Program of All-Inclusive Care for the Elderly

&

Statewide Medicaid Managed Care Long-term Care Program

Comparison Report

2014

Rick Scott, Governor

Charles T. Corley, Secretary, Department of Elder Affairs

Elizabeth Dudek, Secretary, Agency for Health Care Administration

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Executive Summary

This report, written at the request of the Florida Legislature, describes the organizational structure, enrollee characteristics and costs of the Program of All-Inclusive Care for the Elderly (PACE) and compares these findings to the Statewide Medicaid Managed Care Long-term Care (SMMC LTC) Program.

Florida's PACE and SMMC LTC share common goals of providing enrollees with needed care in the least restrictive setting and allowing individuals to maintain their independence for as long as possible. The history of PACE and SMMC LTC, each program's organizational and funding structure, and notable differences between the programs are described in the section *Program Description, Structure, and Services Comparison*.

A comparison of the demographic composition of PACE and SMMC LTC enrollees, and those expected to become SMMC LTC enrollees, was conducted and is described in the section *Descriptive Statistics for PACE and SMMC LTC Enrollees*. The analysis showed that many enrollees in both PACE and SMMC LTC have sensory and cognitive impairments, as well as chronic and persistent physical health conditions. Several differences were also identified including SMMC LTC enrollees having more chronic and persistent health conditions compared to PACE enrollees and a higher percentage of SMMC LTC enrollees needing help across all activities of daily living. Additionally, although a portion of both populations have mental health conditions, PACE enrollees are more likely to report severe emotional problems, such as depression, while SMMC LTC enrollees are afflicted with higher rates of cognitive impairments, such as Alzheimer's disease or related dementias.

The rates and cost to serve enrollees in the two programs are discussed in the section *PACE and SMMC LTC Rates and Cost*. The cost to serve PACE enrollees, should they be transitioned to SMMC LTC, is also estimated. Since most PACE enrollees reside in the community, transitioning PACE enrollees to SMMC would result in a reduction in the blended rates in those regions where PACE enrollees reside. The net monthly cost to serve PACE enrollees in SMMC would be approximately $289,000 less each month than the cost to serve the same enrollees in PACE.

The option of integrating eligible enrollees into a combination of SMMC LTC services and SMMC Medicaid Managed Assistance (MMA) acute care is discussed in the section *Alternative Methods for Integrating PACE*, along with the options of maintaining PACE in the areas where it is currently located and expanding PACE into additional areas. Foreseeable barriers are also discussed.

A comparison of service utilization in PACE and SMMC LTC, as required in the General Appropriations Act, could not be conducted for inclusion in this report. PACE utilization data that identifies the specific type and quantities of services provided are not collected by the State. Though SMMC LTC plans are required to submit utilization data, a sufficient amount of SMMC LTC utilization data was not available for analysis at the time this report was written. This

limitation, along with other study limitations and recommendations, is discussed in the section *Study Limitations and Recommendations*.

Introduction

The Florida Department of Elder Affairs (DOEA) and the Agency for Health Care Administration (AHCA) have written the following report at the request of the Florida Legislature in the 2013 General Appropriations Act (Chapter 2013-40, Laws of Florida):

> *"Prior to approval of new Program of All-Inclusive Care for the Elderly (PACE) programs and prior to additional increases in funded slots for existing PACE programs, other than slots funded in Specific Appropriation 424, the Department of Elder Affairs and the Agency for Health Care Administration shall provide a comprehensive report describing the program's organizational structure, scope of services, utilization, and costs; comparing these findings with similar information for managed long-term care implemented pursuant to s. 409.978, Florida Statutes; and evaluating alternative methods for integrating PACE with statewide managed long-term care. The report shall be submitted to the Governor, President of the Senate, and the Speaker of the House of Representatives by January 15, 2014."*

Program Description, Structure, and Services Comparison

Program of All-Inclusive Care for the Elderly

History

As of this writing, the Program of All-Inclusive Care for the Elderly (PACE) is a managed health care model that was formally established through waivers from the Centers for Medicare & Medicaid Services (CMS) in 1990. Based on a service delivery model developed over two decades in Northern California, PACE is now a Medicaid State Plan service providing comprehensive long-term care and acute care services which supports Medicaid and Medicare enrollees who would otherwise qualify for Medicaid nursing facility services.

Medicare and Medicaid enrollees are eligible for PACE if they are 55 years of age or older, meet nursing facility level of care, and reside in a designated service area. PACE requires the availability of all Medicare services and all Medicaid-covered services determined to be medically necessary and covered in the *Medicaid Coverage and Limitations Handbook* and fee schedules. Because the goal of PACE is to maintain enrollees' independence outside the nursing facility, home and community-based services are provided to participants as needed. The PACE organization may also deliver other services determined necessary by the interdisciplinary team to improve and/or maintain the enrollee's overall health status. Additionally, the PACE enrollee must accept the PACE center physician as their new Medicare primary care physician.

Florida Locations

Individuals who choose to enroll in PACE have both their acute and long-term care needs managed through a single provider, known as the PACE organization. Florida is one of 31 participating states, offering four of the 94 PACE organizations nationally. Currently, Florida has active PACE organizations in Lee, Charlotte, Collier, Pinellas, Palm Beach, and Miami-Dade counties. PACE began serving residents of Palm Beach County in November 2013. An additional Miami-Dade site in Westchester is expected to open in the near future. (Note: because information for the Palm Beach County PACE organization was not available at the time this report was written, it is not included in data analyses conducted for this report.)

Organizational Structure

According to the CMS PACE Manual, a PACE organization must be a distinct part of either: a city, county, state, or tribal government; a private not-for-profit entity/501(c)(3) organization; or a for-profit entity that is subject to a demonstration waiver. In Florida, all of the current PACE organizations are not-for-profit entities.

PACE is administered under a three-way agreement between the PACE organization, AHCA, and CMS. This agreement has no end date, and termination must be agreed to by the State and would require coordination with CMS and possible federal approval.

DOEA is the operating entity and therefore oversees the PACE organizations but is not currently party to the agreement as the federal requirements provide the latitude for this addition. DOEA, AHCA, and CMS must approve any application for new PACE agreements, as well as any expansion of current PACE organizations. The operation of more than one provider per ZIP Code is at the discretion of the State.

Federal specifications regarding the PACE organizational structure include the title and role of management and key staff. For example, PACE organizations must be run by a formal governing body. All current Florida PACE organizations are managed by a board of directors. Likewise, each PACE organization must employ, or contract with, a program director who is responsible for oversight and administration of the organization. Each PACE organization must also employ, or contract with, a medical director who is responsible for the delivery of patient care, clinical outcomes, the implementation and oversight of quality assessment, and a performance improvement program. Each PACE organization must keep on record an organizational chart showing officials within the organization, as well as any contractual relationships to other entities.

While relationships with program directors and medical directors may include direct or contracted employment arrangements, a key component of the PACE organization's structure includes the requirement of the PACE organization to directly employ an Interdisciplinary Team (IDT) of professionals on a continuing basis. The IDT is comprised of the medical director, nurses, social workers, occupational and physical therapists, and other paraprofessional caregivers who together conduct a comprehensive assessment of each PACE enrollee. From this assessment, the IDT develops the care plans for enrollees. In this model, PACE directly provides all care and services for its enrollees. This team of caregivers is closely involved in the needs of enrollees and makes care-related decisions.

Another key component of PACE is the requirement that each PACE organization operate a PACE center. The PACE center, a licensed adult day care center, serves the dual purpose of delivering health care services and providing other social support services. Center staffing includes the medical director and the IDT, as well as other professional staff for pharmacy support and medication dispensing and specialized therapists for physical, occupational, and speech therapies.

Also inherent to the organizational structure is the federal requirement for each PACE organization to provide transportation to bring members to the PACE center. Within the infrastructure described, PACE organizations must provide evidence of a health information system to collect, analyze, and report enrollee data.

Before being approved to operate and deliver services, PACE organizations are required to demonstrate the necessary capital to directly provide PACE center services that include a combined adult day center and primary care clinic, transportation, and a full range of clinical and support staff (including the IDT). In addition, operating and reserve requirements as a risk-bearing entity are required. The PACE capital requirements must meet all standards set by

CMS, AHCA, and DOEA, and are then submitted to CMS for review and approval through an application process.

As part of a continuous improvement process, each PACE organization is responsible for identifying areas in which to improve service delivery and patient care as well as developing and implementing plans of action to improve or maintain quality of care. Such activities are documented and disseminated in the PACE organization's Quality Assessment and Performance Improvement (QAPI) plan. The QAPI plan must demonstrate improved performance in regard to five areas: utilization of services, participant and caregiver satisfaction, effectiveness and safety of staff-provided and contracted services, and non-clinical areas, including grievances and appeals. Prior to its inclusion in the PACE agreement, CMS, AHCA, and DOEA approve the QAPI plan and also review how the organization has implemented the plan during subsequent monitoring visits.

Funding

Perhaps the most unique and progressive structural component of PACE is the provision for PACE organizations to receive both Medicare and Medicaid capitated payments[1] in exchange for the responsibility for offering the full continuum of acute and long-term care services, including nursing facility care when needed. The capitation payment PACE receives from CMS covers Medicare acute care and prescription drug (Part D) services. The capitation payment PACE receives from the State covers Medicaid services. Medicare enrollees who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount, but are not responsible for deductibles, coinsurance, or any other type of Medicare or Medicaid cost-sharing.

Statewide Medicaid Managed Care Long-term Care Program

History

AHCA is in the process of implementing a new system through which Medicaid enrollees will receive long-term care services, called the Statewide Medicaid Managed Care Long-term Care (SMMC LTC) and often referred to as the "LTC program." Although commonly known as the LTC program, this report refers to Statewide Medicaid Managed Long-term Care as "SMMC LTC" so that it is not mistaken for PACE, which is also a LTC program. The SMMC LTC program is a managed health care model that was created by the 2011 Florida Legislature and formally established through a waiver from CMS. It is predicated on over twenty-five years' experience in the State of Florida delivering home and community-based waiver services and over a decade of experience delivering long-term care through a managed care model.

[1] Capitated payments are a flat-rate per person per month payment determined annually based on the estimated cost of serving enrollees, as opposed to the fee-for-service model previously used under many Medicaid programs. Separate capitation rates are provided for individuals dually eligible for Medicaid and Medicare and for individuals who are eligible for only Medicaid.

SMMC LTC is a managed care waiver program providing comprehensive long-term care services and supports to Medicaid-only eligible and dual eligible (Medicaid and Medicare eligible) recipients who qualify for Medicaid nursing facility level of care.

Medicaid recipients are eligible for SMMC LTC if they are 18 years of age or older and meet nursing facility level of care. Additionally, individuals age 18-64 must have a designation of a disability from the Social Security Administration (SSA). SMMC LTC requires the coordination of Medicare services, the delivery of Medicaid long-term care services covered by the waiver, and the coordination of other Medicaid State Plan services, as needed and as determined to be medically necessary and covered in the *Medicaid Coverage and Limitations Handbook* and fee schedules. The managed care plan may also deliver other services determined necessary by the case manager to improve and/or maintain the enrollee's overall health status. The SMMC LTC program does not have any impact on an enrollee's Medicare. The enrollee may select their Medicare physician as determined by their Medicare plan choice.

Depending on their current Medicaid waiver program, age, and/or health status, recipients who wish to continue to receive Medicaid services will be required to do so in the new SMMC LTC program. Recipients currently enrolled in the following five programs who want to continue receiving Medicaid services will be required to participate in SMMC LTC: the Aged and Disabled Adult Waiver (ADA), including those enrolled in the Consumer-Directed Care Plus option, the Nursing Home Diversion Waiver (NHD), the Assisted Living Waiver (AL), the Channeling Waiver, and those enrolled in the Frail Elder Option. Recipients of Medicaid-funded nursing facility services are also required to enroll in the SMMC LTC program.

Recipients who are enrolled in the following seven programs are not required to enroll in SMMC LTC in order to continue receiving Medicaid services, but may choose to enroll if they meet the criteria for the SMMC LTC program: Program of All-Inclusive Care for the Elderly (PACE), Developmental Disabilities Individual Budgeting Waiver, Traumatic Brain Injury and Spinal Cord Injury Waiver, Project AIDS Care Waiver, Adult Cystic Fibrosis Waiver, Familial Dysautonomia Waiver, and Model Waiver. PACE and community-based waiver recipients interested in voluntarily enrolling in SMMC LTC will be placed on a waitlist, though recipients may continue to receive waiver services while waiting to be enrolled. The frailest waitlisted individuals are given priority for SMMC LTC services when funding becomes available.

Florida Locations

SMMC LTC is a statewide program with seven managed long-term care (LTC) plan choices throughout the state. SMMC LTC is comprised of two types of LTC plans that were selected through a competitive Invitation to Negotiate (ITN) procurement process. The first type of LTC plan is a Health Maintenance Organization (HMO), and the second type is a Provider Service Network (PSN). HMOs are paid a capitated monthly rate, and PSNs may use either a capitated rate or fee-for-service plans.[2] The number of long-term care plans available in each region of the

[2] The fee-for-service PSN option will only be available to PSNs for the first two years of the program, then these providers will have to transition to a capitated model.

state varies, but a minimum of two plans is required for each area. These organizations coordinate and deliver long-term care services and supports using a managed care model, wherein the LTC plan is responsible for providing all services needed by the enrollee, including nursing facility care when necessary. The state is divided into 11 geographical regions, referred to as Planning and Service Areas (PSAs) for most DOEA-administered programs, including PACE. SMMC LTC refers to these same geographic areas as "regions." SMMC LTC is being implemented in each region on a predefined schedule,[3] which began on August 1, 2013, and will be fully implemented by March 1, 2014. For detailed reference maps that provide the location of PACE organizations and enrollees in Florida, refer to Exhibits 3-6 in this section under the subsection titled "PACE Participation Areas."

Organizational Structure

SMMC LTC plans signed five-year contracts with AHCA based on a competitive procurement process that considered competition for Medicaid managed care contracts based on value, price, provider networks, accreditation, community partnerships, additional benefits, and performance history. Competition is expected to drive the capitation rates down and encourage innovation in plan design. Specific factors were identified in legislation for AHCA to use in selecting bidders to participate in negotiations, including accreditation and experience, for example:

- Plans must be accredited by a nationally recognized accrediting body or seek accreditation by such a body within one year of plan operation,
- Plans must provide quality data measures on their websites to allow recipients to compare plans,
- Performance must continuously improve based on specific standards that are raised over the term of the contract, and
- Active systems must be used to reduce the incidence of fraud and abuse.

PACE organizations were eligible to bid to become LTC program plans, but no PACE organizations elected to bid. PACE is not subject to the SMMC LTC program procurement process.

Financial requirements

SMMC LTC plans are required to maintain, at all times, a surplus amount equal to the greater of $1.5 million, ten percent of total liabilities, or two percent of the annualized amount of the LTC plan's prepaid revenues. Plans must also furnish to the State a blanket fidelity bond on personnel in its employment and a performance bond in the amount of $1,000,000 per region in which the plan operates (i.e., if the plan is awarded a contract in two regions, it must submit one bond for $2,000,000.00). Each LTC plan must establish a restricted insolvency protection account with

[3] SMMC LTC implementation schedule is as follows: Region 7 in August 2013, Regions 8 & 9 in September 2013, Regions 2 & 10 in November 2013, Region 11 in December 2013, Regions 5 & 6 in February 2014, and Regions 1, 3, & 4 in March 2014.

five percent of the capitation payments made by AHCA each month until a maximum total of two percent of the annualized total current contract amount is reached and maintained.

Additionally, the reduced utilization of nursing facility services is encouraged through successive payment rate adjustments as outlined in Section 409.983, Florida Statutes. Financial penalties will be imposed and contracts will be terminated for reducing enrollment or withdrawing prior to the end of a contract term. Financial penalties will also be imposed for plans that fail to comply with encounter data reporting requirements.

The achieved savings rebates prescribed in Florida Statutes are applicable to risk-bearing SMMC LTC plans and are intended to assure that plans that produce significant program savings share those savings with the State. Plans may retain a reasonable profit of up to seven-and-a-half percent. Plans can earn an additional one percent profit if exceptional performance is demonstrated. Plans will be required to perform and submit detailed audits to verify the achieved savings rebates.

The criteria established in Chapter 409, Florida Statutes, requires AHCA to consider the following factors in the selection of eligible LTC plans:

- Evidence of the employment of executive managers with expertise and experience in serving aged and persons with disabilities who require long-term care;
- Whether a plan had an established network of service providers dispersed throughout the region and in sufficient numbers to meet specific service standards established by AHCA for specialty services for persons receiving home and community-based care;
- Whether a plan proposed to establish a comprehensive long-term care plan and whether the eligible plan has a contract to provide managed medical assistance services in the same region;
- Whether a plan offered participant-directed care services to enrollees pursuant to Section 409.221, Florida Statutes; and
- Whether a plan proposed to provide home and community-based services in addition to the minimum benefits required by Section 409.98, Florida Statutes.

According to the SMMC LTC five-year contracts between AHCA and the LTC plans, the governing body of each LTC plan must set policy and has overall responsibility for the organization of the plan. LTC plans must have a centralized executive administration and ensure adequate staffing and an information systems capability to meet the requirements of the contract. The LTC plan must, at a minimum, have the following staff positions:

- A contract manager who works directly with AHCA who has the authority to administer the day-to-day business activities of the contract;
- Medical and professional support staff, including enrollment staff available during business hours, and sufficient medical staff available 24 hours a day, seven days a week, to handle emergency services and care inquiries;

- A medical director who must be a physician with experience in providing services to the frail elder and adults with disabilities populations and who oversees and is responsible for the provision of covered services to enrollees, the quality management program, and the grievance system;
- A medical/case records review coordinator, qualified by training and experience, who ensures compliance with the medical/case records requirements of LTC plans;
- A data processing and data reporting coordinator who is trained and experienced in data processing, reporting, and claims resolution to ensure that computer system reports provided to AHCA are accurate and that computer systems operate in an accurate and timely manner;
- A community outreach oversight coordinator (required if the LTC plan does community outreach), qualified by training and experience, who ensures the LTC plan adheres to the community outreach and marketing requirements of the contract;
- A Quality Improvement (QI) professional who is qualified by training and experience in QI and who holds the appropriate clinical certification and/or license;
- A Utilization Management (UM) professional who is qualified by training and experience in UM and who holds the appropriate clinical certification and/or license;
- A grievance system coordinator to process and resolve complaints, grievances, and appeals and who is responsible for the grievance system;
- A compliance officer, qualified by training and experience in health care or risk management, to oversee the compliance program, who is also qualified to oversee the plan's fraud and abuse program;
- Care coordination/case management staff who is qualified by training, experience, and certification/licensure to conduct the LTC plan's care coordination/case management functions;
- A claims/encounter manager, qualified by training and experience, who oversees claims and encounter submittal and processing, where applicable, and ensures the accuracy, timeliness, and completeness of processing payments and reports; and
- A fraud investigative unit (also known as special investigative unit) manager, a designated person qualified by training and experience who oversees the special investigative unit for the investigation of possible fraud, abuse, and overpayment, and ensures mandatory reporting as required by the contract and state and federal law.

Additionally, each LTC plan must monitor the quality and performance of each participating provider using measures adopted and collected by AHCA and any additional measures mutually agreed upon by the provider and the plan.

Each SMMC LTC plan must comply with the specific standards that AHCA has established for the number, type, and regional distribution of providers in the plan's network, which must include:

- Adult day care centers,
- Adult family-care homes,
- Assisted living facilities,
- Community Care for the Elderly lead agencies,
- Health care services pools,
- Home health agencies,
- Homemaker and companion services providers,
- Hospices,
- Nurse registries, and
- Nursing facilities.

Funding

The capitation payment SMMC LTC plans receive from the State covers Medicaid long-term care services only and long-term care copayments and deductibles. Capitated plans must cover copayments and cost sharing for all covered services, including expanded benefits. PSNs may offer to waive copayments or cost sharing as an expanded benefit. Medicare is coordinated through SMMC LTC by payment through a separate Medicare plan which covers medical and acute care. SMMC LTC organizations are responsible for the Medicare deductibles, coinsurance, and any other type of Medicare or Medicaid cost sharing for LTC services.

Comparison of PACE and SMMC LTC

Florida's PACE and SMMC LTC programs share common goals of providing enrollees with needed care in the least restrictive setting and allowing individuals to maintain their independence for as long as possible. This is accomplished by providing less-costly home and community-based services in a comprehensive and coordinated model as an alternative to nursing facility care.

PACE and SMMC LTC both have strict requirements for the organizational structure and governing bodies, and both are required to meet financial solvency and/or significant capital investment requirements. Additionally, PACE and SMMC LTC both use a risk model, which allows providers to deliver services based on enrollees' needs. Services are not limited to those that are reimbursable under the Medicaid State Plan, as is the case with non-risk models. The two programs offer all of the same services with the exception of the Participant Direction Option (PDO), which is not offered in PACE. In both SMMC LTC and PACE, all enrollees must have access to a federally prescribed grievance and appeals process.

There are some notable differences between the programs. In particular:

- As of March 2014, SMMC LTC will be operating statewide. PACE is only operating in six counties, namely: Lee, Charlotte, Collier, Pinellas, Palm Beach, and Miami-Dade.

- Unlike SMMC LTC, PACE organizations are not competitively procured. Instead, PACE organizations must go through an application and review process at both the state and federal levels.

- Every PACE center must be specifically authorized by the Florida Legislature, and any approved enrollment slots must be funded through the legislative budget process.

- PACE fully integrates Medicaid and Medicare service delivery by providing all Medicare and Medicaid services, whereas SMMC LTC provides Medicaid long-term care services and coordinates the Medicare and Medicaid State Plan services.

- PACE covers many of the services in an adult day care setting. The PACE organization must operate an approved physical center that serves as both a health care facility and a center for other social support services. Centers typically provide congregate meals, adult day care services, a dispensing pharmacy, speech and physical therapy, socialization activities, and other services. The center itself represents a significant capital investment not typically required in other managed care models.

- Each PACE organization must employ medical and professional staff and follow a specific Interdisciplinary Team (IDT) approach to developing care plans, thereby delivering an array of acute care and long-term care services and monitoring the health and emotional status of its enrollees, rather than subcontracting for those services. However, in order to participate in the coordinated care offered by PACE, enrollees must accept the PACE center physician as their Medicare primary care physician. In SMMC LTC, a medical team may be available, but the consultations and team approach may be less concentrated than in PACE. Instead of an IDT, an individual case manager is the lead coordinator and driver of care delivery in the SMMC LTC model. Case managers use a person-centered approach regarding the enrollee assessment and needs, taking into account not only long-term care services but also medical and other needed services and community resources. In each area of the state, recipients will have a choice of SMMC LTC plans that provide both long-term and medical/acute care services. Many of these plans also have a Medicare line of business, so there will be opportunities for enrollees to have fully integrated care through SMMC.

- There is a primary service provided under SMMC LTC that is not offered in PACE, called PDO. Enrollees authorized to participate in the PDO may hire any individual of their choosing to provide a limited set of services and may choose a representative to assist with the PDO responsibilities. The PDO allows enrollees to hire, train, supervise, and dismiss their direct service worker(s), including family members. This option is intended to provide these enrollees with greater independence and personal choice. Enrollees who live in their own home or family home and who have any of the following services in their authorized

care plan are eligible for the PDO: adult companion care, attendant care, homemaker services, intermittent and skilled nursing, or personal care.

- Most PACE organizations operate their own transportation system to ensure that their enrollees are provided with safe and appropriate door-to-door transportation to and from the PACE center as well as to their medical appointments.

- Data reporting requirements vary within the two programs. SMMC LTC plans must meet stringent State reporting requirements, including the submission of performance measures and encounter data directly to the State. SMMC LTC currently has more quality metrics in place that may be managed by the State. In addition, SMMC LTC plans must have systems in place that reduce the incidence of fraud and abuse.

- While CMS, AHCA, and DOEA review PACE organizations' financial pro forma statements during the PACE application process, the pro forma statements are not formally considered when the Legislature determines PACE appropriations.

Exhibit 1 below details the services that are required to be offered by PACE organizations and SMMC LTC plans under each program's current contracts in a side-by-side comparison. Services highlighted in gray are not offered, and italicized items are services that may be available to some enrollees under the Medicaid State Plan and will also be available under the SMMC Medicaid Managed Assistance (MMA) Program for those who qualify. Medicaid State Plan services are delivered through a fee-for-service or managed medical care system and are not included in the SMMC LTC capitated rates.

Exhibit 1: PACE and SMMC LTC Program Scope of Services Comparison

Services	PACE	SMMC LTC
Adult companion care	Yes	Yes
Adult day health care	Yes	Yes
Assisted living	Yes	Yes
Assistive care services	Yes	Yes
Attendant care	Yes	Yes
Behavioral management	Yes	Yes
Assessment and case management	Multidisciplinary team form assessment and treatment planning	Care coordination/Case management
Caregiver training	Yes	Yes
Medical equipment and supplies	Yes	Yes
Home accessibility adaptation	Yes	Yes
Homemaker	Yes	Yes
Hospice	Yes	Yes
Intermittent (in-home) nursing	Yes	Yes
Skilled (in-home) nursing	Yes	Yes
Home health services	Yes	Yes

Exhibit 1: PACE and SMMC LTC Program Scope of Services Comparison, *Continued*

Services	PACE	SMMC LTC
Hospital	Yes	Available under State Plan Subject to *Medicaid Coverage and Limitations Handbook*
Laboratory services	Laboratory tests, x-rays, and other prescribed diagnostic procedures (includes anything prescribed as medically necessary by the team)	Available under State Plan Subject to *Medicaid Coverage and Limitations Handbook*
Nutritional assessment/risk reduction (counseling)	Yes	Yes
Meals	Home-delivered meals and meals provided in congregate settings	Home-delivered meals only
Medical care	Medical care provided by a PACE physician	Available under State Plan Subject to *Medicaid Coverage and Limitations Handbook*
Medical specialists	Medical specialists (e.g., audiology, dentistry, optometry, podiatry, and speech therapy) coordinated through Medicare, subject to *Medicaid Coverage and Limitations Handbook*	Medical specialists (e.g., audiology, dentistry, optometry, and podiatry) available under State Plan, subject to *Medicaid Coverage and Limitations Handbook*
Medication administration	Yes	Yes
Medication management	Yes	Yes
Nursing facility care	Yes	Yes
Participant Direction Option (PDO)	Not available	Yes
Personal care	Yes	Yes
Personal Emergency Response System (PERS)	Yes	Yes
Prescription drugs	Yes	Available under State Plan Subject to *Medicaid Coverage and Limitations Handbook*
Respite	Yes	Yes
Social services	Yes	Yes
Therapies (Occupational, physical, respiratory, speech, and other prescribed therapies)	Yes	Yes
Transportation	Yes, and additionally to the adult day care center	Yes to/from SMMC LTC program services; transportation to other Medicaid services available under State plan subject to *Medicaid Coverage and Limitations Handbooks*
Other services	Yes	Yes

Exhibit 2 below details the features of PACE and SMMC LTC in a side-by-side comparison, with enhancements, exceptions, and options noted.

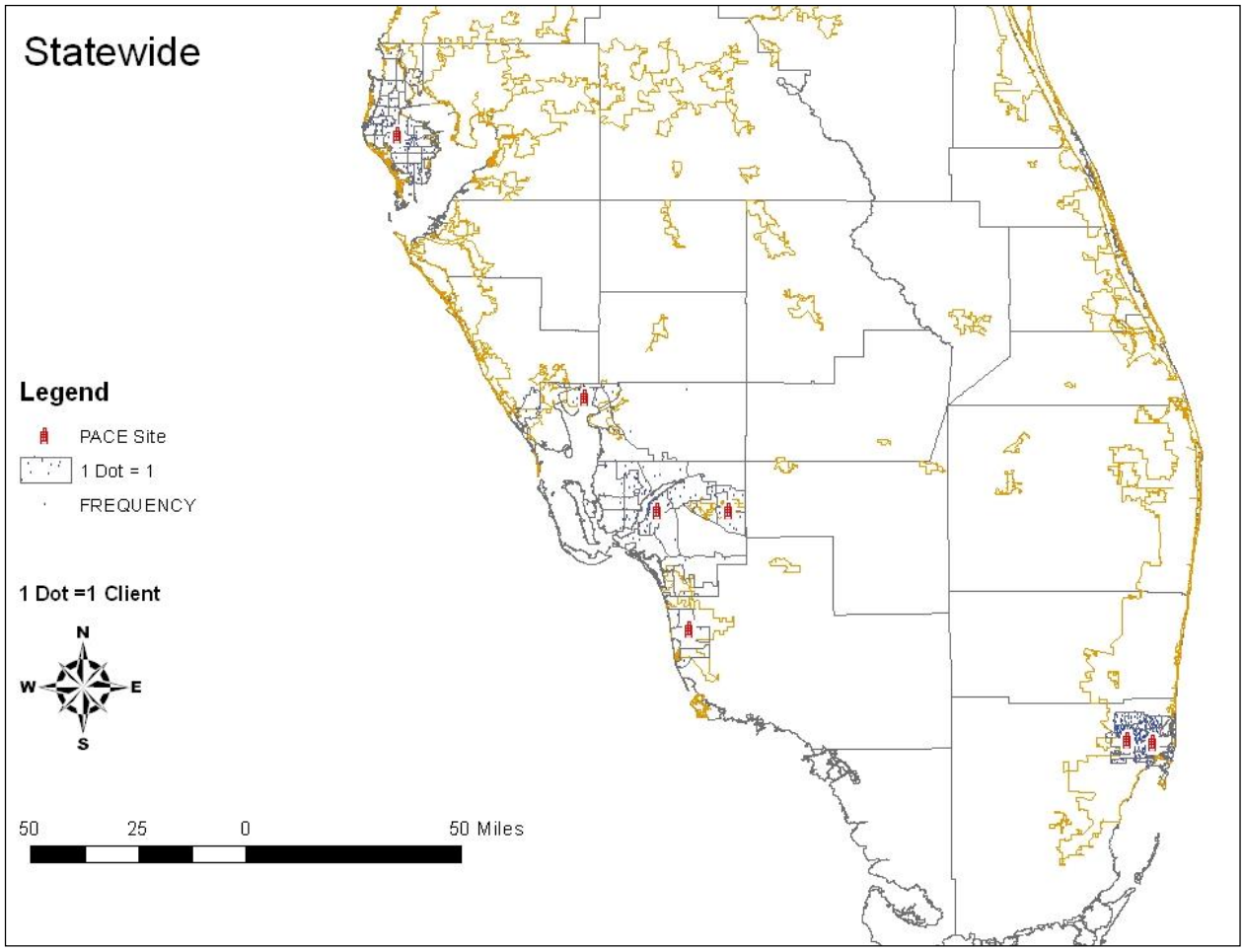
Exhibit 2: PACE and SMMC LTC Program Features Comparison

Program Feature	PACE	SMMC LTC
Program goal to provide home and community-based services whenever possible	Yes	Yes
Coordinated long-term care across different health care settings	Yes	Yes
Financial penalties for termination	No	Yes
Authority to provide other services determined necessary	Yes	Yes
Process for selection of providers	Application	Competitive bid
Specific contract requirements with the State	No	Yes
Statewide	No, part of 6 counties	Yes
Prescribed staffing requirements	Yes	Yes
Organizational and governing body prescribed	Yes	Yes
Financial solvency deposits and bonds under the authority of the State	No	Yes
Capital infrastructure investment for a medical center	Yes	No
Medical Director	Yes	Yes
Interdisciplinary Team	Required	Discretion of SMMC LTC plan
Choice of Medicare physicians	No	Yes
All medical and LTC services provided by one organization	Yes	No
Coordinated care	Yes	Yes
Integrated payments for all LTC and medical care	Yes	No
Medicaid encounter data submitted	No	Yes
Quality data submitted to the State	No	Yes
Audited financial statements required by the State	No	Yes
Actuarially derived rates	Yes	Yes (certified)
Mandated cost savings to the State	No	Yes
Achieved savings rebate to the State	No	Yes
Central location for medical care	Yes	No
Federally prescribed fair hearing, grievance, and appeals processes	Yes	Yes
Additional State-prescribed complaint, grievance, and appeals processes	No	Yes
Enrollment	Voluntary	Mandatory
Ages	55+	18+

PACE Participation Areas

Exhibits 3 through 6 are maps of the locations of the current PACE organizations and enrollees in Florida. The locations of the PACE organizations are shown as red symbols, while the locations of enrollees' homes are the smaller dots in blue. As you can see, PACE is not a statewide program. PACE enrollees reside in PSA 5 (Pinellas County), PSA 8 (Charlotte, Lee and Collier counties), and PSA 11 (Miami-Dade County), all of which have a high concentration of elders.

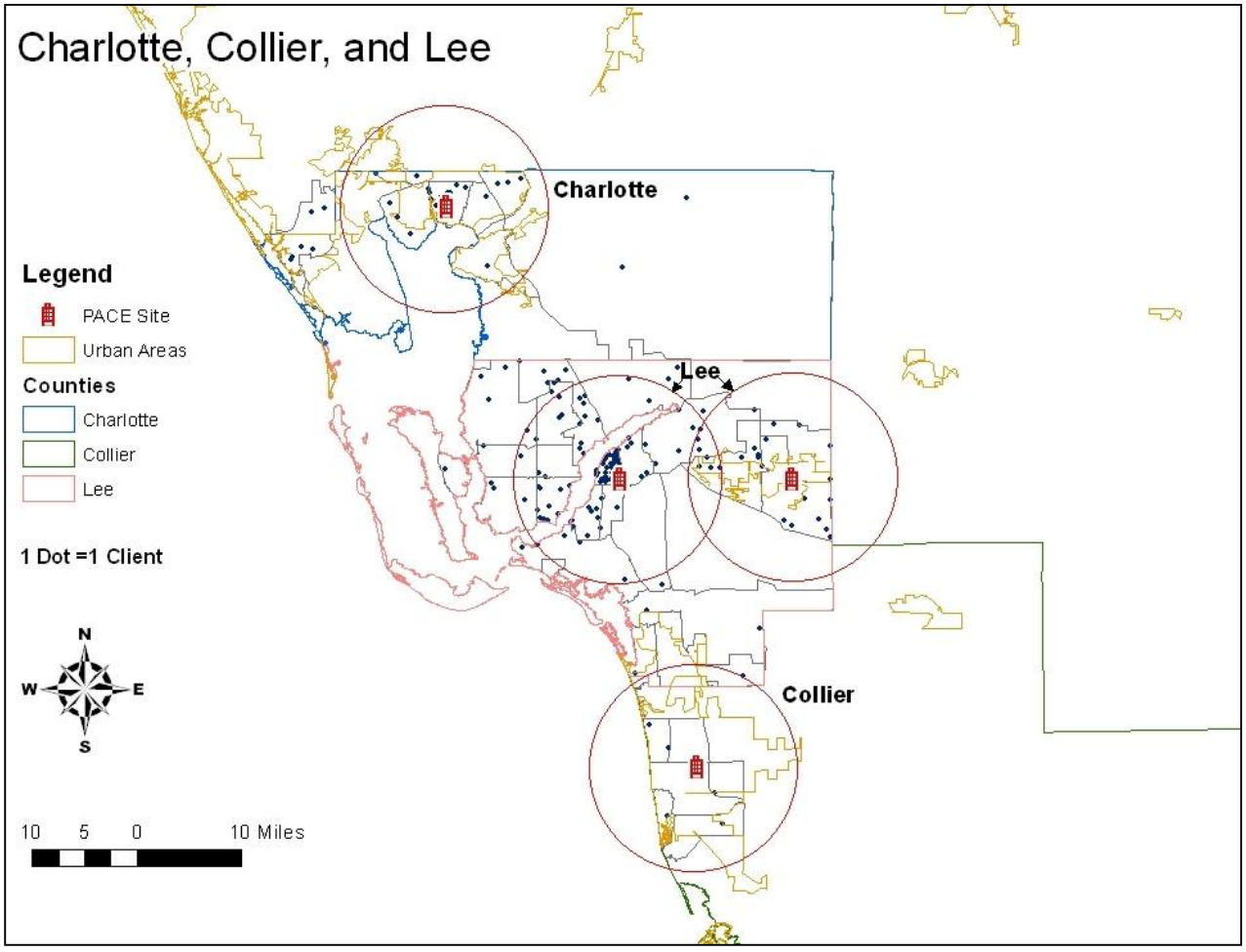
Exhibit 3: State Map of PACE Clients and Provider Locations in PSAs 5, 8, and 11



Source: FMMIS, October 2013 (n=724)

As shown in Exhibit 4 below, the four PACE organizations in PSA 8 each serve enrollees within approximately 10 miles of the PACE adult day care centers. This allows transport of enrollees to and from the PACE centers and ensures that the provider remains in compliance with federal guidance regarding length of time for transport. Geographic proximity to the facility is an essential feature for many PACE participants because many of these enrollees are sick, frail, and disabled, and more lengthy transport times can be a possible barrier to participating in adult day care and the other regular activities out of the home that PACE provides.

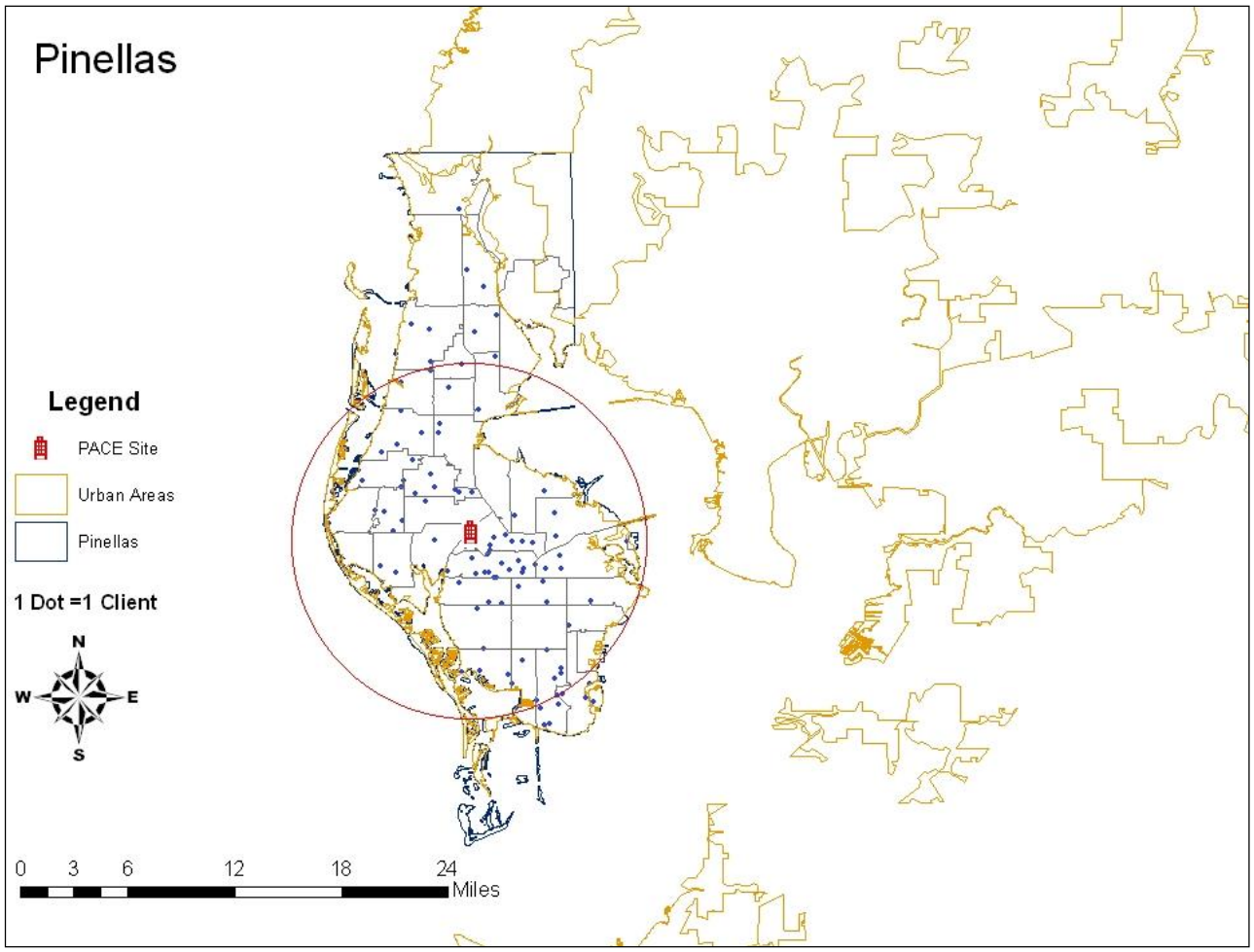
Exhibit 4: Location of PACE Clients in Charlotte, Lee, and Collier Counties (PSA 8)



Source: FMMIS, October 2013 (n=724)

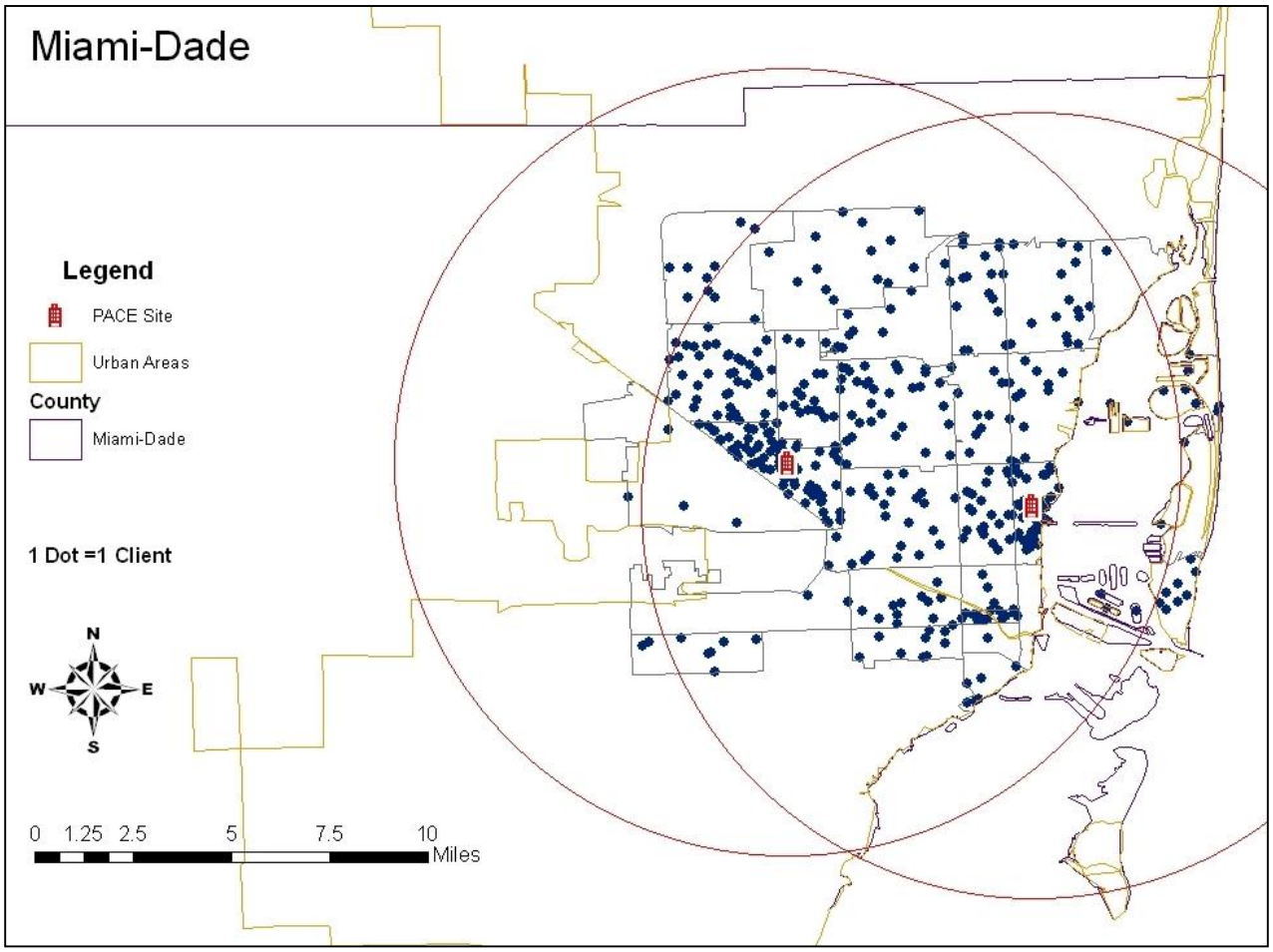
Charlotte, Lee, and Pinellas counties, shown in Exhibits 4 and 5, have lower traffic volume and expected lower transit times. Therefore, it is more feasible to serve enrollees who live further away from a PACE Center. Conversely, in areas with very high traffic volume and higher transit times, as is the case in Miami-Dade County (see Exhibit 6 below), the PACE organizations tend to focus their services on enrollees who live in tight vicinity clusters around the centers.

Exhibit 5: Location of PACE Clients in Pinellas County (PSA 5)



Source: FMMIS, October 2013 (n=724)

Exhibit 6: Location of PACE Clients in Miami-Dade County (PSA 11)



Source: FMMIS, October 2013 (n=724)

Descriptive Statistics for PACE and SMMC LTC Enrollees

Using the data from the most recent comprehensive assessments[4], the demographic composition of PACE enrollees and SMMC LTC enrollees age 60 and older, including those expected to become SMMC LTC enrollees,[5] were contrasted.[6,7] Characteristics, such as age, race, and ethnicity, were contrasted as they are often predictors of enrollee health and function. Also contrasted in this section are the health and functional impairments of the enrollees in the two programs.

The analysis showed that many enrollees in both PACE and SMMC LTC have sensory and cognitive impairments, as well as chronic and persistent physical health conditions. Although a portion of both populations are afflicted with mental health conditions, PACE enrollees are more likely to report severe emotional problems, such as depression while SMMC LTC enrollees are afflicted with higher rates of cognitive impairments, such as dementia. Additionally, SMMC LTC enrollees age 60 and older are physically frailer than PACE enrollees.

A supplemental analysis comparing the health status of PACE enrollees who had available assessments before and after receiving PACE services was also conducted. A similar analysis of SMMC LTC enrollees could not be completed because SMMC LTC enrollees have not been enrolled for a sufficient amount of time for program effects to have yet emerged. For additional details about the methodology and results from these analyses, please refer to Appendix A.

Demographic Profile

The typical PACE participant is a white, English-speaking female who is approximately 76 years of age. Overall, males represent 38.1% of active PACE enrollees, and females represent 61.9%. The youngest age cohort is the only group where males outnumber females. Of PACE's younger enrollees, ages 55 to 64, males comprise 60.4%. This younger cohort of 55 to 64 year-olds

[4] All program enrollees who receive case management are assessed annually with the DOEA 701B Comprehensive Assessment. This assessment collects information on a range of subjects such as health conditions, medications, and functional limitations, which is used primarily to support Comprehensive Assessment and Review for Long-Term Care Services (CARES) staff in making the level of care determination and to assist case managers in identifying changes in enrollee needs and resources for care planning. The assessment results in DOEA having individual-level data that is collected on at least an annual basis, and is available for various types of analysis and comparison.

[5] Enrollees in the following Medicaid programs are included in the SMMC LTC population examined: SMMC LTC (24.0%), Nursing Home Diversion (46.5%), Aged and Disabled Adult Waiver, including Consumer-Directed Care Plus (21.7%), Assisted Living Waiver (6.6%), and Channeling Waiver (1.2%).

[6] Initial assessments for PACE and Nursing Home Diversion (NHD) enrollees are conducted by CARES. Subsequent assessments are conducted by the managed care plans. Aged and Disabled Adult (ADA) and Assisted Living (AL) recipient assessments are conducted by case managers that contract with the Aging and Disability Resource Centers.

[7] Because the overwhelming majority of PACE enrollees are served in the community as opposed to an institution, only SMMC LTC enrollees being served in the community at the time of their most recent assessment are examined. Additionally, only SMMC LTC and soon to be SMMC LTC enrollees age 60 and over are included in this analysis; DOEA did not have assessment data for enrollees under 60 years of age. Eligibility for NHD begins at age 65; eligibility for AL and other Medicaid waivers that target elderly populations begin at age 60.

represents a large portion of PACE enrollees, comprising over one-fourth (26.2%) of active enrollees.

As illustrated in Exhibit 7 below, the average age of PACE enrollees is 75.5 years, and the age range spans from 55 to 104 years. The average age of SMMC LTC enrollees included in this study is 81.1 years, approximately 5.6 years older than the average age of PACE enrollees. For more details on the demographic composition of PACE and SMMC LTC enrollees, refer to Appendix B, Exhibit A.

Exhibit 7: Age Distribution of Current PACE and SMMC LTC Enrollees

Age Categories	Percent of PACE Enrollees (n=625)	Percent of SMMC LTC Enrollees (n=26,533)
55-64	26.2	4.2*
65-74	23.0	23.7
75-84	24.8	37.8
85-99	25.0	33.3
100+	1.0	0.9
Average Age	*75.5 years*	*81.1 years*

Source: DOEA, CIRTS, 2013

**Includes only SMMC LTC enrollees age 60 and older*

The average length of PACE enrollment for the current active enrollees is 2.3 years, with a minimum of 3.4 months and a maximum of 9.7 years. Enrollees began enrolling in PACE in February 2003. The average length of enrollment for all PACE enrollees, both active and inactive, is 1.9 years, with a minimum of 27 days and a maximum of 10.3 years. Additionally, approximately three-fourths of enrollees ever enrolled in PACE have either remained in the program and are still enrolled or remained in PACE until their death. Of the 565 PACE enrollees who disenrolled before December 31, 2012, 6.4% (36 enrollees) entered a nursing facility within 90 days of disenrollment, and had at least 30 days of their care paid with Medicaid State Plan funds (36 enrollees represent 2.4% of all enrollees, not just those that disenrolled). Approximately seven percent of the individuals that disenrolled from PACE entered a nursing facility within six months of disenrollment (see Exhibit 8 below).

Enrollees who disenrolled from PACE and entered a nursing facility under the Institutional Care Program cost the State approximately $5,100 a month (the average cost during State Fiscal Year 2012-2013).

Exhibit 8: Enrollees Who Disenrolled From PACE and Subsequently Entered a Nursing Facility (NF) under Medicaid State Plan

	Number of Enrollees	Percent of Disenrolled Enrollees Who Went into NF	Percent of All PACE Enrollees Who Went Into NF
Went Into a Nursing Facility Within 90 Days of Disenrollment			
Disenrolled and went into a nursing facility for more than 30 days within 90 days of disenrollment	36	6.4%	2.4%
Disenrolled and went into a nursing facility for more than 60 days within 90 days of disenrollment	33	5.8%	2.2%
Went Into a Nursing Facility Within 6 Months of Disenrollment			
Disenrolled from PACE and went into a nursing facility for more than 30 days within 6 months of disenrollment	41	7.3%	2.8%
Disenrolled from PACE and went into a nursing facility for more than 60 days within 6 months of disenrollment	41	7.3%	2.8%

Source: Florida Medicaid, paid claims data from FMMIS, October 2013

Notes: 1,477 PACE enrollees were included in this analysis. Length of nursing facility stay does not include the initial stay paid by Medicare.

Living Arrangement

The goal of both PACE and SMMC LTC is to enable individuals who meet the nursing facility level of care criteria to live safely in their homes and communities by putting services in place to help avoid or delay the use of skilled nursing facilities. PACE has very few enrollees permanently residing in a nursing facility (1.4%), while approximately 42.0% of SMMC LTC enrollees are expected to reside in the nursing facility. This is because Medicaid-funded nursing facility residents must enroll in SMMC LTC, but a resident of a nursing facility cannot choose to enroll in PACE. Since the primary difference between PACE and SMMC LTC enrollees is in the rate of nursing facility use, this section of the report will focus only on details about the community-dwelling portion of SMMC LTC enrollees to provide for a more appropriate contrast with PACE.

Exhibit 9: Living Arrangements and Living Situation of PACE and SMMC LTC Enrollees

Arrangement	Percent of PACE Enrollees (n=625)	Percent of SMMC LTC HCBS Enrollees (n=26,533)
Living Arrangement		
Private Residence	53.6	50.6
Assisted Living Facility	42.6	48.4
Nursing Facility	1.4	*
Adult Family Care Home	1.1	0.2
Other	1.3	0.8
Living Situation		
Living Alone	67.4	66.2
Living With Caregiver	24.0	25.7
Living With Other	8.6	8.2
Primary Caregiver		
Yes, client has a primary caregiver**	26.1	30.1
Marital Status		
Married	13.4	16.1
Single	25.6	12.2
Separated	3.8	2.8
Widowed	35.4	50.7
Divorced	18.7	17.8
Partnered	0.3	0.1
Other or Unknown	2.7	0.4

Source: DOEA, CIRTS, September 2013

**SMMC LTC enrollees residing in a nursing facility at the time of their most recent assessment are not included in this descriptive analysis and are not represented in the total sample (n=26,533).*

***Enrollees with a caregiver may or may not live in the same residence as their primary caregiver. 9,378 assessments did not have information for Living Arrangement and Living Situation (n=17,155).*

As shown in Exhibit 9 above, the majority of current active PACE enrollees live alone (67.4%) in either a private residence (53.6%) or an assisted living facility (42.6%). Regardless of location, it is clear that the PACE organization enables enrollees to live independently as only 13.7% of the enrolled PACE enrollees are married or partnered and only approximately one quarter (26.1%) have a primary caregiver to provide for their Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) needs. Among SMMC LTC enrollees who live in the community, based on the most recent assessment, 48.4% live in an assisted living facility and approximately half live in a private residence (50.6%). Like PACE, many current SMMC LTC enrollees live alone (66.2%), over a quarter have a caregiver (30.1%), and 16.2% are married or partnered.[8]

Mental Health Conditions

It is common for enrollees in PACE to exhibit behavior that indicates a need for supervision (70.1%) due to problems with thinking, memory, or judgment. During the most recent assessment of active PACE enrollees, behavioral problems were present for 43.8% of PACE enrollees and other cognitive problems present in over half of the PACE enrollees (53.6%). Additionally, 40.8% of current PACE enrollees had a formal diagnosis of dementia, and 41.4% demonstrated significant memory problems.

Compared to PACE, SMMC LTC has slightly fewer enrollees with one or more mental health conditions. As illustrated in Exhibit 10 below, 80.0% of PACE enrollees and 73.3% of SMMC LTC enrollees had at least one type of cognitive impairment, behavioral issue, or emotional condition. Although at slightly lower rates, like PACE, many SMMC LTC enrollees exhibit behavior that indicates a need for supervision (65.4%), have cognitive problems (57.3%), and have behavioral problems (40.7%). The two programs differ in the type of mental health conditions that generally afflict their populations. While SMMC LTC enrollees have a slightly higher proportion of enrollees with a formal diagnosis of dementia (50.3% compared to 40.8%) and memory problems (50.0% compared to 41.4%), PACE enrollees exhibit higher rates of severe emotional problems and, in particular, depression. At the time of enrollees' most recent assessment, a depression diagnosis was present for 28.2% of PACE enrollees and only 20.1% of SMMC LTC enrollees.

[8] Because 9,378 assessments did not have information for living arrangement (e.g., assisted living facility and private residence) and living situation (e.g., enrollee lives alone), a total of 17,155 enrollees were included in the calculation of these measures.

Exhibit 10: Cognitive, Behavioral, or Emotional Conditions in Current PACE and SMMC LTC Enrollees

Conditions	Percent of PACE Enrollees (n=625)	Percent of SMMC LTC Enrollees (n=26,533)
Need for Supervision	70.1	65.4
Cognitive Problems	53.6	57.3
Behavioral Problems	43.8	40.7
Dementia	40.8	50.3
Memory Problems	41.4	50.0
Depression	28.2	20.1
Wandering	7.2	6.0
Dangerously Isolated	6.4	3.8
Abusive or Aggressive Behavior	5.6	6.2
Suicide Risk	1.3	0.4
Other Mental Health Problems	25.0	19.5
Percentage of enrollees with one or more conditions	*80.0*	*73.3*

Source: DOEA, CIRTS, 2013

Health Conditions and Medications

Many PACE and SMMC LTC enrollees are faced with chronic and persistent health conditions. As shown in the list of chronic health conditions in Exhibit 11 below, the average number of chronic and persistent health conditions afflicting current active PACE enrollees is 2.3 (with a range of zero to seven conditions). Bladder or bowel incontinence is the most common chronic health condition (58.1%), followed by heart problems (42.9%) and dementia (40.8%). On average, more than half (52.2%) of PACE enrollees take five or more medications regularly, both prescription and over-the-counter.[9] For the complete list of health conditions, count of medications, and therapies, refer to Appendix B, Exhibits B-C.

SMMC LTC enrollees have an average of 2.9 chronic and persistent health conditions per enrollee. Although occurring at a higher rate among SMMC LTC enrollees, like PACE, the most common chronic health condition among SMMC LTC enrollees is bladder or bowel incontinence (76.2%).

[9] Taking five or more medications regularly is the working definition of "polypharmacy." This is a concern because the more medications an enrollee regularly takes, the more complex and expensive the management of daily routines can be, and the more risk for adverse health outcomes and injuries from falls, side-effects, and interactions.

Functional Status and Physical Impairment

Most PACE and SMMC LTC enrollees are either physically or functionally impaired, requiring aids, devices, supervision, or hands-on assistance with some or all of their daily activities in order to remain in the community. The portion of these activities that includes personal care tasks are commonly referred to as Activities of Daily Living (ADLs), and less personal tasks are called Instrumental Activities of Daily Living (IADLs). Combined, ADLs and IADLs are scale measures that can be used to score an individual's functional status and physical impairment.

Exhibit 11: Chronic Health Conditions of Current PACE and SMMC LTC Enrollees

Chronic Health Conditions	Percent of PACE Enrollees (n=625)	Percent of SMMC LTC Enrollees (n=26,533)
Incontinence	58.1	76.2
Heart Problems	42.9	53.7
Dementia	40.8	50.3
Diabetes	31.2	37.5
Stroke	23.2	27.3
Emphysema/COPD	21.2	22.3
Cancer	13.4	18.8
Liver Problems (Cirrhosis, Hepatitis, etc.)	3.0	3.5
Average Number Health Conditions Per Enrollee	*2.3*	*2.9*

Source: DOEA, CIRTS, 2013

Activities of Daily Living (ADL)

ADLs include essential everyday personal care tasks such as bathing, dressing, eating, toileting, walking, and transferring (the term used to describe moving from a lying flat position in bed to a seated or standing position). When individuals are no longer able to perform ADLs, personal care tasks, they may require help from an assistive device or another person. The percentage of enrollees in PACE and SMMC LTC with ADL needs are contrasted in Exhibit 12 below. Overall, across all ADLs, a higher percentage of SMMC LTC enrollees need help compared to PACE enrollees.

Among active PACE enrollees, most require some amount of supervision or hands-on assistance during tasks of bathing (76.2%), walking (44.3%), dressing (67.1%), or transferring (42.8%). Less than half of active PACE enrollees require some supervision or hands-on assistance with toileting (48.0%) or eating (30.5%). The average number of ADL needs for PACE enrollees is 3.1.

Exhibit 12: Percentage of Current PACE and SMMC LTC Enrollees With ADL Needs

Activity of Daily Living	PACE (n=625)		SMMC LTC (n=26,533)	
	No Help Needed	Requires Help	No Help Needed	Requires Help
Bathing	23.7	76.2	4.7	95.3
Dressing	33.0	67.1	8.5	91.5
Eating	69.6	30.5	43.3	56.7
Toileting	52.0	48.0	25.6	74.4
Transferring	57.3	42.8	27.7	72.3
Walking/Mobility	55.7	44.3	28.9	71.1

Source: DOEA, CIRTS, September 2013

Note: "No Help Needed" may include those enrollees who only use an assistive device. "Requires Help" means the enrollee requires either: supervision, some hands-on help from a person, or total help with the ADL task.

Among SMMC LTC enrollees, a majority require help or supervision when performing one or more ADLs tasks. Bathing and dressing are the tasks where the most assistance is needed (95.3% and 91.5%, respectively). A high number of enrollees also require help when toileting (74.4%), transferring (72.3%), or walking (71.1%). Over half (56.7%) require supervision or help eating. The average number of ADL needs for SMMC LTC enrollees is 4.6.

Instrumental Activities of Daily Living (IADL)

IADLs consist of more complex activities that are fundamental to independent living and generally include the ability to perform housework and household chores, using the telephone, managing money, preparing meals, shopping, remembering to take medications, and using transportation. When individuals are no longer able to perform IADL activities, they may require help from an assistive device or another person.

More than 90 percent of enrolled PACE enrollees need at least supervision to perform heavy chores (97.6%) and light housekeeping (93.1%) and to use transportation (90.3%). As shown in Exhibit 13 below, many enrollees also require supervision or hands-on assistance to manage their money (78.4%) and medications (84.8%), prepare meals (89.8%), and go shopping (88.5%). Just over half of PACE enrollees need some help using the telephone (51.5%). The average number of IADL tasks with which active PACE enrollees need some assistance is 6.7 activities.

Exhibit 13: Percentage of Current PACE and SMMC LTC Enrollees With IADL Needs

Instrumental Activity of Daily Living	PACE (n=625)		SMMC LTC (n=26,533)	
	No Help Needed	Requires Help	No Help Needed	Requires Help
Heavy Chores	2.4	97.6	0.1	99.9
Light Housekeeping	6.9	93.1	0.2	99.8
Using the Telephone	48.5	51.5	42.5	57.5
Managing Money	21.6	78.4	14.3	85.7
Preparing Meals	10.2	89.8	2.3	97.7
Shopping	11.5	88.5	1.2	98.8
Managing Medication	15.2	84.8	16.4	83.6
Using Transportation	9.8	90.3	3.6	96.4

Source: DOEA, CIRTS, September 2013

Note: "No Help Needed" may include those enrollees who only use an assistive device. "Requires Help" means the enrollee requires either: supervision, some hands-on help from a person, or total help with the IADL task.

Most SMMC LTC enrollees require at least supervision to meet one or more of their IADL needs. All SMMC LTC enrollees need help with heavy chores (99.9%), and almost all enrollees need help with light housekeeping (99.8%), meal preparation (97.7%), shopping (98.8%), and using transportation (96.4%). Additionally, many SMMC LTC enrollees require hands-on assistance or supervision to manage their money (85.7%), manage medications (83.6%), and use the telephone (57.5%). The average number of IADL tasks that SMMC LTC enrollees need some assistance with is 7.2 activities. Refer to Appendix B, Exhibits D-G for more details regarding the ADL and IADL needs of PACE and SMMC LTC enrollees.

In summary, SMMC LTC enrollees, and those expected to become SMMC LTC enrollees after the transition is complete are frailer than PACE enrollees. A large proportion of both SMMC LTC and PACE enrollees have one or more mental health conditions and many exhibit behavior that indicates a need for supervision; however, PACE enrollees are slightly more likely to have a mental health condition. Although both programs serve a large proportion of enrollees with mental health conditions, PACE enrollees are more likely to have severe emotional problems, while SMMC LTC enrollees have higher rates of cognitive impairments, such as dementia. PACE and SMMC LTC enrollees both have high levels of impairment and illness, with SMMC LTC enrollees having on average one more chronic health condition and two more ADL and IADL deficits than PACE enrollees.

PACE and SMMC LTC Rates and Cost

As of October 2013, PACE had 724 active enrollees in five Florida counties: Pinellas, Miami-Dade, Lee, Charlotte, and Collier. These enrollees are currently being served by three organizations: Suncoast, Florida PACE, and Hope Select Care. A new PACE organization, Morse Life, began providing services in Palm Beach County in November 2013. A count of enrollees served under PACE is shown below in Exhibit 14. There are two organizations that are no longer serving enrollees, Chapters Health, which voluntarily left the program in August 2013, and Neighborly, which was purchased by Suncoast in July 2012. Over 1600 enrollees have received PACE services since the program began in 2009. Suncoast is the PACE organization with the fewest enrollees (106). The largest number of PACE enrollees is enrolled with Florida PACE in Miami-Dade County (417). Collier County has the smallest number of enrollees (10).

Florida PACE was the first PACE organization in Florida. It began operations in July 2003, in Miami-Dade County, and for the following five years, it was the only organization in the state. Hope Select Care began operations in Lee County in July 2008, and a new PACE organization was established in each subsequent year. (See Appendix B, Exhibit I for additional information.)

Exhibit 14: PACE Organizations and Enrollee Counts

PACE Organization Name	Year Began Operating	PSA	County	Number of Enrollees, Current	Total Enrollees, Historical
Neighborly	2009	5	Pinellas	-	185
Chapters Health	2011	6	Hillsborough	-	133
Suncoast	2012	5	Pinellas	106	134
Florida PACE	2003	11	Miami-Dade	417	875
Hope Select Care	2010	8	Lee	163	354
Hope Select Care	2010	8	Charlotte	28	56
Hope Select Care	2012	8	Collier	10	10
Total Number of PACE Enrollees (Unduplicated)				**724**	**1,605**

Source: FMMIS, October 2013

***Note**: Enrollees served by Suncoast who had been served by Neighborly prior to July 2012 are listed as both Suncoast and Neighborly enrollees in the* Total Enrollees, Historical *column.*

SMMC LTC will be operating statewide as of March 2014, when the transition is complete. Expected enrollment numbers in each region in March 2014, are shown in Exhibit 15 below.

Exhibit 15. SMMC LTC Plans and Enrollment by Region

Region	Plan Name	Anticipated Enrollment
1	American Eldercare, Sunshine	2,973
2	American Eldercare, United Healthcare	4,058
3	American Eldercare, Sunshine, United Healthcare	6,911
4	American Eldercare, Humana, Sunshine, United Healthcare	9,087
5	American Eldercare, Molina, Sunshine, United Healthcare	9,963
6	American Eldercare, Coventry, Molina, Sunshine, United Healthcare	9,575
7	American Eldercare, Coventry, Sunshine, United Healthcare	9,338
8	American Eldercare, Sunshine, United Healthcare	5,596
9	American Eldercare, Coventry, Sunshine, United Healthcare	7,854
10	American Eldercare, Amerigroup, Humana, Sunshine	7,877
11	American Eldercare, Amerigroup, Coventry, Humana, Molina, Sunshine, United Healthcare	17,257
Florida Total		**90,489**

Source: AHCA *LTC Timelines: Recipient Enrollment Schedule*

PACE Cost and Rates

PACE organizations receive a capitated Medicaid payment from the State for Medicaid long-term care and other services and an enhanced capitated Medicare payment for acute care from the federal government. Three Medicaid rates are set for each organization: one for enrollees eligible for Medicaid and Medicare Parts A and B, one for enrollees eligible for Medicaid and Medicare Part B only, and one for enrollees eligible for Medicaid but not Medicare. Under these combined capitation rates, PACE organizations must offer all Medicaid and Medicare services and assume full financial risk for enrollee care, including nursing facility care when needed. Exhibit 16 below shows the Medicaid rates by eligibility category for FY 2012-2013 and FY 2013-2014.

Exhibit 16: Medicaid Rates by Organization, County, and Eligibility Category as of October 2013

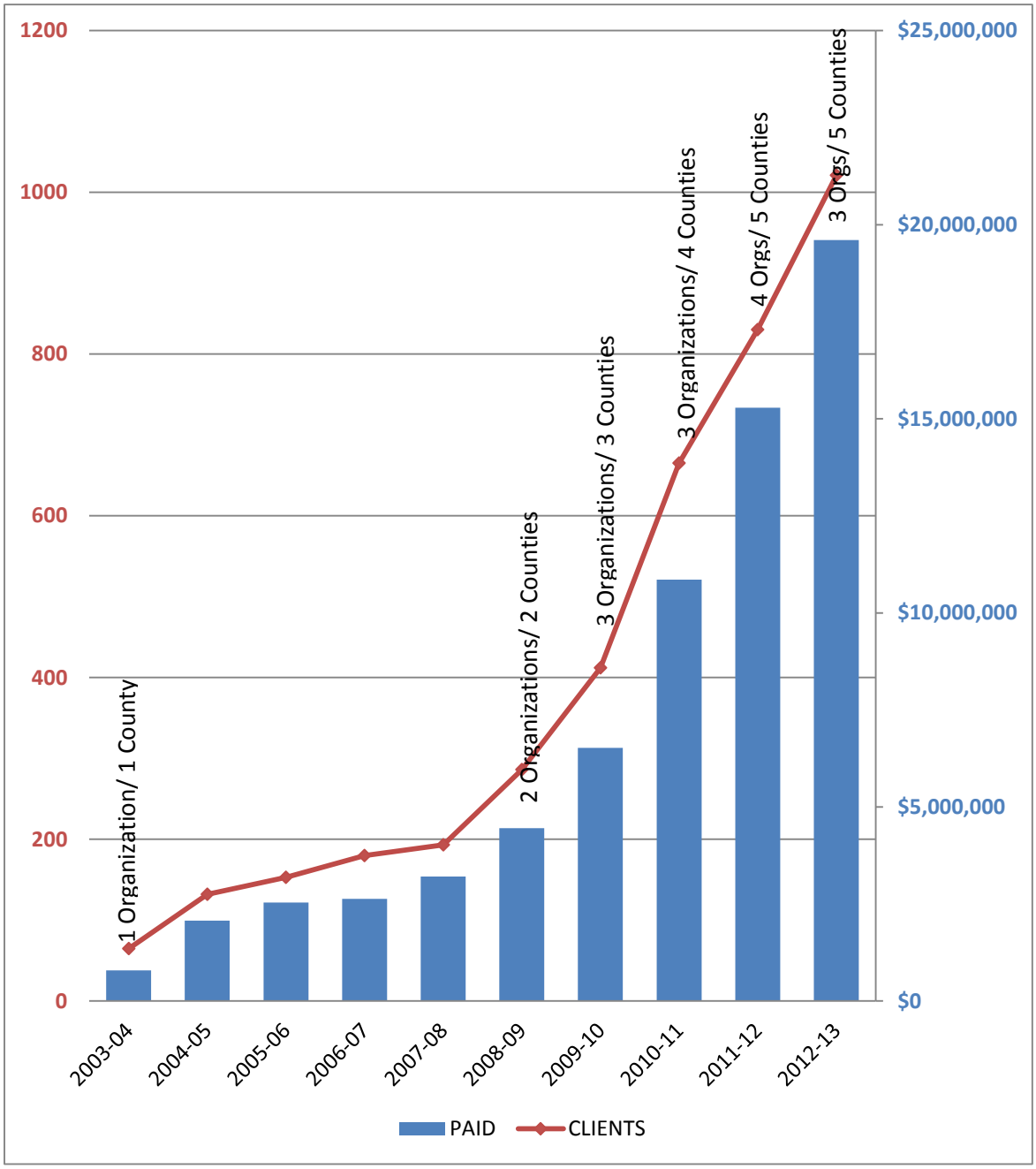
PACE Organizations Name and Location	Eligibility Category	Medicaid Rate Sept 2012-13	Medicaid Rate Sept 2013-14
Suncoast Pinellas	Medicaid and Medicare A & B	$1,567.43	$1,625.95
Suncoast Pinellas	Medicaid and Medicare B Only	$2,400.79	$2,400.79
Suncoast Pinellas	Medicaid Only	$3,251.07	$3,383.91
Florida PACE - Miami-Dade	Medicaid and Medicare A & B	$2,182.08	$2,348.85
Florida PACE - Miami-Dade	Medicaid and Medicare B Only	$3,388.65	$3,388.65
Florida PACE - Miami-Dade	Medicaid Only	$4,011.19	$4,375.12
Hope Select Care - Lee	Medicaid and Medicare A & B	$1,830.05	$2,162.53
Hope Select Care - Lee	Medicaid and Medicare B Only	$2,834.13	$2,834.13
Hope Select Care - Lee	Medicaid Only	$3,294.86	$4,045.01
Hope Select Care - Charlotte	Medicaid and Medicare A & B	$1,446.03	$1,893.07
Hope Select Care - Charlotte	Medicaid and Medicare B Only	$2,186.69	$2,453.87
Hope Select Care - Charlotte	Medicaid Only	$2,716.99	$3,749.01
Hope Select Care - Collier	Medicaid and Medicare A & B	$1,527.34	$1,699.55
Hope Select Care - Collier	Medicaid and Medicare B Only	$2,320.46	$2,320.46
Hope Select Care - Collier	Medicaid Only	$2,888.32	$3,555.49

Source: Milliman's *State of Florida Agency for Health Care Administration and Department of Elder Affairs September 1, 2013 – August 31, 2014 Capitation Rate Development for PACE Organization*

The current average monthly weighted PACE rate is $2,468. This rate increased 10 percent from the previous State Fiscal Year. (Refer to Appendix B, Exhibit J for additional details.)

Exhibit 17 below shows the number of PACE enrollees and Medicaid expenditures by State Fiscal Year (SFY) for the ten-year period of July 2003 through June 2013. Total expenditures rose each year as the number of organizations serving enrollees, and the number of counties in which the organizations operated, increased.

Exhibit 17: PACE Medicaid Expenditures and Enrollees by State Fiscal Year 2003-2013



Source: FMMIS

SMMC LTC Rates

Under SMMC LTC, there are six different Health Maintenance Organizations (HMOs) receiving monthly capitated payments and one Provider Service Network (PSN) operating predominantly under a fee-for-service model (only transportation services are capitated.). Because fee-for-service cost experience was not available at the time this report was written, only SMMC LTC capitation rates were used in the analysis described below.

SMMC LTC capitation rates differ by plan and region. SMMC LTC capitation rates are a "blend" of two rates, one for enrollees living in a community setting and another for enrollees residing in a nursing facility setting. The base capitation rate for enrollees residing in nursing facilities is approximately four times higher than the base rate for enrollees living in a community setting. The "blended" Medicaid rates will be calculated based on each enrollee's setting on the first day of operation each year. Rates are adjusted to reflect a two percent reduction in nursing facility resident bed days and a corresponding increase in enrollees served in the community. This percentage is adjusted downward for plans which began operating after September 2013, given that they had fewer months in this contract year in which to facilitate transitions.

Exhibit 18 below shows estimated capitation rates for SMMC LTC and Managed Medical Assistance (MMA) for the three PSAs in which PACE enrollees are currently enrolled (Regions 5, 8, and 11). One MMA rate is set for the Medicare and Medicaid dual-eligible enrollees and another for enrollees who do not have Medicare. Since SMMC LTC rates are blended specifically for each plan based on their enrollment mix, and we do not know with which plan enrollees would enroll, regional SMMC rates were calculated. These rates were calculated using the most recent data available.

Exhibit 18: SMMC LTC and MMA Capitated Rates

	SMMC MMA		SMMC LTC
Region	SMMC MMA Dual Eligible Rate	SMMC MMA Medicaid Only Rate	SMMC LTC Regional Blended Rate
5	$170	$2,550	$3,687
8	$140	$2,300	$3,921
11	$165	$2,600	$2,487

Source: AHCA; MMA rates are negotiated rates, not final. SMMC LTC rates are not final; pending final blend rates for each region

Note: Actual enrollment counts will be finalized at a later date, at which time rates will be finalized. The rates used in this report are estimates based on information available at the time this report was written.

Cost of PACE Compared to SMMC LTC

The Medicaid cost to serve PACE's current 724 enrollees for one month is approximately $1.8 million. Exhibit 19 below shows the Medicaid rates paid to each PACE organization for each Medicare eligibility category (see column D). At first glance it appears that the Medicaid cost to serve the same enrollees in SMMC for one month would be approximately $2.6 million (see column F), a cost 44 percent higher than the cost of PACE. This includes the Medicaid cost for long-term care and acute care (MMA). **Note**: Medicare payments made to PACE providers are not included, only Medicaid costs.

Exhibit 19: Comparison of PACE and SMMC Monthly Medicaid Costs

PACE Organization Name	Region	County	Number Enrollees Active Oct 2013	PACE Rates Sept 2013-2014	Monthly PACE Cost	Monthly Cost if PACE Enrollees Are Served Under SMMC (Includes LTC and MMA)
	A	B	C	D	E	F
Suncoast PACE-A&B	05	Pinellas	102	$1,625.95	$165,847	$393,379
Suncoast PACE-B only	05	Pinellas	1	$2,400.79	$2,401	$3,857
Suncoast PACE-Medicaid	05	Pinellas	3	$3,383.91	$10,152	$18,710
Florida PACE Center-A&B	11	Miami-Dade	326	$2,348.85	$765,725	$864,552
Florida PACE Center-B only	11	Miami-Dade	0	$3,388.65	$0	$0
Florida PACE Center-Medicaid	11	Miami-Dade	91	$4,375.12	$398,136	$462,917
Hope Select Care-A&B	08	Lee	157	$2,162.53	$339,517	$637,515
Hope Select Care-B only	08	Lee	0	$2,834.13	$0	$0
Hope Select Care-Medicaid	08	Lee	6	$4,045.01	$24,270	$37,324
Hope Select Care-A&B	08	Charlotte	24	$1,893.07	$45,434	$97,455
Hope Select Care-B only	08	Charlotte	0	$2,453.87	$0	$0
Hope Select Care-Medicaid	08	Charlotte	4	$3,749.01	$14,996	$24,882
Hope Select Care-A&B	08	Collier	8	$1,699.55	$13,596	$32,485
Hope Select Care-B only	08	Collier	0	$2,320.46	$0	$0
Hope Select Care-Medicaid	08	Collier	2	$3,555.49	$7,111	$12,441
Florida Total			**724**		**$1,787,18_**	**$2,585,516**

Source: PACE Rates: Milliman's *State of Florida Agency for Health Care Administration and Department of Elder Affairs September 1, 2013 – August 31, 2014 Capitation Rate Development for PACE Organization*
Note: Does not include PSN fee-for-service

However, if PACE enrollees were served in SMMC LTC, the calculated SMMC LTC rates paid for all enrollees would be adjusted. This would be the case for those regions where PACE enrollees transitioned to SMMC LTC. The SMMC LTC rates for those regions would be lowered as a result of adding more enrollees from the community, and this new lowered rate

would be paid for all SMMC LTC enrollees living in those regions, including the PACE enrollees. Exhibit 20 below shows the changes in the case mix for Region 5, 8, and 11 before and after PACE enrollees transition. Exhibit 21 shows the change in rate before and after PACE enrollees are transitioned. The rates are reduced by $24 in Region 5, $86 in Region 8, and $22 in Region 11.

Exhibit 20: SMMC Census Before and After PACE Enrollees Are Added

Region	SMMC Community Census	SMMC NH	Community % SMMC	SMMC + PACE Community Census	SMMC + PACE NH Census	Community % SMMC + PACE
5	3,231	6,473	33%	3,330	6,480	34%
8	1,656	3,320	33%	1,839	3,338	36%
11	13,005	4,964	72%	13,407	4,979	73%

Source: SMMC Census: AHCA; PACE Census: FMMIS, NH Census: Hope Healthcare

Exhibit 21: Monthly SMMC LTC Rates Before and After Adding PACE Enrollees

Region	Latest SMMC LTC Monthly Blended Rate	New Blended Rate With PACE Enrollees Included	Rate Change
5	$3,687	$3,663	-$24
8	$3,921	$3,834	-$86
11	$2,487	$2,465	-$22

Source: SMMC LTC Blended Rate: AHCA

Using the new blended rate, the additional net monthly cost to serve PACE enrollees in SMMC LTC in these three regions would be approximately $1.5 million, $289,000 less than the cost to serve these same enrollees in PACE (see Exhibit 22 below).

Exhibit 22: Monthly Cost to Serve PACE Enrollees in SMMC

Region	LTC Monthly Cost of SMMC w/o PACE	LTC Monthly Cost of SMMC w/ PACE	Net Cost of PACE pop (LTC)	Monthly MMA Dual Rate	Monthly MMA Medicaid Only Rate	Monthly MMA Cost for PACE Enrollees	Total Monthly Cost of Adding PACE to SMMC
5	$35,775,750	$35,932,547	$156,797	$170	$2,550	$25,160	$181,957
8	$19,505,017	$19,847,327	$342,310	$140	$2,300	$54,060	$396,370
11	$44,684,450	$45,313,609	$629,159	$165	$2,600	$290,390	$919,549
	$99,965,217	**$101,093,483**	**$1,128,266**			**$369,610**	**$1,497,876**

Source: MMA rates: AHCA; rates are negotiated rates, not final.

Service Utilization

A comparison of service utilization in PACE and SMMC LTC cannot be made at this time. PACE utilization data that identifies the specific type and quantities of services provided are not collected by the State. SMMC LTC plans are required to submit utilization data. At the time this report was written, a sufficient amount of SMMC LTC utilization data was not available. As the initial rollout of SMMC LTC continues, more utilization data will become available.

Alternative Methods for Integrating PACE

As the State completes the transition of enrollees in DOEA-administered Medicaid waivers to the new SMMC LTC, it is appropriate to consider if PACE should be maintained as a separate Medicaid program option. In this section, three different scenarios are presented: maintaining PACE in the areas where it is currently located, expanding PACE into selected areas, and integrating eligible enrollees into a combination of SMMC LTC services and SMMC MMA care. Where applicable, examples of states that have chosen similar approaches are listed.

Option 1: Maintain Florida's Current PACE Participation Level

One option is to maintain the current PACE organizations at their current site locations while also operating a separate statewide managed Medicaid LTC Program.

The current PACE organizations are demonstrating positive outcomes for their enrollees and could be allowed to continue their services in their current locations. These organizations have invested considerable resources in building their adult day health care sites, provider networks, and interdisciplinary teams. Allowing them to continue to operate would allow them to recoup their investment in this infrastructure. Additional time would also allow the State to compare outcomes for the two programs.

PACE is offered as an option alongside other managed LTC options in at least three other states, namely New Jersey, New York, and Massachusetts.

New Jersey
There are currently four PACE organizations operating in New Jersey offering program participation to individuals residing in their coverage areas. Beginning in July 2014, PACE will be complemented in select areas by the New Jersey Managed Long Term Services and Supports (MLTSS) program. With federal approval under of an 1115 (a) demonstration waiver, New Jersey's MLTSS program will use managed care organizations to coordinate support services according to a participant's needs. Through MLTSS, current Medicaid beneficiaries enrolled in home and community-based services programs as well as Medicaid beneficiaries living in nursing facilities will transition to a single waiver to receive their primary, acute, behavioral and long-term care needs through a managed care plan.

New York
In New York, where enrollment in a managed long-term care program is mandatory, PACE is offered as a direct enrollment option alongside additional LTC options. There are currently nine PACE organizations operating in the state. In 2012, New York received approval to fully implement the transition and enrollment of recipients requiring community-based LTC into one of these two programs.

Massachusetts
Massachusetts offers two managed long-term care program options for seniors. Under the public health insurance program for low-to-medium income residents, known as MassHealth, members, age 65 and older, have the option of enrolling in Senior Care Options, a voluntary comprehensive health plan that covers all of their acute and long-term care services reimbursable under Medicare and Medicaid. In addition, Massachusetts offers a PACE managed care model, which provides services in the community, such as adult day care and interdisciplinary team case management, to very frail elders who are nursing home eligible. There are five managed care plans, and six organizations offering PACE.

Option 2: Expand PACE in Selected Areas

A second option to consider is to expand PACE in select areas of the state. There are some urban areas of the state with concentrated populations of individuals who would be PACE-eligible that do not currently have a PACE organization operating.

Under the current practice, expansion would require obtaining legislative authority to expand the program and ensuring there are sufficient appropriations to serve enrollees in the authorized sites. An alternative to this method of selecting sites would be for the Legislature to direct AHCA and DOEA to create a methodology for determining the need for new PACE sites (e.g., based on concentrations of PACE eligibles) and for selecting PACE organizations. AHCA and DOEA would then present to the Legislature the need for new sites and request allocation of funding as sites and viable PACE organizations are identified.

The primary foreseeable barriers to PACE expansion include the extensive facility costs and upfront capital outlay that are required to establish and start up these medically enhanced adult day care facilities. An additional barrier is PACE organizations being able to differentiate PACE from SMMC LTC in order to attract individuals in need of long-term care services to voluntarily enroll in PACE.

Option 3: Integrate PACE Enrollees into SMMC LTC

In this option, the current PACE enrollees would transition into the SMMC LTC program. This would make the SMMC LTC program the State's primary mode of service delivery for elders and adults with disabilities that meet nursing facility level of care. An advantage to this approach is that enrollees would be served by a single, integrated system that is the same no matter where they reside in the state. This could reduce confusion about LTC options and would decrease administrative activities the State needs to conduct to maintain separate programs. In addition, termination of PACE would require coordination with CMS and possible federal approval.

Currently 19 states and the District of Columbia operate Medicaid without a PACE program.[10] A few of these states, such as Arizona and Minnesota, also currently operate under similar managed long-term care models. The applicability of these models as a comparison to the SMMC LTC model requires a more in depth analysis once SMMC LTC is fully operational and program data are available.

Arizona
The Arizona Long-Term Care system is a Medicaid managed care program operated by the state of Arizona and authorized by an 1115 Demonstration waiver. Enrollment in the program is mandatory, and individuals must meet nursing home level of care. In addition to long-term care home and community-based services, individuals also receive an assortment of acute medical services through the waiver. Services are provided to enrollees by Arizona Long-Term Care System managed care organizations, and enrollee care is coordinated by case managers.

Minnesota
The Minnesota Elderly Waiver (EW) program funds home and community-based services for individuals age 65 and older who are eligible for Medical Assistance and require the level of care provided in a nursing facility but choose to reside in the community. The Department of Human Services operates the EW program under a federal waiver to Minnesota's Medicaid State Plan. Counties, Tribes, and managed care organizations administer the program. Covered services include visits by a skilled nurse, home health aide, homemaker, companion, personal care assistance, as well as home-delivered meals, adult day care, supplies and equipment, personal emergency response systems, caregiver assessment, home modifications, and certified community residential services (customized living services, foster care, and residential care).

One of the primary foreseeable barriers to transitioning PACE enrollees into SMMC LTC is a possible reduction in long-term and acute care coordination. Some, but not all, of the SMMC LTC organizations will also be offering acute care services (MMA), providing the opportunity for enrollees to choose a plan that integrates long-term and acute care services (see Exhibit 23 below). As previously mentioned, many of these plans also have a Medicare product in the area, so there is potential for full integration of care. Future studies should be conducted to see how well care coordination is accomplished under both models.

[10] States without PACE include: Alaska, Arizona, Connecticut, Georgia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Maine, Minnesota, Mississippi, Montana, Nevada, New Hampshire, South Dakota, Utah, Vermont, and West Virginia.

Exhibit 23: Overlap Between SMMC LTC and MMA Plans by Region

Region	Number of SMMC LTC Plans	Number of SMMC MMA Plans	Number of Overlapping Plans	Date of SMMC LTC Roll-Out	Date of SMMC MMA Roll-Out
5	4	4	1	Feb. 2014	June 2014
8	3	4	1	Sept. 2013	June 2014
11	7	10	3	Dec. 2013	Aug. 2014

Sources: AHCA Webinars: "A Snapshot of the Florida Medicaid Long-term Care Program" 06/30/13
http://www.ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/SMMC_LTC_Snapshot_July_30_2013.pdf
"Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) Program" 12/10/13
http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/MMA_101_12-10-2013.pdf
Notes: Formal protest pending in Region 11 for MMA Standard Plans.

Another concern that needs to be addressed is the fact that over one quarter of PACE enrollees may not be eligible for SMMC LTC. PACE currently serves individuals age 55 and older who meet nursing facility level of care without regard for additional physical disability. PACE may be the only publicly funded long-term care option for the subset of enrollees in the 55-64 year age group who do not meet the criterion for SMMC LTC that requires individuals age 18-64 to also be eligible for Medicaid by reason of a disability. These enrollees meet nursing facility level of care, are medically complex enough to benefit from a high frequency of interaction with their health care provider team, and are still mobile enough to benefit from the transportation and adult day care services available in PACE. They do not, however, have a disability determination. Almost 90 percent of these individuals meet level of care requirements due to the presence of one or more cognitive impairments or behavioral problems.

Additional PACE Modifications to Consider if Option 1 or Option 2 is Selected

If PACE is to continue in Florida, with or without expansion, the State may also consider modifying the PACE model to increase accountability and enhance cost-effectiveness.

PACE organizations should be required to submit encounter data and performance measure data to the State in the same format required of SMMC LTC managed care organizations. This would allow the State to compare the two programs and ensure that both are providing appropriate, high quality, cost-effective services to their members.

Another possible modification is to include a one-way lock-in that could lower state costs for enrollees requiring nursing facility care. Currently, PACE organizations are financially responsible for the cost of skilled nursing care should their enrollees enter a nursing facility. However, evidence shows that a small number of enrollees disenroll from PACE and soon thereafter enter a nursing facility where their costs to the State increase. A minor revision to the PACE agreement could be made to include a one-way lock-in that requires PACE organizations to continue administering and paying for services for enrollees who transition to a nursing facility. Under this lock-in option, enrollees would retain the ability to disenroll from PACE at any time, and time limitations could be set to limit providers' financial liability.

Study Limitations and Recommendations

AHCA and DOEA prepared this report as directed by the Florida Legislature. The ability to compare PACE and SMMC LTC programs as requested was limited by the availability of data for these programs. Study limitations, along with recommendations, are listed below.

Limitation: The Legislature requested a comparison of PACE and SMMC LTC utilization. Utilization data for PACE enrollees was not available at the time this report was written, as there is no requirement in the PACE contracts regarding the provision of enrollee service utilization data. In addition, a complete set of SMMC LTC utilization data for the areas where PACE currently operates was not yet available because all areas were not operational or have not been operational for a significant period of time.

Recommendation: It is recommended that monthly utilization data be required from PACE organizations. These data could be compared to utilization data for SMMC LTC enrollees, which should begin to be available for all regions in which PACE operates in the middle of 2014.

The request for utilization data from PACE organizations should include Medicare-funded services. PACE organizations receive a higher Medicare payment for the provision of an enhanced array of Medicare services. A more accurate understanding of the services provided would allow policy makers to better understand the additional benefit that the Medicare payment provides to Florida's PACE enrollees.

Limitation: Preliminary descriptive contrasts between PACE and SMMC LTC enrollees are provided in this report. The descriptive profile presented in this report largely depicts the qualities of "expected" or "soon to be" SMMC LTC enrollees age 60 and older who are currently enrolled in other Medicaid waivers and are expected to transition to SMMC LTC.[11] An accurate description of SMMC LTC enrollees will not be available for comparison until after the statewide transition is complete in March 2014. At the time the data analysis for this report was undertaken in September 2013, approximately one quarter (24%) of the enrollees included in the SMMC LTC enrollee-level descriptive analysis had completed the transition to SMMC LTC.

Recommendation: Once the SMMC LTC transition is final, update the comparison of PACE and SMMC enrollees, including health conditions and frailty, to only include SMMC LTC enrollees who received SMMC LTC services. In addition, expand the analysis to include enrollees age 55 and older if a comparison to PACE is desired.

[11] Enrollees in the following Medicaid programs are included in the SMMC LTC population examined: SMMC LTC (24.0%), Nursing Home Diversion (46.5%), Aged and Disabled Adult Waiver, including Consumer-Directed Care Plus (21.7 %), Assisted Living Waiver (6.6%), and Channeling Waiver (1.2%). It should be noted that the results of the SMMC LTC enrollee analysis will change once the transition of SMMC LTC enrollees is completed.

Limitation: Estimations of SMMC LTC costs included in this report were based on case mix (proportion of enrollees in facilities and the community) and capitation rate estimates. Final case mix numbers, which will be used to finalize the capitation rates, were not available at the time of this report for any of the three regions where PACE is operating. Moreover, the cost of care provided by the provider service network was not included.

Recommendation: A comparison of PACE and SMMC costs should be completed after the transition to SMMC LTC is completed and the SMMC LTC and MMA rates are finalized.

Limitation: In an effort to understand how PACE affects the health and quality of life of the program's enrollees, an analysis was conducted on the portion of current PACE enrollees who had available assessments before and after receiving PACE services (see "Supplemental Analysis of PACE Enrollees" in Appendix A). The analysis showed an improvement in enrollees' ratings of overall quality of life, an increase in the number of enrollees having their needs met, and a reduction in depression. A similar analysis of SMMC LTC enrollees could not be conducted at the time this report was written as the program has not yet been fully implemented statewide.

Recommendation: It is recommended that a similar analysis be conducted on SMMC LTC enrollees after enrollees have been enrolled for a length of time sufficient to allow for the program's effects to emerge. In addition, requiring PACE organizations to submit the same quality metrics required by SMMC LTC plans would allow for a direct comparison of enrollee outcomes.

Limitation: One of the primary foreseeable barriers to transitioning PACE enrollees into SMMC LTC is a possible reduction in long-term and acute care coordination. Some, but not all, of the SMMC LTC plans will also be providing acute care services (SMMC MMA), which may be more successful at coordinating care.

Recommendation: After the network is complete and the MMA program has been implemented in the PACE areas, a future study should be conducted to see how well care coordination is accomplished under both models.

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Appendix A: Methodology and Supplemental Analysis

PACE Analysis Methodology Used in the Section *Descriptive Statistics for PACE and SMMC LTC Enrollees*

PACE Enrollees

As of October 2013, there were a total of 724 active PACE enrollees. A subset of these were identified for the descriptive analysis detailed in the section *Descriptive Statistics for PACE and SMMC LTC Enrollees* (n=625). To be included as a "currently active" PACE enrollee in the descriptive analysis, an enrollee must have met the following conditions:

- The enrollee had a current record in CIRTS (Client Information and Registration Tracking System), which is a system maintained by the Florida Department of Elder Affairs, and was enrolled as an active PACE enrollee as of September 13, 2013.
- The enrollee did not have a gap in their PACE enrollment that was greater than two months.
- The enrollee received a 701B Assessment on or before July 15, 2013 (a new assessment form was introduced on July 16, 2013, and the response data for this new form is not yet available in CIRTS).[12]
- The enrollee had an assessment entered into CIRTS, requiring SSNs in FMMIS to match SSNs in CIRTS. (Seven currently active PACE enrollees did not have assessment data in CIRTS based on their FMMIS SSN and were therefore excluded from this analysis.)
- There was enough assessment information available to be able to generate a risk score for the enrollee. (48 currently active PACE enrollees did not have enough complete assessment data entered to calculate a risk score.)

625 active PACE enrollees met these criteria. Only the enrollee's most recent assessment is included in this analysis. A majority of enrollees (66.7%) were last assessed within the past year and 99.8% were assessed within the past two years. One enrollee was last assessed 30 months ago.

SMMC LTC Enrollees

As of September 2013, there were a total of 26,533 enrollees enrolled in SMMC LTC and/or expected to be a SMMC LTC enrollee once the transition to SMMC LTC is complete in February 2014. Individuals included in this analysis met the following conditions:

- The enrollee is 60 years of age or older.
- At the time of the enrollee's most recent assessment, the enrollee was not residing in a nursing facility. Because a majority of PACE enrollees were living in the community at the

[12] DOEA assessments include the following information: demographics, ADLs, IADLs, and MSQ (Mental Status Questionnaire) and social resource items. Also included are nutrition, special services, medication, environmental, and caregiver items.

time of their most recent assessment, only SMMC LTC enrollees in the community were included in this analysis in order to make the two populations comparable. The enrollee was in one of the following programs: SMMC LTC (24.0%), Nursing Home Diversion (46.5%), Aged and Disabled Medicaid Waiver (21.1%), Assisted Living Waiver (6.6%), Channeling Waiver (1.2%), and Consumer-Directed Care Plus Program (0.6%).

- There was enough assessment information available to be able to generate a risk score for the enrollee.
- The enrollee was assessed within the last two years. Only enrollees assessed within the last two years were included in order to make the PACE and SMMC LTC populations comparable; all currently active PACE enrollees were last assessed within the past two years.
- The enrollee received an assessment on or before July 15, 2013 (a new assessment form was introduced on July 16, 2013, and the response data for this new form is not yet available in CIRTS).

Needs Met

Every enrollee that is administered a comprehensive assessment is asked "How much help do you need with the following ADLs?" After each question, the enrollee is then given a list of activities and is asked to report how much assistance they need to accomplish each given task. To answer this question, the enrollee can report that they need "no help," "no help but relies on assistive device, "supervision," "some help," or "total help."

Additionally, many enrollees require at least some assistance with ADLs and it is important that enrollees have the appropriate resources available to them, so that their essential personal care needs are fulfilled. Accordingly, DOEA identifies enrollees as not having their needs met if they report that they require "supervision," "need some help," or "total help" with any of their ADLs and do not "always" receive the assistance they need to accomplish ADL tasks. This same formula is used to determine if IADL needs are being met.

A good measure of program performance is evaluating the percentage of enrollees who have their needs for personal care activities (i.e., ADLs) met or maintained. More than three-quarters (76.6%) of PACE enrollees are receiving the assistance they require to fully meet their ADL needs. Similarly, 76.5% of SMMC LTC enrollees had their ADL needs met at the time of their most recent assessment.

In regards to IADL needs, 70.0% of the current PACE enrollees have all of their IADL needs met by the program. These activities are fundamental to independent living and include complex tasks that are more difficult for cognitively impaired enrollees who make up the majority of PACE enrollees. Among SMMC LTC enrollees, 75.0% had their IADL needs satisfied at the time of their most recent assessment.

Note: Enrollees who do not need "supervision," "some help," or "total help" will need "no help" or "no help but relies on assistive devices" to complete ADL and IADL tasks. Enrollees who do not "always" receive the assistance they need to accomplish ADL and IADL tasks will receive assistance "sometimes," "rarely," or "never".

Supplemental Analysis of PACE Enrollees

A sample of 397 currently active PACE enrollees was examined. Enrollees were included in this analysis if they followed the methodology noted above for those included in the descriptive analysis. In addition to meeting the above criteria, enrollees also needed to have been assessed at least twice: once within a year before entering the PACE program and at least once after entering the PACE program.[13] The assessment selected after the enrollee was enrolled in PACE is the enrollee's most recent assessment. The enrollment span of the sample of enrollees has a range of one month to nine years.

When considering the results of this study it should be noted that the outcomes may be different for new comers to the LTC system than for those who have lived with limitations for some time. Additionally, some enrollees may have received services from another waiver program before entering the PACE program. If enrollees received services from another program prior to their PACE enrollment, they may show less variation in outcomes (e.g., needs met, risk score, etc.) than enrollees who did not receive services before entering PACE.

Results

In addition to benefitting from the formal mental health services offered in PACE, enrollees are given informal opportunities to eat meals with others, participate in shared activities, and make new friends when visiting the PACE center. This opportunity for socialization may explain the highly improved ratings for enrollees' overall quality of life present in active PACE enrollees. Comparing enrollees before and after receiving PACE services, enrollees' satisfaction with life before entering PACE was "excellent" or "good" only 28.5% of the time. This number doubled to 55.4% after receiving services from PACE.

In other comparisons, the number of enrollees with depression decreased dramatically after they began to receive PACE services. Just prior to entering PACE, 38.5% of enrollees exhibited depressive symptoms. In contrast, only 18.6% of enrollees still exhibited symptoms of depression after receiving services from PACE, a reduction in incidence of depressive symptoms of over half (51.7%). These figures suggest that the PACE model of service provision (such as inter-disciplinary approach to care, including on-site mental health treatment, in combination with social interaction opportunities like adult day care and congregate meal sharing) may be uniquely suited for improving some types of mental, emotional, and behavioral issues.

In the functional assessment of enrollees before entering PACE, 46.6% had unmet ADL needs. In comparing that rate to their most recent assessment after receiving services in PACE, 23.4% had

[13] One enrollee was assessed 13 months before entering PACE.

unmet ADL needs remaining. This shows a 43.5% increase in PACE enrollees whose needs were met or maintained after entering the PACE organization.

Charting IADL scores confirmed a similar trend. Before entering PACE, 41.3% of enrollees had unmet IADL needs, and after receiving services from PACE, their most recent assessment showed only 30.0% had any unmet needs remaining, meaning there was a 19.4% increase in PACE enrollees whose needs were met after entering the PACE organization.

Appendix B. Supplemental Exhibits

Exhibit A: Percentage of Currently Active PACE and SMMC LTC Enrollees by Demographic Group

Demographics	Percent of PACE Enrollees (n=625)	Percent of SMMC LTC HCBS Enrollees (n=26,533)
Sex		
Female	61.9	76.2
Male	38.1	23.8
Race and Ethnicity		
Hispanic	32.6	37.0
White	53.9	70.2
Black	25.6	14.6
Other	20.9	15.2
Language		
Spanish is Primary Language	28.5	35.5

Source: DOEA, CIRTS, September 2013

Exhibit B: Percentage of Currently Active PACE and SMMC LTC HCBS Enrollees With Health Conditions

Health Conditions	Percent of PACE Enrollees (n=625)	Percent of SMMC LTC HCBS Enrollees (n=26,533)
Abnormal Blood Pressure	72.2	81.7
Incontinence	58.1	76.2
Arthritis	52.2	77.5
Heart Problems	42.9	53.7
Dementia	40.8	50.3
Vision Problems	33.4	53.7
Falls in the past year	31.4	39.4
Diabetes	31.2	37.5
Sleep Problems	29.8	43.9
Stroke	23.2	27.3
Other Bladder Problems	22.9	35.5
Emphysema/COPD	21.2	22.3
Hearing Problems	20.6	33.0
Dizziness	16.8	36.9
Allergies	15.0	37.0
Thyroid Problem	14.6	20.5
Osteoporosis	13.9	33.4
Cancer	13.4	18.8
Broken Bones	9.6	21.6
Pneumonia	6.6	9.7
Paralysis	6.2	9.4

Exhibit B: Percentage of Currently Active PACE and SMMC LTC Home and Community-Based (HCBS) Enrollees With Health Conditions, *Continued*

Health Conditions	Percent of PACE Enrollees (n=625)	Percent of SMMC LTC HCBS Enrollees (n=26,533)
Seizure Disorder	5.9	6.7
Pacemaker	5.6	7.5
Ulcers	4.3	8.9
Asthma	4.2	11.7
Parkinson's Disease	3.8	6.8
Liver Problems (Cirrhosis, Hepatitis)	3.0	3.5
Dehydration	2.6	7.7
Gallbladder	2.6	5.2
Amputation	2.4	3.8
Bed Sore(s) (Decubitus)	1.8	3.0

Source: DOEA, CIRTS, September 2013

Exhibit C: Number of Medications and Types of Therapies Used by Active PACE Enrollees

	Percent of PACE Enrollees (n=625)
Number of Medications	
>1	11.2
1 to 3	14.4
4 to 6	39.8
7 to 9	14.9
10 to 13	6.2
14+	2.6
Unknown	10.9
Average number of medications per enrollee	*5.3*
Type of Therapy	
Physical	25.9
Occupational	20.0
Respiratory	1.0
Dialysis	0.6
Speech	0.3

Source: Medicaid Claims, DOEA CIRTS, September 2013

Exhibit D: Percentage of PACE Enrollees With ADL Needs, by Amount of Assistance

Activity of Daily Living (n=-625)	No Help Needed	Relies on Assistive Device	Supervision Needed	Some Help Needed	Total Help Needed
Bathing	13.8	9.9	18.2	43.8	14.2
Dressing	30.4	2.6	19.2	36.2	11.7
Eating	65.3	4.3	13.8	13.0	3.7
Toileting	34.6	17.4	12.6	25.8	9.6
Transferring	36.2	21.1	15.4	21.0	6.4
Walking	28.8	26.9	16.0	18.4	9.9

Source: DOEA, CIRTS, 2013

Exhibit E: Percentage of PACE Enrollees With IADL Needs, by Amount of Assistance

Instrumental Activity of Daily Living (n=625)	No Help Needed	Relies on Assistive Device	Supervision Needed	Some Help Needed	Total Help Needed
Heavy Chores	1.8	0.6	1.3	14.7	81.6
Light Housekeeping	5.1	1.8	2.7	37.1	53.3
Using the Telephone	45.1	3.4	8.3	23.4	19.8
Managing Money	19.8	1.8	5.6	22.9	49.9
Preparing Meals	8.6	1.6	3.7	23.5	62.6
Shopping	9.4	2.1	5.3	27.2	56.0
Managing Medication	11.5	3.7	11.5	42.7	30.6
Using Transportation	7.4	2.4	5.3	29.0	56.0

Source: DOEA, CIRTS, 2013

Exhibit F: Percentage of SMMC LTC HCBS Enrollees With ADL Needs, by Amount of Assistance

Activity of Daily Living (n=26,533)	No Help Needed	Relies on Assistive Device	Supervision Needed	Some Help Needed	Total Help Needed
Bathing	0.9	3.8	5.4	68.2	21.7
Dressing	5.8	2.7	7.7	66.1	17.7
Eating	40.6	2.7	22.5	29.7	4.6
Toileting	7.8	17.9	13.4	48.7	12.3
Transferring	7.7	20.0	18.3	44.0	10.1
Walking	5.8	23.1	19.6	39.8	11.8

Source: DOEA, CIRTS, 2013

Exhibit G: Percentage of SMMC LTC HCBS Enrollees With IADL Needs, by Amount of Assistance

Instrumental Activity of Daily Living (n=26,533)	No Help Needed	Relies on Assistive Device	Supervision Needed	Some Help Needed	Total Help Needed
Heavy Chores	0.0	0.0	0.1	3.9	96.0
Light Housekeeping	0.1	0.1	0.3	22.1	77.4
Using the Telephone	37.2	5.3	7.0	28.3	22.2
Managing Money	13.3	0.9	3.0	22.5	60.2
Preparing Meals	1.4	0.9	1.1	28.2	68.4
Shopping	0.6	0.6	0.8	30.8	67.2
Managing Medication	8.9	7.4	7.1	57.9	18.6
Using Transportation	2.2	1.5	1.7	46.4	48.3

Source: DOEA, CIRTS, 2013

Exhibit H: DOEA Risk Score Factors and Weights

Risk Score Factor	Weight
Primary Caregiver	N=1.6857
Living Situation	Alone=0.0972
Count Backwards	Incorrect * 0.2577
ADL's requiring assistance (ADL count)	# ADLs * 0.4703
Bed Sores	Y=0.3162
Cancer	Y=0.7505
Dementia	Y=0.1292
Emphysema	Y=0.2148
Liver	Y=0.2270
Pneumonia	Y=0.6686
Stroke	Y=0.3274
Require Physical Therapy and/or Require Occupational Therapy	Y=0.4926
Require Repertory Therapy, Require Other Special Therapy	Y=0.4927, Y=0.4928
Take more than 3 Medications per day	Y=1.1201
Lost or gained over 10 pounds in last 6 months w/o trying	Y=0.2060

Note: Risk Score indicates the likelihood that an individual will go into a nursing facility.

Exhibit I: PACE Providers and Location, 2003-14

State Fiscal Year	Providers	Location
2003-04	Florida PACE	Miami-Dade(began July 2003)
2004-05	Florida PACE	Miami-Dade
2005-06	Florida PACE	Miami-Dade
2006-07	Florida PACE	Miami-Dade
2007-08	Florida PACE	Miami-Dade
2008-09	Florida PACE	Miami-Dade
	Hope Select Care	Lee (began July 2008)
2009-10	Florida PACE	Miami-Dade
	Hope Select Care	Lee
	Neighborly	Pinellas (began Nov. 2009)
2010-11	Florida PACE	Miami-Dade
	Hope Select Care	Lee, Charlotte (began Oct. 2010)
	Neighborly	Pinellas
2011-12	Florida PACE	Miami-Dade
	Hope Select Care	Lee, Charlotte
	Chapters Health	Hillsborough (began Nov. 2011, ended Aug. 2012)
	Neighborly	Pinellas (became Suncoast Neighborly July 2012)
2012-13	Florida PACE	Miami-Dade
	Hope Select Care	Lee, Charlotte, Collier (began Oct. 2012)
	Suncoast Neighborly	Pinellas
2013-14	Florida PACE	Miami-Dade
	Hope Select Care	Lee, Charlotte, Collier
	Suncoast Neighborly	Pinellas
	Morse	Palm Beach (began Dec. 2013)

Source: Florida Medicaid, paid claims data from FMMIS

Exhibit J: PACE Weighted Rate

PACE Organization	County	Eligibility Category	Number Enrollees	2013-2014 Rate	Weighted Rate
Florida PACE	Miami-Dade	A&B	326	2,348.85	765,725.10
Florida PACE	Miami-Dade	Medicaid	91	4,375.12	398,135.92
Hope Select Care	Charlotte	A&B	24	1,893.07	45,433.68
Hope Select Care	Charlotte	Medicaid	4	3,749.01	14,996.04
Hope Select Care	Collier	A&B	8	1,699.55	13,596.40
Hope Select Care	Collier	Medicaid	2	3,555.49	7,110.98
Hope Select Care	Lee	A&B	157	2,162.53	339,517.21
Hope Select Care	Lee	Medicaid	6	4,045.01	24,270.06
Suncoast	Pinellas	A&B	102	1,625.95	165,846.90
Suncoast	Pinellas	Medicaid	3	3,383.91	10,151.73
Suncoast	Pinellas	B only	1	2,400.79	2,400.79
			724		**$1,787,184.81**

Weighted Rate	**$1,787,184.81 / 724 =**	**$2,468.49**