

CMS 2010 Regional PACE Conference

November 16 -17, 2010 | Doubletree Hotel | Philadelphia, PA



TRANSCRIPT

PACE Plans' Best Practices

CMS Boston Region I, Richard Singer, Account Manager

CMS Boston Region I, Matthew Stuhl, Account Manager

Plan presentation by:

Upham's Elder Services Plan/PACE

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The presentation you're about to hear by Dr. Burrows was the result of a corrective action recommendation and a corrective action plan developed by Upham's Elder Service Plan back in I think it was 2009 – the last time we had an audit. And the end result of the presentation you're about to hear was sort of a concept that I thought was so unique in its approach and powerful in its result that we have now shared this approach with all of our PACE plans in Region 1 so not a single PACE plan in Region 1 has not been introduced to this concept at this point in time. We thought it was a really good idea; and with Dr. Burrows' permission, we did share this information with all of our plans, and he's going to share it with you. Thank you.

[Applause]

So thank you, Dick, and thank you, Matt, for inviting me to present this. Also I want to thank CMS for appointing me Acting Director for Medicare Advantage Operations. I appreciate that. And I assume it's a temporary position and that does not come with a government pension? I also want to reassure Dr. Davenport, I have no designs on your position.

So, I don't sleep with the regulations under my pillow. I have no trouble sleeping at night. And I don't want to put you to sleep now either. But I do want to highlight some of the regulations that apply here. So the relevant parts are Section 460.104(c)(3). So if a participant or designated representative believes that a participant needs to initiate, eliminate or continue a particular service –in other words, requests a service – the members of the IDT must conduct an in-person assessment. And the PACE organization must have explicit procedures for timely resolution of requests. And the team must notify the participant or designated representative of its decision to approve or deny the request as expeditiously as the participant's condition requires, but – and I want to highlight this – no later than 72 hours after the team receives the request.

We had discussion back and forth with CMS about what it meant for the team to receive the request; and it's an important part of our practice, and I'll come back to it later. The team may extend the 72-hour timeframe by no more than 5 additional days for either of the following reasons: the participant or representative requests the extension, or the team documents its need for additional information and how the delay is in the interest of the participant. It's important to note that you don't have to furnish the service within 72 hours or 5 days later. You must furnish the service, according to regulatory language, as expeditiously as the health condition or the participant requires.

CMS 2010 Regional PACE Conference

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A PACE organization must explain any denials of requests orally and in writing. And if the participant or designated representative is dissatisfied with the decision, the PACE organization is responsible for informing the participant or representative of his or her right to appeal and describing both the standard and expedited appeal process. And it's worth noting that if you fail to respond to the request, that's equivalent to an adverse decision. If you fail to document your response to a request, that's the equivalent to an adverse decision; and that would trigger the appeal process. So this particular part – the service request part of the regulations and the appeal process – are linked. So I won't belabor the appeal process, but the regulations speak to that as well.

So, a little bit about our program. The Upham's Elder Service Plan is operated by our community health center, the Upham's Corner Health Center. We serve the core neighborhoods of Boston. Our current census is 190. We opened our first center in the Dorchester neighborhood in March of 1996; and then after a nine-year search for a second center, we opened our second center in the Roxbury neighborhood in April 2008. That's our Dorchester center. That's the former offices and warehouse of the New England Fence Factory. And that's our Roxbury center which began life as a social hall – no, began life as a grocery store, became a social hall, then an afterschool center, and is now our PACE center.

So these were the deficiencies that Matt alluded to that were discovered during our 2009 audit. First, our participant assessment – SDY04. The PACE organization failed to provide participants with timely notice of the resolution of requests for services. And then the linked deficiency -- participant requests not approved in a timely manner must be processed as denials of coverage, and service denial notices with appeals rights must be issued. And CMS cited the example of a participant who had requested a power-operated vehicle, and was a typical participant with medical/functional/cognitive/social complexity; and it took some time for us to resolve whether that request was appropriate or not. When they went to the chart, they were able to locate, with much effort and different pieces of the chart, the thread that contained the story of this request and its resolution. But there was no easy way to establish the sequence and timing and outcome of that request. There was no easy way for them to find that thread from beginning to end. So therefore it was impossible for them to determine, well, had we issued a denial of the request and were rights to appeal offered? In the end with this particular participant, we evaluated her safety in the community with using a POV and determined that she was not safe to use it, and ultimately recommended an alternative solution which she accepted. But again, that was not transparent or easily discovered in looking at the record.

The other problem with the audit was that during the two-year period we had no appeals, which might be understood as a good thing except that what was the denominator? In other words, in order to know how many appeals were possible, you had to know how many service requests were received and how many of those were denied. So just to outline the process, a service request is made by a participant or by a representative, is brought to the attention of the team, and then there are three possibilities at that point. The team can approve the request; the team can, on the other extreme, deny the request at which point we offer the right to appeal. It's also important to note that we can offer a compromise or substitute solution, which also begets the right to appeal. What do I mean by a compromise or substitute solution? For example,

CMS 2010 Regional PACE Conference

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someone might request increase in two hours of home health services midday on weekends; and we assess the situation and think that an addition of one hour would be sufficient to meet the need, and the participant agrees. Well, that's a compromise solution; but the participant still has the right to appeal.

Someone requests coming to the day center five days a week when they're currently attending twice a week. Let's say that we determine that three times a week is sufficient to meet their social needs. That's a compromise solution, and again begets the right to appeal.

Someone might request laundry services or home delivered meals; and we might determine there's a homemaker in place, that person can help with that. So it's an alternative or a substitute solution. Again, that would be considered a denial of the request made; and the participant would have the right to appeal.

And in the situation of the power-operated vehicle, we couldn't provide the vehicle quickly. We couldn't even make a decision within the 8-day window. But what we could do is say we need to evaluate this carefully. So that was sort of the compromise. And then at the end of the day, we established that the person was not safe; and we offered a different way for the person to get to the supermarket to do their grocery shopping. So it was a substitute solution. But all those would result in an opportunity for the participant to appeal if they did not accept the compromise or substitute.

So what was the solution? What was our corrective action plan? Well, the first thing to note, for better or for worse, our program is entirely on paper – or nearly entirely on paper – and we have logs and ledgers and systems that would not be out of place in the nineteenth century. But that's what we have, and that's what we use. And we listened enviously as we heard about the electronic health records. We hope to have one one day. So we use paper, and we developed this tracking system. We actually created this during our CMS audit. And we track the service request, the team response – whether it is an approval, a compromise or substitute solution, or a denial. And we also document that the right to appeal has been offered both verbally and in writing. It generates a care plan update -- every service request --and then we use this tracking system to contribute to our /INAUDIBLE/ program so that we can aggregate, trend and analyze our data.

So operationally, how does this work? Well, anyone on the PACE team can field a request. So for example the social worker fields a request to increase adult day health center attendance from two days a week to three days a week. Now, when does the team actually receive this request? Well, we have a weekly team updates meeting. This immediately precedes our weekly team review meeting. And in fact it's at our team updates meeting that most of our very important work gets done. This is where we gather the entire interdisciplinary team for essential information sharing and problem solving and care planning. And this is also the place where all the service requests come. And during the audit, CMS sat in on our updates meeting; and they liked it. They saw its value and how it operates, and they recognized that we want to preserve that principle. So that if the social worker fields a request on Tuesday and brings it to the attention of the team on Thursday at our weekly team updates meeting, that's when the clock starts for the 72 hours or the 5 days in addition to that. And CMS accepted that.

CMS 2010 Regional PACE Conference

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So the team can respond again in one of several ways. It can approve, it can offer a compromise solution, it can deny the request, or it can establish that more information is needed – that further investigation or evaluation is required to determine whether this request is appropriate. Our center manager has the responsibility of entering the request into the tracking log at the weekly team updates meeting. Importantly, after we first drafted our policy and procedure around this, CMS responded by informing us that we had to have some process for accounting for urgent requests. So, for example, a caregiver tells us that they need to leave town urgently to attend an out-of-state funeral. This is someone who cannot be left home alone safely. We have to be able to respond to the at immediately, and we have to incorporate that into our policy and procedure – that we would provide the service provisionally if it was an urgent request to meet the health and safety requirements of the participant. And then we've engaged in staff training around this that I'll share with you in a second.

This is the policy that we drafted. I won't take you through all of it. And this is our log, our service request log. I think that's a 7 font up there to fit it all on one page. Obviously ideally this would be better done electronically, but it works for us. But the different columns take you through the process, from service request to field the request. When did that request come? When did it come to the attention of the team? What was the disposition of the team with respect to the request? Was the opportunity to appeal offered verbally and in writing? And there's also a column there for when the service was actually furnished so that we could also do a /INAUDIBLE/ analysis of that. Are we providing our services expeditiously in relation to when the request was made?

So this is an example of sort of the /INAUDIBLE/ process that emerges from this tracking system, and this is 2010 experience for us – January through September. So during that nine-month period, we had 93 service requests. Of those, 49 were approved – 53%. Twenty-nine were denied; of those, everyone was offered the opportunity to appeal, none did. We offered 15 compromise or substitute solutions. They were all also offered the opportunity to appeal and none did. So here we know what the denominator is. There were 0 appeals out of a possible 44 substitutes or denials out of a possible 93 service requests. We can again track, trend, and analyze our data; and these were the requests that were made during this nine-month period.

And we also do training for our staff around this. So we design just a fifteen-item quiz. So at one of our monthly staff meetings give a brief in-service on the topic, and then give the staff a quiz – true/false, fifteen items. Then we go through the 15 items on the quiz, sort of a second round of teaching, and have them take the test again to sort of reinforce things. This 15-item test attests for all the things we just discussed; and then we can look and see how our staff performed. And when we did this in 2009, 15-item test – these were the average scores. And we can see that from the pretest to the posttest, they increased their average score from about 12 to about 14. And then 2010 we did it again, and people retained a little bit more than they had the previous year perhaps and again improved from the pretest to the posttest. So that by the end, they're scoring 14 out of 15 on average on this test and understood the regulations and how it applied to them.

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So before I take questions, I just want to sort of make one editorial comment. So we've been in business for fourteen years, and we take great pride in what we do. We take our mission seriously, the care of our participants seriously, the program seriously, and the model quite seriously. And when CMS comes to visit us, we really like the quality of our program to shine; and it always has. But we also recognize that we have to take regulatory compliance seriously, and we also understand that we may encounter situations where we are not compliant with regulation. But we look at that as an opportunity, just as we look at grievances as an opportunity to improve our program. And so a deficiency really represents an opportunity to identify some way to improve our program.

I think more than anything this was sort of an example of how we collaborated with our regulators from CMS and from Mass Health to create a policy that improved care, improved the regulatory compliance of our program, and ultimately hopefully will improve the quality of our program.

So I'll stop there and take any questions. [Applause]

If anyone has a question, if you could raise your hand and we'd be able get a mike to you. No questions?

Could you tell me what percentage of your participants actually appeal the decisions. I mean, you don't have to have an exact number, but a large number?

Well, the number-- thus far in 2010, none have. But now -- we knew that there were no appeals during that other period, and there were no appeals during this period. But now we actually know there were no appeals out of a certain number of service requests of which a certain number were denied and therefore were eligible for appeal. And we can demonstrate to ourselves and to CMS and to Mass Health that these were the service requests that were denied, and out of these emerged no appeals.

If you had a service request and you made a compromise, how did you handle that with the participant? Did you explain this to them verbally and they accepted it? Did you use written communication?

Verbally we come to some resolution offering a substitute or a compromise, they agree with that., we document that. And then we offer them the right to appeal, because they do have the right to appeal because the service request they made was not actually provided. We provide them something different. But they're satisfied with that, but they still have the right to appeal; and we document all that.

Hi, Adam. /INAUDIBLE/ from PACE Rhode Island. Maybe we have a very need group in Rhode Island, but 93 requests seems really low to me. I don't know if anyone else in the room services requests, so how did you define a service request?

Well, just as the regulations defines it. If a participant or a representative feels that something is required and expresses that, that's a service request. And you can see from the types of



service requests we received, they spanned the entire spectrum of our program -- from home health services to DME to requests for a medical appointment or test.

Following up on that question, can you elaborate a little bit more on how do you draw the line between the dialog in the process of the participant and family having input into the care plan and a service request?

Can you give me an example?

Well, in the process of getting input -- say it's time for somebody's care plan to be updated and you're reviewing with them how do you think it's going, what ideas do you have, etc., etc. And that becomes part of the input that the team brings in. And some of it may be clearly not a discrete request, it's an opinion; but at some point something would become concrete enough that it would be a request. And how do you provide guidance to the team in terms of where to draw that line? So where is it part of the dialog, and when does it become a service request that's either being approved, denied, or compromised?

I would say that if out of that conversation emerges a request for something, then it's a service request. So if in the course of a conversation between a social worker and a caregiver something emerges that leads them to believe that perhaps increased adult day health center attendance would be beneficial to both participant and caregiver, that becomes a service request. And that's then brought to the attention of the team, and we track it as such. I think maybe the important part is if you can define something that is being requested, then we track it.

And do you have any idea how many of your service requests come out of care plan review versus how many are kind of separately initiated?

I don't. I mean, it's something we could look at. We actually don't track that particular quality of the requests, but it's certainly something that we could track as well if we thought it would be helpful.

Thanks.

Adam, what kind of system did you have for tracking service requests before this deficiency was cited?

None.

I think that's where a lot of people are now. It's like we've found or find that some of what we call "grievances" are really service requests that we act on, and we document it in the grievance process; but it's probably not appropriate there. So I think this is a wonderful system, and we'll plan on adopting it.

You're right. I mean a grievance is an expression of dissatisfaction with a service or a complaint. And most of these are not complaints; they're just requests for additional or different services. So actually it enables us to distinguish from grievances and set that aside and track requests for what they are.



Are there any other questions?

I made the mistake of taking Dr. Burrows' true or false posttest; and in defiance of statistical probability, I scored a 30%. [Laughter] Tough test.

I just wanted to say one thing. I have an electronic copy of this worksheet; and certainly, with Dr. Burrows' permission, would be willing to share it with you. I would also like to say that some of the Region 1 PACE organizations have actually implemented an electronic health record tracking tab that takes this idea into an electronic format and really compiles the data for us. Because when we come out to do an audit, we don't mind hearing, "We have very few appeals," but we'd like to see the evidence to support that. We don't like to hear, "We don't have any appeals," especially from an organization that hasn't been audited in 24 months and has 800 participants or something like that. That's a lot of participant months to not have any appeals. It may very well be true. This form, this tracking sheet, allows us to verify that. Show us when you said, "Yes." Show us when you said, "No." It's okay to say, "No"; just show us what happened next.

And I suppose I could give out some information. If you really wanted to have some copies of the information, I will check with Dr. Burrows about sharing that information for any organization that does not have a process in place to track service denials through to appeal. So I will leave my contact information with the moderator, and certainly will check with the Health Plan and see if I can't come up with a very generic package, a starter package if you will, to share with the audience. Thank you.

I'll also mention that one other value of this is that from week to week, the center manager can actually inquire, "Have we responded to the service request," and "Have we furnished the service?" so the center manager knows what is still outstanding through this tracking system so we don't lose track either of those requests. Thanks.