PACE Updates

Caroline Zeman, CM

Stacey Plizga: Alright, our final speaker for today will give us an update on PACE audits, including an overview of the 2017 PACE audit results and a description of updates for the 2018 audit year. It is my pleasure to introduce from the Division of Analysis, Policy and Strategy, Caroline Zeman.

[Applause]

Caroline Zeman: Good afternoon everyone. My name is Caroline Zeman, I work in the Division of Analysis, Policy and Strategy here in the MOED group. Along with conducting and running program audits for MA and Part D sponsors, our group is also responsible for overseeing and conducting audits on PACE organizations, therefore for the first time at this audit and enforcement conference we wanted to present on PACE audits.

Today's session will cover an overview of PACE in general, as well as some of the demographics of PACE. We will also be providing an update on the 2017 PACE audits, including the audit scores, and some of the common conditions. Lastly, we will cover some of the process improvements implemented for 2018. Because this is the first time we have covered a session on PACE during the audit and enforcement conference, I wanted to use the first few slides to give an overview of the program.

PACE stands for Programs of All-Inclusive Care for the Elderly. It is a unique program that was designed to provide comprehensive care to the

frail elderly. And the goal of PACE is to meet the needs of the participants, providing comprehensive care 24 hours a day as needed, while keeping the participant living in the community and out of a nursing facility. PACE involves a three-way agreement between CMS, the state and the organization. And while it is the goal of PACE to keep participants out of the nursing home, all PACE participants are nursing home eligible. Another key component in the PACE program is the use of an interdisciplinary team, or IDT. The team is composed of 11 disciplines who are responsible for managing the needs and health of PACE participants. PACE covers all Medicare and Medicaid services as well as any other care or services determined necessary by the IDT. In other words, PACE organizations can use their capitated payments to cover any services deemed necessary to improve the overall health condition of participants. These services include but are not limited to physical therapy, occupational therapy, primary care services, dental services. But also PACE covers social services, dietary needs, and recreational therapy. PACE organizations are in the unique position of being both a direct care model, as most services are offered at a physical PACE center, as well as a provider. Participants come into the center as needed or desired, and are offered meals, activities, medical services and socialization.

Sorry, I did not advance my slides. Alright, so the PACE program which was established as a permanent provide type by the Balanced Budget Acts in 1997 is still a small program. It includes approximately 41,000 participants as of December 2017. And this chart shows a breakdown of PACE participants by CMS regional office. So the Philadelphia region, which covers the states Pennsylvania, Delaware, Maryland, Virginia and West Virginia has the largest number of PACE participants. However, even though they're the largest number, they only have approximately 7,819 participants enrolled. The Kansas region which covers Iowa, Kansas, Missouri and Nebraska has the smallest number of PACE participants with only 994 participants in their region. Although the program is so small because of the need for a three-way agreement and because PACE covers Medicare and Medicaid services, there are a lot of

varying groups and entities that are involved in overseeing and running PACE. While talking with some organizations this year, we realized that not everyone is familiar or comfortable with who's working behind the scenes on the PACE program. So we wanted to give a brief overview of how different groups and agencies are involved in PACE.

At CMS the primary group responsible for the PACE program is the Medicare Drug and Health Plan Contract Administration Group, otherwise known as MCAG. This group is responsible for the PACE regulations, the PACE manual guidance, and is also the group that is responding to the PACE policy questions in the DMAO portal. The Center for Medicaid and CHIP services is the group responsible for the Medicaid portion of the PACE benefit, including being responsible for coordination amongst the states. And then there's my group, the Medicare Parts C and D Oversight and Enforcement Group and we're responsible for developing and implementing the PACE audit strategy, developing auditing protocols, and overseeing the audit process. Our CMS regional offices also play an important role in PACE, they provide account managers that are responsible for the day-to-day oversight of the operations and they also help staff the PACE audits. Lastly, every PACE organization has a state administering agency who's responsible for coordinating and overseeing the PACE organizations within their state.

Moving on to PACE audits, the statute and regulation require that CMS in cooperation with the state administering agency conduct reviews annually during a PACE organization trial period, which is defined as the PACE organization's first three contract years. The CMS regulation requires that PACE organizations be audited every two years following the trial period. The regulation also requires that audits be comprehensive and include an onsite review. There are approximately 122 PACE organizations currently, 74 organizations received the PACE audit in 2017. And I'm going to pause here for a minute to do a quick comparison because you just heard from my colleagues Greg and Allison. So MOEG conducted 39 MA and Part D program audits, compared to 74 audits conducted in PACE in 2017, and yet in our PACE audits we covered approximately

20,000 PACE participants. While the MA and Part D program audits covered over 7 million. On the other hand, if you look at our averages or percentages, our 74 PACE audits covered approximately 50% of PACE participants, while the MA and Part D audits covered about 16% last year. If we look at a breakdown of the types of audits conducted, we see of the 74 PACE audits conducted in 2017, 50 were routine audits, 23 were trial period, and one was a focused audit.

As a reminder, a new audit protocol was implemented in 2017, the new protocol focused on outcome measures and participant data and experiences. There were five elements audited, service delivery requests, appeals, and grievances and that's closest to CDAG and ODAG from the program world. But we also had clinical appropriateness and care planning, personnel, an onsite element, and quality assessment. Also new for 2017 was the use of conditions in audit. For the first time PACE organizations were cited findings at a condition level and not an element level. That means that under one element multiple conditions might have been cited. But the conditions are narrowly written and focused on individual requirements within the regulations which helps identify what the non-compliance actually is. In 2017 we also implemented a PACE audit consistency team, or PACT and that PACT was responsible for reviewing every condition in the 74 audits. This PACT classified the conditions either as observations, immediate corrective action required or ICARs, or corrective action required CARs. Audits were also scored for the first time in PACE in 2017 and the scoring was similar to the MA and Part D program, where ICARs are worth two points, CARs are worth one point, and observations did not impact score. We have compiled all of the audit data and scores and we're putting together our first ever annual report for PACE. The report will be providing more detail relating to the 2017 PACE audits and will be released within the next few months. And the rest of the slides included in this presentation cover some of the information that will be in there.

So this slide shows a distribution for audit scores for 2017. As you can see audit scores range from the lowest score of a 0.6 to the highest score

of a nine. As a reminder, with how we access score, the lower the score, the better the PACE organization did. You can see from this distribution that most organizations were on the lower end of the range with average scores falling between a one and a three. 26 organizations scored between a two and a three on their final audit report. And 22 organizations scored between a one and a two. In our annual report we discuss and analyze the scores in a variety of ways, but one of the things we looked at is whether enrollment size played – or had an impact on a PACE organization's score. As you can see from this chart, scores do increase as enrollment size increases. That being said, the numbers are not vastly different and we want to remind everyone that this is the first year we're scoring organizations and therefore we only have limited data to analyze at this time. As the years progress we hope to be able to speak with more certainty about trends in audits.

We also looked at whether audit scores were impacted by what type of audit an organization got. Even though we use the same protocol for all audits, we were interested in seeing whether an organization did better if they were in their trial period, or whether they were receiving a routine audit. As you can see, the average score for PACE organizations in their trial period was 2.31, and the average score for routine audits was 2.32. So there was virtually no difference in scores, which we can probably attribute to this being a new protocol and therefore every organization was treated as a new one.

As previously mentioned, the audit scores were derived from the underlying conditions cited during the audit. As you can see with 74 PACE audits conducted in 2017, there were numerous conditions cited. A total of 741 conditions were cited during the 2017 audit year, of those 263 were ICARs, 365 were CARs, and 113 were observations. You'll also note that SDAG, which was a new element for PACE organizations in 2017, had the most conditions cited with 468. SDAG also had the most ICARs cited at 171, with clinical appropriateness and care planning coming in second. When we look at the breakdown in a different way, you can see almost half of all conditions were CARs, or corrective action

required. ICARs are the second most common condition cited with 35% of conditions being classified as an ICAR. And observations only accounted for 15% of conditions. Those numbers may seem high, but now let's look at how the ICARs are spread out per element, per audit. You can see the PACE organizations did not have a high number of ICARs for any one element overall. The most was SCAG again, but PACE organizations only averaged 2.31 ICARs per audit in this element. And organizations averaged less than one ICAR for all other elements.

We're going to move into the common conditions cited during 2017. Starting with clinical appropriateness and care planning. The most frequently cited condition was that the PACE organization failed to maintain a medical record that was complete, accurate and available to all staff. This condition usually stemmed from medical records missing pertinent documents, or being inaccurate for a medical condition or treatment. The second most common condition was that the PACE organization failed to provide services that were adequate and/or necessary to meet the needs of the participant. This usually resulted from a PACE organization not providing approved or ordered services that have been deemed necessary for the participant to receive. For the onsite element, the most commonly cited condition was that the PACE organization failed to have emergency equipment onsite and immediately available. Generally, this condition was cited based on emergency medications not being readily available onsite. And the second most common condition was that PACE organizations failed to provide care and services in accordance with participants approved care plans. As part of the onsite element, auditors also conduct participant observations where they see in real-time wound care, dietary orders, medication administration and other services being provided. This condition was cited when it was observed that an organization did not provide care in accordance with the participants approved care plan.

For personnel the most common condition related to competencies, specifically the PACE organization did not ensure that all staff and contractors were appropriately evaluated prior to those individuals

performing care. Additionally, PACE organizations did not appropriately provide emergency training as required. For quality assessment the number one condition for quality related to the PACE organization not appropriately involving all IDT members, staff, and contract providers in the development and implementation of the quality assessment and improvement program. The second most common condition was an overall failure to develop and/or implement an effective, data driven quality improvement program.

For SDAG, the number one condition cited related to assessments, specifically the PACE organization failed to conduct in-person assessments and/or reassessments as often as required. However, this condition being cited as an SDAG condition is not entirely accurate and can skew the picture of why organizations receive this condition. This condition was cited in 2017 for any missed in-person assessments including those assessments that were not related to service delivery requests such as annual and/or semi-annual assessments, or an assessment that resulted following a change in condition. Since we only cite conditions one time in a report, this condition generally appeared under the SDAG element even when there is clinical information regarding routine assessments as part of the failure.

For 2018 in order to help determine exactly where PACE organizations are struggling, we broke out the different types of assessments into different conditions. The second most common condition found in SDAG is that the denial notifications for service delivery requests did not include the specific reason for the denial in clear and understandable language. This related to denial notices either not being specific to a participant condition, such as saying, it was denied for lack of medical necessity, or not being clearly documented within the notification or within the system. Along with common conditions, we analyzed what was most likely to be the reason or cause of the condition. While we didn't identify a unique cause for every single common condition, we did look overall for causes that impacted most conditions and elements. The following causes are breakdowns that we saw across elements as to why an organization was

cited a condition. The number one cause that led to non-compliance was a lack of documentation or the inability to show compliance with the requirement. For example, a PACE organization would have no evidence or documentation that medications were actually provided as ordered, or the organization would state that their process was to notify participants orally and in writing of service delivery request denials, but they were unable to demonstrate or show evidence that oral notification and/or written notification was actually provided. Another common cause was the misunderstanding of CMS requirements or regulations. For example, we found that most PACE organizations were not aware of the requirement that they must automatically process untimely service delivery requests as appeals. We think one of the benefits of this new audit process is that with the use of specific conditions it will clarify and identify the requirements that PACE organization should be following. Lastly, another common cause that contributed to non-compliance was the lack of oversight or training to ensure that staff and personnel adhered to internal procedures. This was noted when organizations knew what to do, they understood the requirement, they had processes in place, but the staff weren't adhering to the process that would have been developed.

Overall we learned a lot from the PACE audits in 2017, both through the information and data collected from audits, as well as through our own internal experiences and procedures. From these experiences we developed a few process improvements which have been implemented in 2018. First we developed Core Audit Leads and they will be responsible for leading all PACE audits in 2018. Second in an effort to be objective and impartial, we are no longer allowing account managers to be either the audit lead or on the audit team for any account that they oversee. Third, we're splitting the audit fieldwork into two distinct weeks. The first week will be done through a desk review and the second week will be onsite at the organization. We believe that this will reduce the time commitment and burden and organization experiences during the onsite week since the audit will be spread out through the course of two weeks. We're also going to be piloting a survey in 2018 to gather feedback on the audit process directly from PACE organizations in order to help improve

our processes going forward. Along with the process changes that we implemented, we also made several technical process improvements related to the health plan management system or HPMS. We heard from organizations last year that they didn't like having to respond to the draft report by entering comments into an excel document. This year we have built the ability to comment on the draft report directly into HPMS or in the audit module. Our responses to those comments will also go directly into the module and they will be made visible to the organization when the final report is issued. We're also going to be issuing ICAR notifications directly through the system this year, instead of using external email to communicate those conditions. This will help centralize and store all notifications related to the audit in an easily accessible place. And lastly, we build in a mechanism to allow PACE organizations and MA and Part D sponsors to upload and/or download multiple files at once. So while this can't be used for universe files, this can be used for supplemental files, impact analyses, and root cause templates. And organizations can save time by uploading up to five files at once.

Before we move into the questions portion of this presentation I want to remind everyone that we have an email address that handles all PACE audit inquiries, while this can and should be used for any questions regarding the PACE audit process, it should also be used if organizations have questions or concerns about how their audit was handled or if the organization wants to provide feedback on their audit experience. And at this point we will open the floor for questions.

Stacey Plizga: Alright we do have time for questions for Caroline so if anybody in the audience has a question please step up to the microphone in the center aisle. Okay so if there are no questions from our in-house audience we will go to questions we received from the virtual audience. And the first question for Caroline is, "What is the expected timeframe to receive the PACE draft audit report? It seemed to vary significantly in 2017."

Caroline Zeman: So part of our process improvement for 2018 was to actually centralize the review of audit reports, ICAR notifications and the audit deliverables,

like the engagement letter. And so because we have centralized that process we think we're going to be able to have some better control over timeframes and we hope to issue draft reports within approximately 60 days of the exit conference.

Stacey Plizga: Okay we have another question that we received from our virtual audience and that question is, "Why is the account manager no longer a part of the PACE audit team?"

Caroline Zeman: So we continue to value our account managers in PACE, they are an integral part of our team, but we want to make sure that audits always remain objective and impartial therefore the decision was made to remove the account manager from the audit team, but to keep them involved with the organization by having them implement and monitor the CAPS once they've been accepted from the audit team.

Stacey Plizga: Alright well, that is the last question that I had for Caroline. So, with that I would like to thank Caroline for the update on PACE audits.

[Applause]

Alright it's that time again, if you'd like to evaluate this session go ahead and select A as your response. And then follow the link and answer the questions.