
CHAPTER 35: PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

SECTION 35.10: PROGRAM QUALITY AND OVERSIGHT PAGE(S) 6

PROGRAM QUALITY AND OVERSIGHT

Services offered through the Program of All-Inclusive Care for the Elderly (PACE) are monitored to assure compliance with Centers for Medicare and Medicaid Services (CMS) and the Louisiana Department of Health (LDH) as well as applicable State and Federal rules and regulations. Oversight is conducted through licensure compliance and program monitoring.

The PACE provider must designate one staff member to coordinate and oversee implementation of quality assessment and performance improvement activities.

The PACE program agreement will outline the quality initiatives required. This includes:

1. Development of a Quality Assessment and Performance Improvement (QAPI) program;
2. Collecting Quality Data without Root Cause Analysis (RCA); and
3. Collecting Quality Data with RCA.

CMS and LDH/Office of Adult and Aging Services (OAAS) monitor outcomes through review of data submitted through CMS reporting systems, OAAS requests and onsite visits.

Quality Assessment and Performance Improvement Program

The PACE provider must develop, implement, maintain, and evaluate an effective data-driven Quality Assessment and Performance Improvement (QAPI) program. It is important that the QAPI program reflects the full range of services furnished by the PACE provider. In developing the QAPI program, the PACE provider must use organizational data to identify and improve areas of poor performance and take actions to make performance improvements in all types of care.

PACE providers have the flexibility to develop the QAPI program that best meets their needs in order that they may fully meet the obligations to care for their beneficiaries. PACE providers must operate a continuous QAPI program that does not limit activity to only selected kinds of services or types of beneficiaries. The PACE provider must use the QAPI requirements to drive and prioritize continuous improvements.

The QAPI program must include, but is not limited to, the use of objective measures to demonstrate improved performance with regard to the following:

CHAPTER 35: PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

SECTION 35.10: PROGRAM QUALITY AND OVERSIGHT PAGE(S) 6

1. Utilization of PACE services, such as decreased inpatient hospitalizations and emergency room visits;
2. Caregiver and beneficiary satisfaction;
3. Measure and evaluate caregiver and beneficiary satisfaction with care and services;
4. Outcome measures that are derived from data collected during assessments, including data on the following:
 - a. Physiological well-being;
 - b. Functional status;
 - c. Cognitive ability;
 - d. Social/behavioral functioning; and
 - e. Quality of life of beneficiaries.
5. Effectiveness and safety of staff provided and contracted services, including the following:
 - a. Competency of clinical staff;
 - b. Promptness of service delivery;
 - c. Achievement of treatment goals and measurable outcomes;
 - d. Non-clinical areas such as, beneficiary and caregiver complaints and grievances, transportation services, meals, life safety and environmental issues; and
 - e. Mechanisms to receive and address beneficiary and care giver complaints and grievances.

The QAPI program must be written into a Quality Improvement Plan (QIP) and at a minimum, the QIP must contain the following:

1. Identify areas in which to improve or maintain the delivery of services and beneficiary care;

CHAPTER 35: PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

SECTION 35.10: PROGRAM QUALITY AND OVERSIGHT PAGE(S) 6

2. Develop and implement plans of action to improve or maintain quality of care; and
3. Document and disseminate the results of the QAPI activities to the PACE staff and contractors.

The QIP must be:

1. Submitted to OAAS, as requested; and
2. Reviewed by the PACE governing body, annually, and revised if necessary.

Quality Improvement Activities

The PACE providers must ensure that their program is consistently working on internal quality improvement activities by conducting the following:

1. Using a set of outcome measures to identify area of good or problematic performance;
2. Taking actions targeted at maintaining or improving care based on outcome measures;
3. Incorporating actions resulting in performance improvement into standards of practice for the delivery of care and periodically track performance to ensure that any performance improvements are sustained over time;
4. Setting priorities for performance improvement, considering prevalence and severity of identified problems and giving priority to improvement activities that affect clinical outcomes;
5. Immediately correcting any identified problem that directly or potentially threatens the health and safety of PACE beneficiaries; and
6. Ensuring that all interdisciplinary team (IDT) members, PACE staff and contractors are involved in the development and implementation of quality improvement activities and aware of the results of these activities.

The QAPI Coordinator must encourage PACE beneficiaries and their caregivers to be involved in quality improvement activities, including information pertaining to the satisfaction of their PACE services.

CHAPTER 35: PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

SECTION 35.10: PROGRAM QUALITY AND OVERSIGHT PAGE(S) 6

Quality Committees

The PACE providers must establish one or more committees with community input that perform the following:

1. Evaluate the data collected that pertains to quality outcome measures;
2. Address the implementation of and results from the QIP; and
3. Provide input related to ethical decision making, including end-of-life issues and implementation of the “Patient Self-Determination Act.”

Quality Data without Root Cause Analysis

PACE providers are required to submit data elements for monitoring that are regularly reported by PACE providers via the Health Plan Management System (HPMS) PACE monitoring module.

PACE Quality Data without RCA apply specifically to the aggregate data such as: grievances and appeals; enrollments; disenrollments; prospective enrollees; re-admissions; falls without injury, etc. The HPMS database is regularly monitored by CMS and LDH/OAAS.

Quality Data with Root Cause Analysis

PACE providers are required to report events of unusual incidents that results in serious adverse beneficiary outcomes, or negative, regional, or local notoriety related to their PACE program. In these instances, the PACE provider must initiate the RCA investigation internally within 3 business days of identifying the incident. PACE providers are required to document all RCA information in the fields provided in the HPMS, as well as indicate what the beneficiary’s current status is at the conclusion of the RCA investigation.

Additional information regarding PACE Quality Data reporting requirements is outlined in the PACE Quality Monitoring and Reporting Guidance of April 2018.

Reviews and Monitoring

The PACE provider must take action to correct deficiencies identified during the reviews. CMS and/or OAAS monitors the effectiveness of the corrective action through the following:

1. Ongoing monitoring of the PACE provider;
2. Reviews and audits of the PACE provider;

CHAPTER 35: PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

SECTION 35.10: PROGRAM QUALITY AND OVERSIGHT PAGE(S) 6

3. Complaints from PACE beneficiaries or caregivers; and
4. Any other instance CMS or the LDH/OAAS identifies programmatic deficiencies requiring correction.

Failure to correct deficiencies may result in sanctions or termination. Disclosure of the review results must be available as demonstrated by 42 CFR 460.196.

Results

The PACE providers must ensure that all IDT members, PACE staff, and contract providers are involved in the development and implementation of quality improvement activities and are given regular updates on Quality Improvement initiatives.

Corrective Actions

CMS and/or LDH/OAAS report the results of the reviews/audits to the PACE provider, along with any recommendations for changes to the provider's program. The PACE provider must write a corrective action plan, a description of the action that will be taken to correct the identified deficiency.

Sanctions, Enforcement Actions, and Termination

CMS and LDH/OAAS work together to ensure the benefits and services provided are of high quality and meet the requirements set forth in the statute and regulations. When compliance actions fail to achieve the desired result or an instance of non-compliance is especially egregious, CMS and/or LDH/OAAS may take enforcement action.

Some enforcement actions may include sanctions as follows:

1. Civil money penalties;
2. Suspension of payments;
3. Suspension of Enrollment; and
4. Termination of the contract (for a variety of offenses as they relate to the operation of the PACE program).

CMS may impose sanctions if the PACE provider commits any of the following violations:

CHAPTER 35: PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

SECTION 35.10: PROGRAM QUALITY AND OVERSIGHT PAGE(S) 6

1. Fails, substantially, to provide a beneficiary medically necessary items and services that are covered by PACE, if the failure adversely affected (or has substantial likelihood of adversely affecting) the beneficiary;
2. Involuntarily disenrolls a beneficiary in violation of 42 CFR 460.164;
3. Discriminates in enrollment or disenrollment among Medicare beneficiaries or Medicaid beneficiaries, or both, who are eligible to enroll in a PACE program, on a basis of an individual's health status or need for health care services;
4. Engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment, except as permitted by 42 CFR 460.150, by Medicare beneficiaries or Medicaid beneficiaries whose medical condition or history indicates a need for substantial future medical services;
5. Imposes premium charges on beneficiaries enrolled under Medicare or Medicaid that is more than the allowable amount;
6. Misrepresents or falsifies information that is furnished to CMS or the State or to an individual or any other entity under part 460;
7. Prohibits or otherwise restricts a covered health care professional from advising a beneficiary, who is a patient of the professional, about the beneficiary's health status, medical care, or treatment for the beneficiary's condition or disease, regardless of whether the PACE program provided benefits for that care or treatment, if the professional is acting within their lawful scope of practice;
8. Operates a physician incentive plan that does not meet the requirements of section 1876(i)(8) of the Social Security Act;
9. Employs or contracts with any individual who is excluded from the participation in Medicare and Medicaid under section 1128 or section 1128A of the Act (or with any entity that employs or contracts with that individual) for the provision of health care, utilization review, medical social work, or administrative services; and
10. Makes a payment to any individual or entity that is included on the preclusion list identified in 42 CFR 422.2.