REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

STUDY OF EXEMPTIONS AND REGULATORY POLICY FOR PACE AND PRE-PACE PROJECTS PURSUANT TO HB 1130 OF 1996

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 28

COMMONWEALTH OF VIRGINIA
RICHMOND
1997

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Preface

The Program for All Inclusive Care for the Elderly (PACE) is a program which serves frail elderly in the community under a capitated financing arrangement, primarily under sponsorship from the Medicaid and Medicare Programs.

As you know, Medicaid is a program which is jointly sponsored by federal and state governments and is the leading financier of long-term care services. Medicare is administered by the federal government and primarily supports acute health care services such as physician and hospital care.

One of the greatest challenges that we as a nation face in developing services to meet the growing elderly population is breaking through the traditional service and financing barriers which have occurred in the evolution of Medicaid and Medicare. While we at the state level are not in anyway responsible for Medicare expenditures, there is a very strong relationship between these two programs at the client and service delivery level.

The PACE model, which was originally developed in San Francisco by the On Lok Program, is now being replicated in over 60 organizations across the nation. Here in Virginia, Sentara Health System has been the first organization to initiate such a program which is entitled Sentara Senior Community Care, and there are a few other organizations which have expressed an interest.

House Bill 1130 of the 1996 session requested the Joint Commission on Health Care, in cooperation with the Department of Medical Assistance Services and the Bureau of Insurance of the State Corporation Commission, to conduct a study of the following issues: (1) determine whether the exemptions established by HB 1130 should be continued in existing or modified form beyond July 1, 1997; and (2) identify an appropriate state regulatory policy for pre-PACE and PACE Projects whch may provide coverage for individuals who are not eligible for Medicaid.

We worked closely with the Department of Medical Assistance Services, the Bureau of Insurance and Sentara during the course of this study and determined that it is appropriate to establish a legislative foundation for this program. This proposal is currently being drafted for introduction to the 1997 General Assembly.

I would like to thank the Department of Medical Assistance Services for their assistance in drafting this document and staff from both the Department of Medical Assistance Services and the Bureau of Insurance, as well as the Division of Legislative Services, for assistance with drafting the legislation.

Our review process on this topic included an initial briefing which you will find in the body of this report followed by a public comment period during which time interested parties forwarded written comments to us on the report. In many cases, the public comments, which are provided at the end of this report, provided additional insight into the various topics covered in this study.

Jane N. Kusiak
Executive Director

December 18, 1996

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I.
Authority for Study

House Bill (HB) 1130 of the 1996 Session requested the Joint Commission on Health Care, in cooperation with the Department of Medical Assistance Services and the Bureau of Insurance of the State Corporation Commission, to conduct a study to: (1) determine whether the exemptions established by the bill should be continued in existing or modified form beyond July 1, 1997; and (2) identify an appropriate state regulatory policy for pre-PACE and PACE projects which may provide coverage for individuals who are not eligible for Medicaid.

II.
Introduction

PACE: Program of All-inclusive Care for the Elderly is the nationwide replication of the comprehensive service delivery and financing model of long-term care for the frail elderly pioneered by On Lok Senior Health Services in San Francisco in the 1970s.

PACE, is a community-based health care plan that integrates all aspects of care - primary, medical and specialty care, social services, personal care, in-home supportive services, rehabilitative therapies, meals, transportation, hospitalization, and nursing home care - into one program. The goal of the program is to help the frail elderly continue to live in the community while providing comprehensive and preventive care at lower cost than traditional fee-for-service to public and private payers. PACE offers:

- More community-based care;
- Better cost control through the integration of acute and long-term care services; and
- Greater customer satisfaction.

A PACE provides needed care in the most appropriate setting for the enrollee. Services are provided in the PACE Center, at home, and if needed, in the hospital. Specialty and ancillary medical services are provided, as are long-term care services such as transportation, meals and personal care. If nursing

home placement is needed, PACE provides the service and maintains the continuity of care by regular monitoring of the enrollee's condition. By providing preventive and rehabilitative services, chronic conditions can be stabilized and complications averted or lessened, thereby enhancing quality of life. An interdisciplinary team, consisting of professional and paraprofessional staff, assesses enrollees' needs, develops care plans and delivers needed services.

The success of the PACE led to the authorization for the Health Care Financing Administration (HCFA) to award Medicare 222 and Medicaid 1115(a) waivers to replicate PACE sites nationwide. The first PACE replications began operating in 1990. Of the almost 60 organizations in PACE development in 14 states, 11 have both Medicare and Medicaid waivers and 12 others deliver services under Medicaid capitation only. In 1995, PACE sites served over 3,660 enrollees. The PACE is the capitated managed care model currently permitted by the Health Care Financing Administration to pool Medicare and Medicaid dollars to serve persons in need of long-term care services. (The only exception is a demonstration project in Minnesota, known as Senior Health Options, which serves all persons age 65 and over who are Medicaid and Medicare eligible, including the healthy elderly.) See Appendix A for a list of states that are currently operating PACE and pre-PACE sites.

Replications of the PACE can begin as long-term care pre-paid health plans (LTCPHP) with Medicare fee-for-service. These are often referred to as pre-PACE sites. Medicaid covered services not included in partial capitation are provided under fee-for-service. Medicaid in each state calculates the capitation rates using a comparable fee-for-service population. With the acceptance of waivers, HCFA gives a three year "demonstration" status to new PACE sites. By two years into the waiver, Medicare has begun capitated rates, and Medicaid also moves to full capitation, while the site assumes increasing risk. After the three year period, the new site assumes full risk.

PACE sites receive Medicare and Medicaid capitation payments for all eligible enrollees. Persons financially ineligible for Medicaid pay that amount privately.

PACE serves only frail older persons who are certified for nursing home care. When compared with other elderly populations, PACE enrollees are most similar to nursing home residents.

- PACE enrollees average age is 80 years; 33% are 85 years and older.
- PACE enrollees are dependent in at least 3 activities of daily living.
- PACE enrollees each have an average of 8 medical diagnoses.
- Almost 71% of PACE enrollees suffer from mental disorders including dementia and depression (National PACE Association).

PACE providers successfully control enrollees' use of high-cost inpatient services by providing expanded preventive and supportive services.

- **Lower hospital use**: Despite the extreme frailty and advanced age of the participants, PACE sites have reduced their need for hospital care. Participants used fewer hospital days than the general 65 and older population, which includes healthy and frail elderly (5 days for PACE participants versus 8 days for the general population, 1994).

- **Lower nursing home use:** Although everyone in a PACE program is eligible for nursing home care, fewer than 6% resided in a nursing home at the end of 1995 (National PACE Association).

Medicare and Medicaid rate setting methods for PACE produce savings compared to payers' costs in the fee-for-service health care system for equally frail people.

- Medicaid capitation payments to PACE yield states 5 - 15 % savings relative to their fee-for-service expenditures for a comparable nursing home certified population. In 1995, the Medicaid capitation rates ranged from $1486 - $4465; the median payment was $2,033.

- Medicare's rate-setting methodology for PACE guarantees at least 5% savings. PACE organizations have agreed to accept 95% of the cost experienced by Medicare for a comparable population in the fee-for service

sector. In 1996, Medicare capitation rates for PACE ranged from $813 to $1,754 per month (depending on the locale).

- Beyond the immediate cost savings to Medicare and Medicaid for persons enrolled in a PACE, PACE offers state policy makers a less costly community-based alternative to nursing home care.

The PACE Provider Act of 1995 was introduced in June 1995 by Senators Dole and Inouye to increase the number of programs authorized and to afford regular provider status to sites with projected reimbursement being lower than Medicare and Medicaid costs for a comparable population and which meet the national PACE protocol standards. The Health Care Financing Administration also supports making PACE a permanent option for Medicare and Medicaid beneficiaries. A provision to move PACE from demonstration to provider status was also included in President Clinton's FY 1997 budget. At this time, S. 990 is pending in the Congress as the Congressional Budget Office reviews its perceived impact on the federal budget.

III.
PACE in Virginia

The 1995, Virginia General Assembly amended the 1994 - 96 Biennium Budget to request the Department of Medical Assistance Services to "seek an 1115(a) waiver from the Health Care Financing Administration to implement one or more PACE (Providing All - Inclusive Care for the Elderly) demonstration projects, effective July 1, 1995, pending federal waiver approval." The Appropriations Act also stated, "The Department shall contract with providers in selected sites to provide a comprehensive range of services, including prevention, primary, acute, and long-term care services, for elderly Medicaid clients who have been certified as eligible for nursing home care."

In July 1996, Sentara Senior Community Care became Virginia's first long-term care pre-paid health plan (LTCPHP) implemented with plans to become a fully integrated, managed care program modeled after the national PACE replication. As a LTCPHP, the capitation rate is initially limited to selected Medicaid covered services, with other Medicaid and Medicare services available under the traditional fee-for-service payment system. Included in the capitation rate are such services as adult day health care, case management, physician's services, durable medical equipment, nursing facility services, physical therapy, speech therapy, personal care, prescription drugs, respite and transportation. During the first year of operation of the program, the contractor will be reimbursed a total per capita monthly rate per Medicaid enrollee. Carve out fee-for-service services include inpatient hospital, ambulatory surgery, home health, laboratory and radiological services.

This site will transition into full capitation for all health and long-term care services at a later date as the appropriate Medicaid and Medicare waivers are obtained from HCFA. They initially enrolled 4 participants, and plan to reach 50 participants at the end of one year, reaching a maximum of 150 participants over the next three years.

Sentara Senior Community Care provides total care for participants, including comprehensive medical and rehabilitative services, in-home services and transportation. Most services are provided through an adult day health care

center. A full range of services are provided 24 hours a day, 7 days a week, 365 days a year. A Personal Care Team works with the participant and family members to determine what services best meet an individual's needs. The team is made up of doctors, nurse practitioners, nurses, therapists, social workers and a host of other health care professionals who together develop, implement and monitor individualized care plans.

Sentara Senior Community Care is open to individuals who choose this program, as this program is voluntary, and who meet the following requirements:

- Are at least 55 years old;
- Live in the catchment area for the program, which covers Norfolk, Portsmouth, Virginia Beach and Chesapeake;
- Are certified as eligible for Medicaid funded nursing home care; and
- This type of program is appropriate for meeting all of their health and long-term care needs.

A PACE feasibility study has recently been completed for the Fairfax County Department of Health and INOVA Health Systems for Northern Virginia. Interest in a PACE has also been expressed by other groups in the state.

IV.
Why PACE is Important to Virginia

PACE fully integrates the use of health and long-term care dollars. PACE pools all existing resources--Medicare, Medicaid and private dollars--to make best use of such funds, while meeting the individual's care needs. Such pooling reduces the current conflicts between Medicare and Medicaid policy and financing and therefore cost-shifting between the two programs. Pooling funds also increases the likelihood that individuals will receive the services most appropriate to meet their needs. As separate financing systems, the current arrangement leads to the provision of institutional care, duplicative, fragmented and uncoordinated delivery of services, and little control over cost or utilization of services.

PACE provides a comprehensive service package of services to persons living in the community. The program, which provides the full range of preventive and supportive services within one all-inclusive payment rate, is designed to provide participants with a community based alternative to nursing home care. All care needs are coordinated and monitored and authorized through a primary care physician, who serves as a gatekeeper and is part of a multi-disciplinary team of health professionals and ancillary staff.

PACE provides incentives for quality and cost control. The PACE provider receives a set monthly fee per participant. This capitation financing method motivates the program to keep the frail elderly person functional and ambulatory, which in turn keeps the provider's cost low by reducing the need for high-cost institutional care. By contrast, the traditional fee for service approach, and separate Medicare and Medicaid funding, leads to the provision of more services at higher costs, cost shifting between Medicare and Medicaid, and little coordination between providers. Pooling Medicare and Medicaid funds removes the payment motivated incentives for shifting participants to a particular treatment mode.

PACE provides a single point of accountability for tracking total costs and outcomes of care. Within the PACE, the amount and cost of all health care and long-term care services provided, and the client outcomes as the result of

receiving these services, is captured by one provider. For care provided outside a PACE, responsibility for care outcomes is shared by multiple providers. In addition, a complete picture of the total costs of services is often not available because payments and service utilization information is fragmented between the Medicare and Medicaid programs and providers.

PACE assumes financial risk. The PACE organization is responsible for the care that participants need. Safeguards are also in place to assure that savings are not achieved through denial of necessary care and services.

PACE provides savings both to the federal and state governments. PACE organizations agree to accept 95% of the costs experienced by Medicare for a comparable population in the fee-for service sector. The cost to Medicaid is reduced 5 - 15% as well. The PACE incorporates savings from reduced usage of costly hospital and nursing home care into services not ordinarily covered by Medicare and Medicaid--either by type or frequency. For example, meals, non-prescription drugs and physical and occupational therapy are made available through the PACE.

PACE provides a service delivery model that may be applicable to other elderly, chronically ill and younger populations. The Department of Medical Assistance Services' plans for implementation of managed care require that we explore various capitation and service delivery models for elderly and disabled populations. The implementation of PACE will provide us with the experience necessary to implement managed care programs for an older population. Several states are studying the potential for using this type of fully integrated system of care for non-elderly populations. South Carolina, for example, is redefining the model to service medically fragile children. A Massachusetts PACE is studying the applicability to AIDS patients; in the Bronx, New York a study is under way to evaluate a PACE for head injury and multiple sclerosis patients and younger persons with disabilities.

V.
Insurance Regulation

To support the initiation of a PACE in Virginia, the 1995 Virginia General Assembly passed legislation (HB 1130) exempting from insurance regulation pre-PACE, long-term care prepaid health plans having agreements with the Department of Medical Assistance Services. The bill's provisions expire July 1, 1997. The bill also requires the Joint Commission on Health Care, in cooperation with the Department of Medical Assistance Services and the Bureau of Insurance of the State Corporation Commission to review the regulatory exemptions established by the bill to determine whether the exemptions are beneficial to the delivery of health care to the Commonwealth's elderly population and how adequate protections can be provided to the participants and providers of the program.

PACE protocol requires the provider have an insolvency plan approved by HCFA and the State Medicaid agency that provides for:

a. the continuation of benefits for the duration of the contract period for which capitation payment has been made;
b. the continuation of benefits to participants who are confined in a hospital on the date of insolvency until their discharge; and
c. arrangements to protect participants from incurring liability for payment of any fees which are the legal obligation of the PACE provider.

Furthermore, each PACE provider must have a fiscally sound operation as demonstrated by total assets being greater than total unsubordinated liabilities, sufficient cash flow and adequate liquidity to meet obligations as they become due, and a net operating surplus. The program must also demonstrate that it has arrangements in place in the amount of at least the sum of the following to cover expenses in the event it becomes insolvent:

a. one month's total capitation revenue to cover expenses the month prior to insolvency; and

b. one month's average payment to subcontractors, including providers of emergency services, to cover potential expenses the month after the date insolvency has been declared or operations cease.

Currently, in Virginia, for pre-PACE programs, minimum financial security is identified as:

a. tangible net equity equal to three months of capitated payment; and
b. a working capital ratio of at least one-to-one (1:1).

Like an HMO, PACE provides comprehensive health care services on a capitated basis. There are specific laws that regulate HMOs to insure HMO solvency. The PACE model differs in some respects from a standard HMO.

The primary difference between PACE and an HMO is in their risk management strategies. HMOs use an insurance concept spreading the risk of high cost utilization among a large population that includes a majority of relatively healthy members. Benefits are restricted as well. In PACE, on the other hand, all enrollees are already "in claim" i.e. high utilizers of services because of the frailty of its participants. As an alternative to a nursing facility, PACE is a provider type rather than an insurance plan. PACE targets a relatively homogeneous population, the frail elderly, making estimates of costs more predictable. Costs are controlled, not by benefit limitation, but rather by using a specialized team to manage and provide care directly and employing a service strategy which emphasizes prevention, maximum functioning, and substitution of low-cost services in the community in place of high cost institutional care.

- Unlike HMO enrollees, PACE enrollees are not at risk of loss of coverage. For the majority of enrollees who are dually eligible (90%-95% of total enrollees), the PACE model offers the same benefit package as is offered under Medicare and Medicaid, and enrollees are free to disenroll at any time. Should the program close, the beneficiary returns to the fee-for-service system with no loss of coverage.

- For the few enrollees (approximately 5-10%) who are ineligible for Medicaid, coverage of long-term care services is generally paid privately. Therefore there is no risk of financial loss of coverage for these enrollees. The risk of loss is their coverage of services. They will continue to pay privately for services as they had done prior to program enrollment. For those enrollees with existing Medi-gap and/or long-term care policies, insurance becomes the primary payor, and again no loss of coverage occurs upon program termination.

- The following requirements and features of the PACE model minimize risks to vendors:

- A PACE, when fully operational, will likely serve only 200-300 enrollees.

- The PACE model requires that the majority of services be provided directly. Typically no more than 10-25% of expenses are allocated to contract services.

- During the pre-PACE development period, providers will operate under a limited risk contract. While long-term care services are capitated[1], acute care costs continue to be reimbursable through the fee-for-service system. Thus, variability in costs is limited.

- During the initial three years under dual capitation, a risk sharing mechanism is in place which protects sites from unanticipated catastrophic costs which might affect a new site's financial viability. As a condition of participation, the site must demonstrate that it has reserves sufficient to cover its share of any risk sharing.

States may also establish their own reserve requirements for PACE and pre-PACE sites. The following is a sample of states' regulation of PACE and pre-PACE programs.

A Sample of States' Regulation of PACE and pre-PACE Programs

STATE	No. of PACE Sites	Includes Private Pay	No. of Pre-PACE Sites	Includes Private pay	Subject to HMO Licensing	Protections for PACE	Protections for Pre-Pace	Enabling PACE Statute
lfornia	3	Yes, defined as Medicare only	1	Yes, defined as Medicare only	NO	Reserve equal to 5% each month's revenue; commitment from parent corporation to cover losses; subcontracts and contract have hold harmless provisions		
ois	0	N/A	1	permissible	NO	To consider when pre-PACE period ends	Hold harmless provisions; continuation of benefits for participants confined in a hospital; continuation of benefits for period in which capitation has been made; risk reserve per HCFA guidelines	YES
ryland	0	N/A	1	Not at this time, under consideration	NO		Hold harmless provisions; audited financial statements annually; continuation of benefits for capitation period; positive net worth; sufficient cash and adequate liquidity as determined by the Medicaid agency; subcontracts must be covered with 2 month's capitation; malpractice, bonding & workers compensation insurance required	YES
ssachusetts	1	permissible	6		NO	Written assurances through the national PACE feasibility study; Reserve not an issue because of PACE status as a waiver demonstration program.	No reserve requirements. Postpayment for services rendered. Do not consider a Pre-PACE an insurance product.	NO
lchigan	0	N/A	1		NO		HCFA oversight; Hold harmless provision; continuation of benefits for participants confined in a hospital; continuation of benefits for period in which capitation has been made	
w York	2	10% Medicare Only	0	N/A	NO	Guarantee by parent corporation; reserve equal to 5% of program revenues with minimum $50,000 at start-up and $100,000 at the end of first year	Same as protections for PACE	YES
uth Carolina	1	permissible	0	N/A	NO	Hold harmless provisions; continuation of benefits for participants confined in a hospital; continuation of benefits for period in which capitation has been made; risk reserve per HCFA guidelines; project is part of a larger health system		NO
ashington	0	N/A	1	yes, defined as Medicare only	If PACE	Licensure as HMO	Not subject to insurance regulation; postpayment for services rendered rather than in advance.	NO
isconsin	1	Excludes those who are neither Medicare nor Medicaid	1	Excludes those who are neither Medicare nor Medicaid	Exemption from Commis-sioner of Insurance for each site	To consider when pre-PACE period ends	Hold harmless provisions; continuation of benefits for participants confined in a hospital; continuation of benefits for period in which capitation has been made; risk reserve per HCFA guidelines	

VI.
Recommendations for the Regulation of pre-PACE Plans

As requested by the General Assembly, the Joint Commission on Health Care, in cooperation with the Department of Medical Assistance Services and the Bureau of Insurance of the State Corporation Commission, recommends the following to provide adequate protections to the participants and providers of the program.

Legislative/Regulatory framework shall include the following:

- Pre-PACE, long term care prepaid health plans may include coverage for individuals eligible for medical assistance services and those whose coverage is paid from private sources including commercial coverage.

- Operation of a pre-PACE plan that participates in the medical assistance services program must be in accordance with a prepaid health plan contract with the Department of Medical Assistance Services.

- During the pre-PACE period, the program shall have a fiscally sound operation as demonstrated by total assets being greater than total unsubordinated liabilities, sufficient cash flow and adequate liquidity to meet obligations as they become due and a plan for handling insolvency approved by the Department of Medical Assistance Services.

- The pre-PACE plan must demonstrate that it has arrangements in place in the amount of, at least, the sum of the following to cover expenses in the event it becomes insolvent:

    a. One month's total capitation revenue to cover expenses the month prior to insolvency; and

    b. One month's average payment of operating expenses to cover potential expenses the month after the date of insolvency has been declared or operations cease.

- Arrangements to cover expenses must include insolvency insurance or parental guarantees and hold harmless arrangements.

- The Board of Medical Assistance Services shall establish a Transitional Advisory Group to determine license requirements, regulations and ongoing oversight. The Advisory Group shall include representatives from each of the following organizations:

  Department of Medical Assistance Services, Department of Social Services, Department of Health, Bureau of Insurance, Board of Medicine, Board of Pharmacy, Department for the Aging and a pre-PACE provider.

APPENDIX A

Attachment 1
Organizations with Waivers to Operate PACE as of June 1996

CALIFORNIA
ON LOK SENIOR HEALTH SERVICES
San Francisco

CENTER FOR ELDERS INDEPENDENCE
Oakland

SUTTER HEALTH'S SUTTER SENIOR CARE
Sacramento

COLORADO
TOTAL LONG-TERM CARE, INC.
Denver

MASSACHUSETTS
EAST BOSTON NEIGHBORHOOD HEALTH CENTER'S
ELDER SERVICE PLAN
East Boston

NEW YORK
BETH ABRAHAM HOSPITAL'S
COMPREHENSIVE CARE MANAGEMENT
Bronx

NEW YORK (Contíd)
ROCHESTER GENERAL HOSPITAL'S
INDEPENDENT LIVING FOR SENIORS
Rochester

OREGON
SISTERS OF PROVIDENCE'S
PROVIDENCE ELDER PLACE
Portland

SOUTH CAROLINA
RICHLAND MEMORIAL HOSPITAL'S
PALMETTO SENIOR CARE
Columbia

TEXAS
BIENVIVIR SENIOR HEALTH SERVICES
El Paso

WISCONSIN
COMMUNITY CARE ORGANIZATION'S
COMMUNITY CARE FOR THE ELDERLY
Milwaukee

Organizations Delivering Services under Medicaid Capitation as of June 1996

CALIFORNIA
ALTAMED SENIOR BUENA CARE
Los Angeles

HAWAII
MALUHIA
Honolulu

ILLINOIS
REACH
Chicago

MARYLAND
JOHNS HOPKINS ELDER PLUS
Baltimore

MASSACHUSETTS
ESP OF THE CAMBRIDGE HOSPITAL
Somerville

SP at FALLON
Worcester

MASSACHUSETTS (Cont'd)
ESP HARBOR HEALTH SERVICES
Dorchester

ESP OF MUTUAL, HEALTH CARE
Roxbury/Dorchester

ESP OF THE NORTH SHORE
Lynn

MICHIGAN
HENRY FORD CENTER FOR SENIOR INDEPENDENCE
Detroit

WASHINGTON
PROVIDENCE ELDERPLACE OF SEATTLE
Seattle

WISCONSIN
ELDER CARE OPTIONS
Madison

Attachment 1 (continued)
Organizations Delivering Services under Medicaid Capitation by the End of 1996:

NEW MEXICO

SISTERS OF CHARITY HEALTH CARE SYSTEM/ST. JOSEPH'S HEALTH SYSTEM
Albuquerque

NEW YORK

EDDY SENIORCARE
Troy

LORETTO'S INDEPENDENT LIVING SERVICES
Syracuse

OHIO

BETHESDA DAYBREAK
Cincinnati

VIRGINIA

SENTARA LIFE CARE CORPORATION
Norfolk

APPENDIX B

VIRGINIA ACTS OF ASSEMBLY -- 1996 SESSION

CHAPTER 628

An Act to amend the Code of Virginia by adding a section numbered 38.2-226.1, relating to insurance regulation; exemptions for certain health plans.

[H 1130]

Approved April 5, 1996

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 38.2-226.1 as follows:

§ 38.2-226.1. Provisions of title not applicable to certain long-term care prepaid health plans.

A. This title shall not apply to pre-PACE, long-term care prepaid health plans (i) authorized by the United States Health Care Financing Administration pursuant to § 1903 (m) (2) (B) of Title XIX of the United States Social Security Act and the state plan for medical assistance services as established pursuant to Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 and (ii) which have signed agreements with the Department of Medical Assistance Services as long-term care prepaid health plans.

B. The pre-PACE, long-term care prepaid health plans identified in subsection A may include coverage for individuals who have made application for medical assistance services pursuant to Chapter 10 (§ 32.1-323 et seq.) of Title 32.1. Such coverage shall not extend beyond ninety days after the date of such application unless (i) such individuals' applications are approved or (ii) any disapproval thereof is pending appeal conforming to the procedures established for the same by the Department of Medical Assistance Services, and then only for the duration of such appeal.

2. That the provisions of this act shall expire on July 1, 1997.

3. That the Joint Commission on Health Care, in cooperation with the Department of Medical Assistance Services and the Bureau of Insurance of the State Corporation Commission, shall conduct a study to: (i) determine whether the exemptions established by the bill should be continued in existing or modified form beyond July 1, 1997; and (ii) identify an appropriate state regulatory policy for pre-PACE and PACE projects which may provide coverage for individuals who are not eligible for Medicaid. The Joint Commission on Health Care shall report its findings and recommendations to the Governor and the 1997 Session of the General Assembly.

APPENDIX C

Joint Commission on Health Care

Summary of Public Comments on Draft Issue Brief 3: Study of Exemptions and Regulatory Policy for PACE and Pre-Pace Projects

Comments regarding the Exemptions and Regulatory Policy for PACE and Pre-PACE Projects Issue Brief were received from the following 4 interested parties:

State Corporation Commission's Bureau of Insurance
Virginia Health Care Association (VHCA)
Virginia Health Poverty Center
Virginia Hospital & Healthcare Association

Recommendations Presented in Issue Brief

As requested by the General Assembly, the Joint Commission on Health Care, in cooperation with the Department of Medical Assistance Services and the Bureau of Insurance of the State Corporation Commission, recommends the following to provide adequate protections to the participants and providers of the program.

Legislative/Regulatory framework shall include the following:

- Pre-PACE, long term care prepaid health plans may include coverage for individuals eligible for medical assistance services and those whose coverage is paid from private sources including commercial coverage.

- Operation of a pre-PACE plan that participates in the medical assistance services program must be in accordance with a prepaid health plan contract with the Department of Medical Assistance Services.

- During the pre-PACE period, the program shall have a fiscally sound operation as demonstrated by total assets being greater than

total unsubordinated liabilities, sufficient cash flow and adequate liquidity to meet obligations as they become due and a plan for handling insolvency approved by the Department of Medical Assistance Services.

- The pre-PACE plan must demonstrate that it has arrangements in place in the amount of, at least, the sum of the following to cover expenses in the event it becomes insolvent:

    a. One month's total capitation revenue to cover expenses the month prior to insolvency; and

    b. One month's average payment of operating expenses to cover potential expenses the month after the date of insolvency has been declared or operations cease.

- Arrangements to cover expenses must include insolvency insurance or parental guarantees and hold harmless arrangements.

- The Board of Medical Assistance Services shall establish a Transitional Advisory Group to determine license requirements, regulations and ongoing oversight. The Advisory Group shall include representatives from each of the following organizations:

  Department of Medical Assistance Services, Department of Social Services, Department of Health, Bureau of Insurance, Board of Medicine, Board of Pharmacy, Department for the Aging and a pre-PACE provider.

Summary of Individual Public Comments

State Corporation Commission's Bureau of Insurance

Victoria I. Savoy, CPA, Chief Financial Auditor of the Financial Regulation Division, expressed concern that pre-PACE long term health care plans could evolve into a substantial unregulated insurance operation because of a lack of limits on persons whose coverage is paid from private sources. Ms. Savoy also commented that the Department of Medical Assistance Services (DMAS) has not been able to determine the amount of risk it may be asked to assume under a pre-PACE program. She stated that under the current pre-PACE site, net losses are projected for the first three years, with these losses being shared by DMAS, the provider and the federal and state governments. Ms. Savoy expressed concern that comments made at the Joint Commission August 26th meeting suggested that DMAS intends to expand the program to include an "AIDS focused PACE site" which may have an impact on the extent or type of required regulation. She also indicated that the Bureau's concerns remain because some of their questions have not been answered.

Ms. Savoy followed up with additional recommendations regarding the regulation of pre-PACE Plans - Private Pay Participants. These recommendations shall include the following:

- Enrollment at any one pre-PACE site of those individuals considered to be private pay shall be limited to a maximum of 5% of total site enrollment.

- Full disclosure shall be made to all private pay participants, and those individuals in the process of enrolling in the pre-PACE site, that the pre-PACE program is not insurance and should not be considered a substitute for insurance. In addition, disclosure shall include a statement that coverage is not guaranteed beyond a 30 day period.

- An amount equal to two (2) months capitation payment for each private pay participant shall be held in a segregated excrow account of the pre-PACE site, to be used to assist the private pay participants in obtaining substitute services in the case of insolvency or other failure of the pre-PACE site.

Private pay individuals are to be considered those individuals that do not participate in programs authorized pursuant to Title XVIII of the United States Social Security Act, or Title XIX of the United State Social Security Act and the state plan for medical assistance services as established pursuant to Chapter 10 (§ 32.1-323 et seq.) of Title 32.1.

Ms. Savoy also noted that the Department of Medical Assistance had requested that the recommendation "Arrangements to cover expenses must include insolvency insurance or parental guarantees and hold harmless arrangements" be modified to allow parental guarantees **or** a letter of credit in addition to the option of insolvency insurance.

Virginia Health Care Association

Mary Lynne Bailey, Vice President for Legal and Government Affairs, expressed general support for the recommendations. Ms. Bailey expressed concern that the requirements for insolvency insurance may hinder pre-PACE and PACE projects since this type of insurance is expensive and difficult to arrange. She indicated that flexibility is warranted. Further, Ms. Bailey suggested that the Transitional Advisory Group be expanded to include representation by provider associations interested in pre-PACE projects. She expressed an interest in participating on the advisory group.

Virginia Poverty Law Center

Jill A. Hanken, Staff Attorney, expressed "enthusiastic support" for development of PACE projects in Virginia with the following recommendations: clarify who is financially eligible for PACE and consider ways to modify eligibility requirements so higher income individuals who would qualify for Medicaid in an institution would be more likely to utilize the PACE Option, and; incorporate in legislation specific protections for participants which are mentioned as being part of the insolvency protocol.

Virginia Hospital & Healthcare Association

Katharine M. Webb, Senior Vice President, indicated support for recommendations on regulation of pre-PACE projects. She also indicated that DMAS rather than the Bureau of Insurance is an appropriate locus for regulation of innovative programs such as PACE. Ms. Webb suggested consideration be given to involvement of appropriate provider associations, including the VHHA in the Transitional Advisory Group

once initial requirements for licensure, regulation and oversight have been developed.

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