

CMS 2010 Regional PACE Conference

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TRANSCRIPT

Keynote Address

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It's good to be here today. I'm not a huge Redskins fan, but it was kind of difficult coming to Philadelphia today after what happened last night. That was a pretty amazing win for the Philadelphia Eagles. But I'm glad to be here today in particular because CMS in D.C. and Baltimore, oftentimes it's hard for us to get the story on the ground of how care is actually really managed, and I find I learn a lot when I come and talk to people who have really put together the models like you all have put together, and, in particular, the PACE model.

So Jim talked about the conference and the meeting, helping you understand CMS's requirements and that kind of thing. I'd like to actually open your minds even a little further than how you operate the current PACE programs to suggest that some of the models and the interventions you all have filled are really at the heart of the kinds of things that the Affordable Care Act was trying to suggest and incent and require and demonstrate occur in the future. And so at the end of my talk I want to just raise some of the questions about your future as PACE and how you think the PACE model fits into some of the models that are encouraged in the Affordable Care Act.

So I'm going to go through, just in a little more detail, the triple aims that Jim spoke about in his beginning because that really has become the kind of organizing principle for CMS and, to some extent, the Department of Health and Human Services, go through some of what we at CMS are facing in the Affordable Care Act, and then talk about four pieces of the Affordable Care Act that I think are actually quite good opportunities for PACE, and then at the end, have a little bit of discussion about how PACE might fit in and what are some of the obstacles for some of the models that you might want to be a part of.

So, first of all, the triple aim. This is language and an organizing principle that Don Berwick, the new administrator of CMS, brought to CMS and to the Washington health policy environment. It wasn't a framework that he just thought up at the moment. This is something that he has actually been using as an organizing principle for some time. I would suggest that there are also aspects of this that CMS and the administration have been supporting over time, but having it laid out in this way that makes it much more explicit.

So most of what CMS currently does is really in the Better Care for Individuals, you know, the CMS Medicare and Medicaid program, basically are a payer of care. What this does is remind that we also have a responsibility because we are such a large payer and such a large part of the healthcare system to not only make sure that care is good when someone goes to the healthcare system, but also to concentrate more broadly on the population health, and also to think as a responsible payer about the need to make

CMS 2010 Regional PACE Conference

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sure that we have the affordability of healthcare we need for access to be insured in the future, so that's where you get the lower cost through improvement.

So the Better Care for Individuals though, just to go into a little bit more detail, has a few pieces to it, and this is, essentially, when anyone interacts with the healthcare system, what do they see when they interact with the healthcare system. So I will just go through that briefly just to say here are the ways that, in fact, the Medicare and Medicaid program, and you'll recognize some of this, I'm sure, interact with trying to ensure better care for individuals.

First of all, it needs to be safe care, so there was an OIG report that I think just came out yesterday that said, in fact, if you use the definition that they use of adverse effects that, in fact, that one in seven people have adverse events in the hospital. They don't always end up with life threatening problems, but it indicates there's a pretty serious safety problem in the nation's hospitals. The Affordable Care Act has a variety of different provisions to measure and to disincent healthcare acquired conditions, which is part of the safety issue.

Effective care, typically that is when you're making sure that you have some care that has some evidence base behind it, so some of the clinical process measures that you may use in PACE or have seen in other programs are often what we're talking about there; patient-centered to make sure that the care that is delivered, and this is one that I think you probably know, as well as any, in terms of providers that the care is actually centered around the patient and the needs of the patient; that the care is timely, people get the care they need when they need it; that it's efficient.

So in this particular one there is also kind of a cost dimension that says we want the care to be delivered as efficiently as possible. And these come from the IOM report of a few years ago that actually Dr. Berwick was a part of the advisory committee, and these -- actually they used it to define quality, so they put efficiency even within the quality framework. And then equitable just basically says that all groups of people in the United States should get the same access to the same level of care.

Better health for the population, that's controlling risk factors, looking at issues across conditions, across actual care delivery, hypertension, diabetes management, those kinds of things, as well as just making sure that the population lives as vital a life as possible. And then, again, that the other piece of the triple aim is the lower cost.

Recently we've added the words "through improvement" just to make sure it's clear that when we're talking about lowering per-capita cost that we're not talking about, as Don says, "hurting a hair on anyone's head." It's basically understanding that there's a lot of waste in the system that, in fact, when we do a better job managing patients that, in fact, it will decrease per capita cost. So that's the construct that we work with at CMS.

So the Affordable Care Act does a few things. These are kind of the big ones. It, of course, creates major changes to the health system in the next five years and, frankly, beyond that. It does this in two primary ways. It expands coverage to millions of

CMS 2010 Regional PACE Conference

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



Americans through Medicaid, and then through the health insurance exchanges that are typically going to be at the state level. So there's a lot of issues for states. I'm sure Pennsylvania is no different trying to prepare for this expansion of Medicaid to probably hundreds of thousands of more people in Pennsylvania.

Then there's a whole other part of the Act that really focuses on the delivery system and trying to shift the delivery system through shifting the Medicare and Medicaid program. So I'm going to just lay out a few of those, not to just give you a laundry list but just to give you a sense of the breadth, frankly, of what the changes are in the Medicare and, to some extent, the Medicaid program. I tend to be more familiar with the Medicare program, so you'll have to forgive me if I don't focus as much. There are pretty significant Medicaid program as well beyond actually expansion of coverage.

But, for example, the Affordable Care Act put in place or said that we needed to create a plan for value-based purchasing in really every setting of care in which Medicare pays for care. So what does that mean? It means that Congress said that, "CMS, we want you to find a way to tie some level of payment for every provider in the Medicare program to their performance on quality," and typically, in addition to quality, they said, "some level of efficiency," and so we're also working to create cost measures in every setting of care that we pay for.

So that means hospitals, in fact the hospital program is going to be implemented in 2012, next year, home health agencies, physicians, there's a payment modifier that comes into play in a few years so that we'll be creating individual physician quality and resource use measures, and tying some amount of their payment to their performance on that. We're to create a plan for doing so in nursing facilities, ambulatory surgery centers; and there is also a program that goes in place for the Medicare Advantage program to tie payment to performance. So that's a pretty big change and a pretty big challenge.

Also, for Part D, then there was some changes that said that the coverage gap will not be as large for beneficiaries in the coming years. It created a duals office, which I'll talk about in more detail, because it probably has some relevance to you and potential opportunities for the PACE program. So heretofore, CMS typically has a Medicare center and a Medicaid center, and in some ways ne'er the twain shall talk. We go to meetings together and all that, and there's been actually, in recent years, much more interaction, in part, because of our EHR incentive program where we had to really coordinate what the states did with what the Federal Government was going to do at the Medicare level.

But Congress basically said, "Okay, this is a population that needs coordination, Medicaid and Medicare, you don't seem to be, you know, getting together and figuring out what that is," so they actually created an office, a new office in CMS that's called the "Federal Coordinated Health Care Office." So, again, I'll talk to you a little bit about that in a moment. In addition, there was demonstrations that were mandated that CMS perform, and that's in addition the Innovation Center, which, again, you may have heard of, but I'll talk a little bit more as I go through the slides.

CMS 2010 Regional PACE Conference

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



So the four areas that I think that – when I think about PACE and the opportunities for PACE organizations, these are four that just come quickly to mind, I'm sure there's others, but I want to go to these in some detail. If you pay attention to the health policy, sort of, world, in terms of conferences and speeches and all that kind of thing, one of the words you will have heard is “accountable care organizations,” and so I want to talk a little bit about that.

Medical Homes is another concept that I will talk about. Then I want to go into some detail on the Federal Coordinated Health Care Office, which is the office I just mentioned. And then we have a new Center for Medicare and Medicaid Innovation that was established by the law that also, I think, provides some pretty significant opportunities for PACE programs. So I'm going to go through each of these in a little bit of detail, and then I'd like to turn to a little bit more interaction on your thoughts on how your programs might fit into some of these buckets.

So the ACA Medicare Shared Savings Program is one type of ACO that's talked about in the legislation. In addition to this specific requirement that we establish this program, there's also language in there that says that we can basically experiment with any kind of payment options that we -- “we” is usually the secretary -- that the secretary so deems as something that she wants to experiment with, model, pilot, et cetera. So there's quite a bit of flexibility in terms of where we could go with modeling different forms of payment for ACOs, in addition to the program that's established that I'm going to tell you about right now.

So the Shared Savings Program in the Affordable Care Act -- this is something everyone sort of forgets -- is not a pilot, it is a program, and it starts in 2012. And what it does, basically, it's kind of a hybrid between Medicare Advantage and direct payment to providers. So the payment to providers in an Accountable Care Organization is still fee-for-service payment, and there's a calculation that's done – and I'm not going to get into the gory details of what's your baseline and how do you compare and all that -- but there's a calculation that's done, and basically, if the Accountable Care Organization can show that for beneficiaries, through an attribution rule, we say, “Are there beneficiaries? Can they save money over a certain period of time that Medicare will actually share in the savings that were created for the program with the Accountable Care Organization?”

So there are requirements about what an Accountable Care Organization can be. They're fairly broad. You can be a hospital with physicians. You can be a physician without a hospital. Basically, the primary unifying force is you have to have a sufficient number of primary care providers to really provide a level of care necessary for the beneficiaries that would be aligned with that Accountable Care Organization. So a lot of discussions around antitrust and self-referral laws and anti-kickback laws, and how do we really form these things, and for hospitals, does this make sense for us, because really the way that we're going to get savings would be through decreasing admissions, either readmissions or potentially avoidable admissions. Is that really, you know, something we want to do? Do we think we can actually manage care? Can the hospitals and doctors really talk to each other? You know, all those other conversations



are going on really, I would – I mean as far as I can tell, all across the country, from position-led organizations, as well as hospital-led organizations, all with the idea behind of this integration being critical to coordinating care.

So that's a very interesting program, lots of energy and excitement around it, and for the PACE model, I think you all have sort of the tools that these ACOs might need in terms of interdisciplinary teams and some experience with care coordination. You're certainly dealing with some of the more vulnerable people that are in the Medicare program. So, you know, do you become a site for an ACO maybe? Do you get together with other PACE-like programs and try to create some model? There's, you know, all kinds of thoughts going through my head when I think about how PACE might interact with ACOs. So we'll go into that in a little more detail.

The other concept is Medical Homes: So medical homes concept is really focused around the thought that physician offices themselves or physician practices should act more like the medical home for beneficiaries. So instead of you having to integrate, you know, physicians, hospitals, et cetera, the thought is there's some form of payment provided to a physician practice that requires them to take on a little more responsibility for actually managing their individual patient's care.

So there was a couple of provisions in the ACA on this, but I want to mention a couple of other initiatives that we have under way. So one was the Medicaid Health Home State Plan option where there's a temporary 90% match for states that offer this option, and then there's some requirements around what the physician offices would have to do to be paid some additional dollars. And another -- a couple of other initiatives, so today I don't think it's been announced yet or I could tell you a little bit more about which states were chosen, but today there's going to be an announcement later from CMS about the Multi-payer Advance Primary Care Practice Demonstration.

So for this one, states, and I believe Pennsylvania was one of them, applied to be part of a demonstration where the states showed that they had other payers, so that would be some local insurers, as well as Medicaid, maybe the state employees plan, got together and said, "You know, we want to pay some amount of money to physician offices to really manage the care more broadly for the patients they see, but we're not sure that physicians are really going to do that if Medicare doesn't play" because Medicare is such an important player and clearly we really need all payers in the mix.

So states have come to us and asked if they could – if Medicare would come in and be a part of this MAPCP Demonstration. And we are announcing the states that have been chosen to be a part of it today. And, again, I can't talk about that because we're in the age of Twitter, as to who was actually chosen, but that should be an interesting one as well.

The other one is the Federally Qualified Health Center, Advanced Primary Care Practice Demonstration, and this concept is that Federally Qualified Health Care Centers, you know, do provide or are, in essence, sometimes the medical home for those that go to the FQHCs, and so this is a more aggressive effort to acknowledge that, to provide



some additional payment for FQHCs to test out the model of Medical Homes centered around FQHCs. Again, neither of those were required by the ACA, but are administration initiatives.

The next one is the Federal Coordinated Health Care Office. So as I said before, what the ACA did was create an office in CMS called the “Federal Coordinated Health Care Office.” When I say that publically, sometimes it sounds underwhelming, but, frankly, in the CMS culture it’s a pretty big deal to create a whole new office. There are a lot of structural – built-in structures in the Center for Medicare and Medicaid Services, so having an office that actually coordinates across those two big programs is a pretty big deal and one that focuses specifically on a certain population. I mean, that’s not something we do, is – typically, a whole office focused on a certain segment of the population called the “dual eligibles.”

So people have high hopes for the office. Melanie Bella, who many of you may know her name, has been named the director of the office and is going great guns to try to think through what might be the kinds of demonstrations or pilots or state waivers or initiatives or, you know, data sharing with states that we can do to really create a higher level of intelligence around the dual eligibles to provide states and providers information they can use to understand better the care patterns of dual eligibles, and then to think through what are the types of initiatives, payment policy. I mean the door is pretty wide open for the kinds of recommendations that this office could come up with.

You see here the goals on the slide. They were very beneficiary-focused, provide beneficiaries full access to benefits and simplify processes, improve the quality, continuity, care transitions, and then provider performance, improve beneficiary understanding of the benefits, and then eliminate regulatory conflicts and cost shifting between Medicare and Medicaid programs. I think these are all topics that you all are pretty familiar with.

The next slide just outlines the types of responsibilities, so what they’re supposed to do, not the goals. So provide the tools necessary to develop the programs to align the benefits, support efforts to align acute and long-term care services, coordination between states and CMS, to coordinate with MedPAC and MACPAC. I don’t know if you all are aware of what MACPAC is. MedPAC is the Medicare Payment Advisory Commission, so it typically advises Congress on Medicare policy, but the Affordable Care Act also created a MACPAC, which is the same kind of advisory commission now for Medicaid and CHIP.

So expect a lot more, I think, thoughtful analysis of the Medicaid and CHIP program out there more publically, not that there isn’t that now. There are foundations and others that do a good job with that, but now there will be an official body that is tasked with studying and coming up with recommendations for Medicaid and CHIP.

And then there was a specific study in the Affordable Care Act to look at drug coverage for dual eligible beneficiaries and monitor and report expenditures, outcomes, and access to those benefits for beneficiaries. So, again, I point out the Federal Coordinated

CMS 2010 Regional PACE Conference

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Health Care Offices because they are, like the Center for Medicare and Medicaid Innovation, which I'm about to talk to you a little bit more about, looking for innovation, looking for ideas, looking for those nuggets from those on the ground who have been doing this work to say what works, what doesn't work, what can we scale up, how can we scale it up. So a lot of creative energy around that office right now and what it can achieve.

The Center for Medicare and Medicaid Innovation is another pretty significant highlight in terms of establishing a new center in CMS. So this, in a nutshell, basically gives CMS extreme flexibility to – it says we can waive basically anything in the Social Security Act to demonstrate good ideas, and then there's a list of 20 possible, to include good ideas, which came from various senators and congressmen. But at the end of the process it says kind of, "Okay. So you can have all the flexibility you need, but at the end of the day you have OAC to talk to, which are actuaries at CMS, and anything you do, if you want to scale it up, it even allows us to scale up without legislation, so that's one of the problems with demonstrations, sometimes they go on and on and on, and no one bothers to scale them up and so just keep on being demonstrations.

This allowed us to actually scale up successful pilots but said you could only do so if the actuaries determined that, in fact, it does not cost more and improves quality, costs less but doesn't hurt quality, so you can – so that means we're struggling to go, "Okay, so what are those quality metrics? What are those cost metrics? How do we measure that? How do we show and demonstrate through whatever pilots we're doing that we've actually achieved that?" So lots of flexibility, lots of energy, lots of excitement, but we've got kind of a analysis at the end, so everything has to be set up to be able to show that if, in fact, we think that is what will be the result of the actions.

And I just mentioned, actually, on this slide, just a few of the things that are mentioned there, just to give you a sense that it really does relate quite a bit to the kinds of efforts that you all do in PACE. So this is probably too short of a list, but I wanted to just talk a little about a process that's going on internally in CMS.

So as Jim said, Don Berwick is very interested in and excited about the PACE model. His blog is really quite well written, if you call your attention to go and just see what he has to say about PACE. And he's asked us – he said, "So, if this is such a good model – I'm sure you've heard this before – why is it not more broad? I mean why is it not used by more people? Is there a way to scale this up?" So we've been thinking a lot about that question.

And so this list of attributes kind of came out of an inter-Medicare/Medicaid effort to talk to through, so if there was to be some aspects of PACE that were scaled up, what would they be? And so these were the four that came out of that process. One would be the interdisciplinary team as a key way to achieve effective coordination of care, as well as just effective delivery generally. It overlaps with care planning and communication, but I think the concept there was just more consciousness about care planning and the need to continually evolve the care plan, so it's not just to get a care plan and then three months later you revisit, but the constant communication that goes on, and interaction

CMS 2010 Regional PACE Conference

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that goes on in the PACE program between the family, the support system of the family, the people at the center, and how critical that is to effective care coordination and delivery of care.

Opportunity for respite and/or socialization, that many models of care just sort of gloss over that and don't really think about the caregiver that's there all the time, maybe needing a break, that for people in these kinds of program, rather than just be stuck at home, there's a place for them to go and interact with other people, and that that's an important health benefit and health need, as well as some of the more medical problems.

And then the one I think everyone is kind of striving for but doesn't quite know how to do is the fully integrating delivery funding and administration of Medicare and Medicaid services. So, you know, if you woke someone up in the middle of the night who's not from this country and you said, "Well if you have people that are on both these programs, why don't you just put the money together and pay somebody to manage it and there you go?" I mean it sounds simple. But as we all know there's a variety of different – I don't know what to call it – political and market issues that keep us from making it quite that simple. But you all are a model where, in fact, that's done, and so it's an important one to study, at least from that perspective as well.

So that's the end of my prepared remarks, but – and I could have put these in slides, but I thought I would just say a little bit more about what I think some of the questions are for you going forward. So questions, I'll certainly take them from you, but I have questions for you. And it gets back to what I said before. So it seems like a good model, but it hasn't really taken over the world. "Why not" is one question, and you could probably tell me all kinds of things about that. But I'm not sure I really want us to get into, you know, what are the barriers and all that kind of thing. I'd rather actually talk more about the opportunities that you may have in some of these other programs that I talked about.

So in terms of ACOs, and I think I'll just focus on this for a minute and just be interested in getting any feedback or comments you have on ACOs themselves. I don't know how familiar you are, and I'm happy to answer questions. But to me, what I see is two ways you could go with ACOs; one is you could try to find other partners and become one. Now there's probably some legal questions with, you know, how you might have to change your model to do so and can I still be PACE. But let's just think of PACE, for a moment, as kind of a delivery model rather than a program – a specific program. The other you could do is say, "I'm a provider of services," and then work underneath an ACO organization as a type of provider.

So how do you think about it? Are either those options? Are those things that PACE programs are even interested in? I suppose one fundamental question is are you interested in sort of trying new models at all or are you just kind of want to stay as you are? So let me open it up with those few questions to see if anyone has comment.

My name is Amy Minnich and I'm the Executive Director for the Geisinger Program in Danville, Pennsylvania. We're part of an integrated health delivery system and we're



very much actively pursuing an ACO for the organization. So, really, the role that our program has taken is we're a teacher. We provide a lot of resources, and we're not sure how we're going to fit in the big picture. But senior leadership is looking to what we've done in our LIFE program to model, not only to our health plan but to our provider network as well. We have about 700 physicians in our network, 200-plus that are primary care, and we cover about 41 counties in Pennsylvania.

So let me ask you a question, because this is an interesting model, do you know Rick Gilfillan?

Absolutely.

He's a very busy man right now.

He is. He has lots of money we understand, so -- not him personally, but --

Oh, that's the other thing, the Center for Medicare and Medicaid Innovation got \$10 billion, which is an unheard of amount of money for --

He actually came from our health plan so --

Yeah, I'm sorry. Rick Gilfillan is the new interim director of the Center for Medicare and Medicaid Innovation, so that's why I was asking her. And he's crazy busy right now. So basically they've said, "Okay, this is a good model, it's within our system, let's learn from it as much as possible when we're thinking about ACOs more broadly." So would they subcontract with your sites?

Possibly. We're not sure where it's going.

Do your sites see their patients as well as just the PACE?

Well, we're very much linked. Our LIFE program takes advantage of many programs within the system. So we use our hospitals, we use our physicians, our specialists, and we also interface with our Medicare Advantage plan. They're actually our third party administer per claim adjudication. They work with us on Medicare Part D.

Interesting.

So we've had the advantage that many smaller programs don't have, and we interface a lot with our proven health navigator or our medical home nurses. In the health plan they're a great referral source to our PACE program.

Okay. So one general concept is just as someone that ACOs could learn from.

Yeah. It's been good in our organization.

Okay.



Thank you.

Other comments?

We're part of a community health center. So, sort of like Amy, we're part of a larger organization that I think gives us lots of opportunities. Our two organizations actually use the same electronic health record which is kind of an interesting thing. One of the things that we're doing now on the PACE side is we're redeveloping a care plan in the electronic medical record that will be used probably across the board at the health center and probably in our partnerships with hospitals and other providers.

We have a lot of opportunity. At the health center we're a federally qualified health center, so we're part of the Medical Home demo. I don't know if Massachusetts will be part of the state demo. So we're, within the health center, developing Medical Home, and also, same thing, they're learning from the PACE program. They're looking at payment models, probably with our hospital partners or in some other ACO configuration. So I think all of us now are trying to figure out where PACE fits in. I think there's a little bit of difficulty in trying to – we're already obviously dealing with dual eligibles. The Medicare ACO doesn't do that. So I think we're kind of trying to figure out now where all of this fits together. But there's clearly places that PACE is way ahead of everybody else, and I think they're looking toward us for all that learning and systems.

Sue, one of the questions in my mind, I don't know if you have any thoughts on this or – I'm sorry, I forget your name – Amy. So PACE programs are paid capitation, but they're also a delivery site. So, you know, one question is if there's any possibility of continuing the way you are with taking the capitation, but possibly getting fee-for-service for some services, I know that's a funny mix and, you know, some integrated systems are also thinking about that, not as PACE, but many of the systems that come to us that say, "We're interested in ACOs," are like, "Yeah, but I don't want fee-for-service. I'm beyond that. I could do capitation or sub-capitation, so why don't you just do that." Well, that's not what the program had us do, so that's kind of a, you know, bit of a question. But I know there are some organizations – provider organizations that do take some level of capitation or sub-capitation from someone else but also take fee-for-service. So that might be something to think about, and what kind of issues that creates, or is that even feasible?

(INAUDIBLE) and the only issue or the barrier is the capacity limit –

Okay.

(INAUDIBLE)

She was – I don't know if everyone can hear. She said, "One of the examples of that is the daycare program where one question is the capacity, because you can't control the capacity so much when you're taking fee-for-service or – you lose spots for your PACE participants. I see. I see. So there would have to be some flexibility with capacity.



The other issue for fee-for-service has been the perplexity of cost reporting and data that has to then go to the state in carving out those expenses. So the administrative issues that surround fee-for-service adds a level to a PACE program

Okay. Is it primarily an issue because organizations are small or is it just – Yeah. Right. So you have to basically have two administrative systems in some ways if you do that.

(INAUDIBLE)

Yeah. In front.

Through capitation, as you improve patient outcomes, the amount of reimbursement you receive goes down, so how – it's like with capitation system, with risk adjustment, where your payments go down as outcomes improve, it seems to be, you know, difficult to experience. I mean, how could you develop a system for us to experience the savings or, you know, would risk adjustment go away?

I can't see risk adjustment ever going away, but I think you want it as much as we do. So your point being, the way you're currently measured now on risk adjustment, if your outcomes go up, meaning that you have – well, what does your outcomes going up mean to you?

Accrue as much or – incur as much cost. They don't go to the hospital as often, they go –

Right, but they still have the same conditions.

They do. But somehow just, you know, the rate has declined over time. You know, the rates – even though their diagnosed – I guess, the acuity of the diagnosis goes down.

Perhaps. That's a relationship that we definitely do need to keep very good track of, because we don't want improved outcomes to mean you're getting less money.

But it happens all the time.

Yeah. No, I'm -- well, I guess my only question would be if we're sure it's due to that, but, you know – and knowing the risk adjustment model a little bit, I'm not sure that it is, but –

I have a question here on the left.

Okay.

Hi. I'm Joann Gago, the Executive Director of LIFE Pittsburgh. And Pennsylvania is undergoing, as a lot of states are, a pretty bad deficit in the budget.



Right.

We were at a meeting just a few days ago, I think it was, being told pretty much that not only are rates going to be effected on the Medicaid side, but our slots, in terms of the actual number of expansion programs are in a dead stop right now. So we're saying to ourselves, as I have been saying, some of the state systems, frankly, are very contributory to the problem with the census, very, very. I mean that's the main problem. So as I am a program 12 years old, we're a little under 400 participants, we think we can have 1200, not tomorrow, but we could do that, except for some of these systems that are in place. So in terms of really creating a new model and a new – we have the idea of what to do. The expansion of the program, though, is being held back seriously by a lot of these other systems, and now, with the new material, as this budget is such a big problem. I don't know what you think of that.

Well, actually, I would like to hear more on that, because one of the questions we were asking in our internal work group was, "So, why doesn't it scale up more?" And one of the answers was, "Well it's not really a model that is something states" because it's small, because there's a limited number of people it requires. And it's the same for CMS. I mean people think of us as big, and we are big, but to have staff that's devoted to the kinds of, you know, compliance efforts and management that you need for a particular program, it's just hard to have a whole other program that is so specific. So I'm not saying that's right or wrong and so I'm understanding that.

But let me just ask of you or others, so do you think that – are others in the audience like you, willing to scale up, in fact, would like to deliver care at a more – people maybe have more sites, but just, you know, if the states not going to give you the slots, what are you going to do?

Well I especially think that it's slightly more egregious, although I hope there's nobody from Pennsylvania here, that – because we have – Pennsylvania is just amazing in terms of the number of PACE programs.

Right.

I was one of the first ones, and now all of a sudden I have, you know, 15 brothers and sisters in the program – programs, I mean. So to think now we're going to slow the expansion of that at the time where we're right at the cusp of making it be really be major health care provider is a problem. But I also wanted to say that as I'm reminded, the monies go to the nursing homes, which are more the entitlement of the consumer and the community in Pennsylvania, which is completely backwards; entitlement to a service, entitlement to care, yes, but not to specifically the nursing facility.

Okay. The other thing that I would – that I'm going to tie in another comment I was going to make, and also this is asking if you have any ideas about this. So to be able to either get more slots for the current PACE program or to, so-called, sort of sell the concepts for incorporation into other models or even your own sites as delivery sites for other models, one of the things that became clear to us in the workgroup was that we

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don't have enough information on the results of the PACE program, and so that is to say we really need more data on either cost savings or quality improvements. We just – we don't have it. And I know there have been some evaluations, but we really need to have harder information about the PACE program.

I think both, in terms of just making sure people do see the benefits generally so that it maintains itself as a program, but also so that we know what works and -- you know, what particular things do work in the program and how can we replicate that elsewhere, even if it's not in the same model exactly as PACE has now. So I say that as really encouraging you to do anything you can to give us results. Also to know that if there's going to be expansion through pilots where you actually demonstrate on a broader level the possibilities in PACE, we have to have that.

As I said before, for the CMMI, if anything is going to be demonstrated using PACE, there's going to be some really pretty rigorous evaluations. So I say that also because of my colleague, Marcia Davenport. I don't know if she's -- hi, Marcia, hi -- is here and she was a part of that discussion, and that was one of the key things that we talked about, and I think she's probably going to talk about some of that here today with you as well, and the need to get more information from you so we can demonstrate the results of what the PACE programs do. But, yes, I do hear you on the nursing home issue, that's particularly relevant at the state level, but it's also relevant at the federal level as well. One more question.

I just wanted to make a brief comment about the fee-for-service issue.

Uh-huh.

I think what makes PACE as good as it is the capitation and the flexibility provided by capitation. When you're fee-for-service you're locked in. I have to provide a service that I'm going to get reimbursed for; whereas, in our model, if we need to buy a microwave or an air conditioner for somebody to make their lives better, we do home modifications, and housing is a huge part of PACE as well, which is not usually considered in a health delivery system.

Yeah.

And I think that that is -- you know, if you're going to try and pluck the PACE model and put it into a fee-for-service model, it's not going to work.

Okay. All right. Well, thank you very much, helpful feedback for me. I'm here for a little bit longer. I actually have to go back in about a half an hour or so, but if anyone has any other questions or comments, let me know. Thank you.