Developing and Operating Medicare Special Needs Plans in Collaboration with PACE

June 12, 2007
Burlington, Vermont

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COMMUNITY CA

Community Care:

- Private, 501(c)(3) founded in 1977
- Original demonstration site for Wisconsin's Home and Community Based Services programs
- One of the first PACE demonstration sites
- Co-Sponsor of the Albuquerque, NM PACE Program
- A Wisconsin Partnership Medicare Advantage Special Needs Plan serving adults with physical disabilities in 3 counties with 'plans for expansion into 4 additional counties in '08
- A Wisconsin Family Care Managed Care Organization

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Community Care:

Our mission is to develop and demonstrate innovative, flexible, community-based programs to care for at-risk adults in order to optimize their quality of life and optimize the allocation of community resources

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Section One: Overview of Integrated Care Models

Section Two: Compare and Contrast PACE with Other Integrated Care Options

Section Three: Public Policy Initiatives

Section Four: Overview of Medicare and Medicaid Rate Setting

Section Five: Business Planning Considerations

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Why is there a need for Integrated Care?

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Multiple Sources for Multiple Services

Medicare ("Fee-for-Service"):

Entitlement, primary payer for individuals 65+ and some younger adults with physical disabilities

1. **Part A**- Hospital inpatient
2. **Part B**- Physician office- primary and specialty care and outpatient settings
3. **Part D**- Pharmaceuticals

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Multiple Sources for Multiple Services

Medicaid ("Fee-for-Service"):

Means tested entitlement for frail elders, younger physically disabled individuals and young families

1. **Card Services** (e.g., Dental)
2. **Institutional services** (functional and financial qualifications vary by state)
3. **Community support services** (home chore, some transportation, adult day, home delivered meals)… aka "HCBS/HCBS waiver"

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A bit more about Medicaid

- "Waiver" means a waiver of the Social Security Act which mandates Medicare/Medicaid entitlements ("fee-for-service")
- These Waivers allows States to work outside of the mandates for services, eligibility, etc. of the Social Security Act

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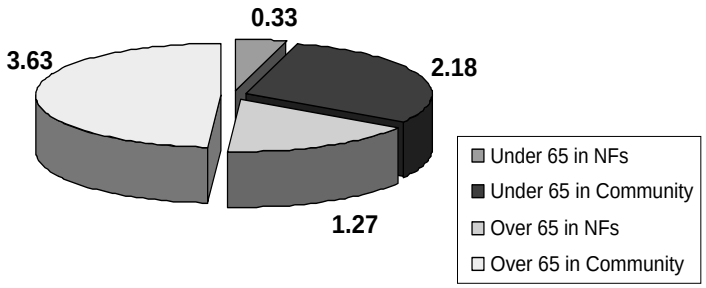
Enrollment in both Medicare and Medicaid

In 2003, there were 7.4 million “Dual Eligibles” nation-wide:

Total Dual Population (Millions)- by Setting



Source: Kaiser Foundation

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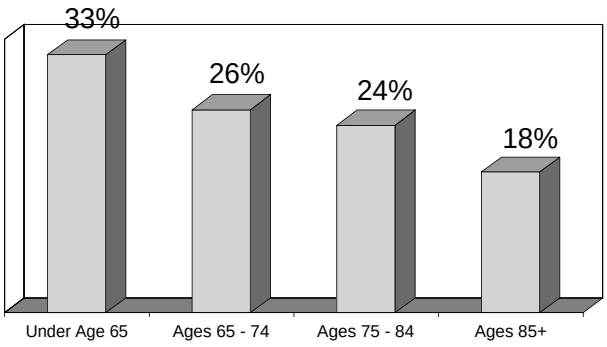
Enrollment in both Medicare and Medicaid

In 2003, there were 7.4 million Dual Eligibles nation-wide:

Age Distribution of Dual Eligibles



Source: Kaiser Foundation

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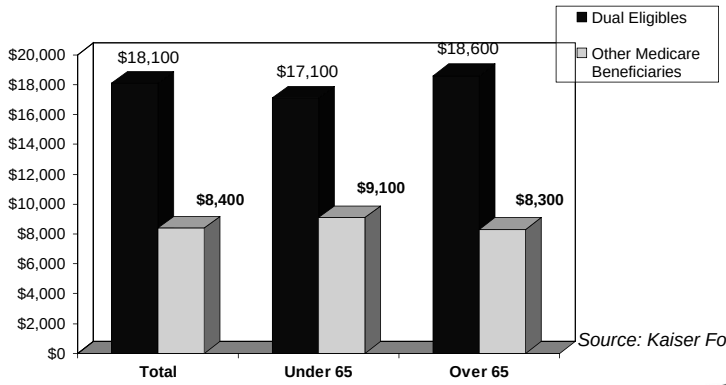
Prevalence of Chronic Conditions Among Dual Eligibles 2000		
Condition	**Under Age 65**	**Over Age 65**
Hypertension	63%	46%
Heart Disease	45%	63%
Stroke	11%	16%
Diabetes	20%	25%
Arthritis	44%	60%
Pulmonary Disease	23%	18%
Mental Disorders	59%	12%

Source: Kaiser Foundation

What do we know about the Dual Eligible Population?

- 2005 estimates are that over 3.5 million people received Medicaid financed long-term care services.
- 55% were in nursing homes
- Average expenditures for *Medicare* beneficiaries with at least one Activity of Daily Living (ADL) limitation is 4 times higher than for Medicare beneficiaries with no Activities of Daily Living impairments
- Elderly and Disabled adults account for 27% of the Medicaid population but almost 75% of all Medicaid spending

Dual Eligibles have substantially higher average per capita total health care expenditures as compared to other Medicare beneficiaries



Source: Kaiser Foundation

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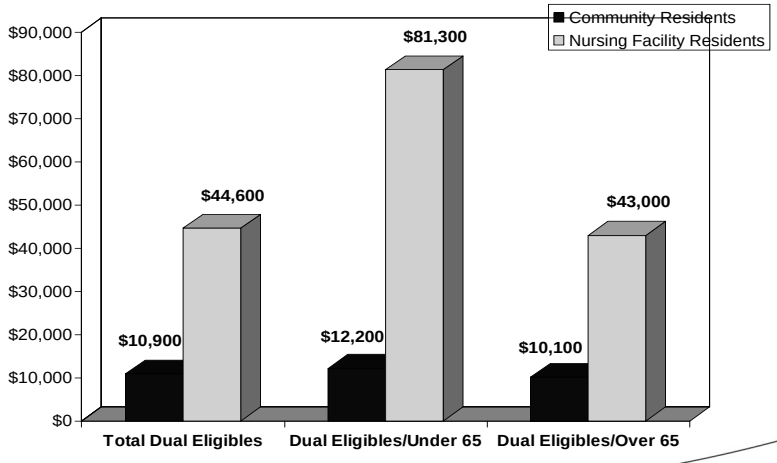
Average per capita total health care expenditures for Dual Eligibles vary greatly by age and residence



Source: Kaiser Foundation

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Dual Eligibles and Unmet Health and Social Needs

- Most community based Dual Eligibles with long term care needs are women, live alone or with people other than a spouse and are in poor or fair health
- 40% are age 80 and older and a similar percent live alone
- Two-thirds are in poor or fair health and more than half used the hospital in the past year
- The vast majority of Dual Eligibles are able to get medical care.
- Those that require assistance with basic care often have their needs unmet and their quality of life and health is placed at risk

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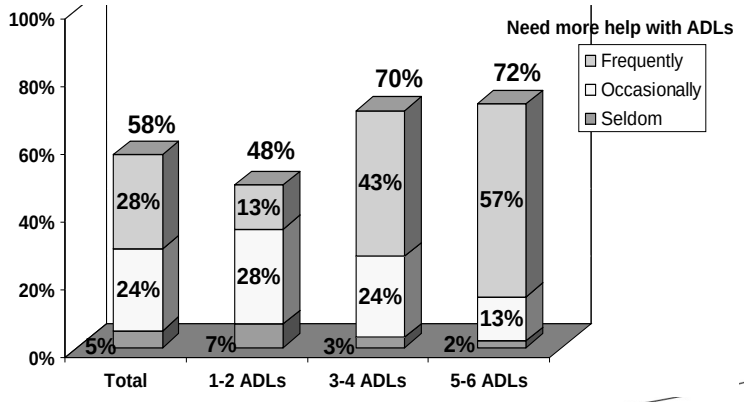
Unmet need is more likely among people with greater levels of disability. More than half of community based, elderly Dual Eligibles who need assistance with ADLs report unmet needs



Source: Inquiry (Summer 2005)

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Why is the dual eligible population difficult to manage?

- By far, the most costly subset of both Medicare and Medicaid populations
- More likely to have 3 or more impairments of Activities of Daily Living
- Significantly higher utilization of Emergency Room, Acute Inpatient Care and Nursing Home
- Higher incidence of chronic conditions
- More likely to suffer from physical and cognitive limitations

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Why is the dual eligible population difficult to manage?

- People are, by definition, impoverished either through a lifetime of poverty or impoverished in response to a sentinel health care event that triggers the need for Medicaid-funded services
- Health needs are inherently unpredictable and costly due to the nature of chronic conditions
- Individuals need a variety of services that cut across multiple delivery sectors and different professional / para-professional domains, each with a distinct clinical focus and boundaries

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Why is the dual eligible population difficult to manage?

- Multiple fee-for-service funding streams with disparate and conflicting regulations that lead to unintended financial dis-incentives and unintended clinical outcomes

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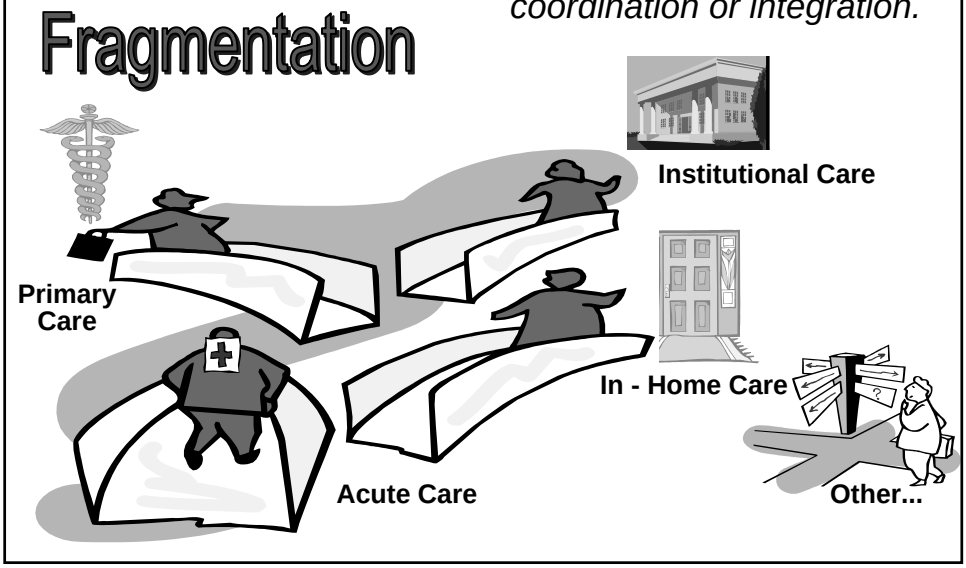
Why is the dual eligible population difficult to manage?

In Fee-for-Service, there is little incentive for coordination or integration.



It's a Fact:

"Why is it so much easier for me to get my 84-year old patient's Coronary By-Pass surgery paid for than a bath?"

- What does the person need?
- How does it allow them to continue living at home?
- How does it contribute to the improvement of their quality of life?

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Overview of Models of Integrated Care

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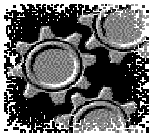
How do you begin to create order in an irrational system?

1. Create appropriate mechanisms to *manage and coordinate* the entire care delivery system
2. *Align* the quality and financial *incentives* of the service provider together
3. *Integrate* fragmented service/funding streams into seamless service packages for people in greatest need



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Key Feature of Managed Long-Term Care:

(1) Managing and Coordinating the Care

- Develop focused, longitudinal interdisciplinary system of care delivery/coordination that spans time, setting and health care jurisdictions ("trans-disciplinary")
- Management of the care is overseen through interface of multiple professionals and para-professionals

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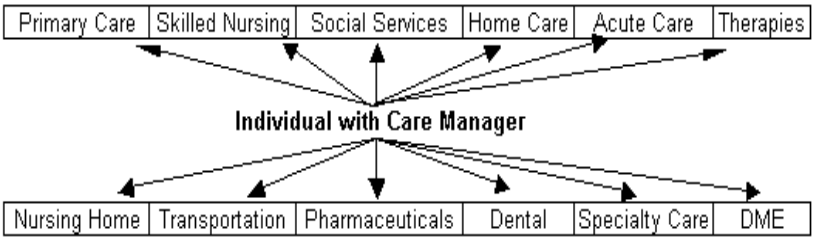
Key Feature of Managed Long-Term Care :

(1) Managing and Coordinating the Care

Simplistic Care Management



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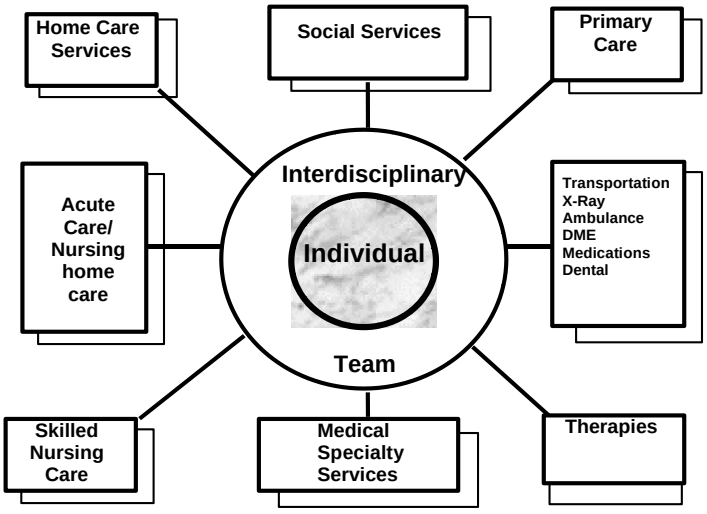
Key Feature of Managed Long-Term Care :

(1) Managing and Coordinating the Care

Full Interdisciplinary Care Management



Key Feature of Managed Long-Term Care :

(2) Fully align quality and financial incentives

- Create incentives for service providers to deliver services that are based on what the individual ***needs*** and not according to what fee-for-service will ***pay***
- Financial incentives for the provider will lead to the delivery of the optimal level of services in the least restrictive environment

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Key Feature of Managed Long-Term Care :

(2) Fully align quality and financial incentives

- Provider assumes financial risk of service costs in exchange for fixed capitation payment
- CAPITATION= fixed payment on a per enrollee basis in exchange for providing necessary services from a menu of mandated services the provider must cover
- Based on *membership* in managed long-term care program not on *units* of services delivered

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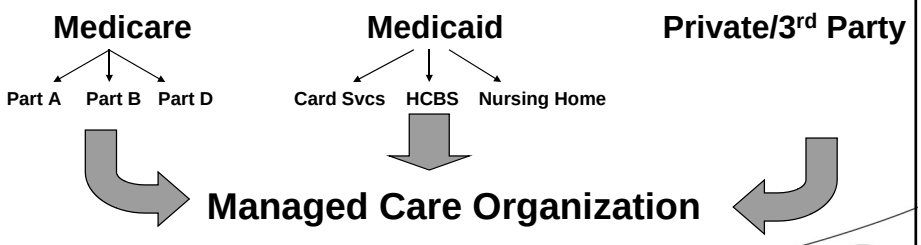
Key Feature of Managed Long-Term Care :

(3) Integrate Funding and Service Streams

Consolidation of disparate service and revenue streams into one service package that creates a single source of services



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Program **A**ll-inclusive **C**are **E**lderly

of *for* *the*

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PACE is…

The highly successful model of fully-integrated primary, acute, specialty and long-term care for frail older adults.

The only federally qualified benefit which **fully integrates** all Medicare and Medicaid services into one seamless service package for beneficiaries.

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Services Provided and Coordinated through PACE include:

PACE Center	Optometry	Emergency Room
Outpatient Services	Dental	Therapy Services
Inpatient Care	Labs and X-Rays	Pharmaceuticals
Medical Specialists	Primary Care	Home Care
Transportation	DME	Nursing Home Care
Chore Services	Meals	Personal Care

…And Other Necessary Services not typically covered through fee-for-service

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Who does PACE Serve?

- 55 years of age or older
- Living in a designated PACE service area
- Certified as needing nursing home care
- Able to live safely in the community with the services of the PACE Organization at the time of enrollment
- Although not an eligibility requirement, PACE has served predominantly dual eligibles

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In the PACE Model

Beneficiaries receive all of their necessary health and social services through the PACE provider organization.

In addition to Participant's Rights, enrollees have access to robust Grievance and Appeal procedures

Full interdisciplinary teams, including primary care physicians, provide and coordinate all services for the enrollee.

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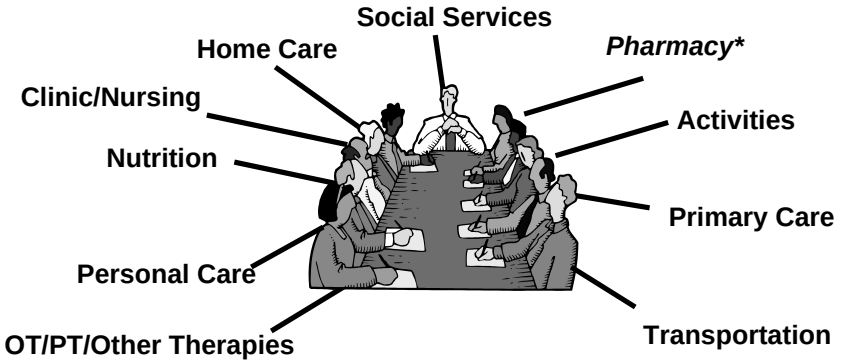
Integrated and Interdisciplinary Team Coordinated Care



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In the PACE Model

The services of the PACE organization follow the beneficiary across all care settings including the home, specialty services, hospital and nursing home.

Beneficiaries receive the full range of health and social services they need to maintain their function and remain living at home.

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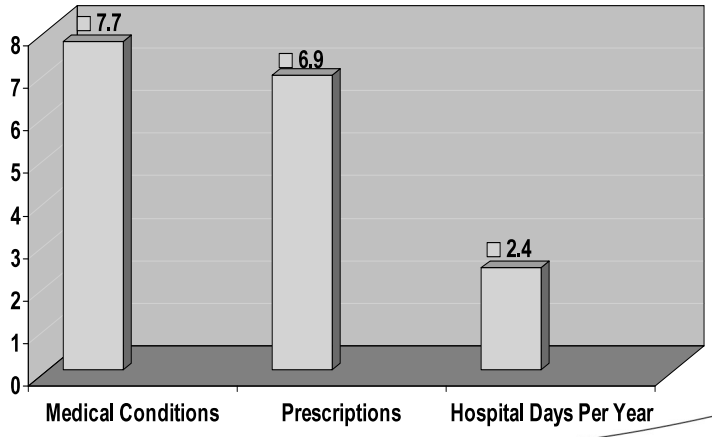
PACE Participants

Average Number of…



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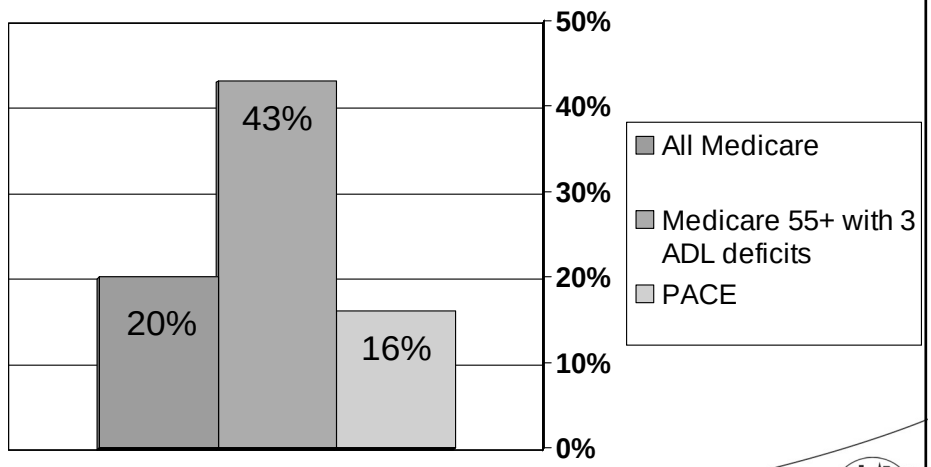
PACE Hospitalization Rates



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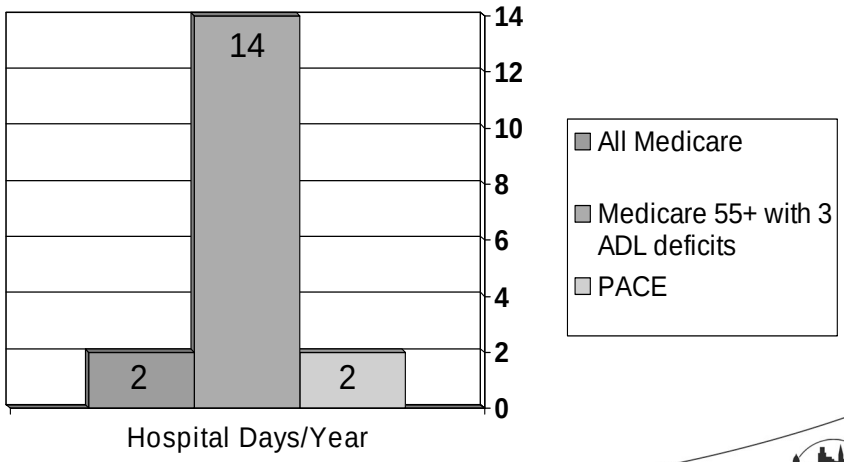

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Key Features of PACE

Flexibility

The PACE organization has the ability to provide services to individuals as they need them and not according to Fee-for-Service schedules.

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Key Features of PACE

All Inclusive Care

PACE Organizations fully integrate all Medicare and Medicaid services into one package for at-risk older adults rather than the fragmented Fee-for-Service system.

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Key Features of PACE

Interdisciplinary Care

The principal care management mechanism in PACE is the interdisciplinary team which directly provides and coordinates all care for the individual.

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Key Features of PACE

Capitated Financing

The PACE Organization pools capitated or fixed payments, typically from Medicare and Medicaid, to provide all of the needed services in the PACE benefit package.

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PACE is the Comprehensive Integration of…

- Service delivery systems (Health and Social Services)
- Care management
- Service delivery and care management
- All Medicare and Medicaid Services
- Primary, Acute, Specialty and Long-Term Care Services
- **Medicare Service Provider and Health Plan**

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Questions about PACE???

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Medicare

Special Needs Plans

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Policymakers are seeking more “coordinated” models of care that can serve large numbers of Dual Eligibles with improved outcomes

- PACE is the only fully integrated Medicaid and Medicare **benefit** to combine all benefits
- Several states have been leading the way towards Medicare and Medicaid integration but these projects have largely been demonstration projects:
  - Wisconsin (WI Partnership evolved from PACE)
  - Minnesota (MN Senior Health Options evolved from Med+Choice)
  - Massachusetts (MA Senior Care Options evolved from PACE, Partnership and Med+Choice)

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What is a Medicare Special Needs Plan (SNP)?

- Medicare Special Needs Plans were created in the Medicare Modernization Act (MMA) as a type of Medicare Advantage (used to be "Medicare+Choice") Coordinated Care Plan (CCP)
- Unlike other Medicare Advantage (MA) plans, SNPs may *limit enrollment to specific subsets of the Medicare beneficiary population* including Dual Eligibles and institutionalized beneficiaries

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Why Were Medicare SNPs Created?

- To enable interested Medicare Advantage (MA) plans to limit enrollment to beneficiaries with specialized care needs
- To find a way to permanently continue already operational demonstration projects:
  - Minnesota Senior Health Options
  - Massachusetts Senior Care Options
  - Wisconsin Partnership Program
  - Evercare (United Health)
  - Social HMOs

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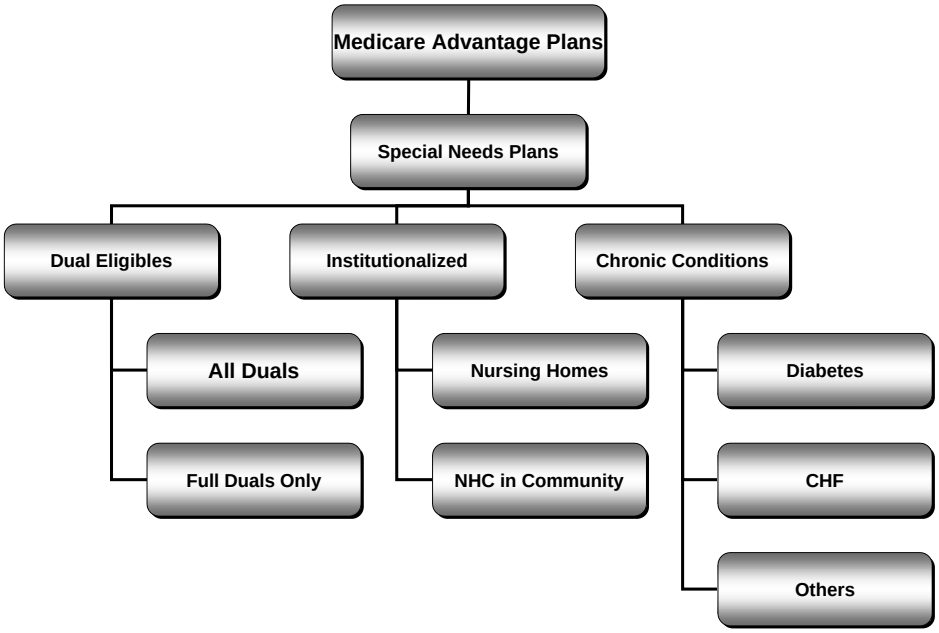
Types of Medicare SNPs



3 Types of Medicare SNPs

- Medicare Advantage eligible individuals (with both Parts A and B) who are:
  1) Dual Eligible
  2) Institutionalized (Nursing Home Certified or NHC frail; "Long-Term Care Eligible in Vermont)
  3) Have severe or disabling chronic conditions
- SNPs may enroll these populations exclusively or can create a "disproportionate" plan that enrolls a greater proportion of the target population than occurs nationally in the Medicare population

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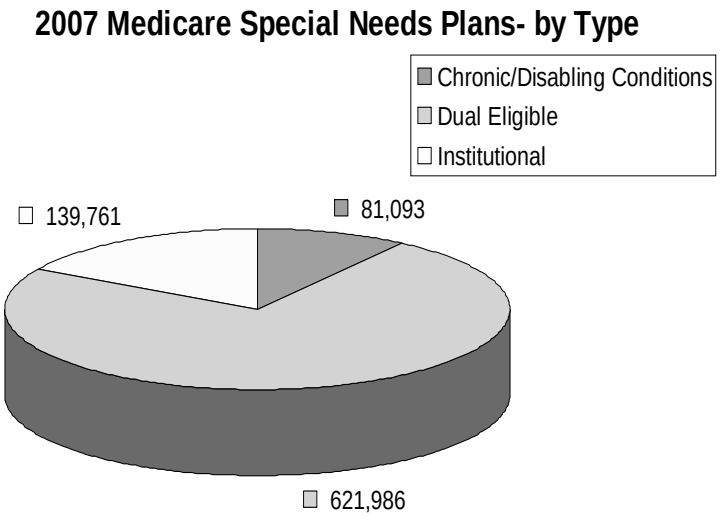

Dual Eligible SNPs

- Enrollees must have Medicaid coverage at the time of enrollment
- A Dual Eligible SNP enrolls “well,” “at-risk” and nursing home eligible beneficiaries
- Generally, a Dual Eligible SNP cannot limit enrollment based on age, e.g., only serve Dual Eligibles 65 and over
- A Dual Eligible SNP may enroll a subset of the Dual Eligible population (full Dual Eligibles versus all Dual Eligibles)

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Institutional SNPs (NHC)

- Enrollees must reside, or be expected to reside, continuously for 90-days or longer in a SNF, NF, SNF/NF, inpatient psychiatric facility and/or ICF/MR
- SNP may enroll either/both SNF residents expected to reside in a SNF for 90 days or longer as well as community beneficiaries eligible for the institutional level of care
- Generally, Institutional SNPs cannot limit enrollment based on age

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Severe/Disabling Chronic Conditions SNP

- Regulations do not contain a detailed definition of "severe or disabling chronic conditions"
- CMS will evaluate proposals from prospective SNPs on a case-by-case basis
- Possible conditions include: cardiovascular disease, diabetes, CHF, osteoarthritis, ESRD, HIV/AIDS, etc.

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Medicare SNP Benefits

- As Medicare Advantage programs, SNPs must offer all Medicare-covered services, including Part D, except hospice services
- SNPs also may provide supplemental benefits
- SNPs must describe to CMS how their plans are appropriate for the target population, e.g., specific plan design, special care management programs; *<u>however, criteria used by CMS to evaluate the plan's design appear vague</u>*.

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Medicare SNP Regulatory Requirements

- In general, must meet Medicare Advantage regulatory requirements, including:
  - State licensure as a risk-bearing entity
  - MA reporting requirements (HEDIS, CAHPS, HOS), except for institutional SNPs (MDS-like requirements)
  - MA marketing requirements
  - All Part D requirements (including many that are waived or modified for PACE, e.g., waiver of Part D marketing and pharmacy access requirements, waiver of Part D co-payment amounts for Dual Eligible enrollees, modified PDE reporting requirements)

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Medicare SNP Payment for Parts A and B

- SNPs are paid like other Medicare Advantage plans
- SNP A/B payments are based on plan bids as compared to benchmark amounts
  - If a plan's bid is higher than the benchmark, the enrollee pays the difference as a beneficiary premium
  - Bids at or below the benchmark create savings which are shared with the beneficiaries and the federal government
- SNPs may charge enrollees premium and cost-sharing amounts
- SNP payments are risk adjusted using the Diagnostic CMS-HCC model

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Medicare SNP Part D Payment

- SNPs are paid like other Medicare Advantage Part D plans (MA-PDs)
- Rx HCC risk adjustment model will be used
- Differences relative to PACE
  - CMS will pay additional capitated amounts to PACE organizations to cover $1/$3 or $2/$5 co-payment amounts, and premiums, if any, for Dual Eligibles
  - In PACE, Medicare-only enrollees are unable to accumulate TrOOP and, therefore, have no access to Part D reinsurance payments

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SNP must submit the following to CMS:

- Required Submissions (all are in the CCP application):
  - Medicare Advantage Application
  - Medicare Part A and B Bid (Part C)
  - Medicare Part D Bid
  - Medicare SNP Application

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Requirements of SNP Proposal

- ☑ Description of the proposed plan and how it meets CMS requirements for SNPs
- ☑ A description of the target population and how it will be identified
- ☑ A statement as to whether the plan will enroll only individuals in the target population or whether its enrollment will include a disproportionate percentage of the target population

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Requirements of SNP Proposal

- ☑ A description of how the plan will limit enrollment in accordance with:
  - ☑ The existence of clinical programs or special expertise to serve the target population
  - ☑ Explanation of how your SNP will provide services to the full spectrum of the target population without discriminating against "sicker" members of the target population
- ☑ An explanation of how the contracted provider network will meet *access and availability* standards, if the network is different from other plans being offered

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Requirements of SNP Proposal

- ☑ An explanation of what types of providers will participate, e.g., home health
- ☑ A description of how the plan is appropriate for the target population, e.g., specific plan design, special care management program
- ☑ Specialized marketing materials for the target population

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Medicare Advantage Call Letters

- Released annually as an introduction to changes made in application and regulation content and process as well as issues related to premiums, marketing, quality and many other administrative elements.
- Very important to pay attention to which type of MA-SNP you're developing because significant differences can exist between the different types of plans.
- Critical component for understanding overall Medicare compliance

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Medicare SNP Timeline

- For the 2009 round of applications, CMS will accept Medicare SNP applications through March 18, 2008
  - This application must include a MA Application, SNP Application, MA Bid and PDP Bid
  - For 2007 SNP plans, deadline for filing Notice of Intent to File a 2007 SNP application is January 15, 2008
- Report to Congress on Medicare SNPs is due at end of 2007
  - Evaluation contract has been awarded to Mathematica Policy Research
- CMS can continue to approve new Medicare SNPs in 2007 to operate through the end of 2008
- Continued operation of SNPs in 2009 contingent upon Congressional action

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Medicare SNP Plans can “coordinate” Medicaid and Medicare and have the potential of serving large numbers of Dual Eligibles

- Medicaid managed care plans serving Dual Eligibles may develop SNPs and provide all Medicare and Medicaid covered services, similar to PACE
- Medicare SNPs are not required to participate in Medicaid managed care, are not required to cover Medicaid benefits, and are not regulated by the state beyond licensure and solvency
- PACE programs may face significant competition from SNPs capable of effectively managing and coordinating the care of a Dual Eligible or institutional population

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Wisconsin Partnership Program?

- In 1996, the State of WI sought ways to create a flexible adaptation of PACE that could be viable in both urban and rural communities and serve populations besides frail elders.
- The Partnership Program began under the state’s PACE waiver and fully integrates all Medicare and Medicaid services to frail, long-term care eligible beneficiaries.

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From the enrollee perspective, the Partnership Model varies from PACE in 4 key elements:

- The participant maintains their relationship with a community-based primary care physician and the provider organization subcontracts with that physician to work closely with a team Physician Extender in coordinating the provision of care.

- The focal point of service delivery is moved from the adult day health center and into the home and other care settings (Day Health Center services may be contracted).

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From the enrollee perspective, the Partnership Model varies from PACE in 4 key elements:

- The core interdisciplinary team is smaller in scale than in PACE.

- Some of the organizations serve adults with physical disabilities as well as frail elders

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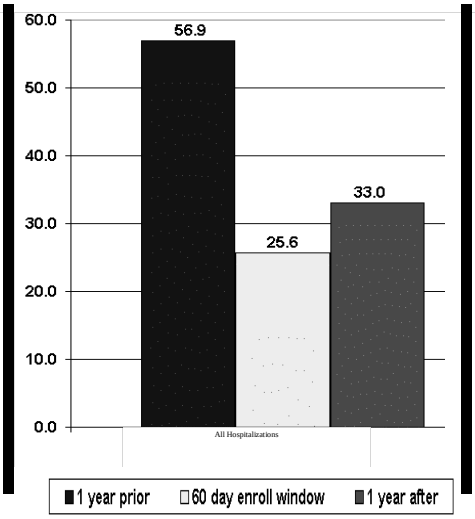
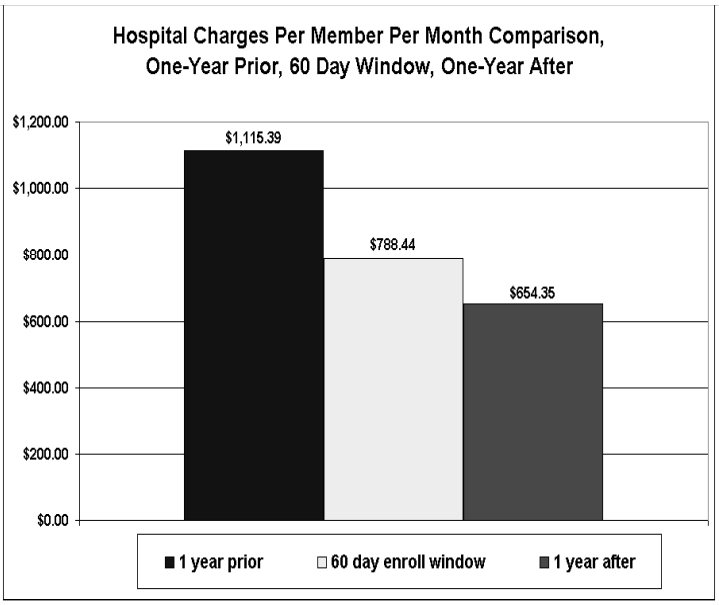
Partnership enrollees experienced a 55% reduction in hospital days within the first 60 days of enrollment and a 42% reduction in hospital days after 1 year of enrollment.

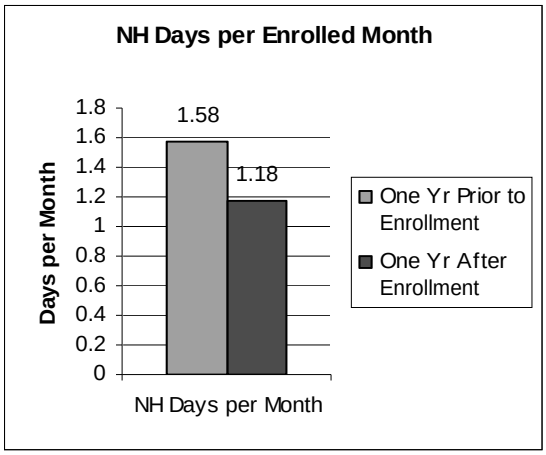


Inpatient Days per 100 Member Months, One-Year Prior, 60-Day Window, & After 1st Year Enrollment, Aggregate Hospitalizations

Compared to their fee-for-service utilization, hospital charges for enrollees were 41% less in Partnership



Compared to their fee-for-service utilization, the number of nursing home days decreased 25% in the first year of enrollment.
Fewer than 6% of the enrollees lived in nursing homes compared to 26% of total Wisconsin Medicaid recipients 65 and older.
For adults 85+, 8.7% of enrollees live in nursing homes compared to 44% of total Medicaid recipients.



Wisconsin Partnership Demonstration

- Evolved from the State's experience with On Lok/PACE to serve both frail elders and adults with physical disabilities
- Serves approximately 3,300 people across 7 counties- *both urban and rural*
- The potential exists for many of the service/care management variations to be implemented under PACE provider regulations… *with the exception of serving people younger than age 55.*

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Questions about Models of Fully Integrated Care???

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Comparison of PACE and Other Models of Integrated Care

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PACE and CMS

- Has been viewed by CMS as successful in accomplishing outcomes not found in fee-for-service or even in other models of integrated care (e.g., satisfaction rates, inpatient care, coordination of care across a continuum of care settings)
- CMS has emphasized this success is due to:
  - Broad interdisciplinary staff model, especially Primary Care Physicians
  - Facility-based service delivery system
- PACE regulations highlight these as success factors and, thus, fundamental to the success of all PACE programs

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PACE Providers

- Successful in accomplishing outcomes not found in fee-for-service or even in other models of integrated care
- Providers have found this is due to:
  - Interdisciplinary, Client-Centered Care
  - Integration of Service Delivery/Care management
  - Assumption of full financial risk and care management across all care/treatment settings
- PACE regulations may constrain flexibility in service delivery setting and staffing for the provision of services

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PACE vs. SNP-

PACE	Medicare Adv-SNP
Focus on tight primary care management	Primary care may be more diffuse
Application emphasizes “how” and “where” services will be delivered	Application emphasizes who will be providing services (network development)
Sponsorship tightly defined (501(c)(3))	Sponsorship defined but not emphasized
Application alludes to CMS data/mgt. systems but is not explicit	Application explicitly refers to CMS data/mgt. systems

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PACE vs. SNP-

PACE	Medicare Adv-SNP
Federal solvency requirements	Deference to state financial requirements for at-risk entities
Emphasis on consumer care in governance	No requirements for consumer care in governance
Service provision	Network monitoring
PACE-specific experience and qualifications for service providers	Services to be provided by Medicare (and, if applicable, Medicaid) qualified providers
Emphasis on PACE center as care setting and *how* services are received there	Little emphasis on *how* services are received in care settings

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PACE vs. SNP-

PACE	Medicare Adv-SNP
PACE Center, PACE Center, PACE Center	Network, Network, Network
Flexibility in service delivery requires waiver	Flexibility in service delivery not addressed beyond network qualifications and adequacy
Network smaller and tightly controlled	Network broader and more diffuse
Medicaid integrated	Medicaid integration not required, in general, for MA plan

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Administrative Efficiencies

In Community Care's experience, administrative systems necessary for compliance with the PACE benefit are approximately 90% identical to the administrative systems necessary to manage a fully integrated Medicare Advantage Special Needs Plan like Partnership

Claims processing, enrollment/disenrollment, data submission, Quality Assurance/Performance Improvement, Medicare Secondary Payor, Compliance

Substantial variance in Part D bidding, management and reconciliation and Part C bidding

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Why Integrated Care?

- Reduction of high cost services (ER, hospitals, nursing homes)
- Increased provision of HCBS
- Move from sentinel event, “sickness” model to holistic, “wellness” model
- More consumer-directed care (client-centered care management)
- Streamlined access to care

udget predictability/cost savings

igh satisfaction levels

ccountability for outcomes=

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PACE Resources

National PACE Association

www.npaonline.org

(703) 535-1565

Center for Medicare and Medicaid Services

www.cms.hhs.gov/PACE

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Wisconsin Partnership Information

Wisconsin Department of Health and Family Services

www.dhfs.wisconsin.gov/wipartnership/

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(414) 902-2391

www.communitycareinc.org

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Medicare Advantage

Center for Medicare and Medicaid Services

www.cms.hhs.gov/HealthPlansGenInfo/

www.cms.hhs.gov/SpecialNeedsPlans/

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