F I S C A L I M P A C T R E P O R T

SPONSOR Gutierrez **ORIGINAL DATE** 02/25/11 **LAST UPDATED** 03/17/11 **HB** 344/aHHGAC/aSFC

SHORT TITLE All-Inclusive Elderly Care **SB**

ANALYST Earnest

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY11	FY12	FY13	3 Year Total Cost	Recurring or Non-Rec	Fund Affected
Medicaid Program		See Fiscal Implications Section				

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Aging and Long-Term Services Department (ALTSD)
Human Services Department (HSD)

SUMMARY

Synopsis of Senate Finance Committee Amendment

The Senate Finance Committee amendment strikes the HHGAC amendment and changes "shall" to "may" on line 19. The permissive language eliminates the administrative cost of the bill. The amended bill would read as follows:

"Consistent with the federal act, the department may provide a statewide program of all-inclusive care for the elderly, consisting of acute and long-term care services, to eligible individuals fifty-five years of age or older."

Synopsis of House Health and Government Affairs Committee Amendment

The House Health and Government Affairs Committee (HHGAC) amendment adds language to require HSD to establish an optional statewide program of all-inclusive care for the elderly (PACE). There may be two interpretations of the amended bill: (1) creating flexibility for clients in choosing the new statewide PACE program or the existing Coordination of Long Term Services (CoLTS) program or (2) giving flexibility to the department in expanding the PACE program statewide. The fiscal impact would be lessened if the department were not required to establish a statewide program.

Synopsis of Original Bill

House Bill 344 would enact a new section of the Public Assistance Act to require the Human Services Department to provide a statewide program of all-inclusive care for the elderly (PACE) for Medicaid eligible individuals fifty-five years of age or older.

FISCAL IMPLICATIONS

The bill, as amended, would put in statute the Program of All-Inclusive Care for the Elderly (PACE). The amended bill does not require HSD to expand the existing program, but would require HSD to keep the program in place, while the department implements cost containment across the rest of the Medicaid program. Establishing Medicaid benefits and programs in statues does limit the department's ability to change the Medicaid program.

SIGNIFICANT ISSUES

The current Program of All-Inclusive Care for the Elderly (PACE) program is available only in Albuquerque and other select parts of Bernalillo, Valencia and Sandoval counties. It has only one approved provider, Total Community Care (TCC). PACE providers are reimbursed through a per-member per-month payment system supported by both Medicare and Medicaid funds.

The PACE program is a partially capitated, community-based services program. The PACE program ensures access to a comprehensive benefit package of services to a frail population that meets nursing facility clinical criteria. HSD reports that enrolling a new PACE provider or expanding an existing provider's geographical area is more complex than establishing other Medicaid provider networks. According to HSD, requirements for PACE providers include the following:

- The State must conduct a readiness review of the provider
- Each PACE site must conduct an initial feasibility study that examines potential Medicaid eligible enrollment, local financial contribution and fiscal soundness (business plan), identification of establishing available qualified health care providers, transportation plans, and local community support-buy-in.
- The State must submit an application (PACE Program Agreement) to CMS, there is a 90-day timeframe for Center for Medicare and Medicaid Services (CMS) approval
- Federal statutory language limits the number of CMS-approved PACE Program Agreements (42 CFR §§460.24). HSD would need to consult with CMS to determine if New Mexico is able to expand the number of PACE agreements. CFR 460.24 limits only 20 new PACE program agreements nationwide per year.
- If approved, the provider must enter into a three-party contract with HSD and CMS.
- The provider must also enter into a Professional Services Contract with HSD

CMS requires that primary medical care be furnished to a participant by a PACE primary care physician at the PACE center. A statewide implementation of this model could impact the PCP structure in the state, as PACE participants who were seeing a PCP in their community would be required to see the PACE PCP, who might not be located within the participant's community.

HSD provided the following information on PACE and the current provider network:

"The uptake rate into the PACE program from the eligible state population would not likely be over 50% given several factors:

- The PACE program requires regular attendance at an adult day care center. Most adults would prefer to receive treatments at home or decide their own schedule of visits.
- Enrollees must switch from their current primary care provider to the PACE program primary physicians.
- Competition from other state-funded long-term care options gives this population many choices: home and community-based services, and personal care option program, for example.

Provider Network

- For-profit providers have had little entry into the PACE program. Primary reasons appear to be the uncertainty of Medicare capitation rates coupled with the financial risk of caring for the nursing home eligible population.
- Non-profit providers face heavy barriers to entering the PACE network because of high initial investment costs, disappearance of national PACE demonstration project grants, and labor needs.
- It is hard to build a participant pool outside of those eligible for Medicaid or Medicare because PACE is unaffordable for most middle-income families.
- Most eligible individuals and their families are unaware of the PACE program. Most primary providers are non-profit providers and cannot afford advertising or marketing. Furthermore, CMS has strict prohibitions on marketing and programs are disallowed mentioning that they are PACE programs prior to full approval by CMS as a PACE site, which can easily be a two year process."

In addition, according to HSD the following costs would apply for creating a statewide program:

- Costs may be higher in the rural areas to properly compensate rural provider networks. States with large rural populations have found it difficult to develop PACE programs, and states with low population densities face additional transportation and care coordination barriers Currently, New Mexico compensates CoLTS providers for cost differentials geographically around the state.
- Some states have rural models of the PACE program, but they were initiated with start-up grant funding authorized by Congress with the establishment of the "Rural PACE Provider Grant Program," in section 5302 of the Deficit Reduction Act of 2005/DRA (Public Law 109-171). Fifteen rural PACE programs were selected through this grant initiative and a report has been made to Congress, evaluating the Rural PACE Provider Grant Program, as provided by the US Health and Human Services Department this current year of 2011.
- New Mexico has a high rural/frontier population. There would be high cost in coordinating care across rural areas. Additionally, New Mexico currently does not have enough providers to sustain a PACE program outside of the metro areas.

ADMINISTRATIVE IMPLICATIONS

None identified for the amended bill.

OTHER SUBSTANTIVE ISSUES

HSD reports:

> The PACE model does not lend itself to a statewide effort. PACE is a full-risk capitation pool endeavor, in that the PACE program has total financial risk for "frail" individuals over 55 years of age with functional challenges such that they meet nursing home eligibility. This identified client group for PACE is profiled as having multiple chronic medical conditions and PACE sites are only able to keep financially viable whereby high-end medical service utilization and associated costs are contained. The PACE model counts on a steady enrollment of client/participants in the PACE program. Most rural PACE programs have not demonstrated a high enough enrollment to have sufficient economies of scale in the client risk pool. Key financial issues have hinged on both steady enrollment into the program and nursing home and hospital admittances. Many rural sites have at times come close to breaking even, as their enrollments climbed, only to have an untimely hospitalization cause them to regress from that target.
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> There are also significant start-up capital expenses for PACE programs primarily for 1) staffing (development of the required interdisciplinary team and with rural areas having shortages of skilled clinical professionals, such as physical therapists, primary care and specialty physicians, licensed master-level social workers); 2) construction and renovation in establishing a hub adult day health center; and 3) equipping sites with furniture, equipment, supplies and vehicles. In the recent evaluation study of rural PACE initiatives, only PACE sites with the highest enrollment base and reputable, experienced and financially strong sponsoring organizations supporting them are able to survive and do well.

BE/bym:mew