NATIONAL PACE ASSOCIATION

STRATEGIES FOR INCORPORATING PACE® INTO STATE INTEGRATED CARE INITIATIVES

A Toolkit for States

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STRATEGIES FOR INCORPORATING PACE INTO STATE INTEGRATED CARE INITIATIVES

CONTENTS

SECTION 1.

Introduction: The Evolving Role of PACE in a Dynamic State Marketplace

> ***Thirty-one states have PACE*** *sites that integrate care and take full financial risk for all Medicaid and Medicare services, including nursing home care. Now many of those states are implementing broader integrated care models through HMOs and other managed care organizations (MCOs).*
>
> ***PACE complements broader integrated care initiatives*** *with a proven approach that supports people with high needs to stay out of nursing homes. PACE sets a high bar for integrated care and gives eligible people a local provider-based alternative to HMOs.*
>
> ***If PACE is not incorporated into a state's integrated care strategy****, an effective community option may be closed off to future participants. But a state can take a few modest steps to incorporate PACE into its broader strategy and ensure continuing access to a proven community option.*

1.1 PACE is the original integrated care option.

The Program of All-inclusive Care for the Elderly (PACE) was the first in the country to offer fully integrated care, in which people with very high needs who are at least 55 years old receive all of their health and long term services and supports through one accountable provider. In 31 states, PACE has provided the "proof of concept" that comprehensive care with risk-based capitated payments can be beneficial for people with high needs. Now, several of those states are implementing managed care models that aim to use PACE concepts to serve people with disabilities of all ages and with a diverse range of needs. This toolkit is designed for those states. It offers model policies and other tools to harmonize PACE with broader integrated care programs in the areas of enrollment, payment and oversight.

In 2004, only eight states had implemented integrated care models outside of PACE. By the end of 2013, the number had grown to 19, with at least 5 more scheduled to implement programs in 2014. Some new programs are being designed to integrate Medicare and Medicaid services as part of the CMS Financial Alignment Initiative, and others are starting as Medicaid managed long term services and supports (MLTSS) programs, with the possibility of adding Medicare services in the future. To the extent that these new programs include LTSS for people who are at least 55 years old, they overlap with PACE.

1.2 PACE is a proven program for people with high needs who are at least 55 years old. It complements other integrated care options.

Many new state integrated care programs are targeting broad groups of people, such as all adults who are dually eligible for Medicare and Medicaid, or all people who fall into the "Aged, Blind and Disabled" eligibility categories. Many subpopulations exist within these target groups. For example, a national study found that 20 percent of dual eligibles account for over 60 percent of the costs of dual eligibles.[1] For Medicaid, the costs of high spenders are primarily attributable to long term services and supports. PACE programs serve a subpopulation of high-cost beneficiaries who are at least 55 years old and certified at the nursing facility level of care. The PACE subpopulation overlaps with several population groups that may be included in integrated care (Tool 1-A).

TOOL 1-A: IDENTIFYING PACE-ELIGIBLE PEOPLE WITHIN TYPICAL INTEGRATED CARE TARGET GROUPS

Integrated Care Target Group	Eligible for PACE?
People 65 and older	Yes, if nursing facility level of care needed
People with physical disabilities ages 18-64	Yes, if at least 55 and nursing facility level of care needed
Adults with behavioral health needs	Yes, if at least 55 and nursing facility level of care needed
Persons enrolled in home and community-based waiver programs	Yes, if at least 55
Persons in nursing homes	Yes, if at least 55 and able to be served safely in the community at time of enrollment
People dually eligible for Medicare-Medicaid	Yes, if at least 55 and nursing facility level of care needed
People with Medicaid coverage only	Yes, if at least 55 and nursing facility level of care needed
Children with disabilities	No

Reasons why a state would want to ensure ongoing access to PACE include the following:

- PACE has expertise in serving a subpopulation with very high needs by supporting their ability to live at home and in other non-institutional settings;
- PACE sites have already implemented key features of integrated care, including person-centered care planning, interdisciplinary teams, comprehensive services, full-risk capitated payments, and emphasis on both quality of life and quality of care;
- PACE has been highly successful at keeping participants out of nursing homes; and
- PACE is a provider-based managed care model that offers beneficiaries a known local provider as an alternative to insurer-based managed care.

PACE sites set a high bar for integrated care. By including PACE in its overall integrated care strategy, a state signals to all contractors that it wants to see a high-quality integrated experience at the beneficiary level.

[1] Coughlin, Teresa A., Timothy A. Waidmann and Lokendra Phadera. Among dual eligibles, identifying the highest-cost individuals could help in crafting more targeted and effective responses. *Health Affairs*, 31, no.5 (2012):1083-1091.

1.3 States can focus on three critical areas to harmonize PACE with other integrated care programs: access, rate setting and oversight.

Harmonizing PACE with a new integrated care initiative is not difficult but it does require some specific considerations by the state. Doing nothing to harmonize options is likely to result in unintended barriers to PACE. The sections in this guide focus on three things that states can do to ensure an appropriate place for PACE in an expanded integrated care strategy. These include:

- Ensuring ongoing access to PACE for eligible individuals (Section 2);
- Harmonizing rates for PACE and other integrated care options (Section 3); and
- Making state administration and quality oversight comparable across integrated care options (Section 4).

SECTION 2.

Ensuring Ongoing Access to PACE for High-Needs Individuals

> ***Integrated care initiatives*** *with mandatory and/or passive enrollment policies may close off access to PACE if not crafted carefully.*
>
> ***States can take modest steps*** *to ensure that eligible people learn about PACE along with other options during the enrollment process.*
>
> ***States can ensure*** *that eligible people receive objective information about all their choices through options counseling.*

2.1 Integrated care enrollment processes may create barriers to PACE if not carefully designed.

If not crafted with PACE in mind, a mandatory and/or passive enrollment process for an integrated care initiative may:

1. Create discontinuity of care for current PACE members;
2. Make PACE invisible to people when an integrated care initiative is first rolled out; or
3. Make PACE invisible to people who become eligible in the future, after an integrated care program has been established.

States can ensure that eligible people always have access to the PACE option, and are informed of the option at key points in time. Federal regulations do not allow mandatory or passive enrollment into PACE, but PACE can be offered as a voluntary option within a broader integrated care program.

2.2 Key features of PACE must be considered when developing enrollment and options counseling processes for an integrated care initiative.

PACE programs are subject to federal regulations (42 CFR Part 460), some of which need to be considered in the enrollment process. PACE programs may enroll people who are at least 55 years old and certified at the nursing facility level of care. Enrollment must be voluntary, and the person must actively choose the option—passive enrollment is not authorized. Tool 2-A compares certain features of PACE with those of broader state integrated care initiatives as they relate to who may be enrolled and how they may be enrolled.

TOOL 2-A: COMPARISON OF ENROLLMENT FEATURES FOR STATE INTEGRATED CARE INITIATIVES AND PACE

	State Integrated Care Initiatives	PACE	Implications and Strategy
Medicaid Enrollment Policy	May be voluntary or mandatory; may be active or passive	Must be voluntary; must be active	In the context of a mandatory state initiative, PACE may be offered as a voluntary alternative that exempts people from mandatory assignment to an MCO
Medicare Enrollment Policy	Must be voluntary; may be active or passive under Affordable Care Act (ACA) demonstration authority	Must be voluntary; must be active—ACA demonstration authority does not extend to PACE	Sufficient time must be built into the enrollment and options counseling processes for eligible people to actively choose PACE as an alternative to an MCO
LTSS Need	May include people with a range of LTSS needs, from no need to NF level of care need	Must include only people with NF level of care need who can be served safely in the community at time of enrollment	Enrollment materials should convey that PACE is an option for some but not all beneficiaries
Age	May include people of all ages	Must serve people 55 and older	Enrollment materials must convey that PACE is an option for some but not all beneficiaries.

The differences between most state integrated care initiatives and PACE need not result in barriers to PACE access. With modest accommodations in the design of enrollment processes, the implications noted in Tool 2-A can be addressed. The model processes below address these implications.

2.3 States can ensure that PACE is a visible option during the roll-out of a larger integrated care program.

Current PACE participants are exempt from the auto- or passive- enrollment processes being used by states for the introduction of new integrated care. Making current participants exempt ensures they will not be disenrolled from PACE arbitrarily. However, that policy alone does not make PACE a visible option to people who are currently in fee-for-service or other managed care programs, and who are subject to enrollment in a new integrated care program. Whether a new integrated care program is mandatory or voluntary, PACE visibility can be built into the enrollment process, as outlined in Tool 2-B. This process should include notices to Medicaid beneficiaries that highlight PACE as an option for eligible persons. Those inquiring about PACE should be transferred to options counselors who are trained in an interactive process to help individuals make informed choices. The options counselors would discuss all LTSS options, including PACE, and are able to make a referral to a PACE organization for those who are interested. PACE organizations would then confirm eligibility and assist applicants in closing the loop with the state's designated enrollment agent.

TOOL 2-B: MODEL PROCESS FOR NOTIFYING ELIGIBLE PERSONS WHEN ROLLING OUT AN INTEGRATED CARE PROGRAM

Activity	Days Before
120 days before enrollment, notify community based organizations that eligible people will receive first notices in 30 days. Highlight that PACE participants are exempt from the process. Highlight that PACE is an option for eligible persons living in PACE service areas.	**120 Days** **Notice to Community Based Organizations, including PACE sites**
90 days before enrollment, notify eligible people that a new program is coming soon, and they will receive more information in 30 days. Highlight that PACE will be an option for eligible persons living in PACE service areas. Provide a toll-free number for those who want more information.	**90 Days** **First notice to beneficiaries eligible for integrated care program**
60 days before enrollment, notify eligible people that it is now time to make a choice (and, if applicable, that they will be assigned to an MCO if they do not act). Include PACE among the list of choices. Provide a toll-free number for assistance and to enroll. Ensure that call center staff is trained to transfer people with questions about PACE and/or LTSS to options counselors. Refer those choosing PACE to site to confirm eligibility.	**60 Days** **Second notice to beneficiaries**
Between 60 and 30 days before enrollment, have options counselors make outreach calls to LTSS users who have not yet indicated a choice. Include PACE among the choices discussed on those calls.	**60-30 Days** **Telephone outreach**
30 days before date of enrollment, send a confirmation of choice made. If applicable (in a passive and/or mandatory system), notify the eligible person of the default assignment if a choice has not been made. Provide a toll-free number to correct errors, reverse the default to a choice, or answer questions.	**30 Days** **Confirmation of choice OR Notice of default assignment**

2.4 States can ensure that PACE is visible when members of integrated care MCOs wish to change options.

People enrolled in fully integrated Medicare-Medicaid products can disenroll and switch to a different option on a month-to-month basis. Persons enrolled in mandatory Medicaid managed care can switch options at least annually, and sometimes more frequently, depending on state enrollment policy. As people with LTSS needs opt out of Medicare-Medicaid products, or switch from one Medicaid product to another, they should be counseled about all their options, including PACE. Tool 2-C offers a model process for providing counseling to LTSS users when they express a desire to change options.

TOOL 2-C: MODEL PROCESS FOR ASSISTING LTSS USERS WHO WISH TO DISENROLL OR SWITCH OPTIONS

Description	Step
A member of an existing integrated care program option who uses LTSS may express a desire to switch options. The request might be made to a care coordinator, ombudsman or other party. The person is referred to the state's conflict-free options counselor.	**Member with LTSS requests to change options**
The options counselor determines the person's needs and preferences and reviews the options. PACE is among the options discussed for those who appear eligible.	**Member receives options counseling**
If the person chooses PACE, the options counselor explains that the choice is tentative pending confirmation of eligibility by the PACE site. The options counselor makes the referral to the site.	**If PACE is chosen, member is referred to site for confirmation of eligibility**
The PACE site assesses the person's needs and confirms eligibility. The PACE site assists the member in closing the loop with the options counselor. If the person has been found ineligible for PACE, the options counselor reviews choices again with the member.	**PACE site assists member to close loop with options counselor**
Once the options counselor has notified the state's enrollment agent of the person's choice, a confirmation is mailed to the person.	**Member receives confirmation of change**

2.5 States can ensure that PACE is a visible option for people who become eligible after an integrated care program is in place.

People who become newly eligible for Medicaid and LTSS after an integrated care program is operating should be fully informed of their options. In states with passive and/or mandatory enrollment processes, the PACE option should be offered before any default assignment occurs. Tool 2-D offers a model process for enrolling people who become eligible for LTSS after an integrated care program is operating.

TOOL 2-D: MODEL PROCESS FOR ASSISTING NEWLY ELIGIBLE PERSONS REQUESTING LTSS

Description	Step
A person who needs LTSS applies for Medicaid through a state or county office or community agency. If the person is financially eligible for Medicaid, a referral is made for a level of care assessment and options counseling.	**Person requests LTSS and Medicaid coverage**
The level of care assessment results in a nursing facility level of care need determination. The options counselor reviews the options, including PACE if the person is at least 55 years old.	**Person is found to need nursing facility level of care and is given options counseling**
If the person chooses PACE, the options counselor explains that the choice is tentative pending confirmation of eligibility by the PACE site. The options counselor makes the referral to the site.	**If PACE is chosen, member is referred to site for confirmation of eligibility**
The PACE site assesses the person's needs and confirms eligibility. The PACE site assists the member in closing the loop with the options counselor. If the person has been found ineligible for PACE, the options counselor reviews choices again with the member.	**PACE site assists member to close loop with options counselor**
Once the options counselor has notified the state's enrollment agent of the person's choice, a confirmation is mailed to the person.	**Member receives confirmation of enrollment**

2.6 States can ensure that the options counseling process is objective, available to all persons with LTSS needs and meets federal requirements.

In its recent guidance to states on managed LTSS programs, CMS indicated that "MLTSS participants must be offered conflict-free education, enrollment/disenrollment assistance, and advocacy in a manner that is accessible, ongoing, meaningful and consumer-friendly."[2] One way to meet this requirement is to offer options counseling. Options counseling is an interactive process to help individuals make informed choices about how to access health care benefits and long-term services and supports. This process is directed by the individual (and may include others that the person chooses), and is centered on the individual's preferences, strengths, needs, values and individual circumstances.

Options counseling should be available to any LTSS user who is transitioning from Medicaid fee-for-service to an integrated care program, switching from one LTSS option to another, or seeking LTSS for the first time. Where PACE is available, it should always be included in the array of options discussed. Options counseling can take many forms, but it should meet certain standards, such as being conflict-free. Tool 2-E offers a model policy for options counseling.

[2] Centers for Medicare and Medicaid Services. *Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs.* Essential Element #5. May, 2013. Accessed 11/26/13 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf

TOOL 2-E: MODEL OPTIONS COUNSELING POLICY FOR INTEGRATED CARE PROGRAMS

Description	Standard
Options counseling will be offered to all individuals with LTSS or other high needs prior to active or passive enrollment in an integrated care option.	**Available**
Special outreach will be made to offer options counseling to individuals with LTSS needs.	**Proactive**
Options counseling will be provided by an independent and objective entity. The options counseling entity shall have no direct or indirect financial relationship with any of the enrollment options (e.g., health plans, PACE) and will not have a financial conflict related to its own line of business that might compete with those enrollment options.	**Independent and objective** **Conflict-free**
Options counselors will be trained to ensure they have a strong understanding of the unique needs of individuals who require LTSS and are fully versed on the various options available, including PACE and MCOs. Counselors will be knowledgeable about eligibility requirements, benefit structures, provider networks, and other features.	**Accurate and comprehensive**
Options counseling will be offered prior to enrollment in a plan, and allow adequate time for level of care determination.	**Timely**
Options counseling should be revisited if a plan participant experiences a change in life situation, health status, level of care need, or indicates a desire to change options in accordance with program policy.	**Ongoing**

SECTION 3.

Harmonizing Rates for PACE and Other Integrated Care Options

> ***PACE programs enroll only people certified*** *at the nursing facility level of care. On the surface, this can make PACE rates appear high relative to the average rates paid for broader integrated care programs that enroll people with a wide range of needs, including people who use no long term services and supports.*
>
> ***PACE takes full risk*** *for all Medicaid services. This too may make rates look high relative to a program in which key services (e.g., nursing home, behavioral health, and prescription drugs) remain fee-for-service and are not reflected in the capitation rate.*
>
> ***Despite differences*** *in target populations and capitated benefits, states can harmonize rates across PACE and other integrated care programs by making rate adjustments that reflect the differences.*
>
> ***With harmonized rates****, it becomes possible for states and consumers to compare outcomes across programs and determine relative value.*

3.1 When rates are comparable for comparable populations and benefits, relative value can be measured.

The positive effects of PACE on consumer health and functioning are well documented.[3] But how do states know if PACE offers good value relative to other integrated care programs? If states offer comparable Medicaid rates for comparable populations and benefits, they can measure the value that each program offers. When rates are comparable, programs with better consumer outcomes offer higher value. When rates are not comparable, consumers and state officials have no way of evaluating the relative value across integrated care options.

3.2 States have broad discretion to set Medicaid rates for PACE.

Federal PACE regulations give states ample flexibility to set PACE Medicaid rates in a manner that harmonizes them with Medicaid rates of other integrated care programs. PACE Medicaid rates must:

a. Be less than what otherwise would have been spent for participants had they not been enrolled in PACE;

b. Take into account the comparative frailty of PACE participants;

[3] A bibliography of PACE studies is available at: http://www.npaonline.org/website/article.asp?id=32&title=Bibliography_of_PACE_Articles

c. Include all Medicaid services on a full-risk basis; and

d. Remain fixed for the contract year, regardless of changes in health status.[4]

These broad requirements are compatible with the way that most states are setting Medicaid rates for other integrated care initiatives. Most States are assuming some level of savings in their Medicaid rates, meeting the "less than" standard (a). Comparative frailty (b) is addressed by states through various risk adjustment methods. States are including most Medicaid services on a full-risk basis (c), and adjustments can be made for those that are not. Similarly, adjustments may be made if States are allowing individual enrollee rates to change as health status changes (d).

3.3 States can start with the same base rate and adjust it as needed to address differences in the people served, benefits provided and level of financial risk.

In most states, new integrated care options overlap with PACE but serve broader populations. The benefits included in the capitated payment may or may not be as comprehensive as PACE, which must include all Medicaid benefits. The level of financial risk may be less than the full risk arrangements required in PACE.

These differences do not prevent a state from creating comparable rates across options. States can begin with common base rates, and make adjustments as needed to address program differences. Which adjustments are needed depends on the design of a state's integrated care option. Needed adjustments can be identified using the checklist in Tool 3-A. They include the following:

- **Age adjustment.** PACE enrolls people who are at least 55 years old. Many states are developing integrated care options for people of all ages. In such cases, in order to make rates comparable, an age adjustment must be made to the rates. Age is among the most common adjustments made in capitated payments.
- **Functional status.** PACE enrolls people who are certified at the nursing facility level of care but are able to be served safely in the community at the time of enrollment. Other integrated care programs include this target group, plus others whose functional status does not rise to nursing facility level of care. In such cases, an adjustment may be made for differences in functional status.
- **Benefits included.** The capitation for PACE covers all Medicaid benefits. No additional amount may be billed to the state. Other integrated care options may include carve-outs, which are specific benefits that are excluded from the capitation and are billed separately. For example, prescription drugs are commonly carved out. In such cases, an adjustment can be made to the base rate to reflect the value of the carved-out benefit.
- **Level of risk.** PACE bears full risk for all Medicaid services. Some state integrated care options limit the financial risk associated with high-cost services. For example, financial risk for nursing home payments are sometimes limited to 90 or 180 days of use, after which additional days may be billed on a fee-for-service basis. Adjustments may be made to reflect different levels of financial risk across program options.
- **Length of risk.** In PACE, once a participant is assigned a rate, that rate remains fixed for at least the length of the contract year, even if the participant's health status changes. In other integrated care programs, individual rates may be allowed to change when a person has a major change in health status. Rates may be adjusted to reflect the different time horizons of risk that are built into the programs.

[4] 42 CFR 460.182

TOOL 3-A: CHECKLIST FOR HARMONIZING MEDICAID RATES FOR PACE AND OTHER INTEGRATED CARE OPTIONS

The PACE model includes:	If the other integrated care option includes…	…then the following adjustment is appropriate to keep rates comparable across options:
People 55 and older	People younger than 55	Age adjustment
People certified at the nursing facility level of care	People who are not certified at the nursing facility level of care	Level of care/functional status adjustment
All Medicaid services	Carved out benefits	Adjustment for additional services included
Full risk for unlimited nursing facility days (and all other services)	Limitations on nursing facility days (or other services)	Adjustment for days of nursing home (or other services) included
Rates for each participant that remain fixed for the contract year	Rates for each participant that change when health status changes	Adjustment for duration period of financial risk

3.4 In many states, PACE assumes more comprehensive financial risk than other integrated care programs. Harmonizing rates across options allows consumers and other stakeholders to focus on relative value in making choices.

As states continue to expand integrated care options, the ability to compare value across options is critical for consumers, state officials and other stakeholders. By establishing comparable rates for comparable populations and benefits, states can focus on comparing key outcomes, such as diversion from nursing homes and consumer experience.

SECTION 4.

State Administration and Quality Oversight of PACE and Other Integrated Care Options

> ***States may achieve efficiencies*** *by combining the administration of contracts for PACE and other integrated care contractors. Combined administration facilitates consistent performance expectations across contractors.*
>
> ***A core set of quality measures*** *can be applied to PACE and other integrated care models, allowing consumers and policy makers to compare the value of services across program options. Measures must be adjusted to reflect any differences between PACE and other programs in the target population.*

4.1 The administration of PACE has many similarities to the administration of Medicaid managed care in general, and of dual eligible financial alignment demonstration programs in particular.

State administration of PACE has many similarities to administration of Medicaid managed care: contracts address benefits, enrollment and disenrollment processes, capitated rates, solvency requirements, quality management, grievances and appeals, etc. States use multiple methods to monitor contracts, including on-site audits and analysis of data submitted by contractors.

The administration of PACE is particularly similar to administration provisions emerging in the CMS Financial Alignment Demonstration for dually eligible beneficiaries. Both PACE and Financial Alignment Demonstration programs are subject to:

- A three-party agreement executed by CMS, the state administering agency and the contractor;
- A joint readiness review process undertaken by CMS and the state administering agency, which includes readiness to provide the full range of Medicare and Medicaid services;
- Regular submission of data to CMS and the state administering agency;
- Provisions for how Level of Care is evaluated and periodically re-evaluated for members; and
- Compliance with applicable federal and state laws and regulations.

The ideal experience and skills of a state contract manager are similar for PACE and for other integrated care programs. They include knowledge of Medicare, Medicaid, and long term services and supports; and experience with managed care and contract administration.

4.2 As a direct provider of services, a PACE site is subject to additional oversight not applicable to HMOs, but combined administration may still be advantageous.

PACE contractors are provider organizations that assume risk for all PACE benefits and deliver many of them directly. In most states, this means PACE contractors must meet the requirements of multiple types of providers, typically including licensure as primary care clinics, home health and home care agencies, adult day health centers and transportation agencies. Like HMOs, they are also subject to solvency requirements and, for services not provided directly, they must maintain adequate networks of providers to ensure access as needed.

A state's objective is to purchase high-value integrated care, regardless of the characteristics of the contractor. Despite the differences between provider-based organizations and HMOs, combined administration by the state facilitates common performance expectations and comparable measurement of outcomes across programs. This is advantageous to both the state and consumers in determining the relative value of programs.

Integrated care contract managers must be skilled at working across state agencies in either case. For both PACE and other integrated care programs, state insurance departments are typically involved in evaluating solvency, and state aging and disability agencies are often involved in monitoring long term services and supports. For PACE, the coordination extends further, to include state units that license providers, but the concept is the same: the state contract manager is the point person and is responsible for coordinating with other state personnel as needed to ensure efficient and effective administration of the contract. Tool 4-A identifies state agencies typically involved in administering PACE and HMO-based integrated care initiatives.

TOOL 4-A: TYPICAL STATE OVERSIGHT OF INTEGRATED CARE

State Agency	Plays Role in PACE Administration	Plays Role in HMO-based Integrated Care Administration
Medicaid	✘	✘
Aging and Disability	✘	✘
Insurance	✘	✘
Adult Protective Services	✘	✘
Ombudsman Services	✘	✘
Health: Quality Monitoring	✘	✘
Health: Provider Licensure	✘	

4.3 PACE sites regularly submit data elements that could comprise a core set of measures for comparison across integrated care programs.

In order to compare performance and value across programs, states must collect and analyze comparable data. Under federal requirements, PACE sites submit data elements pertaining to the PACE target group (people 55 and older who meet nursing home level of care criteria) on a quarterly basis. Many sites also participate in DataPACE 2, a voluntary effort to compile comparable data across multiple sites nationally. A state could collect the same data elements for the same target group from other integrated care programs for comparison.

Tool 4-B compares some of the federally mandated PACE elements to similar elements proposed for the Financial Alignment Demonstration. The similarity creates an opportunity to define a core set of measures across integrated programs.

TOOL 4-B: COMPARISON OF SELECTED MANDATORY DATA ELEMENTS SUBMITTED BY PACE AND PLANNED FOR FINANCIAL ALIGNMENT DEMONSTRATION

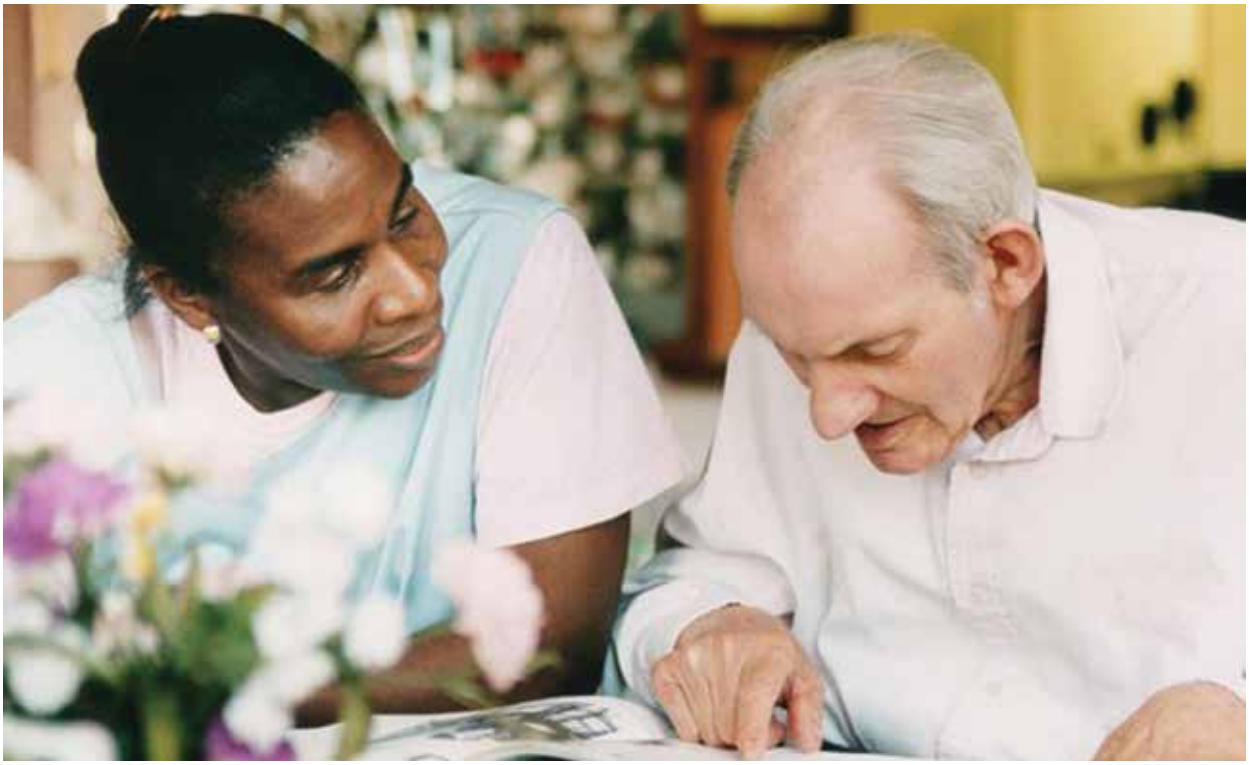
Measure	PACE Measure	Financial Alignment Measure	Potential Adjustments Needed
Flu Vaccine	Percent of participants who were immunized during the reporting year	Percent of members who were immunized prior to flu season	Use subset of members who were 55+ yrs and NF level of care; clarify reporting period
Hospital Readmissions	Percent of participants readmitted in the last 30 days	Percent of members readmitted within 30 days, for same or different condition	Use subset of members who were 55+ yrs and NF level of care; clarify if for same or different condition or both
Voluntary Disenrollments	Percent of participants who voluntarily disenrolled	Percent of members who chose to leave the plan in the calendar year	Use subset of members who were 55+ yrs and NF level of care; clarify reporting period
Appeals	Percent of participants submitting appeals during the quarter; initiation and resolution dates	Percent of members who got a timely response to appeals	Use subset of members who were 55+ yrs and NF level of care; clarify time period and definition of "timely"

4.4 Balancing the long term services and supports (LTSS) system is a key goal of integrated care. PACE sites contribute to state balancing goals. States can develop comparable balancing measures across PACE and other integrated care programs.

Balancing the LTSS system is a key goal for many states that pursue PACE and other integrated care programs. States can develop balancing measures and apply them across integrated care programs to measure the relative success of those programs in reducing the use of institutional services. Tool 4-C provides examples of balancing measures under development in two states for their Financial Alignment Demonstration programs that could be applied to PACE.

TOOL 4-C: EXAMPLES OF BALANCING MEASURES UNDER DEVELOPMENT IN SELECTED FINANCIAL ALIGNMENT DEMONSTRATION PROGRAMS

State	Balancing Measure Under Development	Potential Adjustment Needed for PACE
New York	Percent of plan participants who did not reside in a nursing facility for more than 100 continuous days in the measurement year	Calculate for subset of members who were 55+ yrs and NF level of care
Ohio	Percent of plan participants who did not reside in a nursing facility for more than 100 continuous days in the measurement year, compared to the percent in the previous year	Calculate for subset of members who were 55+ yrs and NF level of care



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