



CMS 2012 Tri-Regional PACE CONFERENCE

Programs of All-Inclusive Care for the Elderly

Philadelphia | March 2012



TRANSCRIPT

PACE Updates

Carrie Smith, Technical Director, CMS

For those of you that don't know me, I am Carrie Smith; and I have worked on PACE for a very long time – over 13 years now. I really enjoy working on the program. I had the pleasure of seeing the demonstrations transition to permanent PACE providers in 2001 and 2002. You will probably hear my name come up if you are a new timer. I love answering questions about PACE. I have been to PACE organizations across the country. So I am here to give you some updates.

I do not have slides, so I keep cringing when the evaluation comes up and people are pushing their buttons for that. So I know I'm not going to get a good score on the slides and the clarity of the slides. But what I want to talk to you about is really general, so I didn't feel like we needed to have in the deep depth of the slides that you've been seeing on the other important topics that people have been talking about today.

There's a lot going on at CMS and a lot going on with Medicare, a lot going on with Medicaid. Over the years, we have seen PACE grow. We are up to 86 PACE organizations across the country. We have 16 pending applications. We have PACE in 29 states. We have two new states that we have pending applications from. One of those is in this tri-regional area, which is Delaware, which I'm happy to say because I was once a Fighting Blue Hen from University of Delaware, and also from Wyoming. We've been talking to a lot of other states as well. We expect Nebraska to come in with an application soon; so we're excited about that, to see PACE growing in new states.

Over the last year, we have approved ten applications. At the same time, as of the year before, we had approved five applications over the last year. So we are seeing them grow; and at that point, we had eight applications pending and we thought that was a lot. And now we have 16 pending. So as you can see, sort of the rate of growth is increasing over time; so we're really happy about that.

In this tri-regional area, you have over half of the PACE organizations in the country. You have 44 approved applications, and 9 of the 16 pending are here and in nine states. So these numbers are about to change because we have a new organization that will be effective April 1st, which is in Northern Virginia, in this tri-regional area. So we're happy about that, a big shout out to them. So hopefully they're here – I can't see – all right, good, good to see you. So we're happy to have them aboard – and then, again, we keep seeing new applications coming in; and the ones that are pending are rapidly getting approved, so we're happy about that.

PACE continues to be a state plan option and has always been. So it's an optional service for the state. Some states have warmly embraced PACE and taken it into the realm of things that they want to offer for long-term care services. I'm sure a lot of you are aware of things that are going on in states now. States continue to be in budgetary crisis mode and trying to find programs that can serve to eligibles that can include Managed Long-Term Care. So you will see a lot of your states talking about that, exploring it. Recently we had a state, who shall remain nameless, that came in and was considering eliminating PACE in the state. It had been a strong supporter. But I'm happy to say that they have decided not to do that.

So we try to educate states. And I encourage you all as well to establish good relationships with your states, as we do when we enter into the three-way agreement as well. And keep them educated about PACE. Sometimes what happens is different folks in different parts of the states are trying to revamp or redesign the Medicaid program in their state; and they may not be familiar with all the programs that are offered in their state and all of the good things that they are doing. So whoever comes in and tries to redesign the Medicaid program may not know all the benefits of PACE. And we try to educate them on that. But I would encourage all the PACE organizations to do that as well, and make sure that they know what you're doing and then know the program. And it's something that we struggle with at CMS; but hopefully as things go by, as in the case that recently happened, we were able to talk to them and they have decided – they learned more about the program and decided to keep it in their package of services that are to be offered in Managed Long-Term Care.

So Managed Long-Term Care is kind of the wave of the future that we're seeing at CMS on the Medicaid side. There's a lot going on, a lot of states coming in with 1115 demonstrations. And some of those states have PACE already. And we are working with those states to make sure that they know that they can keep PACE in the package. And one of the choices that they are offered -- that folks that need long-term care services are offered – and make sure that they know that that is an option; and it's an option to keep it while keeping other Managed Long-Term Care options available, which is the way states are exploring. You know, PACE is already out there operating as a program to serve to eligibles; and that's something that states are looking to do in budgetary times when you can try to fix the costs so that you know what your costs are going to be with a capitated rate. So that's why they're looking into that. And they already have that with PACE. But trying to serve more people – larger populations with it and talking to other managed care programs. So something that we're working a lot right now at CMS on making sure that we have that covered.

So I also wanted just to go over a couple things about things that we've been working on and things that we're continuing to work on and let you know about that and then open it up to questions. But hopefully you all know that this year we released our PACE Manual that went out in June of last year. It is on our website. We went through and we had -- in the ten years, we had never issued a manual. So there were a lot of things that we felt like that we knew in our head and that folks knew what we were doing, but we wanted to make sure we get some of that down on paper. That is a living document that we will continue to update because we are aware that there are some additional guidances that need to be addressed, such as the ones we're working on now which include marketing.

I know that some of the guidance we have in there right now is general. And we hope to be issuing soon some additional marketing guidance -- things about what's included as marketing materials, what to do with them, the approval process. A little bit of that is in the Manual now, but we hope to be able to issue some more very detailed guidance about what to do so that you won't have any questions. You know, these days with social networking – and I know that PACE organizations are trying to – it's very

important for them to be able reach the folks that they need to reach. And you wouldn't think that possibly your target population would be into social marketing; but if they're not, their relatives are. So we're trying to make sure that we stay with the times too and have that as part of our guidance.

Some other things we are also working on – alternative care setting guidance. This is a particular issue. I know that we are trying to be – what we struggle with is we're trying to be as flexible as possible to help the PACE programs grow, but at the same time trying to maintain the PACE model and the integrity of the PACE model. So right now, our guidance that's in the Manual is very general and says, "Hey, let us know about it. Let us know what you're doing." But truly we have found that that's not enough, that we need to know a little bit more. So we are going to be issuing some more guidance – hopefully, later this year – to let folks know our expectations and make sure that we can help you all grow and make sure that we stay comfortable.

We are also working on updating the audit process. Hopefully that will be coming out soon. And we have had some teams looking closely at the audit process. We always try to streamline that process and make sure that we are getting at the important points that we need to know, and make sure that you all know what our expectations are. There's been a lot of talk at the conference about some of the details of our expectations, so it's really good. I think this has been a great conference to give you all the kind of information that you need to help you better understand some of the hot topics that do come up on audits – you know, service delivery (like Peggy was just talking about), care planning, things like that which I know is coming up later today. So I think those are really important to pay attention to. So we will be rolling out the new audit model later this year.

So that's about it that I have for updates. I do want to – I know you all have been really quiet as far as questions go. But I do want to throw it out there for you. I have been to many PACE organizations and have seen many different scenarios from the national perspective. So I know you've gotten a lot of information on detailed in the weeds things. But I would be happy to answer any questions that I can from the national perspective. You know, we do want to let you know that CMS is still very supportive of the PACE program from Central Office, and we are happy to see it growing nationally. So if anybody has any questions from the national perspective, I would be really happy to answer them.

Yes?

Good. Thanks, Karen.

Can you give us an update on encounter data? It's a big issue for a lot of us. It's another huge regulation for us to deal with. And it also feels like – I don't know if you were here yesterday when I mentioned this – it just feels so different than the original PACE model that many of us grew up with. We're starting now to dissect everything we do and put an ICD 9 code to it or a CPT code.

Right.

So I guess that's a comment and a question.

Sure, yeah, and that's something that's happened. You know, over the years we've had to adapt; you all have had to adapt. You know, things like Part D came along. Before Part D came along, PACE was providing drugs and everything was going peachy; and then all of these new requirements come along --

reporting requirements and all kinds of things that came along with Part D, so we've had to adapt to that.

The same kind of thing is happening with encounter data. You know, it's something that they're being required -- everybody's looking for ways to have evidence of things and, you know, now when we're looking at new programs, everybody wants to be able to compare them. And I think that encounter data is something that they're requiring of everyone. So it's not just PACE; you know they're starting to require it of everyone. But either we do recognize that there's difficulty in that in PACE because an encounter -- you don't operate on encounters. And we know that.

And I know that -- it's not my area. Things are siloed at CMS. But I do know that there's a work group that's being formed, and the National PACE Association has been actually representing you all and working with CMS to form a work group to try to make sure that since we do have these requirements now, to try to make sure that it makes sense to the best of our abilities of what an encounter is and how we can track that for PACE. So I can't tell you where it's going to end up. We do recognize the issue and are trying to work within where we can, the means that we can, to address it. Thank you.

Other questions?

I just want to say thank you for the Care Planning Guidance document that CMS put in place in September. It has definitely been a great training tool, and I would ask that you would continue to update that if it needs to be because the PACE programs have had a great success in applying that. In addition to that my question is -- and this centers around community-based physicians -- Will there be any guidance that you all will put out for community-based physicians? Because right now it's dealt with through the BIPA Waiver process, but it would be helpful to have some guidance on that.

Okay, thanks. Thank you about the care planning guidance. You know, we do know that that's a very important issue, particularly for new organizations learning the model and being able to have that. I know that there are talks of trying to update that guidance and make sure that we are as clear as possible in our care planning guidance. So I know that there are teams forming to make sure that gets updated, and our clinical teams know the importance of that.

Community-based physicians -- you know, when we first did the model, we didn't anticipate that community-based physicians would be something that PACE organizations would want to do. But quickly we found out that that was not the case. And in some instances, organizations have been successful in having community-based physicians and having them interact with the team and be part of the model. But right now, we don't have that ability in the regulation. So that's why we have to go through the BIPA Waiver process.

We are very cautious because some organizations have taken on several community-based physicians, and it has not worked out very well -- you know, physicians that said they would participate in team meetings and do assessments ended up not doing that. And maybe there were too many of them at once, and a new organization just couldn't handle that situation very well. But then there have been others that have done very well with it. So it's something that we continue to have in the BIPA Waiver process. It is on our list of things to consider for when we do our vision to the regulation to try to see what we can do to allow that, and to what extent we can and still be comfortable that the proper oversight is there and, again, always protecting the integrity of the model. But we do recognize that it's something that can be valuable. So thank you.

Do you anticipate – some states are talking about having Long-Term Managed Care options and that they would be a standalone, separate or parallel to PACE. There are other states that are talking about inquiring of those managed care products to have PACE as a benefit option within their plans. Do you foresee any issues with that in terms of contracting opportunities for PACE?

Yeah, it's interesting because so far when that has come up, we've been able to keep them on a parallel track rather than – because of working out the contracting issues like an MCO offering PACE and then who would the contract be with and who would be at risk and making sure that they did the model. So there could be issues with that. We haven't gotten to the point because so far, we've been able to keep them separate; and personally, that's my preference. But I do recognize that down the road, as all of these 1115s come in, and in some cases and in some states statute would prohibit something separate, so that's something we do need to explore should that come down. But it's definitely on our radar screen. Thank you.

See, you guys are asking questions. I like it. Keep it coming. Anybody else?

Okay, and I wanted to – since I had a couple of extra minutes, if anybody had questions for Peggy that didn't get answered – I wanted to make sure that everybody got their questions of Peggy, if they may not have been in the room.

Anybody else? Okay, well thank you and really keep up the good work.