Framework:
At-Risk Medically Complex PACE Pilot

National PACE Association

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This framework proposes key features for the design of a PACE pilot serving individuals who are medically complex, with functional limitations, and at risk of needing a nursing home level of care. The framework was developed by the At-Risk Medically Complex Workgroup of the National PACE Association. The workgroup consisted of currently operating PACE organizations and health policy experts, representing consumers and delivery system reform advocates. The framework is divided into four sections: eligibility criteria, service delivery design, payment and quality indicators.

ELIGIBILITY CRITERIA

The At-Risk Medically Complex PACE Pilot would serve individuals who do not meet the nursing home level of care criteria for their state and therefore not be eligible for traditional PACE. The pilot is intended to serve individuals with complex medical and social needs who could benefit from intensive care coordination, care management, and delivery of long-term services and supports (LTSS). A potential At-Risk Medically Complex participant must meet demographic, medical and non-medical criteria to qualify. Recognizing that nursing home eligibility varies by state, each state participating in the pilot may need to adjust the participant criteria to ensure that a participant does not meet state nursing home eligibility criteria. The criteria for participant eligibility in the pilot are as follows:

Demographic Criteria

- The pilot population age criterion will be set by each pilot PACE organization, working in collaboration with its state Medicaid program and the Centers for Medicare & Medicaid Services (CMS).
- While this framework primarily addresses older individuals, some states and providers may seek to serve a younger population through the pilots.
- For example, a pilot PACE organization may serve the following populations:
  - the currently eligible PACE cohort of people age 55 or older,
  - a more targeted elderly population such as those 65 and older, or
  - a younger cohort of those age 18 and older.
- In determining the age cohort of the pilot PACE organization, the pilot will take into consideration the availability of other Medicaid and Medicare programs, including other PACE pilots that may be developed.

Medical Criteria

- The participant has two or more chronic medical conditions and/or early stages of cognitive impairment. If cognitive impairment results in impaired judgment, the participant would meet the cognitive impairment criteria.
- The participant has two instrumental activity of daily living (ADL) dependencies (e.g., shopping, housekeeping, cooking) or requires assistance with one or more functional ADLs (e.g., walking, feeding, toileting).

Non-Medical Criteria

- The participant has coverage from traditional Medicare (Parts A and B) or Medicaid or is dually eligible for both Medicare (Parts A and B) and Medicaid.
- The participant must be determined as not yet eligible for nursing home placement.
- The participant resides in a community setting, private residence, apartment, independent living situation or other state-defined situation.
- The participant must agree to follow the plan of care developed by the interdisciplinary team (IDT).

If at any point a participant's status changes to meet the state criteria for nursing home level of care, the participant becomes eligible for the traditional PACE benefit and would be transitioned out of the pilot. States and PACE pilot organizations should be granted flexibility in considering how best to assure that transitions from the pilot to the traditional PACE program are structured to promote access and continuity of care.

Though not a criterion for enrollment in the pilot, all participants will be advised of the need for a power of attorney for health care to assure that care decisions can be made in the event that they are incapable of making decisions for themselves. During the intake process, pilot PACE organizations will screen prospective participants to determine if they have a power of attorney for health care in place and, if not, will provide a referral for one to be obtained. A participant may refuse this referral and still be eligible for enrollment in the pilot.

Following are examples of participants who would benefit from the pilot.

Name: Jane Smith
Age: 88

Characteristics:

- ✔ Jane is at an advanced age and is at great risk of decline.
- ✔ Jane is in an early stage of cognitive impairment.
- ✔ Jane had a non-elective hospital admission or ER visit within the last 12 months.
- ✔ Jane is residing in the community with fragmented access to care, with or without family caregivers.
- ✔ Jane is being administered six or more medications.

Name: Jack Smith
Age: 67

Characteristics:

- ✔ Jack has COPD and CHF.
- ✔ Jack has low health literacy. He needs help understanding when to call his PCP and how to arrange and prepare for medical appointments, understanding and remembering to take medications as prescribed.
- ✔ Jack performs self-care (ADLs), but symptoms make shopping and housekeeping hard to manage. As a result, he eats poorly, and his apartment is becoming cluttered.
- ✔ Jack does not own a car.
- ✔ Jack has had four ER visits in the past year due to breathing problems and/or dizziness.

SERVICE DELIVERY DESIGN

The pilot framework proposes a number of service delivery design components that vary somewhat from the traditional PACE model, while simultaneously maintaining the core elements of traditional PACE. As with the traditional PACE model, the IDT is essential in determining the services and supports that are needed by potential participants. To address the needs of an at-risk medically complex population, a core IDT will administer the participant assessment, develop a plan of care, and provide ongoing care. The core team will be comprised of a primary care physician, nurse practitioner or physician's assistant (dependent on state licensing requirements); a registered nurse; and a professional with a master of social work (MSW). The IDT can access additional health care professionals as needed. Consistent with traditional PACE, the pilot program is at full risk for all benefits and must meet all participant needs.

Traditionally, a PACE center provides care, social activities, and the opportunity to easily communicate information across different health care professions regarding a participant. The pilot would not require participant access to a PACE center; rather, pilot programs would utilize congregate activities and services available in the community. Pilot programs will be required to develop a robust network of services and supports, including opportunities for socialization as well as the provision of care. A pilot program must develop a communication structure to streamline the sharing of information between the pilot IDT and its network of services and supports.

Similar to the traditional PACE model, the participant may receive primary care from the PACE-employed primary care provider (PCP). However, in the pilot participants will have the option to retain their current community physician without requiring completion of a waiver from the PACE regulations. The pilot model will necessitate a broader relationship with community PCPs, given that many participants will choose to continue receiving care from their community PCP. The pilot program will establish a formal contractual relationship between the program and selected community providers that sets forth the roles of both parties. At a minimum, a PCP must integrate with the IDT and be able and willing to be involved in the care plan discussion. Utilization of community-based providers (CBPs) will vary by market. (Pilot programs also may consider partnering with medical homes or federally qualified health centers.)

SERVICES AND PAYMENT

Payment under the pilot is tier-based, with a set of care services associated with each tier. Participants will be assessed and placed in a tier that aligns with their care needs and associated cost. The specific services furnished to participants and the predetermined criteria for assigning a participant's level of need to a service tier will be set by the pilot program. The pilot program, in conjunction with Medicaid, will be responsible for agreeing on general parameters for the types (as well as amount and frequency) of services provided in each tier. The pilot program IDT, including a community-based physician, if applicable, will be responsible for adhering to a participant's care plan, coordinating and managing care delivery, and meeting a participant's needs.

The pilot program will account for the following in developing a tier-based system:

- Pricing for each tier will need to be developed with actuarial assistance. All Medicare services are covered through the PACE Medicare capitation.
- All Medicare (Parts A and B) and Medicaid-covered services (primary, acute and LTSS) and items (e.g., dental care to allow for proper nutritional intake, basic eyeglasses) are included,

as needed, according to a participant's care plan (and, essentially, tier placement).

- Services or items considered medically necessary for the purpose of implementing a care plan that meets the participant's care needs are covered. If a service (e.g., extra companion care hours) or item (e.g., cosmetic dentistry or eyeglass frames that exceed a certain cost limit) is not covered (i.e., that is not a Medicare or Medicaid service and is not considered necessary in order to implement a care plan that assures a participant's care needs are met), participants may choose to purchase those services on their own, outside of the capitated payment paid to the pilot program (as they can now in traditional PACE).

- If services are needed on a limited time basis (e.g., 45 days) that exceed the limits of a service tier, those services are covered. If the participant's needs continue to exceed the service limits of a tier after the limited time period, the participant moves to a higher tier level.

Table 1 illustrates the type of tier-based system that a pilot program might develop for the at-risk medically complex population:

MEDICARE PART D

Aside from Medicare Parts A and B and the Medicaid/LTSS services provided under the pilot, participants also will have Medicare Part D coverage. Dual-eligible participants will receive Part D Prescription Drug coverage through the Medicare Part D plan of the pilot program. Medicare-only participants will be able to choose either the Part D plan of the pilot PACE organization or an alternative Part D plan. The Part D flexibility furnished under the pilot model will offer Medicare beneficiaries a coverage option that reflects their care needs, rather than the needs of the traditional PACE-eligible population, and is more affordable than the Part D plan of the PACE organization. To assure that PACE

Table 1

Tier	Services
1	» IDT assessment and care planning » Care coordination (navigation, transitions, provider communication) » Patient/family education
2	All tier 1 services, plus: » In-home nursing visits and phone contact to assist with medication management and “self-administered” treatments » In-home social work visits and phone contact to assist with management of psychosocial issues and service coordination » Transportation to medical appointments
3	All tier 1 and tier 2 services, plus: » LTSS “lite” services for functional deficits that do not qualify the individual for nursing facility clinically eligible (NFCE), e.g., housekeeping, grocery shopping, meal preparation, light ADL assistance, check-ins, either ongoing or for caregiver respite. Another feature could be a set amount of respite per year, either in a personal care/assisted living facility, in-home staffing, or if the participants are allowed in adult day care.

continues to be affordable for the Medicare-only individual, those individuals who transition from the pilot to the permanent program will be able to retain their Part D plan or enroll in the Part D plan of the PACE organization.

PAYMENT METHODOLOGY

Dual-Eligible Participant: Medicare will pay a risk-adjusted rate based on a county benchmark and risk adjustment factors. The v. 21 CMS-HCC risk adjustment model will be utilized for Medicare payments. The v. 21 HCC model takes into account dementia status. Given that the pilot may serve participants with early-onset Alzheimer's disease, among other participants with dementia, it is essential to use an HCC risk-adjustment model that captures dementia in its payment. In addition to the Medicare capitation, Medicaid will pay a rate based on the tier at which a participant's level of needs is assessed and at which their care needs can be met effectively.

Medicare-Only Participant: Medicare will pay a risk-adjusted rate based on a county benchmark and risk adjustment factors (see above). Additionally, the participant will pay a rate based on the tier at which a participant's level of needs is assessed and at which their care needs can be met effectively. Participants who choose to move to a higher tier to receive a higher level of services may do so at their discretion and will pay the correspondingly higher tier rate. Participants may not choose a tier that is below their assessed level of need.

Medicaid-Only Participant: The state would set a Medicaid-only rate reflecting the cost of both LTSS and non-LTSS services by tier.

Quality Indicators

The recent wave of quality improvement initiatives has allowed health care providers an opportunity to demonstrate their value – and has been a tool in empowering health care beneficiaries as they make care decisions. **Studies** have demonstrated the value of the traditional PACE model in its ability to deliver quality care, with high satisfaction from participants and caregivers alike. Looking to maintain the high caliber of care in the pilot, the proposed quality indicators of the framework reflect an environmental scan of three Centers for Medicare & Medicaid Innovation initiatives to identify quality measures currently in use. Based on this scan, the framework provides a set of measure domains and sample measures within the domains for the pilot. The sample measures were selected to support quality improvement, accountability and evaluation. The sample measures proposed are meant to serve as a reference in developing measures specific to the pilot population. This recognizes that the specifications for the sample measures drawn from the Financial Alignment Initiative (FAI), Accountable Care Organizations (ACOs), and Independence at Home (IAH) programs were developed to reflect a specific population. In considering the measure specifications for the pilot, slight changes – such as adjusting the age criteria – may be required.

The measures, with appropriate risk adjustment, will provide PACE programs, participants and stakeholders the opportunity to compare the pilot to other available care delivery programs. Identifying comparison groups in those programs will be necessary to assess the effectiveness of the pilot.

The proposed measure domains are as follows:

- Functional Status*
- Chronic Disease Management*
- Service Utilization*
- Medication Management/Reconciliation*
- Preventive Services: Screening and Assessment*
- Satisfaction*
- Cost/Financial Measures*
- Quality of Life
- Follow-Up Discussions and Planning
- Care Transition
- Self-Care/Patient Preference
- Education
- Care Coordination

** Priority*

Sample measures in these domains are drawn from the FAI, ACO, IAH and other sources, including measures developed by NPA. These sample measures are presented in Table 2 below.

Table 2

Measure Domain	Sample Measure
Functional Status	CAHPS* Survey: Health status/functional status, ACO
Chronic Disease Management	Blood pressure control: Controlling high blood pressure, FAI Diabetes care, comprehensive diabetes care: Selected components include HbA1c control, LDL-C control, retinal eye exam, FAI (age- and function-appropriate)
Service Utilization	Ambulatory care-sensitive condition admission: Admissions with primary diagnosis of a severe and persistent mental illness or substance use disorder, FAI All-cause unplanned admissions for patients with multiple chronic conditions, ACO Avoidable ER visits: Preventable/avoidable and primary care treatable ER visits, FAI "Heads in Bed"/days in the community measure, workgroup suggestion (to be developed) Number and duration of participants receiving care in each tier, workgroup suggestion Conversion rate of participants to traditional PACE when medically eligible, workgroup suggestion
Medication Management/ Reconciliation	Medication management: Annual monitoring for patients on persistent medications, FAI Medication reconciliation in the home, IAH

Table 2

Measure Domain	Sample Measure
Preventive Services: Screening and Assessment	Immunizations: Influenza immunization, FAI Immunizations: Pneumococcal vaccination for patients age 65 and older, FAI Falls: Screening for future fall risk, ACO Depression remission at 12 months, ACO Urinary incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older, NCQA Dementia: Cognitive assessment, PQRS Depression screening performed during enrollment year, **NPA** Depression screening performed annually, **NPA** What percent of participants in the pilot are being assessed for alcohol and substance abuse? When identified, what percent of participants are treated/recommended to a program for treatment? Workgroup suggestion. Number of participants with appropriate screenings based on goals of care, workgroup suggestion.
Satisfaction	Voluntary disenrollment rate, IAH Referrals, IAH Patient satisfaction, IAH
Cost/Financial Measures	No sample measure proposed
Quality of Life	Caregiver stress assessment, IAH CAHPS* Survey: How well your providers communicate, ACO CAHPS* Survey: Stewardship of patient resources, ACO Inclusion of an anxiety/confidence measure, demonstrating participant confidence (or lack thereof) in the availability of a support system. For example, "How many times in the last week have things felt out of control or frightening?" Workgroup suggestion.
Follow-Up Discussions and Planning	Follow-up after hospitalization for mental illness, FAI

Table 2

Measure Domain	Sample Measure
Care Transition	Inclusion of a measure that addresses timeliness of information transfer, workgroup suggestion
Self-Care/Patient Preference	Patient preferences documented, IAH Beneficiary/caregiver goals, IAH CAHPS* Survey: Shared decision-making, ACO
Education	CAHPS* Survey: Health promotion and education, ACO
Care Coordination	NQF#0326: Advance Care Plan Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Age 65 and Older, NCQA

* These items illustrate sample survey topics for participants. The framework does not recommend utilizing the CAHPS survey as the data collection tool for these topic areas. The pilot would benefit from a standardized satisfaction instrument to capture this information from the new population of PACE participants served under this pilot. Participant satisfaction or dissatisfaction with PACE services received must be identified and tracked.

ADDITIONAL INFORMATION

The National PACE Association developed this framework to support CMS in the development of a PACE pilot serving those at risk of needing a nursing home level of care. For additional information, contact **Peter Fitzgerald**, executive vice president of Policy and Strategy.