STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Program of All-Inclusive Care for the Elderly (PACE) Transmittal No. 2
December 07, 2010

TO: Director, PACE Program
Hopkins ElderPlus

FROM: Susan J. Tucker, Executive Director
Office of Health Services

NOTE: Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal.

RE: **Administrative and Reporting Requirements and Formats – Maryland Medical Assistance PACE Program**

The purpose of this transmittal is to update administrative, data reporting, and utilization review requirements for the Maryland Medicaid-designated Program of All-Inclusive Care for the Elderly (PACE), operating at a single site on the campus of the Johns Hopkins Bayview Medical Center campus in southeast Baltimore, as Hopkins ElderPlus.

The updates that take effect with the issuance of this transmittal make changes to the PACE Enrollment Contract, to the requirement for submission of utilization data on a new enrollee before capitation payments may begin, to the forms and formats of both the Annual Financial Monitoring Report and the quarterly utilization reports, and to the requirement for subsequent annual determinations of medical eligibility, after the first annual review results in a participant's continuation with the PACE program.

Changes to the PACE Enrollment Contract and to Data Requirements for New Enrollees

To allow for a more accurate enrollment of new participants into the appropriate administrative unit, the Maryland Medicaid Program has approved the addition of a text box, at the top of the first page of the current form, which will alert enrollment staff of the Medicare status and the age of the enrollee. Both of these variables are significant, since the PACE program in Maryland is divided administratively into two provider numbers, one for persons 55 to 64 years of age, and the other for those 65 and older, and these units are further divided into those who are dually eligible, i.e. for Medicare as well as Medicaid, and those who are eligible

for Medicaid only. Establishing these variables at enrollment will help ensure that the correct capitation rate is paid for each enrollee. The new form is attached to this transmittal.

At least two months before a participant's 65th birthday, PACE staff will submit to the DHMH Beneficiary Services Administration (BSA) a new page 1 of the contract, clearly marked "Update to Payment Status," which will place the participant in the over-65 provider number group, and in his or her new Medicare category (if applicable), and provide the effective date of that change. BSA staff will submit this change in time for the new capitation payment rate to become effective for the month after the participant turns 65.

Also, the Program's requirement for the submission of utilization data on a new enrollee before the first capitation payment will issue is, with this transmittal, discontinued. This requirement dates from the beginning of the PACE program in Maryland. Years of experience have demonstrated that, by the time a participant is actually enrolled, he or she has typically already received a thorough medical, nursing, and psycho-social evaluation, so numerous encounters have already taken place in the determination of a person's appropriateness for PACE participation. In addition, the provider has assumed full risk for a new participant from the date of enrollment, so providing all necessary care for the person is an immediate imperative from the point of view of both participant and the PACE provider. Consequently, a separate submission of medical encounter data before first payment issues is no longer required.

Changes to the Form and Format of PACE Program Data Reporting

This transmittal also authorizes two changes to the annual reporting required of the PACE program in the area of financial performance and activity, and in the quarterly reporting of clinical utilization by program participants.

First, beginning with the FY 2010 report, the medical staff encounters reported as part of the annual Financial Monitoring Report, a component of rate-setting for the next calendar year period, will be estimated using the so-called "superbill" counts completed by the PACE primary care providers, with 80% attributed to Medicare and 20% attributed to Medicaid payment. This will replace the present system that attempts to quantify medical encounters for each participant that are, by the very nature of the collaborative and participant-centered nature of the PACE model, happening constantly on both a formal and informal level, in team meetings, phone calls, and hallway discussions as well as in clinics and facility settings.

Second, the Program will change its required form and format for quarterly reporting of clinical data and participant status. The present, basic spreadsheet that the PACE organization submits quarterly consists of person-specific data, including each person's residence, days of attendance, and types of care visits, and was required by the Program at a time before the National PACE Association (NPA) had developed more robust data reporting.

DataPACE2, its current version of this electronic application, reports participant information in the aggregate (the Medicaid Program has a significant amount of participant-specific information available in its own management information system), and also benchmarks the Maryland PACE program's performance against all other PACE sites across the nation, in

such additional measures as hospitalizations, ED visits, prevalence of depression or dementia among participants, level of ADL dependency, and many others. This method of program reporting provides an added dimension of accountability, and is already prepared each quarter for benchmarking purposes. Accessing the DataPACE2 reporting information will give the Medicaid Program more — and better — data, and eliminate a duplicate administrative task.

Elimination of Subsequent Annual Redeterminations After the First Annual Review

As with all other home- and community-based programs, PACE participants must be re-evaluated for medical necessity on an annual basis. Because of the continuity and intensity of ongoing involvement by the PACE interdisciplinary team, this annual re-evaluation consumes many staff hours for each participant. The development of so-called "deeming" criteria (permitted under federal regulations, and incorporated since November 2007 into the three-way agreement between CMS, Hopkins ElderPlus, and the Department) for the first time established benchmarks that enabled participants whose overall condition had improved to be "deemed" medically eligible if the improvement depended upon continuation in the PACE program (see "Deeming Criteria for the Programs of All-Inclusive Care for the Elderly (PACE)", attached.)

Since the establishment of these deeming criteria in late 2007, no participant has been found medically ineligible to continue in the program. What this demonstrates is that Hopkins ElderPlus has appropriately enrolled medically fragile people who are at risk of institutionalization without the PACE program's intervention, not persons in need of short-term rehabilitation who would not meet the required nursing home level of care at the annual re-evaluation. The first annual re-evaluation would be the juncture at which the less-fragile participant would likely be identified and denied continued participation in the Program. Consequently, it makes sense from the perspective both of the participant's peace of mind and of the most efficient use of staff time to do the first annual re-evaluation only, and then recognize that the participant will be part of the PACE program as long as he or she continues to meet the other conditions of enrollment, and chooses to remain in the PACE program.

Summary of Administrative and Reporting Changes to the PACE Program

With the issuance of this transmittal, the following changes to the administrative and reporting requirements of the PACE program become effective:

1. The Enrollment Contract now has a text box on which a new enrollee's provider unit assignment and Medicare enrollment status will be entered. Two months before a participant turns 65, the PACE organization will fax a replacement page 1 of the contract, marked "Update to Payment Status" on which the impending age change and Medicare enrollment status (if applicable) are entered. Medicaid staff will make these changes in time for the new capitation rate to take effect in the month following the participant's 65th birthday.
2. Utilization data is no longer required before a new enrollee's capitation payments begin.

3. Medical encounters used for annual rate re-calculation will be estimated using the medical system's "superbill" counts completed by the PACE primary care providers, allocated in an 80-20 ratio between Medicare and Medicaid payment.
4. The PACE provider will make available to the Program its quarterly DataPACE2 reports generated through the National PACE Association reporting system. This will replace the current quarterly submission of participant-specific information.
5. If at his or her first annual redetermination of medical eligibility, a PACE participant is found to meet the Program's medical eligibility requirements, including through the application of the deeming criteria as confirmed by the Department's physician program specialist, no further annual redeterminations of medical eligibility are required. The participant will remain in the PACE program as long as he or she continues to meet the other requirements of the PACE organization, and chooses to remain in the PACE program.

Please call the Division of Long Term Care Services at (410) 767-1736 if you have any questions about the actions outlined in this transmittal.

Attachments
cc: Utilization Control Agency
Beneficiary Services Administration, Office of Eligibility Services
Provider Relations, Office of Systems, Operations, and Pharmacy

STATE OF MARYLAND
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Office of Health Services
Medical Care Programs

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PAYMENT STATUS:

Provider ID # (Over 65): **409639800**

Provider ID # (Under 65): **409642800**

____PACE Aged with Medicare
____PACE Aged MA Only

____ PACE Disabled With Medicare
____ PACE Disabled MA Only

Medicare Part "A" Effective Date: _____
Medicare Part "B" Effective Date: _____

HOPKINS ELDERPLUS/PACE – MEDICAL ASSISTANCE ENROLLMENT CONTRACT
(410) 550-5920

PART A. **Enrollment Effective Date:** _____

PART B. **HEAD OF HOUSEHOLD:** (Please Print)

Full Name	Medicaid ID No.	Relationship

Street Address	City	Zip Code	Res/Co

PART C. **COVERED FAMILY MEMBER** (Please Print)

PART D. HEAD OF HOUSEHOLD AGREEMENT AND SIGNATURE:
(Please read or have read to you before signing below)

I understand that PACE enrollment is voluntary. I understand that PACE enrollees must receive all of their Medicaid Benefits from PACE except in an emergency when there is no time to contact PACE first. I also understand that PACE enrollees cannot receive care from the doctors or hospitals that they used before without authorization from PACE. I understand that if I am dissatisfied with PACE I may file a complaint at my Day Health Center.

I also understand if I am still dissatisfied after filing a complaint, I may call the Medical Assistance Program at (410) 767-1444. I also understand that I may withdraw from PACE by completing a Disenrollment Request at the Day Health Center, although I will have to remain a temporary member for three to eight weeks until new Medicaid cards can be issued. (Withdrawal forms can be mailed to you by PACE upon request, although this may delay the effective date of disenrollment.)

I understand that my Social Services worker must still periodically update my Medicaid eligibility in order to remain enrolled in PACE.

I understand that this enrollment contract is subject to acceptance by the Medicaid Program and when approved takes effect on

_____ _____ _____
Month Day Year

If you have any questions about your rights and obligations as PACE enrollees, or about the benefits or services provided by PACE, please call the Department of Health and Mental Hygiene at (410) 767-1444 before signing this contract.

_____ _____ _____
Head of Household Signature Today's Date Day Phone No.

PART E. PACE-Medicaid CERTIFICATION AND SIGNATURE

I hereby certify that my enrollment presentation clearly presented the benefits and limitations of PACE-Medicaid enrollment. I also certify that I have provided in writing the information to new enrollees as required by PACE-Medicaid Contract. I also certify that I have executed my signature in the presence of the head of household named above.

_____ _____ _____
Enrollment Representative Signature Today's Date Day Phone No.

_____
Name of Enrollment Representative (Please print)

Deeming Criteria for the Programs of All-Inclusive Care for the Elderly (PACE)

The Maryland Department of Health and Mental Hygiene has developed criteria to use in making deemed eligibility determinations. The deeming criteria can only be used during the annual recertification process for PACE participants who no longer qualify for nursing home level of care, but in the absence of continued services through PACE, would reasonably be expected to meet the nursing home level of care requirement within the next six months. Individuals can be deemed eligible based on the presence of at least one of the following criteria:

- Severe cognitive impairment (with a mini-mental of 9 or less).
- Participants who require oversight or intervention from a health professional, on a weekly basis at minimum, to comply with the medical regimen for a complex medical condition(s) and to remain medically stable.
- History of two or more hospitalizations and/or trips to the emergency room during the 6 months prior to PACE participation, and the ability of the PACE Organization to avert hospitalization and/or emergency room use through intensive medical management. This only applies to conditions that had originally caused the hospitalizations and are still active diagnoses.
- Psychiatric diagnoses and behaviors requiring ongoing and frequent intervention by PACE Organization health professionals. In the absence of support and services, the participant would not likely be able to comply with medical regimen for chronic disease.

If a participant does not meet the nursing home level of care criteria for PACE, then the PACE physician will be notified. Specific documentation must then be submitted within 10 business days to the DHMH PACE administrator and Medical Director that outlines how the participant meets the criteria for deeming. Review of this documentation as well as supporting documentation (including pertinent medical records such as progress notes, clinical diagnoses, medication regimen, and plan of care) will be performed by the Department's PACE Administrator in consultation with the DHMH Medical Director.

Deemed continued eligibility will be granted until the next annual recertification.

This deeming provision only applies to PACE and cannot be used for other NF level of care programs.

These criteria have been developed to comply with the requirement of 42 C.F.R. § 460.160(b)(3)(i) as amended December 8, 2006, which calls for establishment of criteria for use in deeming.