



CMS 2012 Tri-Regional PACE CONFERENCE

Programs of All-Inclusive Care for the Elderly

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TRANSCRIPT

Open Forum – Potential Flexibility in PACE

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This must be what it's like at the Oscars. There's big lights up here. Can everybody hear me okay I'm not known for being very loud. Great. Thank you. If that changes, raise your hand or – I may not be able to see you, but let me know. Because I do want to take advantage of this opportunity. I'm really, really excited to be here. Thank you, Tammy, for that wonderful welcome. I hope I can live up to it.

When Tammy invited me here, and I could talk for 30 minutes, but I thought it would be more interesting for you all to tell me what's on your minds. We've been meeting a lot with the National Case Association. We're with the Medicare-Medicaid Coordination Office, the Dual Eligibles Offices for short. The Affordable Care Act set us up back in 2010, which seems very long ago but was not actually that long ago. And one of the first things I did when I got hired was SCAN Foundation had a sort of one day conference on the future of PACE. So in our office since the very beginning we've been thinking about PACE. It's obviously the existing model for integrated care for dual eligibles. I'm grateful not to have to explain what a dual eligible is to you all. You know even better than I do. So really it's all about me getting your feedback right now and continuing a conversation we have had for about a year.

I will tell you I was a little bit scared when I saw on the back of yours, not mine, the little feedback buttons, because I thought feedback there was more about little shocks. If you don't like what I say, you could hit nine and – but I've been assured that that's not the case. That you'll actually use microphones and you'll, you know, give me your feedback verbally in the old fashioned way. I'm very 2000. Or maybe 1900s for some of you.

So what I want to talk about is that we, in our life, just as you in your life are doing lots of things in parallel where it would be lovely to have sequential stuff where we could address the existing model of PACE and some of the places where there's limitations and fix those, and then think future, and start testing things, and sort of go in a nice, sequential linear way. But we don't. We do everything in parallel, and so I want to talk about both sides of what we're doing and get your feedback on both sides of that.

We have one area that we call Program Alignment, which is the area I head up, which is what can we fix within the current regulatory and sub-regulatory framework for the PACE organizations to make it much easier for you to do the good work that you do. And I know the National PACE Association has worked a lot with you all to get the ideas that they sent us late last year. And we have been working with colleagues in our Center for Medicare at CMS and then Center for Medicaid, CMCS. I'm sorry. I forget

the acronym. But both the Medicare and Medicaid side, obviously, in the regional offices who work on the PACE side within CMS to see where can we make things more efficient, remove some of the road blocks, obstacles, that are either in reg or sub-regulatory guidance. And a few of those things are flexibilities and settings, contracting with community-based physicians and the process for doing that. Some personnel requirements for new folks to have a – a year's worth of experience with frail elderly, which we know can be challenging, and maybe not so relevant when we're talking about PACE being a very different model of serving this population. And delegating some credentialing to downstream entities or subcontractors.

So, we're working internally to see which of all these different ideas have been teed up that we can move on, so stay tuned. We hope to be able to provide some updates more officially soon. You may know if you work with government, when you tell us ideas, and then we go and start talking about it, we go into what I call the cone of silence. We can't tell you what we're thinking about. We can ask for your feedback, but we can't tell you, you know, exactly what's going on, but I'm hopeful by late spring, early summer we can actually talk with the cone of silence and start making some progress in that particular arena.

The other place that we're very active in, and maybe you all are familiar with this, is the demonstration arena, partnering with states especially, although we have another one I'll mention just briefly. To think about looking forward on integrated models of care, coordinated care, for dual eligible beneficiaries, all the Medicaid and Medicare is provided by a single organization or a single framework. You all have been doing that since the eighties, I think. A very long time. So obviously we're looking to a lot of the lessons learned and also including PACE in these ideas. And, again, National PACE Association shared with us some different ideas about what would work. And what we were able to do, again the demonstrations right now we're focused on what the states are interested in moving forward. Some of them are looking at PACE. Some are looking actually demonstrations, Medicaid only demonstrations – I'm sorry to sound like a bureaucrat – it's a different demonstration authority that involved PACE. So we're involved in all those conversations internally. But we have an annual report to Congress that's required in the legislation that set us up. And in there, you may or may not be aware of it, it just came out last month, a couple weeks ago, and we're supposed to – or we're permitted to, I should say – make legislative recommendations. So we only made two. We're still early days. We think there's a lot that we can do, either in demonstration or regulatory, sub-regulatory environment. But PACE was one of the areas where we signaled to Congress a real interest in exploring flexibilities. And those specific flexibilities were around eligibility, so right now you know the population that's eligible could expand that to folks essentially under 55 who maybe are not quite at the nursing home level of care.

Additional operational partners. We know there's been some work with the VA in Montana, my old home state, they've had to scale back a bit, but are there ways to continue partnering with other entities who might want to do PACE whether or not the state is able to engage.

Alternative care settings is a big one. And then tailoring the interdisciplinary team. We know that what's currently in statute and reg and sort of downstream is based on the model that was developed back in the day when PACE was starting, and that's great. I mean it's really great that we were able to use demonstration authority to test something and put it into law. But it's so specific, that we're locked into that model, as you know. I don't have to tell you. So can we make some flexibilities based on the growing needs of folks and what we know more about care delivery.

So National PACE Association also teed up some other ideas, and none of these are going to be new to you because you probably gave them to the PACE Association. But things like transitioning folks who are currently in nursing homes to community-based care. Are there possibilities of exploring risk-sharing for new PACE organizations? We know it's a very intense small population, and financially there's sort of a long lead time before you get up and going, so is that something that could be explored? The eligibility determination process and some of the steps with that. And reviewing the process for how we look at applications. Two-way contracts. Right now they're three-way, state, SMS, the PACE organization. What are the – the options?

So these are the ones they teed up, and again, just to be clear but I want to be pretty open in having a conversation that we're exploring all these. We haven't committed to any of them. But what I really wanted to do is throw open the conversation to all of you to see what you're interested in in all those things and what are the pain points so we could help remove whatever were the authorities. We don't even have to talk to that.

So I've done my job, I've talked for less than ten minutes, which was my goal. And what I'd love to do is open it up to you all and ask you what your thoughts are, and what you'd love to see us explore, what's most on your mind in terms of what's next or, as Jim alluded to, the existing model is growing. We've never had so many PACE applications in the pipeline. That's exciting. So the existing model \INAUDIBLE\ future. And again, just continue the conversation that our offices had for the last 14 months now. So, let's see, I think there's – mic's here. There might be a mic wandering around some folks as well. But if anyone has questions – either that or you get a really early break. But I'd love to hear what's on your mind.

Morning. In New York there's a lot of expansion going on. The state has really embraced the dual programs and – and PACE and is really saying grow, grow, grow. And one of the questions that keeps coming up from the PACE organizations is when we have opened up additional sites and when we have opened up alternate care settings over many, many years some of the PACE programs are some of the oldest in the country. Is there an opportunity to not have to go through – through your four-month process for opening up another center when the state is literally going to be doing mandatory enrollment for managed long-term care and thus PACE programs will have the opportunity to grow by hundreds in a month. That means getting new interdisciplinary teams, literally sometimes one or two teams a month. It's too hard to get approvals for new centers when you're – when you're trying to do that, so, you know, what flexibility can happen when the state is really on board with a grow, when they want to do it responsibly but they need to do it fast?

That's a great question. Some of it will depend on the degree to which they're expanding under demonstration authority. And again, I'm so sorry to be a bureaucrat but we have much more flexibility there in terms of streamlining the processes for expansion of existing organizations or bringing new ones on board. So some of what I can take back is exploring that question of what is the way that we could get to what you're talking about. Especially, I think, in your instance it's when existing organizations just want to open up additional spots, so you're already tested, you've already gone through the initial hoops for however many months or years you've been doing that. So, thanks, that's a great suggestion.

Let's see. I think we have someone in the back?

I really don't need it. Okay. So.

Is it on?

It's on now. Okay. Thank you for the comment on the eligibility. I absolutely agree that the level of determination has been difficult for us PACE providers. But how – what considerations are being made for opening up eligibility beyond the first of the month? These aren't well seniors, they're frail duals. So you mean an effective date of the first of the month? So that if I'm doing it – today's the seventh? The sixth? And I have to wait until April first, and that's a long time to wait. So we've – we've had some conversations about that, or at least I've heard conversations about how we could effectuate that. I think there's just some logistical challenges about that, and I'm a little unclear, I'm sorry, I don't know if the statute constrains us in that way. But let us take a look at what might be able to get us there because you're right, it's a long time to wait for folks who need care right now, in this model.

Good morning everybody.

\INAUDIBLE\.

A little bit out of – anyway –

\INAUDIBLE\.

\INAUDIBLE\.

One of our challenges in New York is to try to get the enrollment in participants, interested people, elderly, dually eligible participants, they love the program but they don't want to give up their physician. And we continue encountering this issue, is a big one. What flexibility CMS or legislation can do to help us, because if these programs are going to be growing throughout the nation, we are restricting the participants. And they want to be part of – of these programs, but that's a big problem for us.

My understanding, and I – you probably already can tell I'm not the PACE expert in the world. We coordinate many, many things, but my understanding is that right now there is an option and a pathway to contract with community-based physicians, and we are trying to learn more about the actual experience of plans – or PACE organizations who've done that. One of the concerns we've heard in this conversation is that – the good side is they get to keep their doctor and then enjoy the rest of what the PACE model brings to them, but if that doctor does not buy into the way a team-based delivery of care and does that create some problems or tensions. It doesn't mean to shut down that option, that existing option, but how do you balance that, so there is an existing methodology. It's – I think it's a waiver thing, and I – but we're taking a look at that right now just to see the degree to which we want to streamline it or what we could do to improve that, but also keeping mindful of that connection to the PACE model care and that delivery team-based care.

Okay. We have someone here?

Is there a conversation about specialty populations? It kind of gets into the under 55 conversation a little bit, but the adults with disabilities or traumatic brain injuries, or any conversation about that?

Yes, absolutely. So when we think about the populations under 55, there's quite a broad population in one area. We've had conversations with the Veterans Administration because they're very interested in bringing that to some of the returning veterans especially. Older ones as well, but some of the younger

ones who are going to need intensive care for – for many years to come. We've had some conversations about individuals with developmental disabilities. And then individuals with – with other disabilities, and that's where some of the care setting issues come in because they may or may not be interested in coming every day to a physical site. There may be virtual ways to connect that are much beyond me, but, you know, between all the different social media that has different types of connection that give the same feel. So, absolutely, those are the ones that we've heard conversations about. And I don't know if there's others that you're interested in – TB – sorry, traumatic brain injury is a good one. Thanks for that idea.

Good morning.

Good morning.

One of the things that we struggle with in Pennsylvania and it may also be true in other states is the vast number of licenses that we're required to have, different regulatory oversights, and I just wondered if there's any thought – I know that – I congratulate the state of Delaware which has decided that CMS is enough. And I just wondered if there's any way for CMS to address that with the states or have a single licensing or something like that.

I can definitely understand the appeal of that. I'm not sure that we're in a position to take an advocacy role on that particular issue. If a state's wanting to say CMS is enough, that makes some sense. I feel like we have a pretty good oversight program and approval process. So I'm sorry on that one. Maybe we're more of a spectator.

There's a gentleman in the back.

Hi there. I'm with the Boston Regional Office, and I'm a PACE account manager. And I – I'm so keen on the model of care, and yet it seems like it's very – the awareness of PACE among the frail elders is very poor. Both my parents were PACE eligible, and neither of them really had any awareness of it. And I didn't tell them about it – no. But I'm wondering why this is. I'm sure on one hand it's a question of marketing, but on the other, it seems sometimes that from the state level of it there are competing programs on the Medicaid side. And is there any effort from CMS to – to, I guess, somehow sort out these Medicaid, or these state-sponsored programs and how they might cannibalize participation in PACE or – or just crowd it out?

I'll tell you the thoughts that I have, but maybe folks here can actually respond to the question even better than I because I'm sure that there's been lots of effort to raise the profile of PACE in your individual communities so people are aware of it. Some of – is the – I can't see over in that direction, but the woman who asked the question earlier about, say, the first day of the month. You have to wait and go through a process and make sure you meet the level of care and it's the first of the month so that's a delay, where other models of long-term care, either a nursing home or some of the other home community-based \INAUDIBLE\ services are more instantaneous. When you qualify, you get to go in and you're there. So I think some of that can present challenges. But I would actually open it up to ask people here about efforts to raise awareness and where the potential roadblocks are, the potential struggles outside of that particular issue. Is there any insight that people here want to share?

\INAUDIBLE\ We've thought about this a little bit in the Philadelphia area. But even in the Philadelphia area there are, at this point, part of the city of Philadelphia and three surrounding counties without a program. So to do regional advertising has some limitations in terms of – so I think that's one thing.

Yeah. Right. And I think because as we think about some of the demonstrations, for instance, that we're talking about with states that maybe over quite a large part of the state and include many or most dual eligibles in the state, we can think about including information on PACE, but it's a specific subset of the population who can qualify for it. So when we have many folks who won't qualify but a good number who probably do, how do we focus that in a broad-based outreach effort? And it – it's a question we're needing to think through on our end.

I'm not sure how much of this is a state issue, so I think, you know, going back to the licensing thing, but I know for the state that I come from, which is Rhode Island, they're still in the throes of making a decision about whether people will be auto enrolled into these long-term managed care products, and then it cuts the pipeline off for PACE. And so, you know, to the extent that CMS is asking those questions of states when they're submitting their proposals for long-term managed care initiatives, I think that's an important conversation to have. If you know it's a PACE state already, I think the question, back to Dick's comment, is, you know, you say to the state, have you thought about PACE's role in this and what's your strategy to insure that all of these models succeed because they all reach a different audience and at the end of the day provide good care and are cost effective. I think the other piece in terms of managed care products so of cannibalizing PACE is that they're generally larger machines. You know, they're run by United, they're run by Blue Cross. They have a bigger machine, and the whole purpose behind PACE to some extent was a much more personal approach to care. Um hmm.

And so I don't think they're the same product. And how states are going to be encouraged to differentiate and really give consumers accurate choice I think is a piece that CMS has a role in in terms of rights and communication.

Okay. Great. Thanks for that feedback. Oh, hi. Please.

Hi. Thank you for coming today. I'm Karen Armacost from Hopkins Elderplus in Baltimore.

Right.

And I wondered if your office has any input or influence on the encounter data requirement for January 2013 and/or the Part D requirements. So, if you could let me know.

Sure. Our office is a coordination office. We don't own those two programs. That gives me the freedom to come here and talk in a different way than the owners of those programs. So the encounter data – I was just talking to Dan Drake out here about that, and his colleagues. We can talk through some of the challenges there, and it's actually going to echo the challenges we face when we set up these new demonstration plans. They will be brand new, need to set up encounter data, I need to parse it out what's a Medicare encounter versus not. So we can reach out to you all and make sure we understand the nuances of it. Is it just the whole effort to – is it just aggregating, is that the challenge? Is it the, you know, non-CPT services, all the interesting stuff PACE does that's worthwhile and important and part of the model that doesn't have a CPT code necessarily, is that part of the challenge as well?

I think those of us who grew up with the model and have been in it for quite a while, and I'm sure you new folks, it seems to me these new requirements take apart what's great about the PACE model. And that we have all these conversations, and now – and we – we got the capitated rate and we coordinate care very informally and that's part of the beauty of the model and now we have to go back and dissect it and put it into CPT codes, etc., and it's pretty fundamental. So I think that's a concern.

Okay. I hear – I hear you on that. That would be really challenging, because you, as you said, you've gone for a number of years delivering the services. I will say from our perspective having some insight into what happens in PACE or any capitated organization is really important to us and – and I think necessary and worthwhile. And we can take back the challenges around it. I'm not sure that we would say no encounter data ever or even our office would be interested in something like that, but keeping it workable. And then on the Part D, we have talked some with the PACE Association those issues, and we haven't brought those up internally yet. We're aware of them, so we can go back and take a look at that and see to what degree we can simplify given that you're delivering a Part D benefit that so many of those requirements are – as the other woman had said, you know, makes sense in a massive prescription drug plan but maybe not so much for this.

Okay. Anyone else? This is your chance. CMS. Here to listen. Okay. Well, if – if there's nothing else, I'll be around just for a little bit and you're welcome to get in touch with me. I'm not sure – I'm sorry – if my email is on the agenda, but it's sharon.donovan with a one after my name, @cms.hhs.gov. Or you can always get in touch with Tammy. I've known her for years and she can always lead you to me. But we hope that we can continue to reach out, ask for your help as we try to support you in – in taking the program where it can go. Thanks very much for your attention.