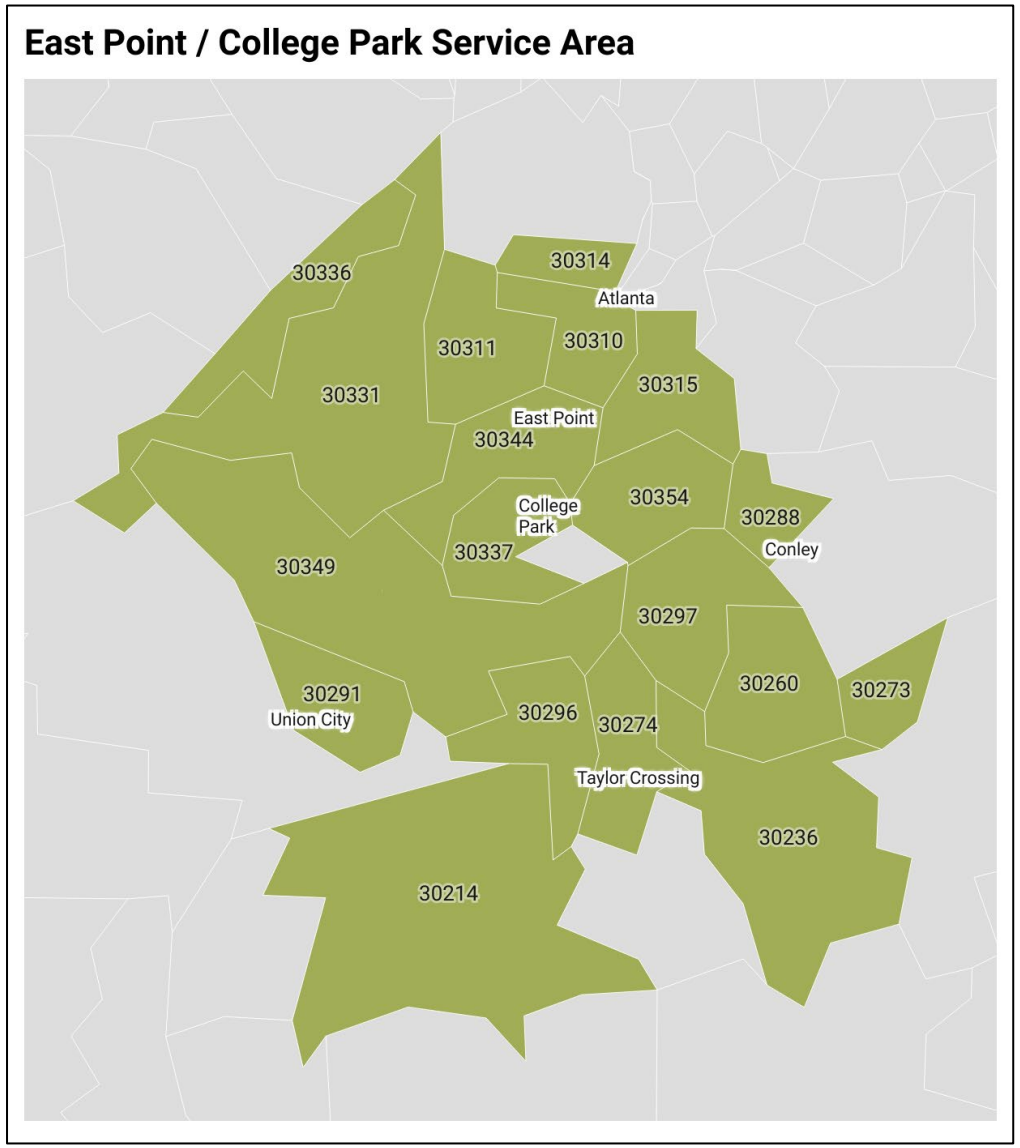
Draft Service Region - Decatur

Decatur Service Area



Zip Codes		
30002	30084	30313
30021	30088	30316
30030	30294	30317
30032	30303	30322
30033	30305	30324
30034	30306	30326
30035	30307	30329
30072	30308	30334
30079	30309	30345
30083	30312	

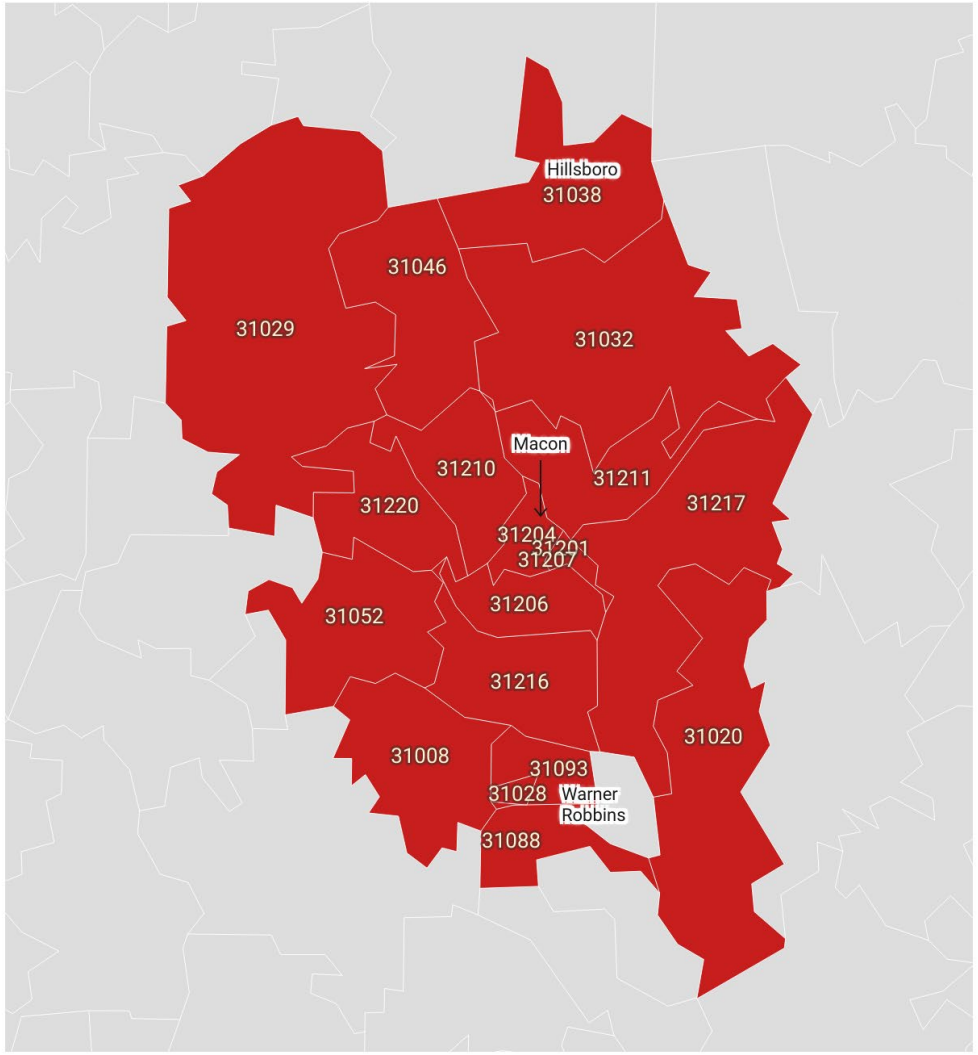
Draft Service Region – East Point / College Park



Zip Codes		
30214	30297	30344
30236	30310	30349
30260	30311	30354
30273	30314	
30274	30315	
30288	30331	
30291	30336	
30296	30337	

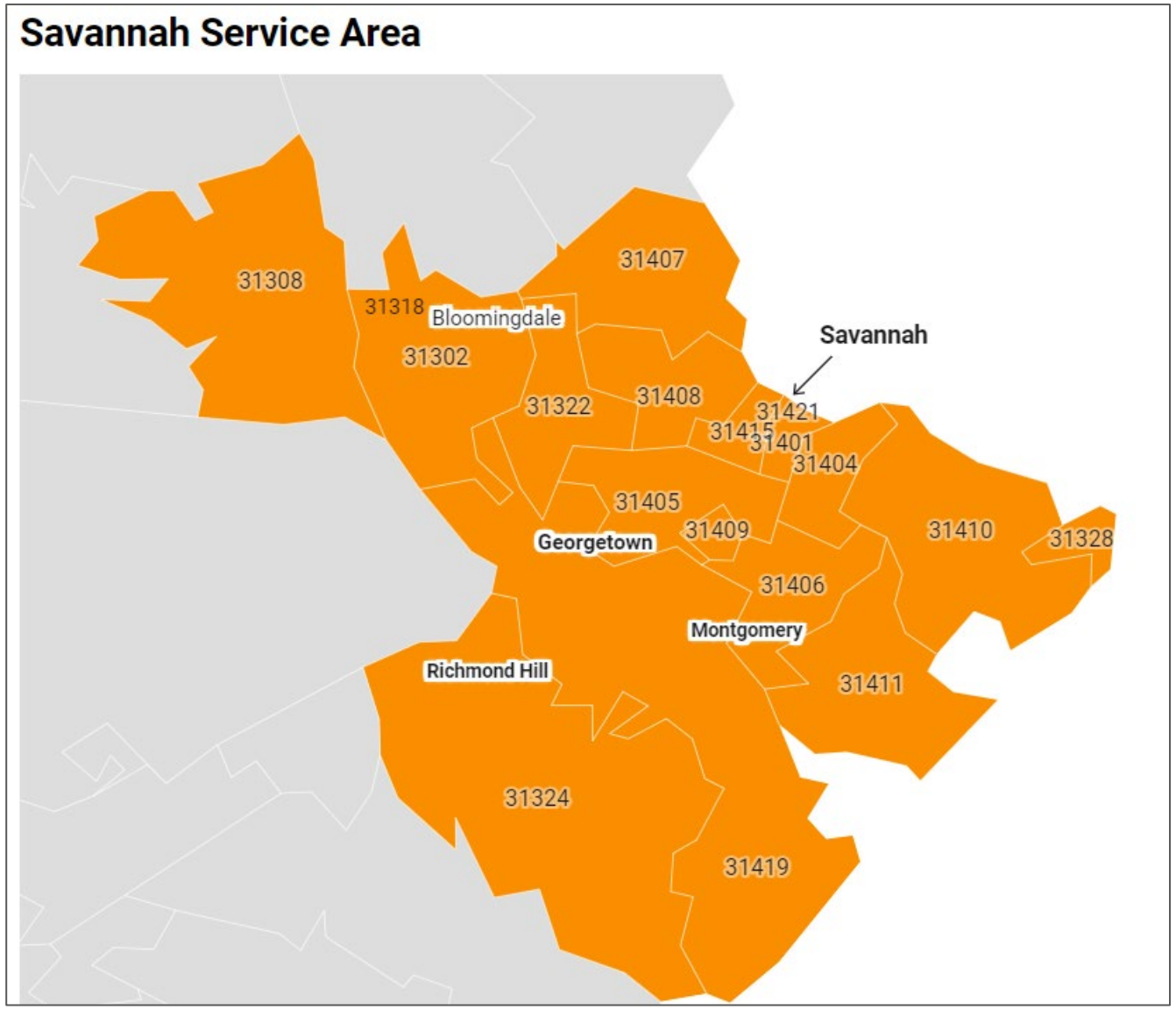
Draft Service Region – Macon

Macon Service Area



Zip Codes	
31008	31201
31020	31204
31028	31206
31029	31207
31032	31210
31038	31211
31046	31216
31052	31217
31088	31220
31093	

Draft Service Region – Savannah



Zip Codes	
31302	31406
31308	31407
31318	31408
31322	31409
31324	31410
31328	31411
31401	31415
31404	31419
31405	31421

Special Health Focus Service Area

DCH will consider proposals that present compelling and viable models for Special Health Focus Service Areas within the PACE service areas previously discussed. Such proposals should seek opportunities to present PACE models based on population values and characteristics that could offer better optimization of and approach to the community-focused-concepts of PACE. All Special Health Focus Service Area proposals must include:

- All requirements in the RFP solicitation
- A detailed financial viability analysis
- A feasibility study and a business plan that supports the submitter's proposal to establish a Special Health List of contiguous ZIP codes that the submitter intends to serve as part of the Special Health Services Focus Area
- A rationale for creation of the Special Health Services Focus Area, including an explanation of what unique aspects of the population can be served/addressed
- A detailed explanation of how the organization will accommodate and support participants who enroll, but who do not identify as part of the Special Health Services Focus Group

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PACE Implementation Process

PACE Organization Implementation Overview

Submit an Application

- Submission to CMS
- Includes assurance from State that the supplier is qualified and state will enter an agreement
- Describe service region designated for PACE services

Construct PACE Center

- Safe design
- Primary care clinic
- Activity area
- Transportation services
- Dietary services
- Emergency preparedness
- Network contract for specialty care
- Therapy (PT/OT)
- Pharmacy

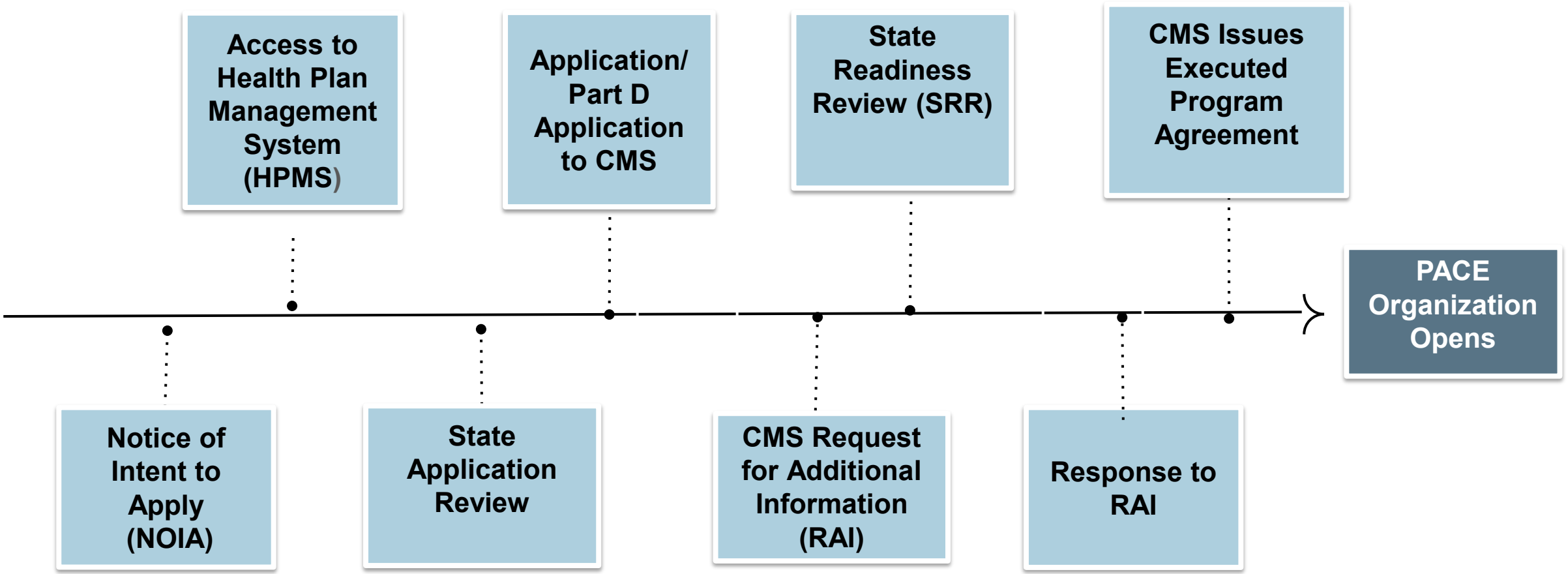
State Readiness Review

- Determines the organizations readiness to administer the PACE program
- Minimum set of criteria established by CMS
- Review of policies and procedures
- Design and construction of PACE center
- Compliance with OSHA, FDA, state and local laws and Life Safety Code

PACE Program Agreement

- Three-way agreement between PACE organization, CMS, and State administering agency
- Once signed, PACE organizations can being enrolling participants

Implementation Overview (cont'd.)



Resources

- Centers for Medicare & Medicaid Services https://www.cms.gov/medicaid-chip/medicare-coordination/qualified-beneficiary-program/program-all-inclusive-care-elderly-pace
- Medicaid.gov https://www.medicaid.gov/medicaid/long-term-services-supports/program-all-inclusive-care-elderly/index.html
- PACE Manual https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019036.html
- 42 CFR 460 https://www.ecfr.gov/current/title-42/part-460

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Questions?