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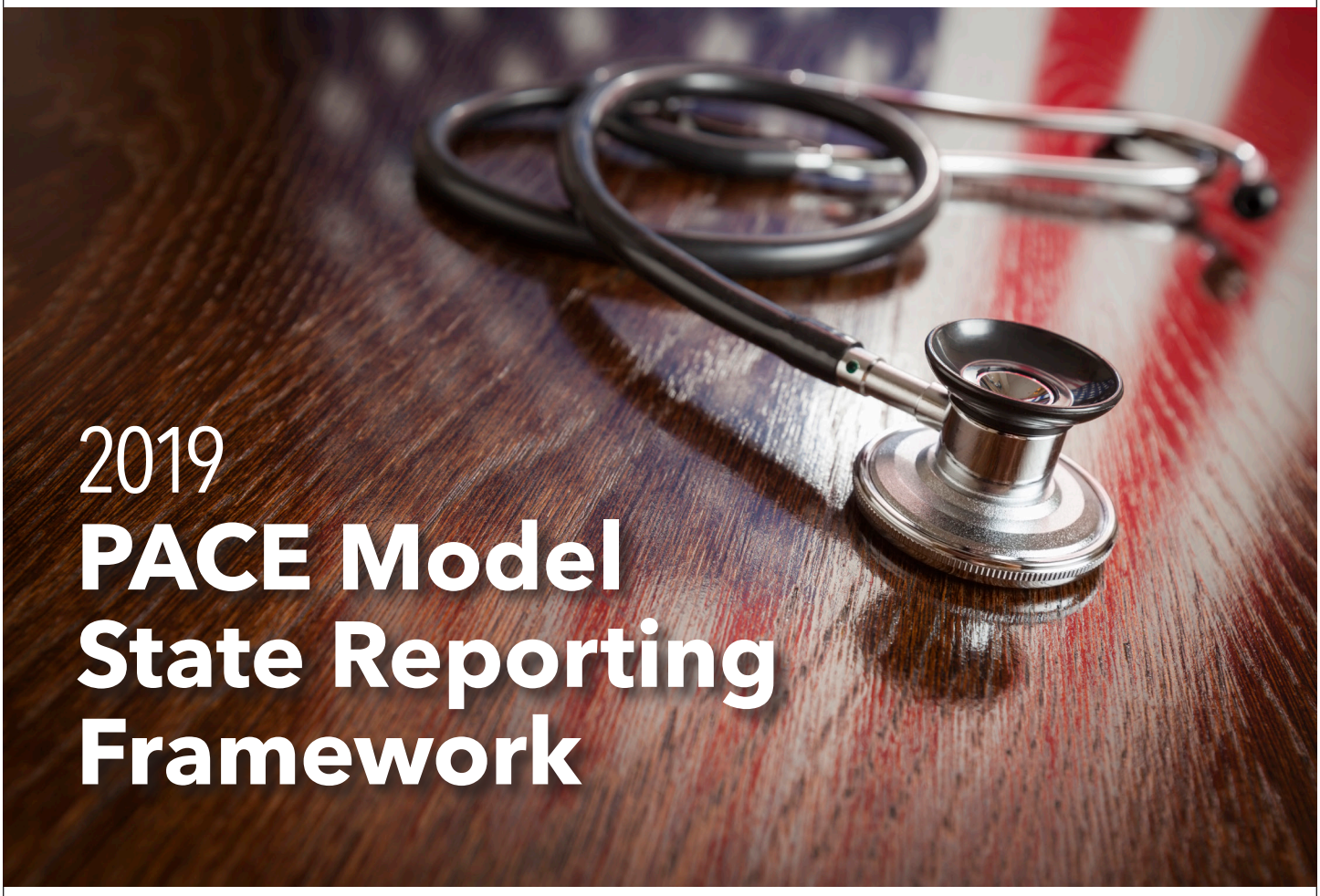

2019

PACE Model State Reporting Framework

Prepared for the National PACE Association by IBM Watson Health

Contents

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I. Introduction

A. Purpose

The Program of All-Inclusive Care for the Elderly (PACE®) model is poised for significant growth in the coming decade. Attributes of the PACE model, including full integration of Medicare and Medicaid and emphasis on home and community-based services (HCBS), have become central tenets of long-term services and supports (LTSS) program development across populations and states, and the PACE Innovation Act authorizes experimentation with new populations and program features. As PACE has grown and evolved, so have other capitated models enrolling adults with significant LTSS needs. Most significantly, a range of managed long-term services and supports (MLTSS) models are being adopted by states at a rapid rate, expanding from 16 states in 2012 to 24 states in 2017 and now covering an estimated 1.8 million people nationally (Lewis et al., 2018).

As increasing numbers of states offer both PACE and MLTSS, policy-makers and other stakeholders in those states are seeking information about the relative value of the models. This framework offers a modest number of items that can be used to measure important and actionable program elements without overwhelming states, PACE organizations or MLTSS plans. The framework is envisioned as a starting point for PACE organizations and their state oversight agencies as they discuss evolving PACE reporting requirements.

The greatest challenge in assembling this framework has been identifying measures that are comparable across program models. The majority of MLTSS plans combine adults of all ages who have LTSS needs with dual eligibles regardless of LTSS need. In contrast, PACE enrolls only people 55 or older who are certified at the nursing facility level of care. A study conducted by the National Committee for Quality Assurance (NCQA) for the Centers for Medicare & Medicaid Services (CMS) found that relative to Medicare Advantage (MA) enrollees, PACE participants are older, have more activities of daily living (ADL) limitations, and have poorer physical and mental health. PACE participants had poorer physical and mental health than all types of MA enrollees, including those in Dual Eligible, Institutional and Chronic Condition Special Needs Plans (Ng et al., 2012). Many existing national measures (e.g., several HEDIS measures) include people with no LTSS needs in their denominators, making a comparison to PACE inappropriate. Accordingly, the framework includes measure concepts, which suggest types of measures that are important to the PACE population, with the expectation that state-specific measures may be adopted in those areas, or appropriate national measures may emerge over time. Moreover, since most PACE measures will not be fully comparable with MLTSS measures, some states have explored modifying existing measures as necessary.

B. Approach

The research team conducted an inventory of the state reporting requirements of eight MLTSS programs in five states, representing a range of MLTSS model types and prescriptiveness of reporting requirements. Requirements were categorized in three domains: effectiveness of care, utilization and cost. After removing duplicates, 134 MLTSS measures were identified. The measures were reviewed to identify which currently are being reported by PACE organizations at either the state or federal level, are appropriate for the PACE population, and meet other criteria described in the next section.

Concurrently, the research team conducted two focus groups with PACE organizations and 11 key informant interviews with state staff, PACE organizations, actuaries, and others familiar with state data collection from PACE organizations and MLTSS plans. These interviews focused on recent changes in

reporting requirements, drivers of those changes, uses of the data, feasibility of reporting, and unique attributes of PACE that are not captured in current reporting for PACE or MLTSS. From these interviews and focus groups, additional potential measure areas important to PACE were identified.

The work was guided by a workgroup comprised of PACE organizations that are experiencing significant change in their state reporting requirements. The workgroup met eight times throughout the project to provide expert advice. Workgroup members and others from their organizations also reviewed MLTSS measures and provided feedback regarding the appropriateness of the measures for PACE and the extent to which the measures or similar measures currently are reported by PACE. Data and quality staff from the National PACE Association (NPA) reviewed the measures and provided feedback regarding similar measures available from DataPACE3 (DP3), the Common Data Set (CDS), and Per Member Per Month (PMPM) reports and noted similar measures under development by CMS.

Finally, measures were assessed against the criteria in the next section, resulting in the set of measures and concepts proposed in this framework.

II. Criteria for Inclusion

The following criteria guided the development of the model state reporting framework for PACE.[1]

1. Useable: Measures should address issues that are important to PACE stakeholders and can be acted upon by PACE organizations to improve quality. When available, measures that are comparable across service delivery alternatives (e.g., PACE and MLTSS plans) are of greatest use to participants, policy-makers and PACE organizations.

2. Reliable and Valid: When implemented, measures must reflect consistent and credible results. This includes testing in the service delivery models that will use them.

3. Feasible: Measures should be based on data that are readily available to use without undue burden. In general, measures that rely on administrative data are most feasible.

4. Transparent: Measures should be transparent, with stakeholders having a clear understanding of their basis and use.

III. Recommended Reporting by Domain

The reporting recommended in this section is organized into three domains: effectiveness of care, utilization and costs. Taken together, these reporting elements represent a balanced set of items focusing on issues of particular importance to the PACE population.

[1] The criteria were adapted for PACE from "The ABCs of Measurement" of the National Quality Forum.

A. Effectiveness of Care[2]

Table 1. Recommended Effectiveness of Care Reporting

Name	Description	Source	Notes
Consumer Satisfaction	I-SAT Integrated Satisfaction is a standardized in-person participant satisfaction survey developed in partnership with CalPACE.	Vital Research	Developed, tested, and validated in partnership with CalPACE and in use in California and multiple other states. Enables comparison across PACE organizations but not in use with MLTSS.[3]
Initial Health Assessments	Percentage of participants with initial health assessments completed within 90 days of enrollment.	NPA	Ninety days is the standard for Medicare Advantage and commonly is adopted for MLTSS. However, CDS includes the shorter timeframe (30 days) required for PACE. This measure will need to be modified for PACE.
Advanced Care Planning	Percentage of PACE participants with an advance directive or surrogate decision-maker documented in the medical record and percentage of PACE participants who had documentation in the medical record of an annual review and discussion about their advance directive or surrogate decision-maker.	CMS	This currently is a proposed measure to be reported to CMS.
Annual Flu Vaccine	Percent of PACE participants who receive an influenza immunization during the influenza immunization season. (Three percentages to calculate.)	CMS	This currently is reported to CMS.

[2] The top three Hierarchical Condition Categories (HCCs) are Vascular Disease, Diabetes with Complications, and Congestive Heart Failure. There are no measures for these three HCCs included in the framework. States and PACE organizations may want to consider if it would be appropriate to include them in their specific reporting requirements.

[3] The CAHPS Home and Community-Based Services Survey potentially could enable comparison to MLTSS but has not been tested in PACE.

Name	Description	Source	Notes
Pneumococcal Vaccine	Pneumococcal immunizations on a quarterly basis.	CMS	This currently is reported to CMS and captured in DP3.
Participants Living in the Community	Percentage of participants not in nursing facilities at point in time.	CMS	Proposed by CMS as PACE quality measure and captured in DP3.
Medication Administration	Medication administration errors without adverse event, adverse drug reaction, medication-related occurrence with adverse outcome.	CMS	This currently is reported to CMS.
Pain Screening (HEDIS)	Percent of participants who had a pain screening or pain management plan at least once per year.	NCQA (HEDIS)	This measure is based on CPT codes not available to PACE organizations and will need to be modified to be feasible.
Treatment for Clinical Depression	Percentage of participants with depression receiving treatment during the quarter.	CMS	This is proposed by CMS as a PACE quality measure.
Screening for Dementia	Participants screened for dementia with a validated tool.	CMS	This currently is a proposed metric to be reported to CMS as part of the treatment for clinical depression, which includes a data element related to participant screening for dementia with a validated tool.
Percent of High-Risk Patients with Pressure Ulcers (Long-Stay)	Percentage of participants enrolled during the quarter who have at least one documented PAPU/I (stages 3, 4, unstageable or deep tissue injury) acquired while a PACE participant.	CMS, NQF endorsed	This currently is reported to CMS, proposed by CMS as a PACE quality measure, and endorsed by NQF.
Participant Falls	Participant fall rate and participant fall with injury rate.	CMS, NQF endorsed	This currently is reported to CMS, proposed by CMS as a PACE quality measure, and endorsed by NQF.

B. Utilization

Table 2. Recommended Utilization Reporting

Name	Description	Source	Notes
Nursing Facility Long Stays	Percentage of participants with nursing facility stay of 90 days or longer.	CMS	The metric proposed by the CMS PACE Quality Measure is "percentage of participants not in nursing homes." This measure is calculated by subtracting the percentage of PACE participants with an extended nursing home stay from 100. The metric proposed in the framework "Percentage of participants with a nursing facility stay of 90 days or longer" is an intermediate step in calculating the metric proposed by CMS.
Emergency Department (ED) Utilization	Percentage of participant ED or urgent care visits that did not result in being admitted to the hospital.	CMS	This currently is reported to CMS in part (ED reported but not urgent care) and proposed by CMS as a PACE quality measure.
Plan All-Cause Readmissions (HEDIS)	All-cause readmissions for Cohort 2: 60 years of age and older.	NCQA (HEDIS)	This HEDIS measure is broken into two age cohorts; only cohort 2 (60 and older) would be reported. However, modification would be needed to report only the subset that is NF-certified in the denominator.[4]
Psychiatric Bed Days	Psychiatric bed days per 1,000 participants.	NPA DP3	This currently is not reported but is captured in DP3.
Community Behavioral Health Services and Counseling	Can be developed from CDS elements.	NPA	CDS includes elements for outpatient, including drug rehab, mental health/behavioral health counseling. Specific measure will need to be developed.
Prescription Drugs	Can be developed from PACE Data Analysis Center (PDAC) elements	NPA	Part D utilization is currently reported to CMS via PDAC. Specific measure will need to be developed.
Access to Primary Care	Can be developed from DP3 elements.	NPA	DP3 collects information on primary care encounters with physicians, physician assistants and nurse practitioners. Specific measure will need to be developed.
Specialty Care	Can be developed from DP3 elements.	NPA	DP3 collects information on specialist encounters, including audiologist, dentist, optometrist, podiatrist, psychiatrist and medical outpatient specialist. Specific measure will need to be developed.
Home Care	Can be developed from DP3 elements.	NPA	DP3 collects information on home care. Specific measure will need to be developed.

[4] CMS has determined this measure is not appropriate in the context of PACE. CMS wanted to gain a better understanding of the All-Cause Readmissions measure and whether there might be a better measure to suit the uniqueness of PACE (e.g., participant days in the community) given the unique focus of keeping participants in the community.

Name	Description	Source	Notes
Interdisciplinary Team (IDT) Utilization	Can be developed.	NPA	The PACE IDT process is far more extensive than in MLTSS. It is in person and involves many clinical and non-clinical staff. Care coordination is reported in MLTSS but generally only includes the time of the care coordinator. MLTSS IDTs are usually virtual and involve few providers. PACE reporting in this area should capture intensity and broad participation in the IDT process. Specific measure will need to be developed.
Non-Traditional Service Utilization	Utilization of services not traditionally covered by Medicaid or Medicare, such as spiritual care/ chaplain services outside of hospice, pet care, pest control services, reminder calls, staff to escort clients to appointments, housing support and other social services.	NPA	Non-traditional, flexible services are a hallmark of PACE and are not captured through encounters or other utilization reporting. MLTSS plans may offer and report on "value-added" services; however, PACE has more flexibility in the breadth of non-traditional services provided. Typically, value-added services must be defined for the MLTSS benefit year and offered to all members. Specific measure will need to be developed.

C. Cost

Table 3. Recommended Cost Reporting

Name	Description	Source	Notes
Program Expenditures	Comprehensive cost reporting by service category, including administrative costs, on a PMPM basis.	NPA	Most PACE organizations currently submit cost reports, but they are not standardized across states. Specific measure will need to be developed.
Capital Expenditures	Capital expenses and building costs: furniture, equipment, construction, modernization, leasehold improvements, land and related costs.	NPA	MLTSS plans may have expenses related to their office space, but PACE provides care on-site at their centers. PACE typically is required to meet square footage requirements and safety standards for adult day care. Additionally, PACE programs may have dental chairs, IV units, bladder scanners and other equipment found in an urgent care setting. Specific measure will need to be developed.
Independent Financial Audit Report	Annual independent financial audit report.		Demonstrates overall financial health of a PACE organization, including its ability to bear risk. CMS requires PACE organizations to submit the Fiscal Soundness Reporting Requirements on an annual basis based on their fiscal year.

IV. Encounter Reporting

Federal Medicaid managed care regulations require states to collect encounters from Medicaid managed care plans and submit them to CMS. The federal requirement is longstanding, but poor compliance in many states led CMS to add a strong enforcement measure in the Final Medicaid Managed Care Rule of 2016, making receipt of federal matching funds for payments made to managed care plans conditional on submission of validated, complete and timely enrollee encounter data (Paradise et al., 2016). Federal compliance aside, states use encounter data to monitor quality and utilization, calculate and validate rates, and conduct evaluation and research studies (Byrd et al., 2013).

The federal PACE rule does not mandate encounter reporting, but a handful of states has begun requiring PACE organizations to submit them. State officials report that PACE encounters are beneficial to compare utilization of PACE with other service delivery models, develop risk-adjustment methods, and set rates. However, the unique nature of the PACE model creates several challenges for encounter reporting. (See Table 4.) PACE organizations are essentially hybrids of managed care plans and provider organizations. They receive capitated Medicaid and Medicare payments and pay network providers like plans, but they also employ clinical and ancillary staff and provide intensive services directly in centers, alternative care sites and participant's homes. While at a center, a participant receives several encounters a day from multiple staff and multiple encounters from a single staff person. On the way to the center, participants encounter van drivers and attendants. A participant's interdisciplinary team meeting is typically an in-person meeting comprised of several clinical and non-clinical staff. These attributes are central to the PACE model, yet many of them are not captured easily through the standard 837 encounter format.

Table 4. Features of PACE That Make Encounter Reporting Challenging

Unique PACE Attribute	How PACE Differs from Typical MLTSS Plans
Interdisciplinary Team (IDT)	• Always in person, sometimes in the home setting • Includes multiple clinical and ancillary staff meeting concurrently • IDT meetings occur frequently as part of regular care
Direct Care Staff	• Many staff encountering participants multiple times a day at the center • Drivers and attendants transporting participants to the center and to appointments • Personal care provided throughout the day as needed at the center
Non-Traditional Covered Benefits	• Chaplain and other spiritual services provided outside of hospice • Pet care • Reminder calls • Food and nutritional services • Group health education
Capitated Medicare and Medicaid Financing	• Services are delivered as needed, without regard to funding source; IT systems generally are not set up to separate Medicare encounters from Medicaid encounters • Allocation of IDT and other staff-provided services particularly challenging
Care Coordination and Other Care Services	• Care coordination often occurs multiple times a day in less than 30-minute increments • Care coordination encounters involve multiple providers, not solely the care coordinator

States considering encounter reporting for PACE should explore these challenges closely with their PACE organizations. The risk is that encounter reporting will add significantly to the administrative costs of the organizations while under-reporting the unique features of the model. This may undermine the original intent of a state to compare utilization with other models (because PACE utilization will not be fully captured) or to set fair rates (because encounters will not reflect true costs). Alternatively, states can consider working with PACE organizations to require targeted utilization reporting on services of particular interest to policy-makers, such as hospital and nursing facility use.

V. Conclusion

This framework offers a basis for discussions between states and PACE organizations on what PACE organizations should report to states. The recommendations were developed after careful consideration of what MLTSS plans report, the unique attributes of PACE, and what is most likely to be appropriate, feasible and useful.

[5] California, New York and Wisconsin currently require encounter reporting.
[6] IBM Watson Health interviews with state officials, 2018.

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