Response to NC Department of Health and Human Services Division of Medical Assistance
Request For Information RFI-DMA 100-13

From:

NC PACE Association
Linda S. Shaw, Executive Director
2401 Weston Parkway, Suite 203
Cary, NC 27513
919-821-0485/919-632-9306(m)
Linda.shaw@ncpace.org

The NC PACE Association was formed in April 2011 by 14 North Carolina healthcare organizations that operated or planned to operate PACE programs. Our mission is to support the development, expansion, success and quality of PACE programs throughout North Carolina. North Carolina's first PACE program, Elderhaus, opened in Wilmington in 2008. Currently, there are six PACE programs[1] operating in the state, located in Wilmington, Burlington, Fayetteville, Greensboro, Lexington, and Newton (Hickory). All six organizations are North Carolina entities that are licensed providers participating in Medicaid.

PACE has grown steadily in North Carolina, now surpassing our southern neighbors who have also found PACE beneficial. Our six sites are providing high quality, cost-effective care to 592 frail, low-income seniors, keeping them out of much more costly fee-for-services alternatives, including skilled nursing facilities.

PACE was designed to and currently addresses the needs of the frail elderly and disabled adults age 55 or older. The growth of this population and its impact on health care costs is tremendous. In the next two decades, the number of North Carolinians age 65+ will grow to almost 2.3 million, representing roughly a fifth of the state's population. During that same period, the number of people aged 75-84 will almost double (96%), and the eldest of the elderly (85+) will increase by 70%.[2]

Health care utilization and costs also escalate with age. Medicare data (2009) show that the number of skilled nursing facility stays are 672% greater for those aged 85 and older than for those aged 65-74. Not surprisingly, health care expenditures doubled between these two age groups. And health care expenditures are almost five times greater for those in institutional settings than for Medicare enrollees living in the community. Costs also are significantly higher for impoverished elderly and for those with five or more chronic conditions. By age 75, more than 12 out of a hundred North Carolina elderly live below the poverty level, while an additional 30% live between 100 and 199% of poverty.

North Carolina is experiencing this elderly health care explosion already. According to the DMA Monthly Dashboard Report (2/8/2013) increases in durable medical expenditures, lab/rad costs and ER costs all are being driven by growth in the Aged, Blind and Disabled population.

[1] See addendum 1 for additional information on the PACE facilities

[2] NC Division of Aging and Adult Services *A Profile of People Age 60 and Over, North Carolina 2012*

PACE was designed with this older, more frail, and poorer population in mind. Most PACE participants are "dual eligibles", qualified for both Medicare and Medicaid. PACE has demonstrated repeatedly that it can serve the dual eligibles effectively and efficiently with quality outcomes and high client satisfaction. We have been successful in keeping people in the community and out of far more costly nursing homes. We propose PACE as a solution to this growing and costly segment of the population and suggest that its lessons may be applied in other settings as well. Thus, the NC PACE Association is pleased to submit the following suggestions for innovative systems and payment reforms for North Carolina's Medicaid program.

OVERVIEW AND HISTORY

PACE (Programs of All-inclusive Care for the Elderly) is a federal and state program that provides comprehensive, integrated, highly coordinated care to frail older adults who meet state eligibility criteria for nursing home level of care. Individuals enrolled in PACE receive all Medicare and Medicaid covered items and services, and additional benefits, through PACE, either directly from the PACE organization's staff or through its network of contracted providers. PACE organizations receive capitated payments from Medicare, Medicaid and private pay sources for which they assume full financial risk for all medical services, including long-term institutional care.

PACE was authorized as a permanent Medicare provider benefit in the Balanced Budget Act of 1997 and established as an optional service under the North Carolina State Medicaid Plan in 2007. It is the only fully-integrated model of care serving the frail elderly. In existence nationally for over 20 years, PACE organizations have demonstrated the capability to control costs, improve health care outcomes and achieve high consumer satisfaction.

PACE is a capitated program that provides comprehensive services ranging from medical care to transportation that allow nursing-home eligible individuals to continue living in the community. Approximately 97% of PACE participants are eligible for Medicaid. The PACE program assumes FULL risk for the medical care and expenses of PACE participants. The capitated payment covers every aspect of the participant's care. It (along with the interdisciplinary team approach that is core to this model) encourages PACE providers to look at the individual's health care from a holistic and creative perspective: what will help these folks get and stay healthy? The provider has a cost stake in making sure that health costs stay under control. While providing all that is needed, there is a disincentive for providing unnecessary and overly expensive services.

To enroll in PACE, an individual must qualify for skilled nursing level of care, be 55 or older, reside in an area served by PACE, and be able to live in the community with support. Medicaid eligibility for PACE in North Carolina is limited to 100% of poverty. Despite our growth, PACE currently reaches only 20 counties and serves only a small portion of North Carolina's eligible population, but we believe the model could and should be extended to serve a broader segment of the Medicaid population.

PRINCIPLES ADDRESSED

PACE programs ***are market-based and utilize NC community-based providers***. In addition to the six operating PACE sites in North Carolina, two more programs which will serve our largest metropolitan areas of Charlotte and Raleigh-Durham continue to await final regulatory approval. All are not-for-profit entities established by North Carolina providers and located in the predominately low-income communities they serve. All PACE participants live within a 45-minute drive to the facility – most are within 30 minutes. Communities are enriched by these not-for-profit PACE providers who have

demonstrated a commitment to their communities through their stability and continuity. They remain resilient resources with their communities and are poised to grow and expand.

PACE provides professional jobs within the community. Each PACE facility is required to have a full-time interdisciplinary team of at least 10 on staff, which increases as the number of participants grows. The team consists of a doctor, nurse, therapists, social worker, pharmacist, personal care and home care specialists and other professionals on-site, along with drivers and activity specialists, offering an array of employment opportunities for the surrounding community. While purchasing practices vary from center to center, gas, food, assorted supplies and other necessities are generally purchased locally. PACE organizations also leverage Medicare funds approximately equal to the Medicaid expenditures. The PACE center concentrates these sources of income and the resulting disbursements for a greater local economic impact than would be felt in a highly dissipated fee-for-service model. An economic analysis of Carolina SeniorCare, the PACE facility in Lexington, projected a total economic impact of almost $13 million in its start-up years.

The PACE financial model yields a system that ***reimburses for proven and documented results***. PACE is unique because it is both the health provider AND the health insurer. PACE programs assume **full risk** for all aspects of the individual's care. Rather than being reimbursed for services, PACE receives a monthly capitated payment for each individual (which, by law, is less than what the state would pay in a fee-for-service scenario). That monthly capitated payment PACE receives from Medicaid (and from Medicare for the dually eligible participants) must cover anything and everything the participant needs, from immunizations to long-term care. The state has no further financial culpability beyond the capitated payment. This requires the PACE provider to be both creative and highly focused on prevention and wellness-care. It demands a patient-centered approach, which yields both cost-savings and better outcomes for the patient.

Research has demonstrated PACE's unique ability to uphold many of the competing and challenging objectives in caring for frail seniors – controlling costs while improving outcomes. PACE organizations fully integrate and coordinate care, successfully support individuals ability to live in the community, operate viably on Medicaid funding that is far less costly than nursing home care, achieve superior outcomes in terms of utilization and health status and achieve very high levels of reported satisfaction among those they serve and their families.

PACE is the only existing model of care that fully integrates Medicare and Medicaid financing without requiring special waivers or demonstrations. It shapes frail elders' health services into a comprehensive form, bringing federal dollars to bear at a local level and allowing individuals to remain living in their homes.

The PACE capitated payment system and integrated disciplinary team approach also ***enhances recipients' personal responsibility for health care decisions***. The best way for PACE programs to ensure that the capitated payment will cover all of an individual's health costs is to engage that individual and his/her caregivers in the comprehensive effort to live as healthy and safe a lifestyle as possible. This applies not only at the PACE center but in the participant's home as well. An in-home assessment is done by a member of the PACE interdisciplinary team to determine if the person can live safely there. So, for example, if steps or throw rugs pose possible falling hazards, this is discussed and remedied, with the participant's agreement. Physical and occupational therapy is available on site to strengthen muscles and improve coordination and balance that enhances the participant's independence. At Elderhaus, the medical director installed exercise machines that she initially had to cajole participants to use. Now they "fight" to get time on the equipment and more has been ordered.

Caregivers are engaged in education and decision-making as well, especially for those participants with dementia or other limiting disabilities. PACE provides caregiver support, education programs, and home care services that improve the caregiver's quality of life, provide respite, and allow them the opportunity to work outside the home. This reduces the burden of caring for their loved ones and enables the PACE participant to continue living at home.

This comprehensive, all inclusive approach to health care has proven effective in improving the health of the very frail, elderly PACE population, which is more limited in options than most other groups.

PACE is fully ***integrated in the NC health care system and enhances the community care network***. PACE is the primary care provider and the medical home for the people it serves. For any service that PACE cannot provide in house, the program contracts with other medical providers, and PACE programs coordinate all of that care for the individual. The range of providers is as extensive as the individual's needs. It includes dentists, cardiologists, neurologists, podiatrists and nephrologists, as well as alternative health providers.

To enhance the availability and effectiveness of needed care, PACE programs build partnerships with other primary care providers and networks. PACE programs have led collaborative community efforts to reduce hospital admissions, to share best practices on coordinated interdisciplinary healthcare and to host caregiver conferences. Partners include hospitals, the community care networks, hospice, home care agencies, nursing homes, accountable care organizations and entities such as the Alzheimer's Association and area agencies on aging.

PACE also provides an option for the community care network and other medical providers to secure the comprehensive and intensive care needed by many of their sickest and poorest patients – the ones who cost the most to serve. CCNC has come to recognize that PACE serves this population most effectively. PACE provides a cost effective alternative that enables many frail elderly and disabled adults to remain in the community, keeps them out of more expensive nursing homes and yields better health outcomes and fewer hospitalizations. It is a critical piece of affordable primary care for the elderly in North Carolina's health care system.

The PACE model is uniquely designed to ***assess the optimal level of benefits to appropriately meet the health care needs of Medicaid recipients.*** The assumption of full financial risk for all health care expenses creates significant incentive for PACE programs to appropriately address participants' health care needs. Appropriateness is determined by the Interdisciplinary Team which establishes a plan of care based on all aspects of the participant's situation incorporating medical, behavioral, physical and social conditions. The care plan is reviewed by the team on a regular basis. Additionally, participants are transported to the PACE site up to five times per week, according to their individual needs, allowing for regular observation, treatment if necessary, and/or adjustment of the care plan. As indicated elsewhere, PACE also provides home and caregiver support. And PACE is not limited by Medicaid/Medicare limitations on what an acceptable (and reimbursable) service is. If a participant needs something out of the ordinary to enable her to improve or sustain her health, PACE has the flexibility to procure it. And all of these services are paid for by PACE at no additional cost to the state.

Cost Savings and Quality Outcomes

The elderly and disabled represented only 25% of North Carolina's Medicaid population in 2008, but they accounted for 80% of total Medicaid costs, incurring more than 40% of all inpatient admissions and two-thirds of all potentially preventable readmissions.[3] As the number of elderly continues to increase, the

[3] DuBard, C. A. (2012, April 5). Collaborative Accountability for Care Transitions: The Community Care of North

need to control these expenditures, while still providing quality care, is evident.

PACE provides both short term savings for the Medicaid program, as well as a sustainable and predictable program for the future. It provides more appropriate care, at lower costs and with better outcomes for the frail, elderly population it serves.

All PACE participants qualify for nursing facility level of care. PACE participants are much poorer and less healthy than the overall NC senior population. Almost all (97%) qualify for Medicaid. The typical PACE participant is an 80 year-old woman with 7.9 medical conditions who is limited in approximately three Activities of Daily Living (ADLs) and has a 50-50 chance of having dementia. Yet PACE provides all necessary supports to allow these very frail, very low income individuals to living safely in their communities, rather than going to far more costly nursing homes.

PACE is saving money for NC now because payment rates for PACE are less than other options such as skilled nursing facilities and fee-for-services. Federal regulations require states to set prospective monthly capitation rates at less than the amount the state plan would pay if participants were not enrolled in PACE.[4] The rate should also account for the comparative frailty of PACE participants, and is a fixed amount regardless of changes in the participant's health status. North Carolina utilizes an "upper payment limit" (UPL) methodology to determine the costs of other Medicaid services for beneficiaries eligible for nursing home level of care. Two rates are established - a higher one for Medicaid only and one for enrollees eligible for both Medicaid and Medicare. (The higher payments to PACE for enrollees who are eligible only for Medicaid reflect the full share of costs the state bears for this population - including physician and hospital services.) Currently, the Medicaid-only upper payment limit for those 55+ is $4,733, while the North Carolina Medicaid-only PACE capitated rate is $3,562, a savings of 25% to the state. The PACE capitation rate for dually eligible individuals over 65 is $300/year per person less than the duals upper payment limit, yielding a six-figure savings for the state.

If individuals enrolled in PACE were in skilled nursing facilities instead, Medicaid would be paying an average monthly reimbursement of $4,843 to the facility. So the state is saving between $14,315 to $18,400 annually for each person PACE keeps out of nursing homes. PACE also covers all the additional expenditures not included in the skilled nursing facility rate, such as hospitalizations, copays and some drugs, which otherwise Medicaid would pay, so the savings are actually much greater.

PACE is responsible for **all** costs with the one capitated payment, so PACE saves money for the state compared to fee-for-service. PACE provides an array of services to its participants – services that would otherwise be paid for by the state on a fee-for-service basis. These services include rehabilitation, primary care, home care, transportation, social services, meals, adult day care, inpatient, pharmacy, case management and end-of-life care. PACE covers all of this. So if the PACE participant required hospitalization or nursing home care, PACE would pay for those services at no additional cost to the state.

The PACE model also has helped hold down the otherwise rising cost of health care. Nationally, Medicaid costs for people aged 65+ have grown rapidly in the past few years. According to CMS' National Health Care Expenditure Data, Medicaid spending for the 65+ population continues to consume 34% of all expenditures and grew at 6.8% in 2011. Spending was expected to increase by 8.2% for 2012 and continue at this growth rate through 2020, even with a predicted decrease in optional services.

Carolina Transitions Program. *North Carolina Medical Journal, 73*(1), 34-40.

[4] 42CFR, section 460.182

Nationally, PACE rates have had an annual growth rate of less than 1% since 2007, while North Carolina has not had a rate increase for PACE since 2006.

PACE provides a sustainable, predictable Medicaid program for the future. Because PACE programs assume FULL risk for patient care at a fixed monthly cost, costs to the state per individual are a known quantity that will not change during the year. This is especially important when serving the frail elderly population. Approximately 1 in 4 Medicare dollars is spent treating individuals in their final year of life. Similarly, Medicaid bears a disproportionate burden of end-of-life care, especially for older enrollees who rely on costly nursing home care in their final days. This creates an unpredictable environment for state budgets – a catastrophic illness or disability could significantly increase costs for a state.

PACE programs receive a fixed monthly payment from North Carolina to provide the full range of Medicaid-covered services to program participants. This payment does not change throughout the year in response to changes in participants' health status or where services are provided, e.g. in community settings, nursing homes, or hospitals. In this way, PACE affords states greater predictability in their Medicaid budgets.

Development and expansion of new PACE programs is a very measured process, involving both state and federal regulations and oversight. Thus, the predictability of growth of PACE in North Carolina is accurate and can be easily budgeted for.

PACE provides better outcomes for patients. Numerous studies have shown that PACE participants live longer, are hospitalized less, and are unlikely to ever be admitted to nursing homes. This is true, even though PACE is treating individuals with multiple and complex health care needs.

A 2010 study[5] identified PACE as a chronic care model that includes processes that improve the effectiveness and efficiency of complex primary care. Four processes present in the most successful models of primary care for community-based older adults who have multiple chronic conditions, including PACE, are: 1) development of a comprehensive patient assessment that includes a complete review of all medical, psychosocial, lifestyle and values issues; 2) creation and implementation of an evidence-based plan of care that addresses all of the patient's health needs; 3) communication and coordination with all who provide care for the patient; and 4) promotion of the patient's (and their family caregiver's) engagement in their own health care. PACE is effective and efficient in treating individuals with multiple and complex health care needs.

A South Carolina specific study[6] determined that PACE participants live longer than enrollees in a home- and community-based waiver program. Researchers examined long-term survival rates of participants in PACE and an aged and disabled waiver program over a five-year period. Despite being older and more cognitively and functionally impaired than those in an aged and disabled waiver program, PACE participants had a lower long-term mortality rate. When stratifying for mortality risk, "PACE participants had a substantial long-term survival advantage compared with aged and disabled waiver clients into the fifth year of follow-up." The benefit was most apparent in the moderate- to high-risk admissions,

[5] (Boult, C. & Wieland, G.D. (2010). Comprehensive primary care for older patients with multiple chronic conditions: "Nobody rushes you through." JAMA, Vol. 304, No. 17, pp. 1937-1943.)

[6] (Wieland, D., Boland, R., Baskins, J., and Kinosian, B. (2010). Five-year survival in a Program of All-Inclusive Care for the Elderly compared with alternative institutional and home- and community-based care. J Gerontol A Biol Sci Med Sci. July: 65(7), pp. 721-726.)

highlighting the importance of an integrated, team-managed medical home for older, more disabled participants, such as those in a PACE program.

PACE prevents and/or significantly reduces preventable hospitalizations. PACE enrollees had fewer hospital admissions, preventable hospital admissions, hospital days, emergency room visits, and preventable emergency room visits than a comparable population enrolled in the Wisconsin Partnership Program[7]. Research by the National PACE Association (NPA) in 2011 revealed that PACE hospitalization rates were 43% lower than for non-PACE dually eligible recipients of Medicaid home and community based services (HCBS) and 24% lower than for dual eligibles receiving Medicaid nursing home services. PACE participants experienced 46% and 34% fewer hospital days (per 1000 per annum) compared to dually eligible receiving HCBS and nursing home care, respectively. And PACE hospital readmission rates were 17% lower for PACE participants than the national rate for 65+dual eligible beneficiaries, even though all PACE participants qualify for skilled nursing level of care.

The PACE interdisciplinary team focus on assuring effective care coordination over time and across settings has a positive effect on reducing hospital admissions and readmissions, yielding not only better care outcomes for the individual but significant cost savings for the Medicaid program. A real-life example:

"Ms. M. is a 79-year-old female who has been a participant at our PACE facility since October 1, 2012. She has several serious medical problems including congestive heart failure, dementia, type 2 diabetes, depression, chronic anemia, osteoarthritis, and chronic back pain on narcotics (and many other). She had been hospitalized several times over last 4 years which seemed to accelerate in 2012. She was hospitalized once in 2008, twice in 2009, once in 2010, once in 2011, and she had 3 hospital admissions in the first 6 months of 2012. Her hospital admissions were typically for exacerbation of congestive heart failure, urinary tract infections, and dehydration. Since being a participant of PACE (October 1, 2012), Ms. M. has had 3 separate occasions where she started to become dehydrated and had a urinary tract infection. She also had an episode of gastrointestinal bleeding. Because these conditions were caught early and treated appropriately, we were able to avoid admissions that probably would have resulted if she had not been a participant in the PACE program."

Contrast that outcome with the following authentic email about an elderly woman who is not a PACE participant: "Ms. J. was taken to the hospital emergency room yesterday. She is suffering from a urinary tract infection, was dehydrated and was disoriented. She is presently in the ER Extended Stay Unit. It is not known at this time how long she will be there."

PACE reduces the need for costly, long-term nursing home care. Another study[8] found that, "Despite the fact that 100% of the PACE participants were nursing facility certifiable, the risk of being admitted to a nursing home long term following enrollment from the community is low." The risk of admission to nursing homes for 30 days or longer was 14.9% within 3 years. Based on this study of 12 PACE sites, fewer than 20% of participants who died spent 30 days or more in a nursing home prior to death.

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[7] *(Kane, R. L.; Homyak, P.; Bershadsky, B; & Flood, S. (2006). Variations on a theme called PACE. Journal of Gerontology Series A, Vol., 61, No. 7, pp. 689-693.)*

[8] *(Friedman, S.; Steinwachs, D.; Rathouz, P.; Burton. L.; & Mukamel, D. (2005). Characteristics Predicting nursing home admission in the program of all-inclusive care for elderly people. The Gerontologist, Vol. 45, No. 2, pp. 157-166.)*

PACE is designed to deliver ***the right level of care at the right location and at the right time.*** PACE is the definition of a "medical home". All health care is coordinated through, paid for and/or delivered by the PACE program. Participants carry a PACE card rather than a Medicare or Medicaid or insurance card identifying them and identifying PACE as their insurer and medical provider. Because the PACE program is responsible for all costs, there is great incentive for PACE providers to keep participants as healthy as possible, to practice preventative measures, to monitor conditions, to prevent falls and take a holistic and creative approach that will keep participants out of expensive hospitals, emergency rooms and nursing homes.

With PACE, medical care is integrated with other needs and issues. Each PACE participant is "served" by an interdisciplinary team that assesses the participant's situation and works together to determine and implement a comprehensive plan of services. The participant is transported to the center up to five days a week if necessary where s/he receives nutritious meals, exercise, therapy, socialization, personal care, medication and medical attention. Medications and food are frequently sent home with the participant. PACE employees also work with the participants' caregivers, providing information critical to the participants' care, along with support and respite for the caregiver. In short, PACE looks at the whole person, taking into account and addressing not just the medical issue, but the social, family, environmental and other factors that influence the participant's health. PACE treats the underlying concerns, not just the medical symptom, thereby alleviating or mitigating the causes of some of the presenting health issues and preventing hospitalizations and lesser "crises".

The PACE physician becomes the primary care physician when someone joins PACE. In some instances, this has proven an obstacle to enrollment because patients are reluctant to leave the doctors they've known for so long and the doctors may be loathe to refer someone to PACE as they will lose a patient. PACE supporters are seeking changes that would address this concern and would allow for more flexibility in rural areas particularly.

Accepted and verifiable financial measures have been used to evaluate and assess the efficiency of the PACE program as indicated throughout this RFI. Most tie directly to the cost of providing long term care in various settings and through various approaches. These costs derive primarily from CMS data, DMA data or other respected and accepted health information sources, such as the Kaiser Family Foundation. Many independent studies also have been cited.

PACE is a Medicare program, so it is integrated into the federal system. All PACE programs must receive approval from the Centers for Medicare and Medicaid Services (CMS) before they open and they are monitored on an ongoing basis for the first three years and then at least every two years thereafter. If compliance is an issue, focused audits may take place. The PACE program is a three-way partnership between CMS and the state, so NC DMA staff are also engaged in these evaluations. So in short, PACE books are open to both the state and federal government.

PACE uses accepted and verifiable quality, utilization, customer satisfaction metrics to ensure efficacy and appropriate levels of care and service that is coordinated Medicare and Medicaid.
As stated above, PACE is integrated into the Medicare system. PACE programs are required to participate in the CMS Complaints Tracking Module through the Health Plan Management System which allows citizens to file complaints about PACE programs on line. PACE is required to respond to participant and family suggestions for improving services through a rigorous quality improvement process.

PACE programs also are required to report any serious injuries or deaths occurring at the PACE facility. These are considered "Level II" issues. CMS determines if further investigation is needed (a root cause analysis) based on the report. CMS designs clinical trainings for PACE providers based on these Level II reports.

PACE has utilized standardized CMS data programs in the past, but found them insufficient to illustrate PACE value, program performance, and PACE enrollees. So despite these tie-ins with CMS, there is no standardized assessment instrument for PACE. Our understanding is that CMS is working on a global set of standards that will cover all the dually-eligible programs they administer, to be finished in 18-24 months. The National PACE Association (of which the NC PACE Association and all North Carolina PACE sites are members) is working closely with CMS to develop these common performance measures while continuing to develop a more detailed PACE-specific common data set.

Additionally, the National PACE Association has created its own patient and family satisfaction survey. It is administered face-to-face to randomly selected participants by a trained interviewer. Family members receive mailed surveys. At least half of our current NC PACE sites plan to participate in this survey this year: We may achieve 100% participation.

SUMMARY

PACE has provided care and improved the lives of thousands of our most frail elderly throughout the nation and since 2008, here in North Carolina. We are ready to expand our services to meet the growing need for health care for frail, lower income elderly and disabled adults who present the most complex and costly challenges to the Medicaid system. PACE has demonstrated its effectiveness at keeping people in the community and out of nursing homes, reducing hospitalizations, and saving public money while providing quality outcomes for participants. (Additional studies substantiating that are listed in Addendum 2.)

So, in summary, why PACE?

- PACE addresses the most complex and costly health needs of a rapidly expanding elderly population
- PACE assumes FULL risk for all health care needs for one fixed Medicaid payment
- PACE saves money now and will help hold down future health care costs.
- PACE prevents costly long-term care institutionalization.
- PACE participants have better health outcomes
- PACE participants and their caregivers have a better quality of life.
- PACE saves money

We look forward to working with the state of North Carolina to continue and expand this proven solution.

ADDENDUM 1

PACE Programs in North Carolina

(3/13/2013 update)

Program Name	Service Area	Starting Date	Census
Elderhaus	New Hanover County and portion of Brunswick County (Wilmington)	February 2008	124
Piedmont Health SeniorCare	Alamance, Caswell, Orange, Chatham and portion of Lee Counties (Burlington)	November 2008	129
St. Joseph of the Pines	Cumberland County and portions of Harnett and Hoke Counties (Fayetteville)	April 2011	155
PACE of the Triad	Guilford and Rockingham Counties (Greensboro)	July 2011	94
PACE @ Home	Catawba County and portions of Lincoln, Caldwell and Alexander Counties (Newton)	January 2012	53
Carolina SeniorCare	Rowan, Davidson, Davie and Iredell Counties (Lexington)	October, 2012	37
	TOTALS	**6 programs**	**592**

DEVELOPING PACE PROGRAMS

Program Name	Service Area	Starting Date	Census
PACE of the Southern Piedmont*	Mecklenburg and portion of Cabarrus Counties (Charlotte)	Second Quarter, 2013	N/A
Senior CommUnity Care of North Carolina*	Wake and Durham Counties (Raleigh)	Second Quarter, 2013	N/A
Senior Total Life Care	Gaston County and portions of Cleveland and Lincoln Counties (Gastonia)	Second Quarter, 2013	N/A
Community Care Partners	Buncombe and Henderson Counties (Asheville)	Third Quarter, 2013	N/A
StayWell Senior Care	Randolph County and portions of Montgomery and Moore Counties (Randolph County)	Third Quarter, 2013	N/A

*Awaiting final approval from state

ADDENDUM 2

Additional National Studies Demonstrating Cost Savings and Quality Outcomes from PACE

- PACE costs less than what it would cost to serve a comparable population.
    - A National PACE Association review of Medicaid capitation rates for dually eligible found that on average PACE rates are 14% less than the state's costs of providing alternative services to a comparable population.
      (NPA Analysis of PACE Upper Payment Limits and Capitation Rates, July 6, 2012.)
    - A recently published research study of Medicaid payments to PACE organizations in South Carolina found that PACE organizations cost 28% less than what the state would have otherwise paid to serve a comparable population.
      (Wieland, Darryl, Bruce Kinosian, Eric Stallard and Rebecca Bolan, "Does Medicaid Pay More to Program of All-Inclusive Care for the Elderly (PACE) Than for Fee-for-Service Long-term Care?" The Journals of Gerontology, 5/7/2012.)
    - An analysis by the state of Oklahoma indicated that for every 100 participants served by its PACE program the state saves $103,587 per month, or $1,243,044 per year.
      (Oklahoma Proposal for State Demonstrations to Integrate Care for the Dual Eligibles Individuals)
    - New York's Department of Health noted that while program costs for other long term service and support options averaged a 26.2% increase per recipient between 2003 and 2009, the rate of growth in PACE was 0%. By maintaining its costs per recipient, the PACE program achieved significant savings relative to what the state would have paid for services through other programs.
      (New York State, Department of Health, "Redesigning the Medicaid Program," Presentation January 13, 2011)

- **PACE costs less than what it would cost to serve a comparable population even in another managed care program**
    - In a study comparing PACE to other managed care options available in Tennessee, PACE provides a 17% cost savings relative to the TennCare managed care organization/behavioral health organization nursing facility system. Inpatient hospitalization rates are low, averaging 1140 days per 1000 and a 3.1 day average length of stay; an average of 8% of participants received care in a nursing home.
      (Damons, J. (2001). Program of All-Inclusive Care for the Elderly (PACE) Year 2 Overview. Long Term Care, Bureau of TennCare, Tennessee.)