Guidance in Completing the Organizational and Market Self-Assessment for Community Health Centers Considering PACE Sponsorship

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Program of All-Inclusive Care
for the Elderly at Community Health Centers

PACE @CHCs

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As a companion piece to "PACE Program Development Considerations: Organizational and Market Self-Assessment for CHCs Considering PACE Sponsorship," this document provides tips and guidance to Community Health Centers (CHCs) as they consider the feasibility of offering a Program of All-Inclusive Care for the Elderly (PACE) for their frail elder patients. Critical areas of consideration are detailed below.

Demand for Services

Market Size

- The Community Health Center must select a geographic area for focus in examining the demand for PACE services. The PACE service area may be the whole or a part of the CHC's current service area; the selected area may also be non-contiguous to the current CHC service area. For example, there may be a particular area outside the health center's current service area that is underserved and which offers a unique opportunity to expand in order to serve a frail senior population due to elder housing resources, etc.
- As you consider the service area, review the most recent census information by zip code in the selected service area. Census information reviewed should include the size of the population over 65, the number of these individuals/households that are below the state's Medicaid financial eligibility level and the number of individuals who report with types of disabilities that reflect a frailty level that requires nursing home level of care consistent with state regulatory requirements.
- Travel time to the projected PACE Center must be considered and be no greater than 45 minutes to one hour one-way from the residence to the Center; this guideline will assist in determining the circumference of the selected service area.
- After taking all of these factors into account, consider the reasonable penetration or market share you may be able to attract. In general, you will need to be able to enroll a minimum of 150-200 individuals in the PACE program, which should constitute no more than approximately 10-12% of the eligible PACE population.

Assessment of Competitive Service Alternatives

- By consulting state policies and elder service resource alternatives, the CHC should determine what publicly-funded (Medicaid supported) resources are currently available for individual elders and families looking for assistance in supporting frail elders needing long term services and supports (LTSS) in the community. Such resources may include such services as the following: Nursing Homes, Adult Day Health Centers, PACE programs, Assisted Living, Home Health Care, and Personal Care services.
- The capacity of each of these programs operating in the CHC's selected PACE geographic service area should be assessed: how many individuals can each of these programs serve and how many are currently being served? Are there waiting lists for any of these programs? What is the range of services that each program provides and are there regulatory, financial, or clinical eligibility requirements for each? What are the quality ratings and/or reputations for each program?

- A full review of the competitive alternatives should be considered in assessing the potential for success of offering a CHC-sponsored PACE program in the selected geographic area.

Organizational Structure and Capacity

Leadership and Key Staff

- While the PACE program goals and mission are wholly consistent with the CHC mission in their commitment to providing comprehensive health and social services to an underserved and frail elder population, the operation of a PACE program requires clinical, financial, and operational skills that may be new to a CHC. It is important that the CHC assess its current leadership structure and determine who would provide the program development leadership for the PACE program. If there is not someone on the current leadership team who can fulfill this responsibility, then the CHC must have a plan to address this need through recruitment or potential partnership with another community organization that would strengthen the leadership team in this regard.

- As PACE requires strong clinical leadership (through a physician/nurse/nurse practitioner) that may go beyond current staff roles and experience, it is important that the organization have such resources available and, if not, the CHC should have a plan for addressing this need.

- Once the PACE program is developed, the CHC must articulate how PACE leadership will be integrated into the overall CHC leadership and management structure so that the PACE program can have the autonomy it needs to operate effectively as well as an ability to integrate into the overall CHC administrative structure to draw upon IT, financial, administrative, EMR, and quality improvement resources appropriately.

Operational Readiness

- The CHC should assess its experience and infrastructure, directly or in partnership, in the following clinical and program areas, to determine its readiness for PACE:

  - ☐ Geriatric Care: Primary care for frail seniors
  - ☐ Hospital, nursing home, home health, and 24/7 on-call coverage
  - ☐ Interdisciplinary Teams: the cornerstone of the PACE model of care
  - ☐ Provision and/or arrangements for community-based long-term services and supports, including transportation, home health and personal care, homemaking and shopping, meal preparation and provision, residential and aide services, relationships with senior housing
  - ☐ Caring for a dual-eligible (Medicare and Medicaid) population

- The CHC should assess its experience in the following operational and administrative areas:

  - ☐ Managed care financing and managing financial risk arrangements
  - ☐ Claims processing and monitoring service use
  - ☐ Developing, contracting for and managing service networks
  - ☐ Outreach to and enrollment of individuals
  - ☐ Meeting expectations for both internal and state/federally driven formal quality assurance initiatives and improvement plans
  - ☐ Medicare Part D and 340B pharmacy programs

Community Relationships

- The CHC should identify both internal and external resources with whom it has strong referral and working relationships to ensure that its PACE program will receive appropriate referrals to its program and will have effective ongoing collaboration in caring for PACE participants; such resources include community health and social service agencies such as Area Agencies on Aging (AAA), home health providers, transportation agencies, etc.
- The CHC should work with its geriatric care providers and PACE clinical leadership team to identify key medical specialists, hospital and nursing home providers with whom the CHC clinical providers have strong collaborative patient care experience to guide its PACE network outreach and contracting activities.

Partnership with State

- The CHC should assess what their state's commitment is to PACE. Is PACE included in the state Medicaid plan? If so, are there PACE programs currently operating in the state and what is each PACE plan's current status: how many PACE programs are in operation and what is each plan's enrollment and geographic service area? Is the state "PACE friendly" and supportive of new PACE programs coming online? If PACE currently operates in the state what are the state's PMPM Medicaid PACE rates and what is the rate setting history?
- What is the state environment with respect to commitment to publicly-funded (Medicaid) long term services and supports (LTSS)? Does the state support community-based services in general and if so how? Are there mandatory and/or voluntary enrollment programs offered by the state, such as managed long-term care plans (MLTCP), that are competitive with PACE? If so, what MLTCP plans are in operation and what is each plan's current enrollment and geographic service area?
- The CHC should determine what licensing and certification requirements the state requires for PACE programs and what the state oversight structure and process is for PACE development, sign off and operation.
- What is the history of the CHC's relationship with the state and its CHC oversight structure: is the health center in good standing with the state regarding its operation and quality measures?

Organizational Commitment

Strategic Fit

- Will developing services for the PACE population provide a new market for the CHC or will PACE offer a new model of care for an existing patient population?
- What has led the CHC organization to consider sponsoring PACE? Mission alignment? CHC patient data? Clinical interest? Changing demographics/population growth? Consider how sponsoring PACE fits into other priorities in the CHC organization's plans.
- What are the competing priorities for the CHC and why is PACE a priority for the organization?
- What is the current CHC board structure and how will PACE board representation requirements fit into the current governance structure of the CHC?

Financial Capacity and Timeline

- **Financial Capacity:** PACE generally requires significant financial resources, especially during the start-up phase. Because of regulatory rules and requirements, PACE programs cannot begin outreach and enrollment activities until the PACE center has been built and approved by CMS and key members of its Interdisciplinary Team have been hired. As a result, a sponsoring health center will need to be able to support the capital costs of building/renovating the PACE center and secure working capital to support operations during the initial enrollment period until achieving break-even operations, which may take approximately 18-to-24 months. It is important to consider the following questions in evaluating financial capacity to take on PACE:

  - ☐ Does the health center have a track record of strong financial performance?
  - ☐ Does the health center have cash reserves to support its general operations as well as contribute to PACE start-up costs?
  - ☐ What is the center's history with debt financing? Does the organization have additional debt capacity if borrowing is needed to fund facility costs and working capital needs?
  - ☐ What sources of funding can be identified and available to the CHC to support PACE start-up and capital costs?

- **PACE Center:** Has a site been identified for the PACE Center? Most PACE Centers range in size from 12,000 SF to 25,000 SF, to accommodate a primary care clinic and equipment; team meetings; therapeutic recreation; restorative therapies; socialization; dining; and personal care. The CHC should evaluate space options and construction/renovation costs in its area in developing a complete capital budget for the PACE center.

- **Timeline:** Preparing for and applying for licensure as a PACE sponsor is a multi-layered process, including approvals at the state and federal levels, which can vary from state-to-state and can often take several years to accomplish. What is the projected opening date for the CHC PACE program? Is your timeline realistic given the processes required in your area?

Once you have considered these important questions and issues, you will be ready to make a decision regarding whether to proceed to the next steps in assessing PACE feasibility for your CHC. These steps include developing a complete market assessment and pro forma financial projections, checking assumptions and financial feasibility as you go. All of this work will ultimately be needed if you decide to move ahead with a complete PACE application at the state and federal levels.