2017 Programs of All-Inclusive Care for the Elderly (PACE) Audit and Enforcement Report

Medicare Parts C and D Oversight and Enforcement Group

Date: July 17, 2018

This report is also published online at:

https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PACE_Audits.html

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Executive Summary

The Medicare Parts C and D Oversight and Enforcement Group (MOEG) within the Centers for Medicare & Medicaid Services (CMS) is now responsible for overseeing audits of PACE Organizations (POs). In 2017 these audits were conducted by regional Consortium for Medicare Health Plans Operations (CMHPO) staff in conjunction with MOEG support. Regular and consistent auditing of these organizations provides measurable benefits by:

- Ensuring participants are receiving necessary healthcare services;
- Verifying PO adherence to selected aspects of their contract with CMS;
- Providing a forum to share audit results and trends; and
- Soliciting feedback from the PACE community and external stakeholders on potential audit improvements.

This report is intended to share analyses and information that PACE Organizations can use to continue improving performance. In addition, this report describes initiatives undertaken by CMS to advance the transparency, accuracy, and reliability of the audits. Highlights in this year's report include:

- **Current PACE Landscape:**
  - The number of PACE Organizations has grown steadily since the inception of the program, expanding from 39 PACE Organizations in 2007 to 124 PACE Organizations in 2017, with an average yearly increase of 8.5 organizations.
  - PACE Organizations tend to be highly concentrated in a small number of states. In 2017, Pennsylvania, Michigan, North Carolina, California, and New York had about 50% of all PACE Organizations.
  - The total PACE population expanded from 42,043 participants at the end of 2016 to 47,240 participants at the end of 2017 (an increase of 5,197 participants, 12.4%).
  - The average size of PACE Organizations expanded from approximately 347 participants per organization in 2016 to 381 participants per organization in 2017 (an increase of 34 participants per organization, 9.8%).
- **Audit Landscape and Lifecycle:**
  - CMS conducted 74 PACE audits in 2017 (approximately 60% of the total number of organizations) with 23,986 participants (about 51% of the total PACE population) enrolled in audited organizations.
  - Twenty-three (31%) of these audits were trial period audits, 50 (68%) were routine biennial audits, and one was a focused audit.
  - The average time from the exit conference to the receipt of the final report was 84.4 days, which is within our 2018 goals for audit time frames.

- **Audit Innovations and Process Improvements:**

  Based on feedback about the audit process from PACE Organizations and external stakeholders, the following changes were implemented:

  - Redesigning PACE audits using an outcomes-based, data-driven approach;
  - Releasing the PACE audit protocols for public comment;
  - Implementing an audit score and condition classification system;
  - Utilizing a PACE Audit Consistency Team (PACT) to review, discuss, and consistently classify conditions of non-compliance; and
  - Reducing the burden placed on organizations undergoing an audit by refocusing the audit elements and reducing documentation requests.

- **Audit Results:**

  - The 2017 audit scores ranged from 0.6 to 9, where a lower score represents better audit performance.
  - A total of 741 conditions were cited in 2017 with the following classifications: 113 observations (15.2%), 365 Corrective Actions Required (CARs) (49.3%), and 263 Immediate Corrective Actions Required (ICARs) (35.5%).
  - The greatest number of conditions was cited for the Service Delivery Requests, Appeals, and Grievances (SDAG) audit element at 498 (67.2%), and the fewest conditions were cited for the Onsite Review element at only 17 (2.3%).

- **Enforcement Actions:**

  - Enforcement actions were taken against three PACE organizations in 2017; two sanctions and one civil money penalty (CMP).

Introduction

The Programs of All-Inclusive Care for the Elderly (PACE) is a capitated managed care benefit for the frail elderly featuring a comprehensive medical and social service delivery system and integrated Medicare and Medicaid financing. Initially developed at On Lok Senior Health Services in San Francisco through a series of demonstration projects, PACE was established as a permanent Medicare program by the Balanced Budget Act of 1997. Through a three-way partnership between the Federal Government, the states, and the PACE Organizations, PACE provides a range of integrated preventative, acute, and long-term care services to manage the often complex medical, functional, and social needs of its participants. At the most fundamental level, PACE seeks to:

1) Enhance the quality of life and autonomy for frail, older adults;
2) Maximize the dignity of, and respect for, older adults;
3) Enable frail, older adults to live in the community as long as medically and socially feasible; and
4) Preserve and support the older adult's family unit.

CMS conducts audits to evaluate the delivery of health care items and services to participants enrolled in the PACE Organizations. When PACE audits identify systemic non-compliance, PACE Organizations are required to develop corrective action plans and undergo monitoring to ensure correction of cited deficiencies. CMS' enforcement authorities allow for imposition of civil money penalties, sanctions (suspension of payment or enrollment), and for-cause contract terminations.

This report summarizes audit-related activities as well as the scope, process, and results of the 2017 PACE audits, including the most common conditions of non-compliance and resulting enforcement actions. It also outlines anticipated improvements in the CMS audit process moving forward.

Current PACE Organization Landscape

Before turning to discussion of the audit process and audit results, this report will provide an overview of the current landscape of PACE Organizations (POs), including the distribution of POs at the national and regional levels, enrollment numbers, and program experience.

National and Regional Distributions

In 2017, there were 124 active PACE Organizations serving 31 states. This continues a steady, decade-long expansion of PACE, up from only 39 PACE Organizations serving 20 states in 2007 (Figure 1). On average, PACE expanded by 8.5 organizations per year between 2007 and 2017.[1]

Figure 1: Number of PACE Organizations by Year

In 2017, PACE Organizations were not evenly distributed among the states: Pennsylvania, for example, had the largest number of organizations with 19, followed by Michigan with 12, North Carolina and California each with 11, and New York with 9. These five states together contained 50% of all PACE Organizations within the United States. Twenty-nine states did not have active PACE Organizations, and 14 states had only one PACE Organization. Figure 2 on the following page provides a heatmap of the United States with darker shades of green indicating a greater number of PACE Organizations operating within the state in 2017.

[1] Data taken from December HPMS Enrollment and Contract Information Extracts, 2007-2017.

Figure 2: Number of PACE Organizations by State[2]

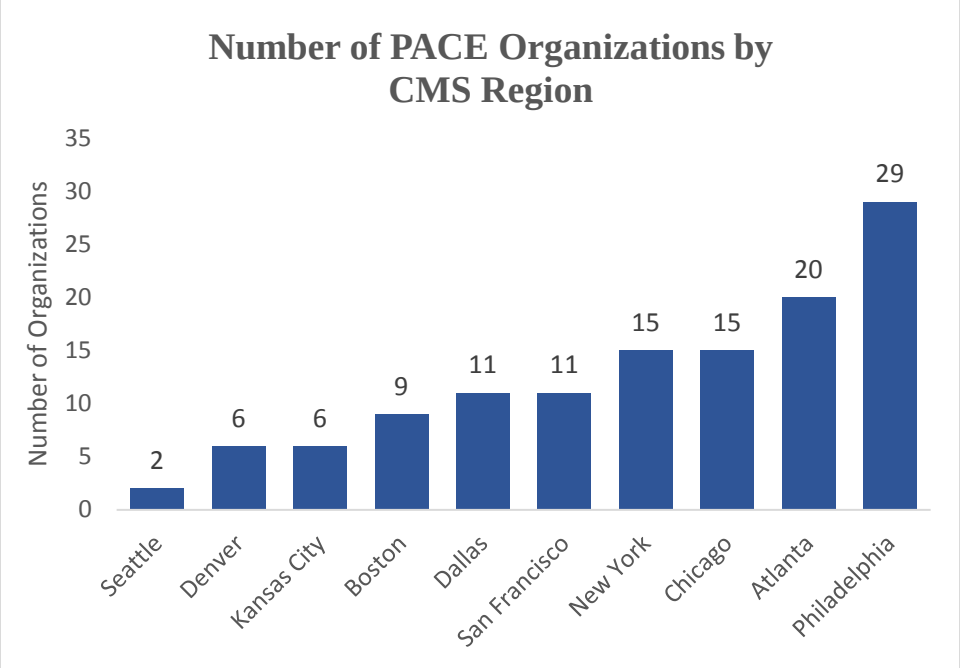


Figure 3: Number of PACE Organizations by CMS Region[3]

[2] Data taken from the HPMS Contract Information Extract, 2017. For the exact number of PACE Organizations per state, see the appendix.
[3] Data taken from the HPMS Contract Information Extract, 2017.

There was a similar concentration of PACE Organizations within certain CMS Regional Offices (see Figure 3, previous page). At the high end, the Philadelphia region was responsible for 29 PACE Organizations, followed by Atlanta with 20, and New York and Chicago with 15 each. The Philadelphia and Atlanta regions alone contained nearly 40% of the total number of PACE Organizations in 2017. At the low end, the Seattle region was responsible for only two PACE Organizations, followed by Denver and Kansas City with six each.

ENROLLMENT

The PACE population can be divided into three groups:

i) Duals (participants enrolled in both Medicare and Medicaid);
ii) Medicare-only participants; and
iii) Medicaid-only and private pay participants.[4]

Data on these populations are taken from two sources. First, the Health Plan Management System (HPMS) enrollment database provides data on the subset of the PACE population enrolled in Medicare. This includes both Medicare-only participants and duals, but the HPMS does not capture Medicaid-only/private pay participants. In most cases, the analyses in this report utilize data from the December HPMS Enrollment Extract from the year in question.

Second, data on Medicaid-only/private pay populations are derived from fourth quarter PACE Comparative Data Reports based on Level 1 data, which are self-reported by PACE Organizations. Whereas the HPMS enrollment database only provides data on the subset of the PACE population enrolled in Medicare, the Level 1 data reports provide the size of the total population (i.e. total census), including Medicaid-only/private pay participants, for each PACE Organization. Using this total PACE population count, the Medicaid-only/private pay subset of each organization's population can be identified by subtracting the Medicare-only and duals populations from the total. Although numbers based on this calculation did occasionally reveal discrepancies between the HPMS enrollment database and the information provided in the PACE Comparative Data Reports, these discrepancies tended to be either minor or easily corrected, and often appeared to be the result of data entry errors in the comparative reports.[5]

[4] Due to the way data was collected in 2017, it is not possible to separate Medicaid-only and private pay participants. For this reason, the two classes are combined into a single Medicaid-only/private pay category throughout this report.

[5] We found two types of errors. First, in a number of cases PACE Organizations conflated the 'Total New Enrollments' and 'Total Census' fields in the PACE Comparative Data Reports. Second, in four cases the total enrollment given in the PACE Comparative Data Reports was less than the sum of the duals and Medicare-only populations given in the HPMS enrollment database. This is problematic because the total enrollment should always be greater than or equal to this sum. It is unclear what caused this discrepancy. To sidestep these issues, for these four cases the analyses given below substitute the sum of the duals and Medicare-only populations provided by the HPMS database in place of the total given in the PACE Comparative Data Report when representing the total population for the organization in question.

The breakdown of dual, Medicare-only, and Medicaid-only/private pay participants in 2017 is shown in Figure 4. Just under three quarters of the PACE population were duals, with the remaining subset of the population evenly divided between Medicare-only and Medicaid-only/private pay. As Figure 5 shows, from 2016 to 2017 the total PACE population increased from 42,043 participants to 47,240 participants. The number of Medicaid-only/private pay and Medicare-only participants increased by 1,886 and 4,581, respectively, while the number of duals decreased by 1,270.

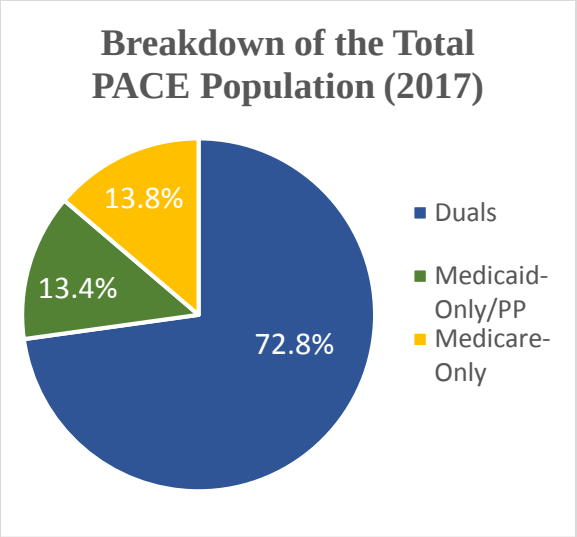


Figure 4: Breakdown of the Total PACE Population

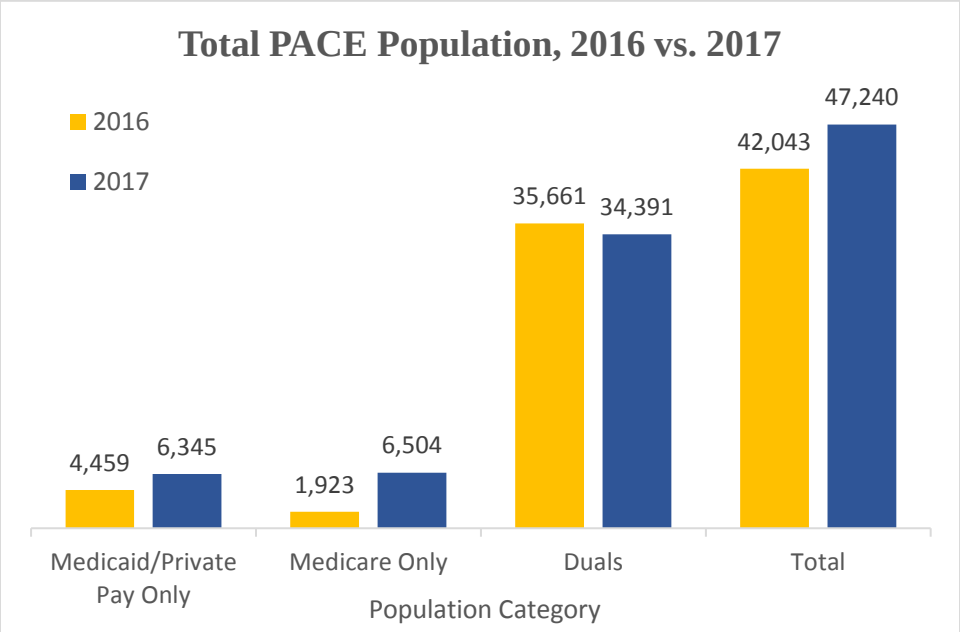


Figure 5: Total PACE Population, 2016 vs. 2017

Although data on the Medicaid-only/private pay PACE population are only available for 2016 and 2017, over a decade of data are available for the Medicare PACE population, and these Medicare data can provide a sense of the long-term growth of PACE.[6] As shown in Figure 6 (next page), the Medicare PACE population has steadily increased from 13,677 participants in 2007 to 40,895 participants at the end of 2017, with an average yearly increase of 2,722 Medicare participants.[7]

[6] This is due to the different sources of data on the various PACE subpopulations. The PACE Comparative Data Reports (used to calculate the Medicaid-only/private pay subpopulation) are only available for 2016 and 2017.
[7] Data taken from December HPMS Enrollment Extracts, 2007-2017.

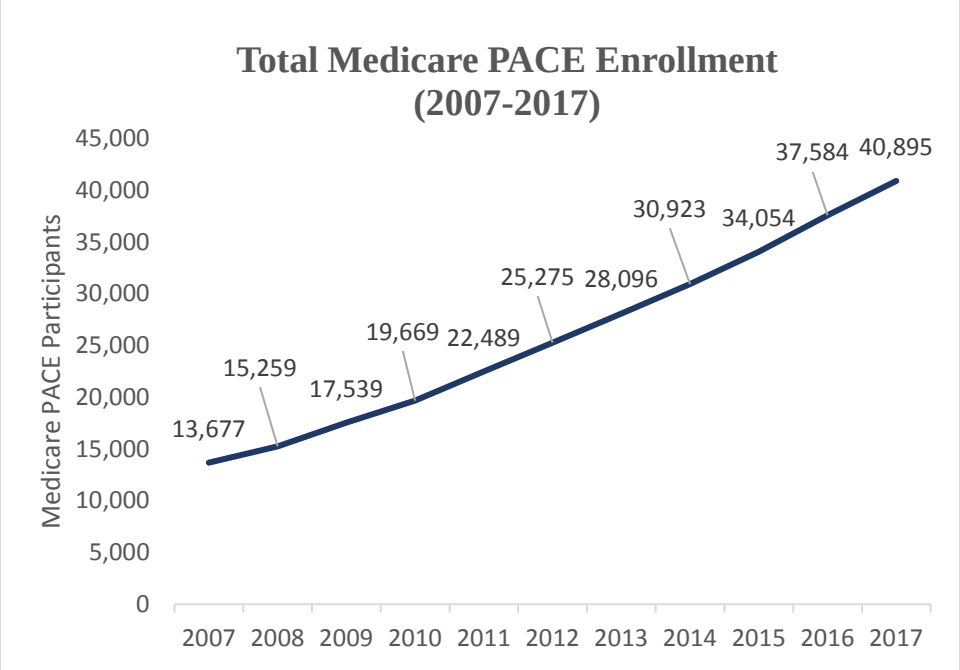


Figure 6: Total Medicare PACE Enrollment

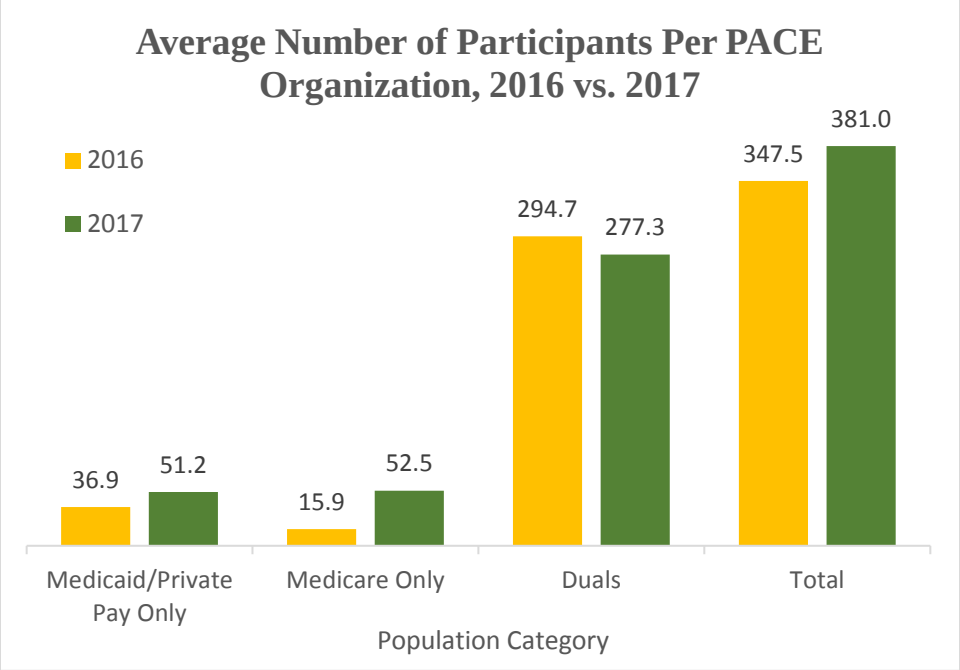


Figure 7: Average Number of Participants per PACE Organization[8]

As shown in Figure 7, the average size of PACE Organizations in 2017 was 381 participants, with approximately 51 Medicaid-only/private pay participants, 53 Medicare-only participants, and 277 dual participants. Mirroring the trends seen with the total PACE population, the average number of Medicaid-only/private pay and Medicare-only participants increased since 2016 (by approximately 14.3 and 36.6 participants, respectively) while the average number of dual

[8] Data taken from the fourth quarter PACE Comparative Data Report and the December HPMS Enrollment Extract, 2017.

participants decreased (by approximately 17.4 participants). For comparison, the average number of participants per *site* (as opposed to participants per organization) in 2017 was approximately 184 participants, with about 40% of PACE Organizations operating multiple sites. On average, PACE Organizations operated two sites in 2017, and the greatest number of sites for a single organization was 12.[9]

Once again, although data on the Medicaid-only/private pay PACE population are only available for 2016 and 2017, data on the Medicare PACE population are more extensive and can provide a sense of the long-term trend with respect to the typical size of PACE Organizations. As Figure 8 shows, in 2017 PACE Organizations had the largest average Medicare population since 2007 at 330 Medicare participants per organization, up from 311 participants per organization in 2016. Similarly, the median Medicare population size in 2017 was 204 participants per organization, up from 185 participants per organization in 2016. Both average and median Medicare population sizes decreased between 2007 and 2009, but have since shown steady upward trends. For example, from 2009 to 2017 the median population size increased by 46%, from 140 participants per organization to 204 participants per organization.[10]

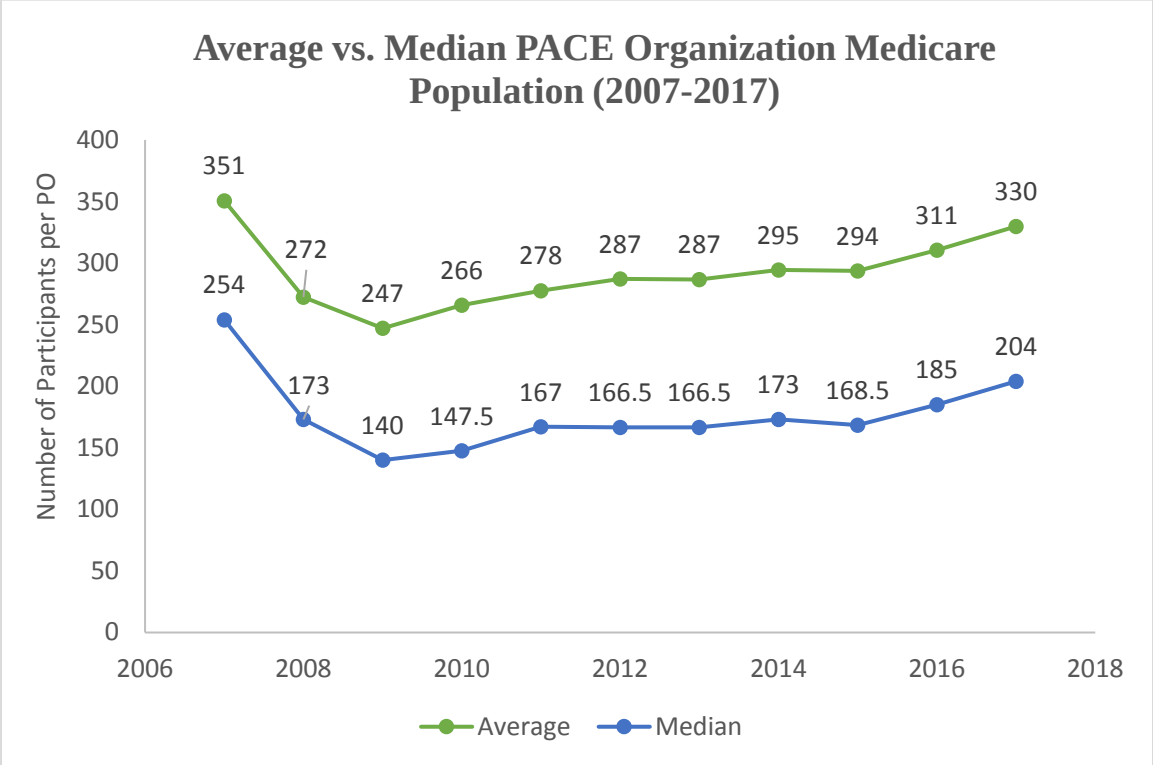


Figure 8: Average vs. Median PACE Organization Medicare Population

[9] Data taken from the HPMS Sites Extract, 2017.
[10] Data taken from December HPMS Enrollment Extracts, 2007-2017.

PACE Organizations vary considerably in size. The largest organization in 2017 had 3,084 participants while the smallest had only five participants. However, as Figure 9 shows, the majority of these programs tended to be moderately sized: approximately 42% of PACE Organizations had under 200 participants, 31% had between 200 and 400 participants, and 27% had over 400 participants.

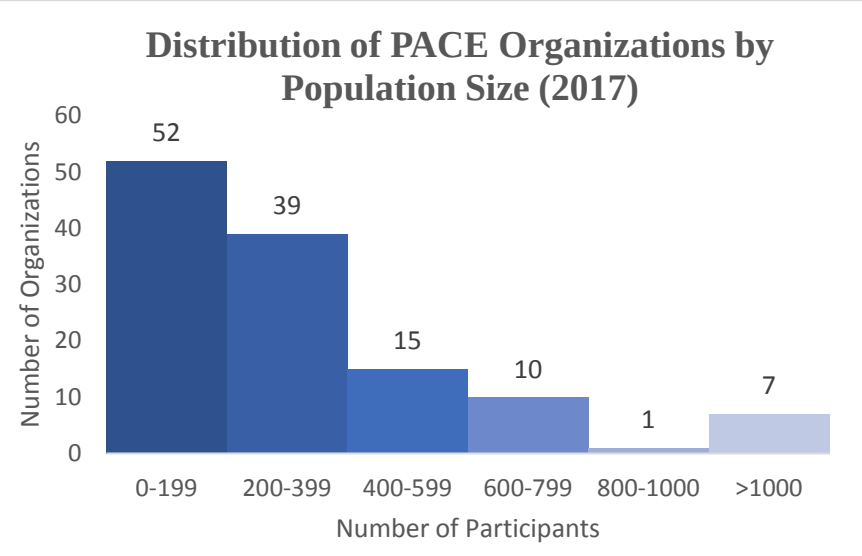


Figure 9: Distribution of PACE Organizations by Population Size[11]

Nonetheless, the larger organizations enrolled a vast share of the total PACE population. The eight PACE Organizations with over 800 participants (about 6% of the total number of organizations) served approximately 33% of the total PACE population. By comparison, approximately 37% of the total PACE population was enrolled in 91 moderately sized organizations with populations under 400 participants. See Figure 10.

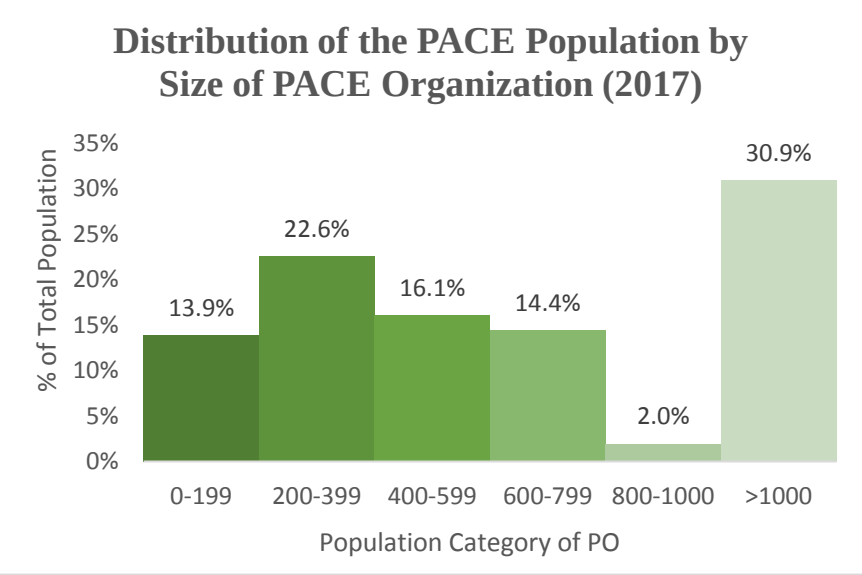


Figure 10: Distribution of PACE Population by Size of PACE Organization

[11] Data taken from the fourth quarter PACE Comparative Data Report, 2017.

At the state level, the PACE population is heavily concentrated in a relatively small number of states. The top five states with the greatest PACE populations in 2017 were California (7,647 participants), Pennsylvania (6,501 participants), New York (5,840 participants), Massachusetts (4,537 participants), and Colorado (3,971 participants), which together served 28,496 PACE participants, or about 60% of the total PACE population. It is worth singling out Colorado from this list, which (unlike the others) had a relatively small number of PACE Organizations (4). Its high overall enrollment is due to a single organization, Total Longterm Care, Inc., which had the second largest population of any PACE Organization at 3,047 participants.[12]

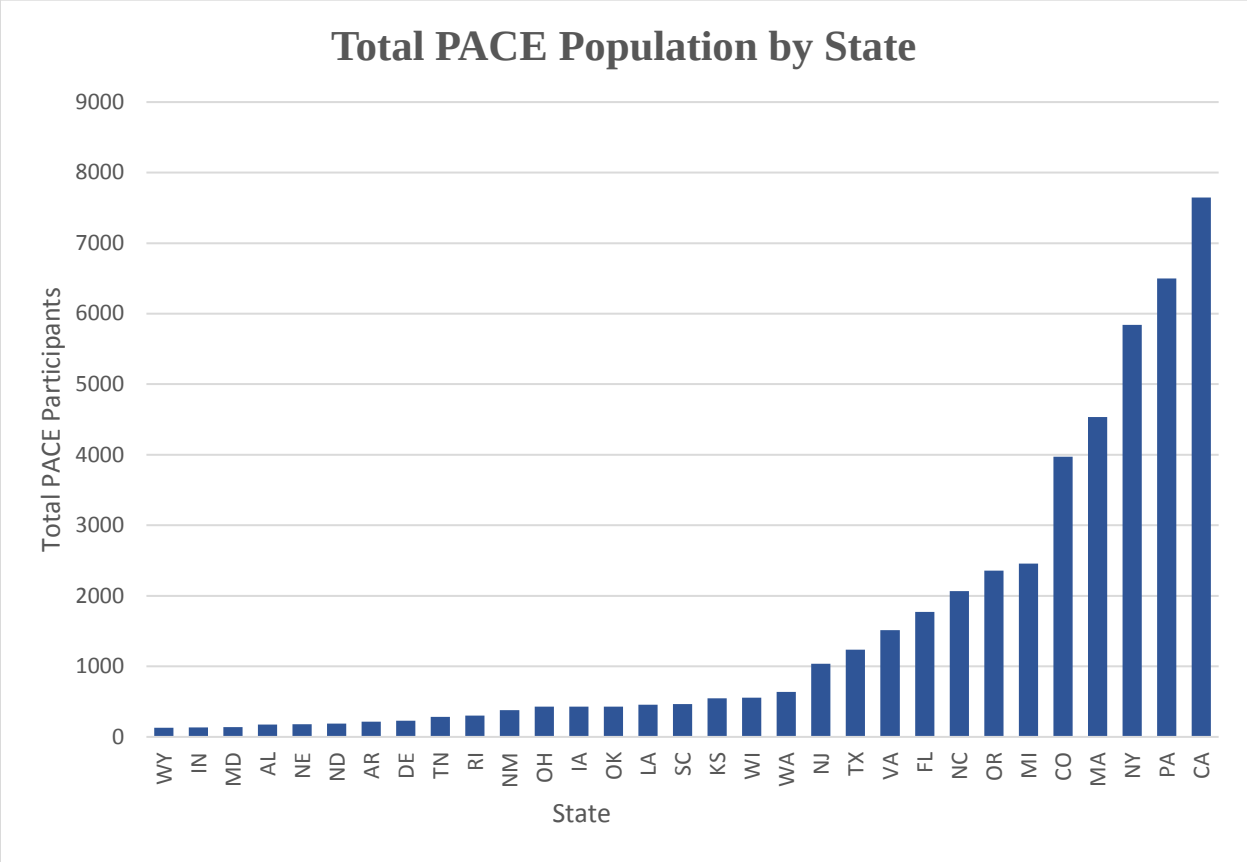


Figure 11: Total PACE Population by State

In terms of the CMS Regions, the Philadelphia (8,383 participants), San Francisco (7,647 participants), and New York (6,878 participants) regions had the largest total PACE populations (together comprising about 48% of the total 2017 PACE population), while the Kansas City (1,156 participants), Dallas (2,719 participants), and Seattle (2,998 participants) regions had the smallest PACE populations. Figure 12 (next page) displays each regions' share of the total PACE population in 2017.[13] Table 1 (next page) provides the total PACE population size per region.[14]

[12] Data taken from the fourth quarter PACE Comparative Data Report, 2017. States not included in Figure 11 did not have active PACE Organizations in 2017.
[13] Data taken from the fourth quarter PACE Comparative Data Report, 2017.
[14] Data taken from the fourth quarter PACE Comparative Data Report, 2017.

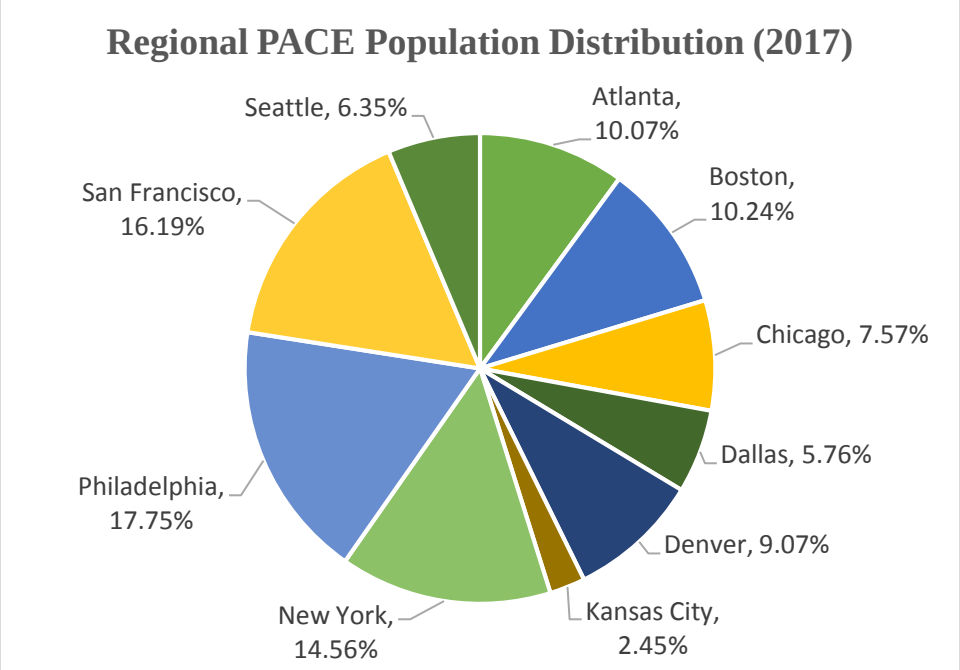


Figure 12: Regional PACE Population Distribution

Table 1: PACE Population by CMS Region

CMS Region	Total PACE Population
Philadelphia	8,383
San Francisco	7,647
New York	6,878
Boston	4,837
Atlanta	4,759
Denver	4,287
Chicago	3,576
Seattle	2,998
Dallas	2,719
Kansas City	1,156
Grand Total	47,240

In terms of the average PACE Organization's population per region, the Seattle region tops the list with an average of 1,499 participants per organization, followed by the Denver region with 715 participants per organization. The Kansas City region again occupies the bottom position with just 193 participants per organization. See Figure 13 (next page).

Between 2016 and 2017, all but one of the regions increased its total PACE population, with an average increase of approximately 585 participants. The San Francisco region had the largest increase adding 1,229 participants, followed closely by the Seattle region with 1,154 participants.

The only region to decrease in total PACE population from 2016 to 2017 was the New York region, which lost 72 participants. See Figure 14.

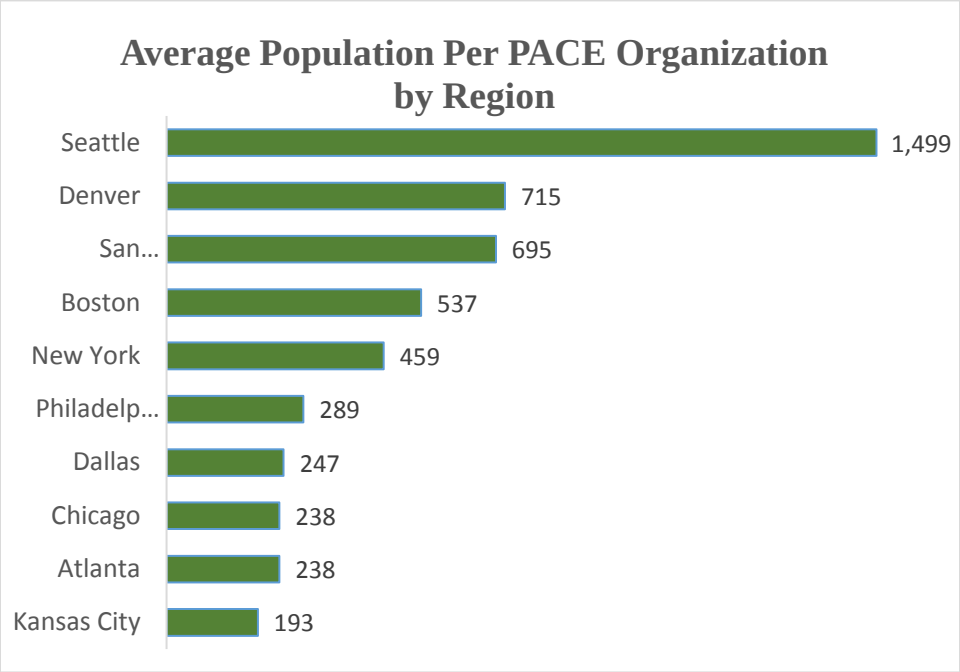


Figure 13: Average Population Per PACE Organization by Region[15]

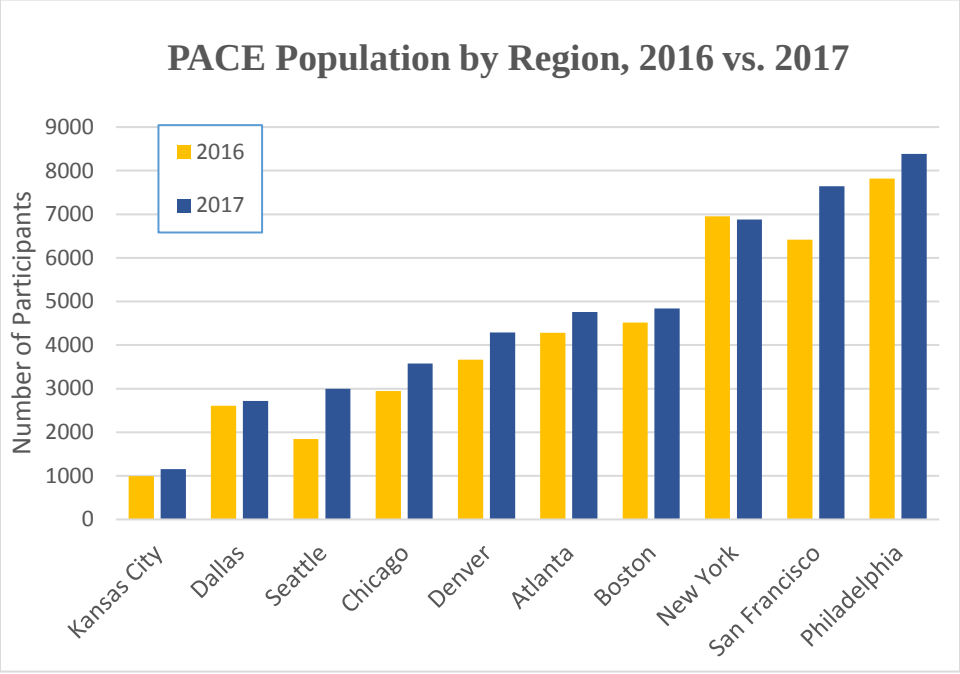


Figure 14: PACE Population by Region, 2016 vs. 2017[16]

Finally, looking again at the Medicare subset of the PACE population, Figure 15 shows how the CMS regions' PACE Medicare populations have changed over the past decade.

[15] Data taken from the fourth quarter PACE Comparative Data Report, 2017.
[16] Data taken from the fourth quarter PACE Comparative Data Reports, 2016-2017.

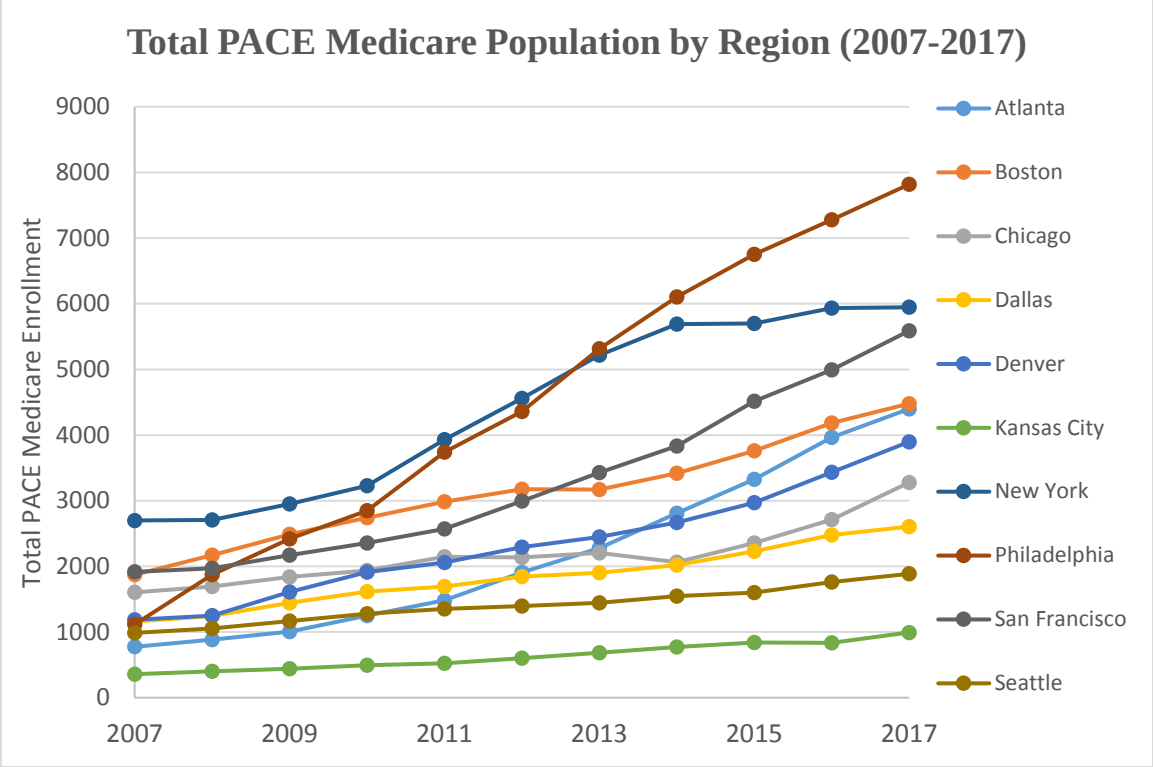


Figure 15: Total PACE Medicare Population by Region[17]

As this figure shows, some regions have experienced only modest Medicare PACE growth over the past ten years while others have grown considerably. The Seattle region, for example, has grown by only 900 Medicare PACE participants, whereas the Philadelphia region has grown by 6,703 Medicare PACE participants. Moreover, in 2007 the Kansas City region had the smallest PACE Medicare population with 358 participants while the New York region had the largest with 2,700 participants (a range of 2,342 with a standard deviation of 1,928 participants). By 2017, this range drastically increased from a low of 994 Medicare PACE participants in the Kansas City region to a high of 7,819 Medicare PACE participants in the Philadelphia region (a range of 6,825 with a standard deviation of 1,928 participants). In other words, the variation between the sizes of the regions' Medicare PACE populations has significantly increased over the past decade.

[17] Data taken from December HPMS Enrollment Extracts, 2007-2017.

PROGRAM EXPERIENCE

There is a wide variety in years of program experience among PACE Organizations, ranging from three new PACE contracts in 2017 to 33 organizations with 12 or more years. Average program experience was slightly under eight years (with a standard deviation of 4.6 years) and 27 PACE Organizations were in their trial period (defined as the first three contract years in which an organization operates under a PACE program agreement).[18] Figure 16 shows the distribution of PACE Organizations by years of program experience.[19]

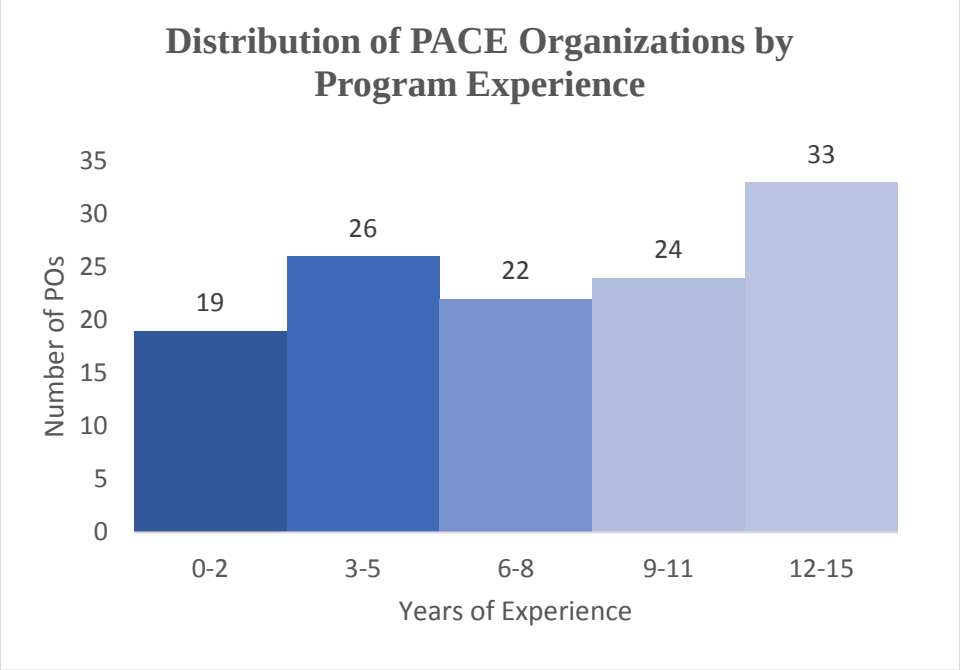


Figure 16: Distribution of PACE Organizations by Program Experience

[18] In some cases, due to the timing of the annual audit cycle the initial trial period will extend into a PACE Organization's fourth year.
[19] Data taken from the 2017 HPMS Contract Information extract.

Audit Category, Scope, and Lifecycle

This section examines the audit process: which organizations will be audited, the content of the audits, and the audit timeline.

CATEGORY

The regulations at 42 CFR §§ 460.190 and 460.192 mandate that CMS conduct comprehensive onsite reviews of PACE Organizations according to the following schedule:

- For those PACE Organizations within the trial period, CMS will conduct annual audits.
- For those PACE Organizations beyond the trial period, CMS will conduct a routine audit at least once every two years.

CMS conducted 74 audits in 2017: 23 (31%) were trial period audits, 50 (68%) were routine audits, and one was a focused audit (see Figure 17).[20] The single focused audit was for an organization not scheduled for a trial or routine audit in 2017, which was selected due to reports of non-compliance. Approximately 60% of the total number of PACE Organizations were audited in 2017, covering 23,986 participants or about 51% of the total PACE population (see Figure 18).[21]

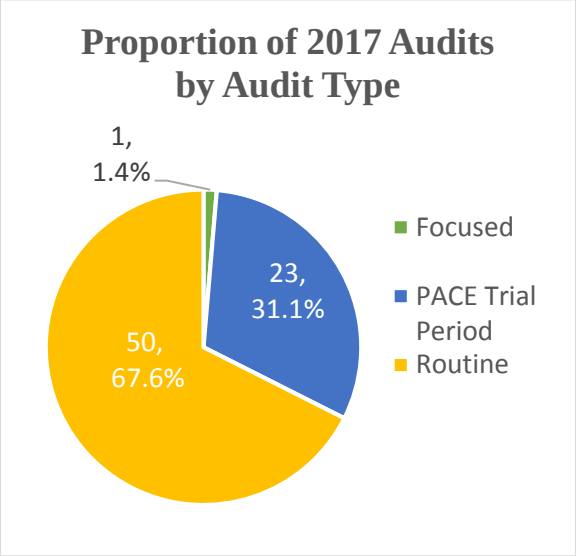


Figure 17: Proportion of 2017 Audits by Audit Type

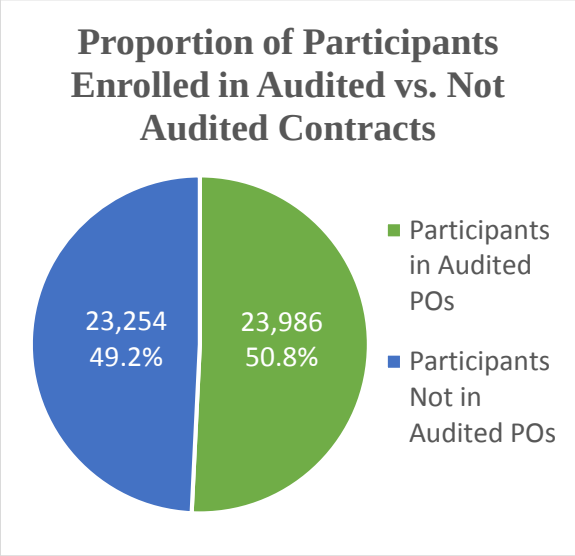


Figure 18: Proportion of Participants Enrolled in Audited vs. Not Audited Contracts

[20] Although 27 organizations were within their trial period in 2017, only 23 received a trial period audit based on when their contracts began. The four unaudited contracts will all receive their first trial period audit in 2018. Data taken from the HPMS Contract Information Extract, 2017.
[21] Data taken from the December HPMS Enrollment Extract, 2017.

AUDIT CONTENT

In 2017, CMS introduced a new PACE audit protocol which placed greater emphasis on outcome measures as well as participant data and experiences. Under this protocol, auditors evaluate PACE Organizations' performance in the following areas during the audit review period:[22]

- Service Delivery Requests, Appeals, and Grievances (SDAG)
- Clinical Appropriateness and Care Planning (CACP)
- Onsite Review
- Personnel Records
- Quality Assessment

Audit procedures test PACE Organizations' compliance with CMS PACE requirements for each of these elements. The procedures were designed to test specific audit objectives, identify non-compliance, and evaluate outcomes achieved by the PACE Organization. Examples of these procedures include:

- Reviewing data and documentation submitted by the PACE Organization prior to the audit fieldwork;
- Analyzing and selecting samples from data universes submitted by the organization prior to the review to probe for and evaluate areas of potential non-compliance;
- Reviewing the PACE Organization's systems, operations, and documentation by conducting reviews of samples and case files;
- Interviewing the organization's personnel; and
- Observing staff activity and inspecting equipment.

[22] The audit review period is defined as one year preceding the date of the issuance of the audit engagement letter.

AUDIT TIMING

The lifecycle of an audit begins the day a PACE Organization receives an engagement letter and concludes with the PACE Organization's receipt of an audit closeout letter. As Table 2 shows, in 2017, the average time from the exit conference to receipt of the final audit report was approximately 84.4 days. Additionally, 69 out of the 73 non-focused audits conducted in 2017 have been closed, and the average time from engagement letter to audit closeout for those 69 closed audits was approximately 284 days.[23] Note that the length of time required to close an audit is dependent on how quickly the PACE Organization has their Corrective Action Plans (CAPs) approved and implemented.

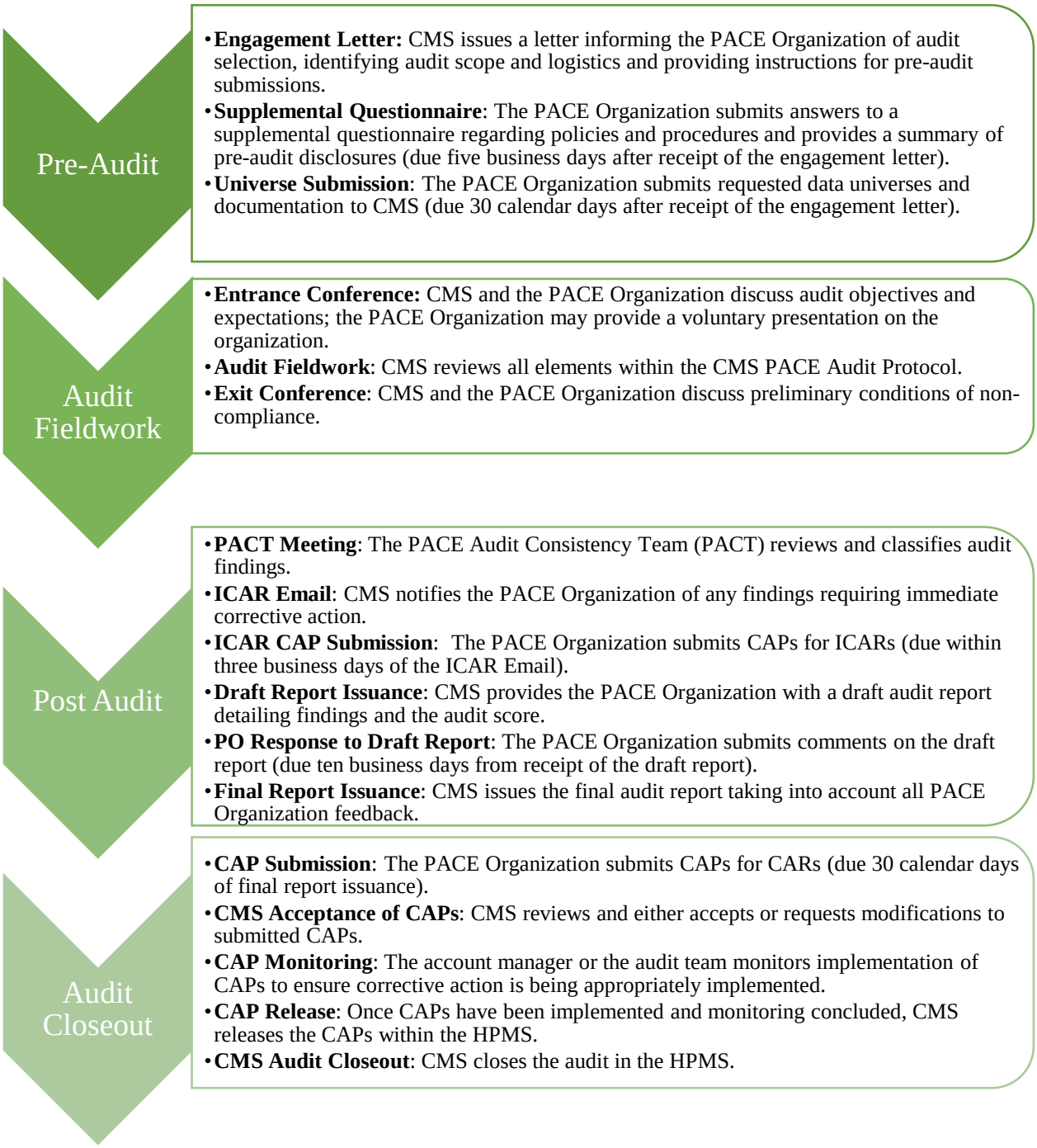
Table 2: 2017 Audit Timings

Audit Phase	Average # Days	Min # Days	Max # Days
Exit Conference to Receipt of Draft Audit Report	61.2	25	243
Exit Conference to Receipt of Final Audit Report	84.4	31	265
Engagement Letter to Audit Closeout (For Closed Audits)	283.6	173	578

[23] These numbers exclude the single focused audit conducted in 2017, which is a special case with a significantly different time frame from routine and trial period audits.

AUDIT LIFECYCLE

Figure 19: 2017 PACE Audit Lifecycle[24]



[24] The figure above reflects the process that was in place for the 2017 PACE audits. This process has slightly changed for 2018; see the section 2018 Audit Process Improvements for an overview of these changes.

AUDIT STAGES

The audit lifecycle can be divided into four stages:

- Pre-Audit
- Audit Fieldwork
- Post-Audit
- Audit Closeout

The Pre-Audit stage involves major deliverables such as the submission of the audit engagement letter as well as the PACE Organization's preparation and submission of its data universes and documentation requests. In 2017, the Audit Fieldwork stage consisted of a week of fieldwork done onsite at the PACE Organization, and for some organizations, a portion of the review conducted remotely via desk review. The Post-Audit stage includes the PACE Organization's submission of requested Impact Analyses, the PACE Audit Consistency Team (PACT) meeting, the issuance of any ICAR notification, and the issuance of the draft and final audit reports. Finally, the Audit Closeout stage involves the corrective action process following the final audit report, including the submission of Corrective Action Plans (CAPs) by the PACE Organization, the acceptance of the CAPs by CMS, monitoring of the CAPs to ensure implementation, and finally, the release of the CAPs by CMS. Following the release of all CAPs, the audit is officially closed. Figure 19 (previous page) provides a detailed overview of the process that was in place for the 2017 PACE Audits during each of these stages.

Audit Results

This section provides information related to the 2017 audit results, starting with a discussion of the scoring system followed by analysis of the data.

SCORING SYSTEM

An overall score for each audited PACE Organization is generated based on the number and severity of non-compliant conditions found during the audit, with a lower score representing better audit performance. Conditions are initially identified by the audit team and later classified by the PACE Audit Consistency Team (PACT) using the following three categories:

- A **CAR** (Corrective Action Required) is a systemic deficiency that must be corrected, but the correction can wait until the final audit report is issued. These issues may affect participants, but are not of a nature that immediately impacts their health and safety. Generally, they involve deficiencies with respect to non-existent or inadequate policies and procedures, systems, internal controls, training, operations, or staffing.
- An **ICAR** (Immediate Corrective Action Required) is a systemic deficiency that is so severe that it requires immediate correction. These types of issues would be limited to situations where the identified deficiency resulted in a lack of access to care and/or services or posed an immediate threat to participant health and safety.
- **Observations** are conditions of non-compliance that are not systemic, or represent a "one-off issue." A "one-off issue" may be an issue dealing with one employee or a singular case that was lost or misidentified.

The audit score is calculated by assigning zero points to observations, one point to each CAR identified, and two points to each ICAR identified, and then dividing the sum of these points by the number of audit elements tested (five) to reach the overall score for the organization. Expressed as a formula:

$$\text{Audit score} = (\#\ \text{CARs} + (\#\ \text{of ICARs} \times 2)) / \#\ \text{of audited elements (5)}$$

Note that although observations do not figure into this equation (i.e. they do not increase an organization's audit score) they do represent instances of non-compliance and will appear in the final audit report. Organizations are not required to submit CAPs for observations since the non-compliance is isolated in nature.

AUDIT SCORES

The 2017 audit scores ranged from 0.6 to 9 (where lower scores represent better audit performance), with an average score of 2.4 (and a standard deviation of 1.5). There were three notable outliers with scores of 5.8, 8.4, and 9 (values over two standard deviations above the mean). Figure 20 gives the distribution of PACE Organizations by their audit scores.

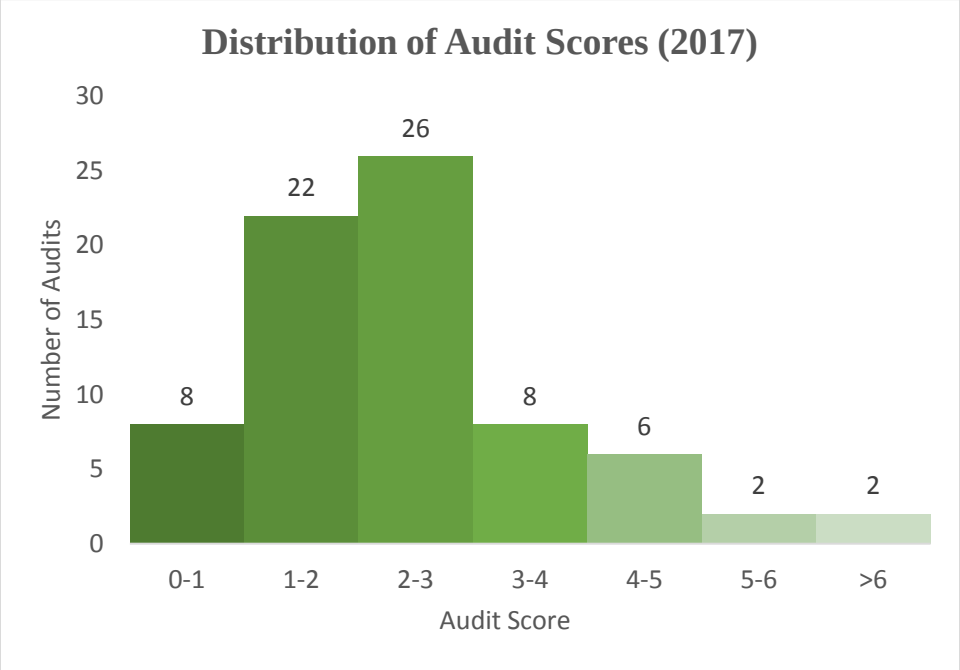


Figure 20: Distribution of Audit Scores

As this figure shows, the majority of audited PACE Organizations (65%) received scores between 1 and 3. Approximately 11% of the audited PACE Organizations had scores below 1, while about 24% had scores above 3. Figures 21 and 22 (next page) display the individual audit scores for each audited organization. The scores are in two charts: the first indicates those PACE Organizations that had the lowest scores of 2017 (a score of two or below) while the second chart displays those PACE Organizations that had the highest scores of 2017 (scores greater than 2).[25]

Note: Because 2017 was the first year PACE audits were scored, there is no year-to-year audit score comparison for this annual report.

[25] A table displaying the audit score for each PACE Organization can be found in the appendix.

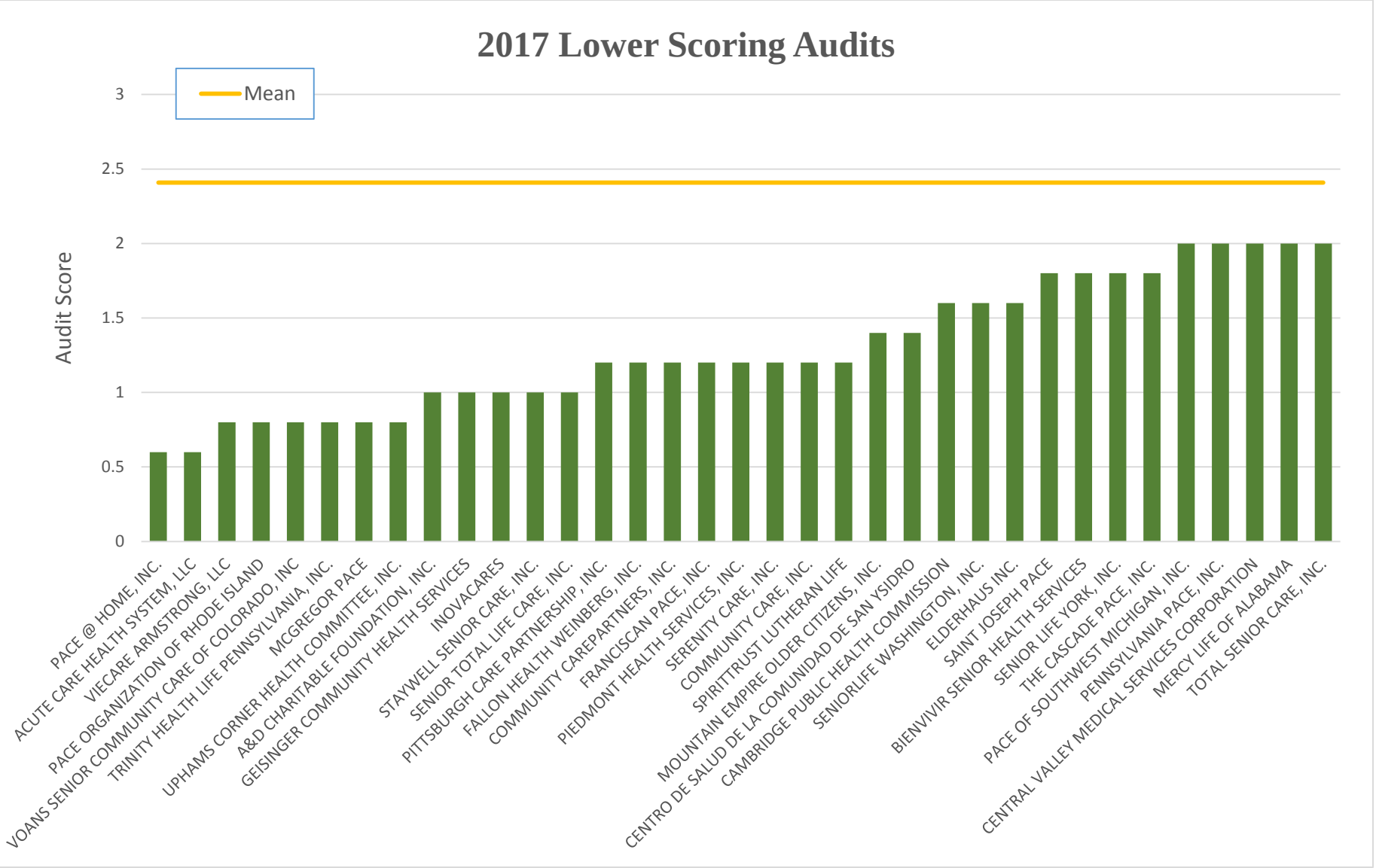


Figure 21: Lower Scoring Audits

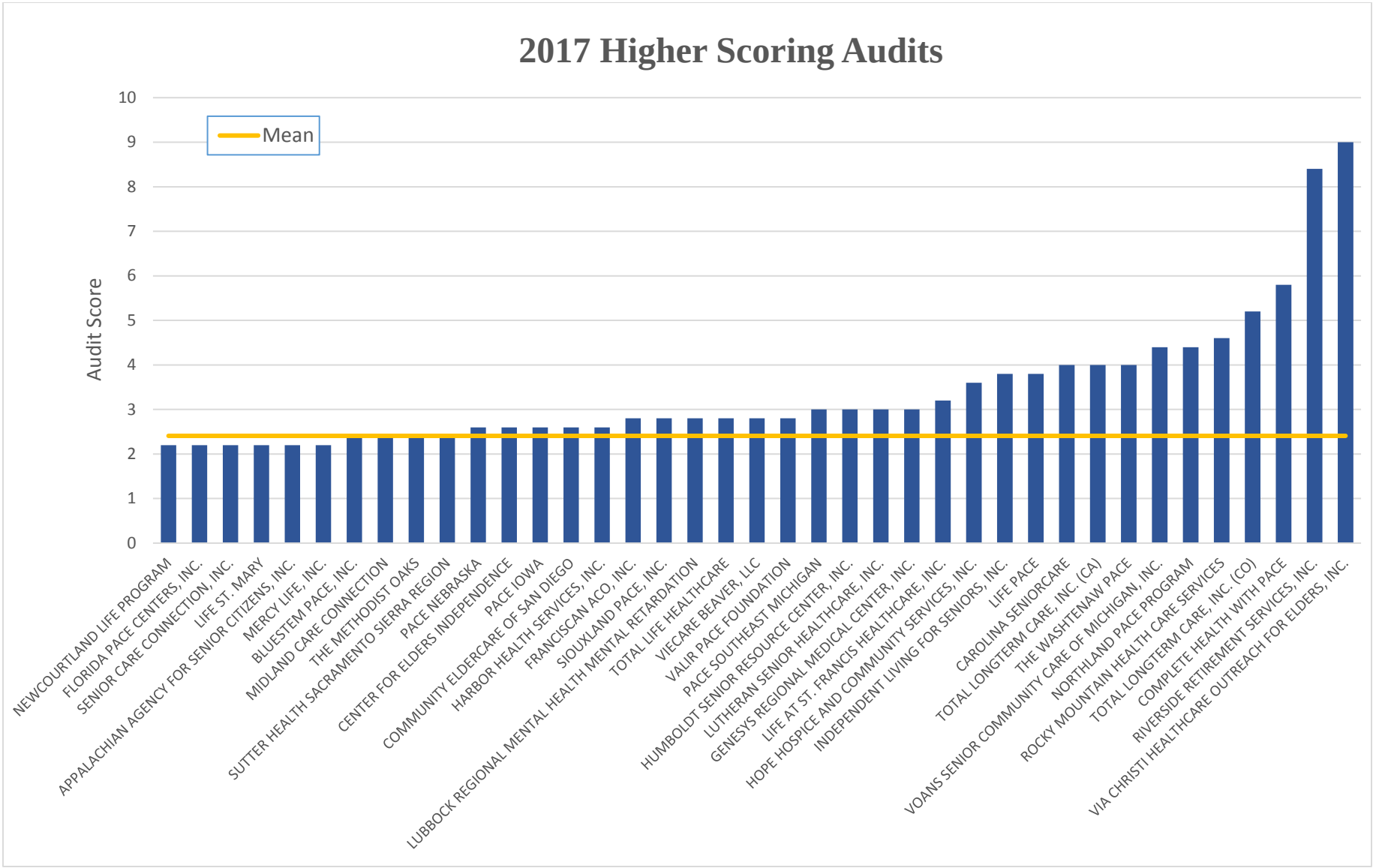


Figure 22: Higher Scoring Audits

SCORES BY PROGRAM EXPERIENCE

The next several sections examine possible correlations between audit scores and PACE Organization characteristics, beginning with the relationship between audit score and program experience. It is important to note that 2017 was the first year PACE Organizations received an audit score, making it difficult to draw definitive conclusions. As Figure 23 shows, there was virtually no difference in audit scores between routine and trial period audits in 2017. There was one focused audit conducted in 2017, which uncovered significant non-compliance. As a result, there was a substantial difference between the one focused audit score and the average scores for routine and trial period audits. Overall, there was not a significant correlation between years of program experience and audit scores, as shown in Figure 24 (correlation coefficient = .05).

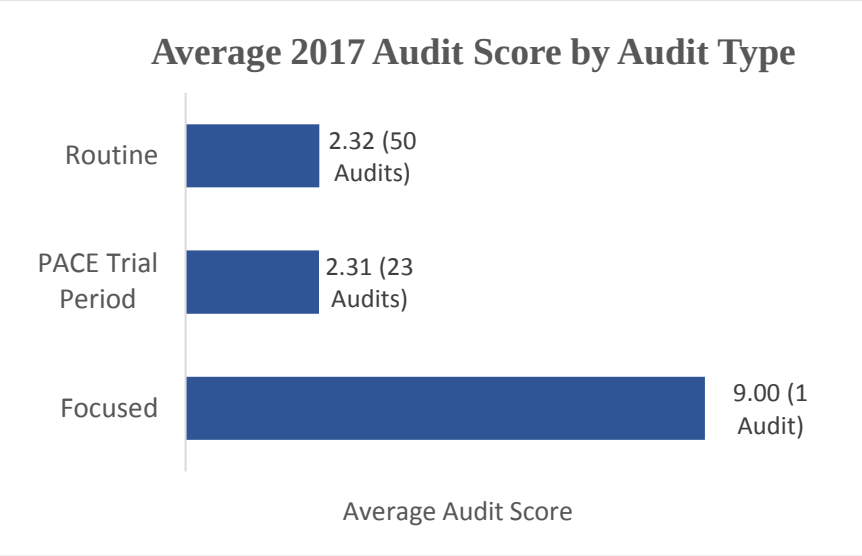


Figure 23: Average 2017 Audit Score by Audit Type

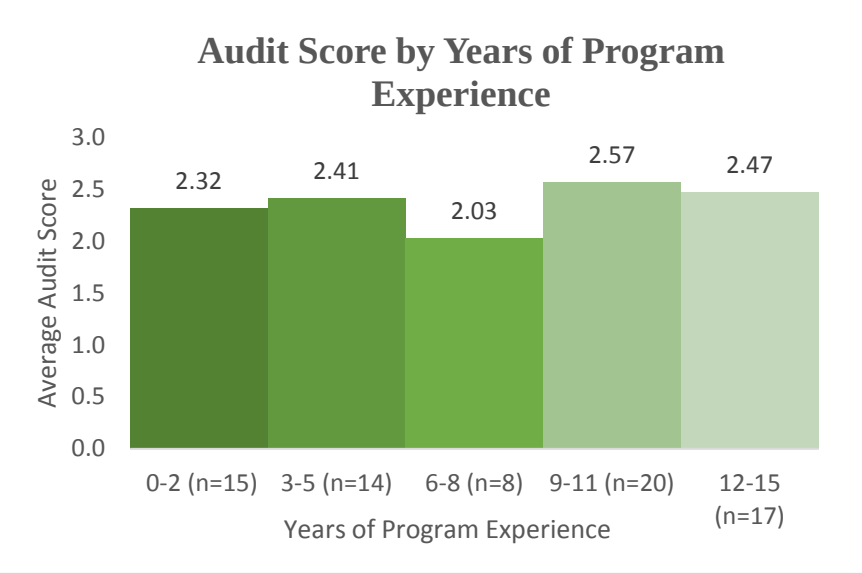


Figure 24: Audit Score by Years of Program Experience

SCORES BY TAX STATUS

There was a relatively minor difference between scores of for- and not-for-profit PACE Organizations in 2017. Of the 74 audited PACE Organizations, 67 (about 91%) were not-for profit while 7 (about 9%) were for-profit. The average audit score for the not-for-profit PACE Organizations was 2.40, compared to an average score of 2.53 for the for-profit organizations (a difference of .13). Figure 25 compares the average score between not-for-profit and for-profit PACE Organizations, while Figure 26 contrasts the relative distributions of for-profit and not-for profit organizations across score categories.[26]

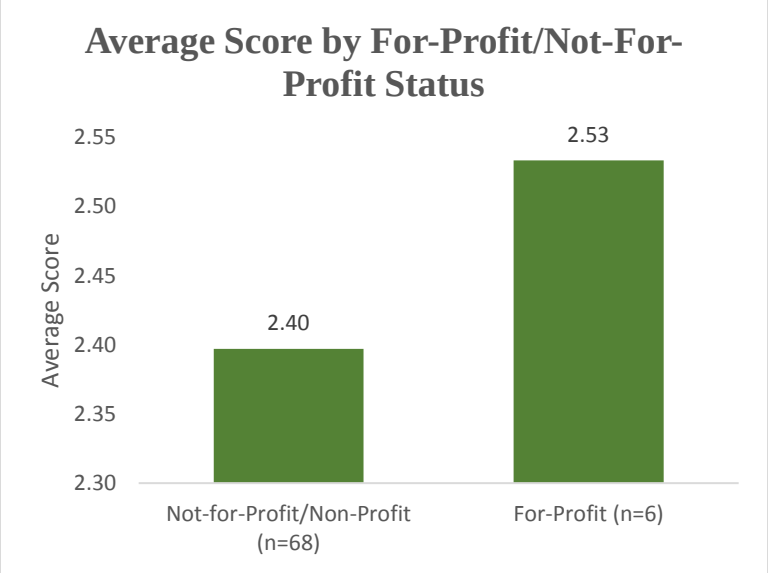


Figure 25: Average Score by For-Profit/Not-For-Profit Status

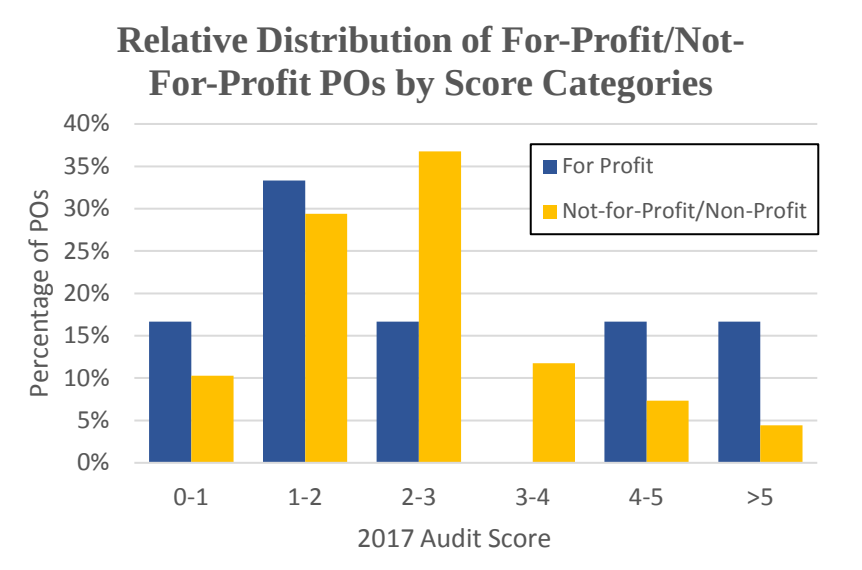


Figure 26: Relative Distribution of For-Profit/Not-For-Profit POs by Score Category

[26] Data on PACE Organization tax status taken from 2017 HPMS Contract Information Extract.

SCORES BY TYPE OF LOCATION

Of the 2017 audited programs, ten were located in rural environments, forty-five in urban, and nineteen in both rural and urban environments. On average, the rural organizations outperformed the urban organizations by 0.4, with those organizations that were both rural and urban falling in between.[27]

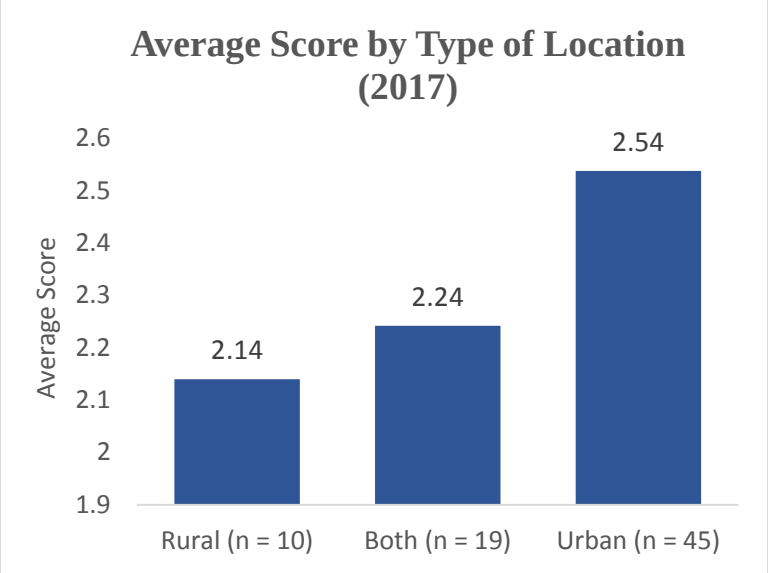


Figure 27: Average Score by Type of Location

SCORES BY ENROLLMENT

Figure 28 (next page) displays the average audit scores for PACE Organizations of various size categories. The largest PACE Organizations (with enrollment sizes over 800) had an average audit score of 3.5, organizations with between 400 and 800 participants had an average score of 2.6, and organizations with under 400 participants had an average score of 2.3. While there does seem to be a positive correlation between population size and audit score, the relationship is fairly weak (correlation coefficient = .26) and is based on a small number of data points when it comes to organizations with large populations (while 53 PACE Organizations audited in 2017 had under 400 participants, only two organizations had over 800 participants).

[27] Data on PACE Organizations' rural/urban status taken from 2017 HPMS Contract Information Extract.

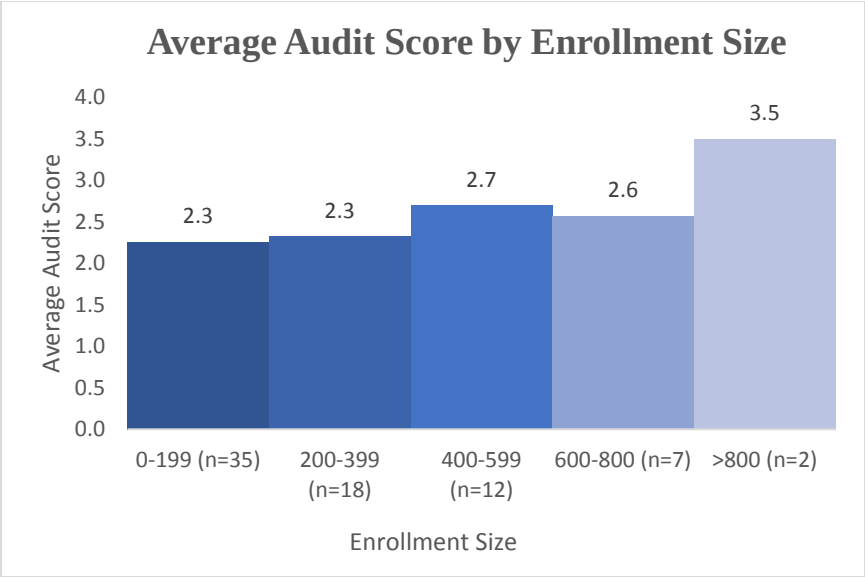


Figure 28: Audit Score by Enrollment Size

SCORES BY POPULATION BREAKDOWN

To examine potential correlations between audit scores and PACE Organizations' dual, Medicare-only, and Medicaid-only/private pay populations, it will be useful to categorize organizations using the following breakouts:

- **Low scoring** if its score is 0.86 or below
- **Below average** if its score is between 0.86 and 2.41
- **Above average** if its score is between 2.41 and 3.96
- **High scoring** if its score is 3.96 or above

These cut points are based on the mean (2.41) and standard deviation (1.55) of the 2017 audit scores. Table 3 displays average population characteristics for those organizations falling into each of these categories:

Table 3: Average Population Characteristics by Score Category[28]

Score Category	Number of POs	Average Total Enrollment	Duals (%)	Medicare-Only (%)	Medicaid-Only/Private Pay (%)
Low	8	266	75.20%	13.76%	11.04%
Below Average	37	276	73.92%	13.27%	12.81%
Above Average	19	321	74.97%	16.07%	8.96%
High	10	555	69.72%	19.07%	11.22%

[28] Data taken from HPMS Enrollment Extract, 2017.

As this table shows, lower scoring PACE Organizations tended to have smaller population sizes, smaller percentages of Medicare-only populations, and larger percentages of dual populations. The percentage of Medicaid-only/private pay participants remained relatively similar across score categories. Figures 29 provides a closer look at the relationship between the percentage of Medicare-only participants and audit score, while Figure 30 shows the relationship between audit score and the percentage of dual participants.

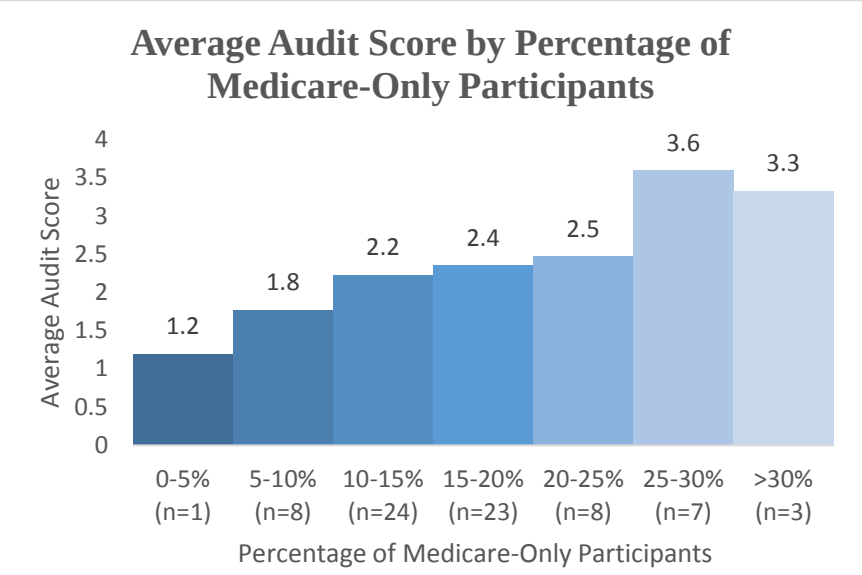


Figure 29: Average Audit Score by Percentage of Medicare-only Participants[29]

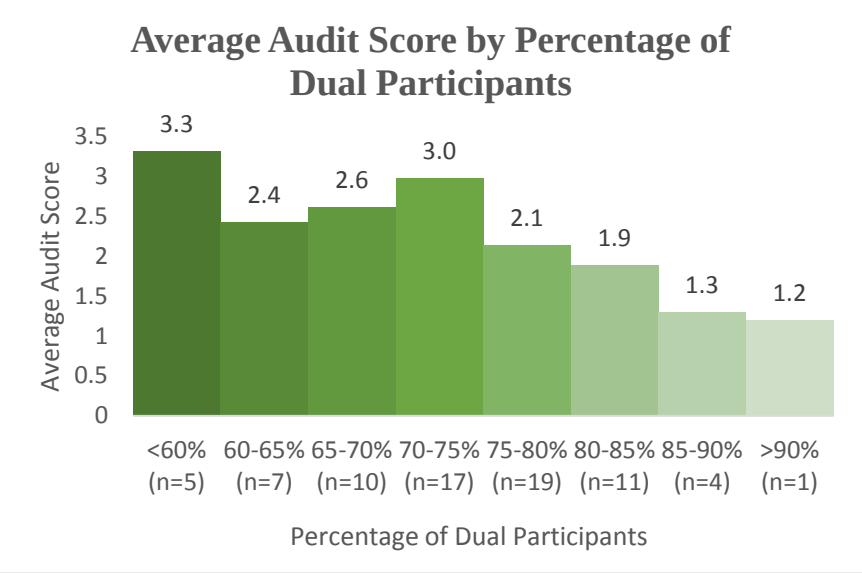


Figure 30: Average Audit Score by Percentage of Dual Participants

[29] Data taken from the December 2017 HPMS Enrollment Extract.

DRAFT-TO-FINAL REPORT

After the issuance of the draft audit report, PACE Organizations have a period of time in which to comment on the audit findings. CMS then reviews the comments and makes revisions to the audit report when appropriate. Occasionally, audit scores are revised when the PACT decides to re-classify a condition based on comments received (e.g., an ICAR becomes a CAR). Across all audits in 2017, six scores were revised in this manner. The largest of any of these changes was 0.6, with an average change of 0.3. This analysis does not take into account all of the instances that CMS revised a final audit report in response to a PACE Organization's comments when those revisions did not change the classification of a condition and therefore the score was not impacted.

TYPES OF CONDITIONS CITED

In total, there were 741 conditions cited in the 74 PACE audits conducted in 2017. This includes 113 conditions classified as observations (15.2%), 365 as CARs (49.3%), and 263 as ICARs (35.5%); see Figure 31:

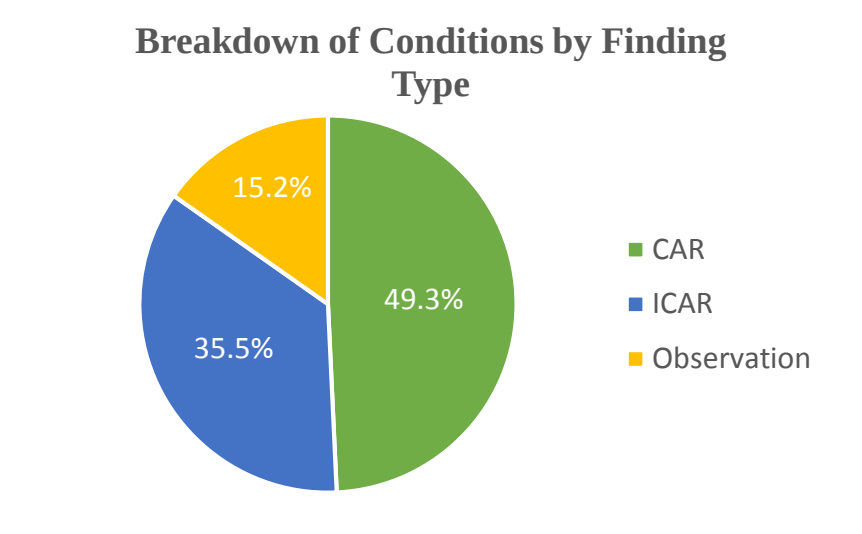


Figure 31: Breakdown of Conditions by Finding Type

Similarly, these 741 conditions can be categorized by their associated audit element: Service Delivery Requests, Appeals, and Grievances (SDAG); Clinical Appropriateness and Care Planning (CACP); Personnel; Onsite Review; and Quality Assessment. The most common class of conditions cited were those relating to SDAG, with a total of 498 citations (67.2%); the element with the fewest number of conditions cited (only 17) was Onsite Review. See Figure 32. Table 4 (next page) provides a more detailed look at the number of CARs, ICARs, and observations for each element.

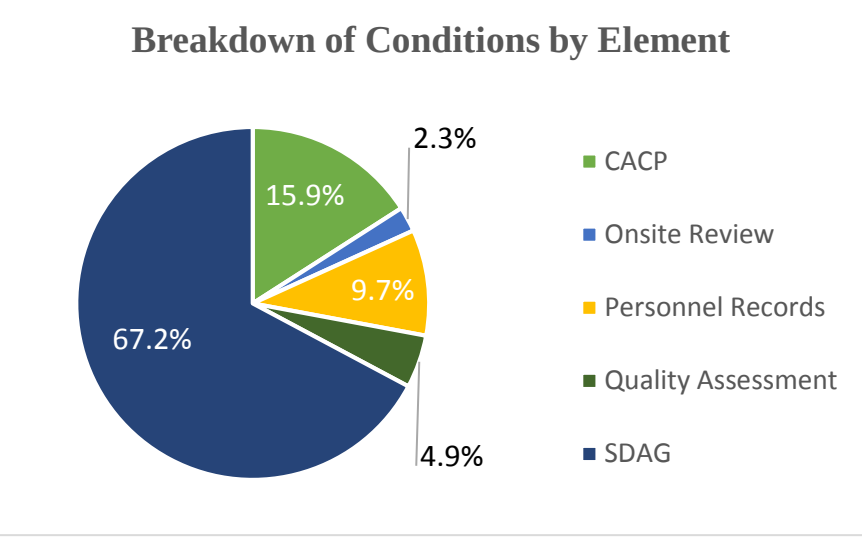


Figure 32: Breakdown of Conditions by Element

Table 4: Finding Type by Element

Element	Finding Type	Count	Percentage
CACP	CAR	44	5.94%
	ICAR	55	7.42%
	Observation	19	2.56%
Total		**118**	**15.92%**
Onsite Review	CAR	1	0.13%
	ICAR	15	2.02%
	Observation	1	0.13%
Total		**17**	**2.29%**
Personnel Records	CAR	36	4.86%
	ICAR	20	2.70%
	Observation	16	2.16%
Total		**72**	**9.72%**
Quality Assessment	CAR	33	4.45%
	ICAR	2	0.27%
	Observation	1	0.13%
Total		**36**	**4.86%**
SDAG	CAR	251	33.87%
	ICAR	171	23.08%
	Observation	76	10.26%
Total		**498**	**67.21%**
Grand Total		**741**	**100.00%**

The element with the greatest average number of ICARs was SDAG with about 2.31 per audit, followed by CACP with 0.74 per audit. On the low end, Quality Assessment had only 0.03 ICARs per audit followed by Onsite Review with 0.20 per audit. See Figure 33.

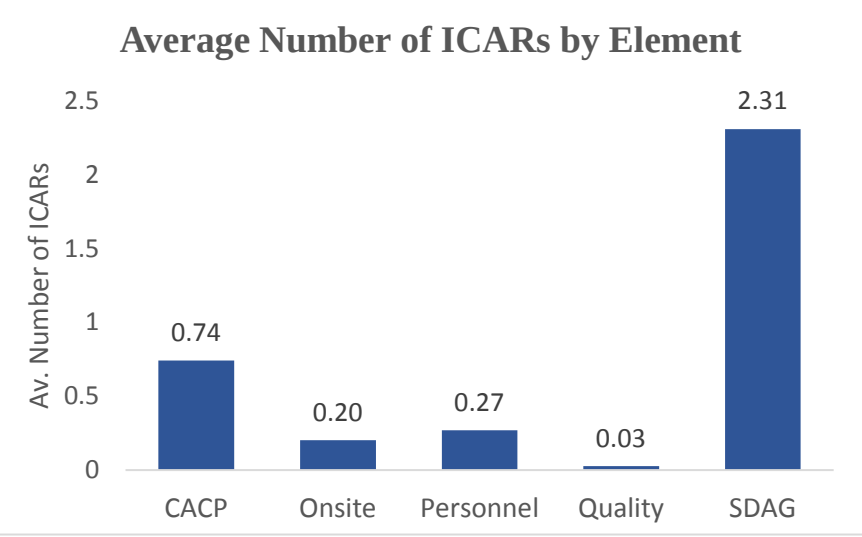


Figure 33: Average Number of ICARs by Element

It is not surprising that SDAG had the highest average number of ICARs, given that SDAG had the most conditions cited on average. However, looking at the *rate* of ICARs cited within each element (e.g. the number of ICARs cited per one hundred conditions of each element type) the results looks quite different. 88.2 per 100 Onsite Review conditions and 46.6 per 100 CACP conditions were classified as ICARs, whereas only 34.3 per 100 SDAG conditions were classified as ICARs. Thus, although Onsite Review conditions were less frequently cited than SDAG conditions, once cited, a condition in Onsite Review was more likely to be an ICAR than any given SDAG condition. At the other extreme is Quality Assessment, whose rate of ICARs was extremely low: only about 5.6 per 100 Quality Assessment conditions were ICARs.

Similarly, Quality Assessment, SDAG, and Personnel conditions had the highest rates of CARs (at 91.7, 50.4, and 50 per 100, respectively), whereas Personnel, CACP, and SDAG had the highest rates of observations (at 22.2, 16.1, and 15.3 per 100, respectively). See Table 5.

Table 5: ICAR, CAR, and Observation Rates by Element

Element	Finding Type	Rate Per 100
CACP	CAR	37.3
	ICAR	46.6
	Observation	16.1
Onsite Review	CAR	5.9
	ICAR	88.2
	Observation	5.9
Personnel Records	CAR	50.0
	ICAR	27.8
	Observation	22.2
Quality Assessment	CAR	91.7
	ICAR	5.6
	Observation	2.8
SDAG	CAR	50.4
	ICAR	34.3
	Observation	15.3

MOST COMMON CONDITIONS

This section provides a summary of the most common conditions of non-compliance cited in 2017 audits. Conditions are developed from specific regulatory and manual requirements to which PACE Organizations are required to adhere. A condition is a statement that describes how the PACE Organization failed to comply with these requirements. Some conditions of non-compliance are more commonly cited than others. Below is a summary of the most common conditions of non-compliance cited in 2017 audits. See Tables 6 and 7.

Note: A condition is only ever cited once within a report, even if that condition could potentially be cited under multiple elements in that report. For example, if a given condition were cited under SDAG, then even if the audit team also found sufficient grounds to cite that same condition under CACP, the condition would not be cited a second time. Instead, the information for both elements would be included in the cause and effect language, and the condition would be cited under whatever element was deemed to be the primary element.

Table 6: Top 10 Conditions Cited Overall

Condition	Condition Count	Audit Elements	Condition Language
#1P.57	74	CACP, SDAG	The PO failed to conduct in-person assessments and/or reassessments as often as required.
#1P.61	65	SDAG	The PO's denial notifications did not include the participant's right to appeal the denial and/or information about how to appeal the denial.
#1P.60	65	SDAG	The PO's denial notifications failed to include the specific reason(s) for the denial in a clear and understandable manner.
#1P.62	62	SDAG	The PO did not automatically process an appeal following an untimely decision for a service.
#1P.56	55	SDAG	The PO failed to notify participants or their representatives of its decision to approve or deny a request for reassessment within 72 hours from the date of receipt of a request by the Interdisciplinary Team (IDT), or within 8 days if an extension was taken.
#1P.59	33	SDAG	The PO failed to provide written notification of denials.
#1P.78	29	SDAG	The PO failed to resolve and/or notify participants and/or their caregivers of the resolution of their grievances in a timely manner.
#1P.22	21	CACP	The PO failed to maintain a medical record that was complete, accurate, and available to all staff.
#1P.81	18	CACP, SDAG, Onsite	The PO failed to provide care and services in accordance with participants' approved care plans.
#1P.02	18	CACP, SDAG, Onsite	The PO failed to provide services that were accessible and/or adequate to meet the needs of its participants.

Table 7: Top 5 SDAG Conditions

SDAG	Condition Count	Condition Language
#1P.57	74	The PO failed to conduct in-person assessments and/or reassessments as often as required.[30]
#1P.60	65	The PO's denial notifications failed to include the specific reason(s) for the denial in a clear and understandable manner.
#1P.61	65	The PO's denial notifications did not include the participant's right to appeal the denial and/or information about how to appeal the denial.
#1P.62	62	The PO did not automatically process an appeal following an untimely decision for a service.
#1P.56	55	The PO failed to notify participants or their representatives of its decision to approve or deny a request for reassessment within 72 hours from the date of receipt of a request by the IDT, or within 8 days if an extension was taken.

Table 8: Top 5 CACP Conditions

CACP	Number	Condition Language
#1P.57	74	The PO failed to conduct in-person assessments and/or reassessments as often as required.[31]
#1P.22	21	The PO failed to maintain a medical record that was complete, accurate, and available to all staff.
#1P.02	15	The PO failed to provide services that were accessible and/or adequate to meet the needs of its participants.
#1P.81	13	The PO failed to provide care and services in accordance with participants' approved care plans.
#1P.14	9	The PO failed to ensure that the Interdisciplinary Team remained alert to pertinent input from other team members, participants, and caregivers.

[30] In 2017, condition 1P.57 was cited for any missing in-person assessment, including semi-annual, annual, initial and unscheduled, and therefore the condition often overlapped both SDAG and CACP. Because this condition overlapped both elements on a routine basis, it is listed as the most commonly cited condition under both elements.

[31] In 2017, condition 1P.57 was cited for any missing in-person assessment, including semi-annual, annual, initial and unscheduled, and therefore the condition often overlapped both SDAG and CACP. Because this condition overlapped both elements on a routine basis, it is listed as the most commonly cited condition under both elements.

Table 9: Top 5 Onsite Review Conditions

Onsite Review	Number	Condition Language
#1P.79	6	The PO failed to have emergency equipment onsite and immediately available.
#1P.81	3	The PO failed to provide care and services in accordance with participants' approved care plans.
#1P.02	2	The PO failed to provide services that were accessible and/or adequate to meet the needs of its participants.
#1P.14	2	The PO failed to ensure that the Interdisciplinary Team remained alert to pertinent input from other team members, participants, and caregivers.
#1P.63	2	The PO failed to ensure personnel donned and doffed personal protective equipment (PPE) when providing care in accordance with the Centers for Disease Control and Prevention (CDC) standard precautions.

Table 10: Top 5 Personnel Records Conditions

Personnel Records	Number	Condition Language
#1P.35	15	The PO failed to evaluate the competency of all personnel and contractors prior to those individuals performing participant care.
#1P.29	11	The PO failed to provide emergency training as required.
#1P.41	10	The PO failed to ensure that all personnel and contractors who have direct participant contact are free from communicable diseases before performing participant care.
#1P.19	9	The PO failed to provide OSHA training as required.
#1P.42	6	The PO failed to ensure that all personnel and contractors who have direct participant contact have all immunizations up-to-date before performing participant care.

Table 11: Top 5 Quality Assessment Conditions

Quality Assessment	Number	Condition Language
#1P.53	8	The PO did not ensure that all IDT members, PACE staff, and contract providers were involved in the development and implementation of quality assessment and performance improvement activities.
#1P.43	6	The PO failed to develop and/or implement an effective, data driven quality assessment and performance improvement program.
#1P.54	5	The PO failed to maintain, aggregate, and analyze information on appeal proceedings and use this information in the organization's internal quality assessment and performance improvement program.
#1P.55	4	The PO failed to maintain, aggregate, and analyze information on grievance proceedings and use this information in the organization's internal quality assessment and performance improvement program.
#1P.46	3	PO failed to use objective measures to demonstrate improvement in all pertinent areas of the quality assessment program.

COMMON CAUSES

Conditions of non-compliance found in 2017 audits tended to arise from a small number of common causes. These causes, or reasons for the non-compliance, were similar across elements, and CMS did not identify any unique element-specific causes in analyzing the audit results. Across the board, the causes of non-compliance could be attributed to several factors:

- **Misunderstanding a regulatory requirement:** One of the most common causes in 2017, which impacted all elements, was PACE Organizations' failure to understand regulatory requirements.
    - **SDAG Example:** Most organizations did not understand the requirement that once a service delivery request becomes untimely (i.e. notification is not provided in a timely manner) the request must be automatically processed as an appeal.
- **Ineffective or inadequate processes or procedures:** This occurred when an organization understood the requirement and what was expected of them, but had not developed appropriate and/or adequate processes to ensure compliance with the requirement. Examples of this cause were seen across all elements.
    - **Personnel Example:** An organization knew staff had to be medically cleared before having direct participant contact, but did not have a good process for ensuring all staff were cleared. In other words, they lacked an effective process to track medical clearance in order to ensure that personnel were appropriately screened.
    - **CACP Example:** An organization knew the specific disciplines of the IDT that needed to conduct in-person assessments, but lacked an appropriate process to ensure that those members actually conducted the assessments when required.
- **Inadequate documentation:** This related to situations where an organization lacked the evidence or documentation to show they were compliant with CMS requirements. This often appeared when an organization understood CMS expectations, and had a process in place, but did not have adequate documentation or evidence to satisfy the requirement.
    - **SDAG Example**: An organization had a process in place to take extensions for service delivery requests, but did not adequately document the rationale for taking the extension in order to show the extension was appropriate.
    - **CACP Example**: An organization determined that services were necessary for a participant but then did not document that the services were actually provided to that participant. The organization was unable to demonstrate that the services determined necessary were ever actually rendered.

- **Ineffective or inadequate training:** Another common cause in all elements was either inadequate or ineffective training of staff to ensure all staff were aware of the processes and policies in the organization.

    - **Onsite Example:** An organization did not appropriately train staff on CDC standard precautions before those individuals provided care to participants.

    - **SDAG Example:** An organization did not adequately train staff on what constitutes a service delivery request to ensure that when requests were made to staff members they were appropriately routed to the IDT for review.

Enforcement Actions

CMS has the authority to impose civil money penalties (CMPs), sanctions, and for-cause terminations against POs when an organization is substantially non-compliant with PACE contract requirements. In collaboration with the State Administering Agency (SAA), Department of Health and Human Services Office of General Counsel, the Office of Inspector General, and the Department of Justice, all enforcement actions receive clearance prior to issuance. The SAA may choose to be a party to the action but it is not required. When referrals involve suspected fraud, waste, and abuse, information is immediately referred to the Center for Program Integrity for investigation.[32]

In 2017, three enforcement actions were imposed against the following PACE organizations: Riverside Health Systems, Via Christi Healthcare Outreach for Elders, and Senior LIFE York. The enforcement actions included two enrollment suspensions imposed on Riverside Health Systems and Via Christi Healthcare Outreach for Elders, and one CMP against Senior LIFE York. The details for each of these enforcement actions are given below.

CIVIL MONEY PENALTIES

The federal regulations outline nine bases for which CMS may impose sanctions or CMPs against PACE Organizations.[33] The majority of CMPs are imposed due to the PACE Organization failing substantially to provide participants with medically necessary items and services that are PACE covered services, where this failure adversely affected (or had the substantial likelihood of adversely affecting) participants.[34] On this basis, CMS is authorized to impose $25,000, adjusted annually for inflation, for each violation.[35]

There was a single CMP levied in 2017, as shown in Table 8:

Table 12: 2017 Civil Money Penalties

Date of Imposition	Organization	Basis for Action	CMP Amount
11/14/2017	Senior LIFE York, Inc.	Failure to provide items and/or services	$37,396

[32] Enforcement actions are publicly posted on the Part C and Part D Compliance and Audits website: http://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDEnforcementActions-.html
[33] The PACE enforcement action bases are listed in 42 C.F.R. § 460.40.
[34] See 42 C.F.R. §460.40(a).
[35] See 42 C.F.R. §460.46(a)(4) and 45 C.F.R. §102.3.

PACE SANCTIONS

Sanctions can result in either the suspension of an organization's ability to enroll new Medicare PACE participants or the suspension of payment to the organization for new Medicare PACE participants. To date, CMS has only imposed sanctions that have resulted in the suspension of enrollment. In 2017, the following sanctions were imposed on PACE Organizations:

Table 13: 2017 Sanctions

Date of Imposition	Organization	Basis for Action	Type of Sanction
12/20/2017	Riverside Health Systems	Contract Administration	Immediate Suspension of Enrollment
10/3/2017	Via Christi Healthcare Outreach for Elders, Inc.	Contract Administration	Immediate Suspension of Enrollment

For both of these sanctions, the SAA joined the action in order to facilitate the suspension of non-Medicare participants. However, SAA involvement is not required to impose sanctions for Medicare participants.

Once sanctions are in place, the PACE Organization must develop and implement corrective action plans to remedy the deficiencies which formed the basis for the sanction. In order to be released from sanctions, the PACE Organization must successfully pass a validation audit. CMS and the State will conduct the validation audit once the PACE Organization acquires enough clean data to validate correction of their deficiencies. Riverside was released from sanction on June 18, 2018. At the time of issuance of this report, Via Christi remains under sanction. CMS is currently monitoring Via Christi as they implement their corrective action plans. They are currently in their clean period and are scheduled to undergo validation testing in late August 2018.

APPEALS

PACE Organizations may appeal all enforcement actions either to the Departmental Appeals Board (CMPs) or to a CMS hearing officer (sanctions and terminations). For CMPs, organizations must file appeal requests no later than 60 days after receiving the CMP notice. If the organization does not appeal, the CMP is final and due for payment. For sanctions and terminations, organizations must file appeals no later than 15 days after receiving the enforcement or termination notice. An appeal does not delay the imposition of the sanction, but it will delay the imposition of a termination unless there is imminent and serious risk to the health of the enrollees.

2018 Audit Process Improvements

CMS continues to work to ensure PACE audits are conducted consistently and smoothly. To help achieve those goals, we are implementing the following changes and improvements for the 2018 PACE audit year:

- PACE Organizations will still have 30 calendar days to submit all required universes; however, for 2018, auditors will start the element review approximately 2 weeks after universes are received rather than 4 weeks after (as was the case in 2017). Beginning audit fieldwork earlier helps streamline the audit process and reduces the time organizations are engaged in audit related activities while still allowing sufficient time to submit universes.

- Audit fieldwork for both routine and trial period audits will be conducted over two consecutive weeks. Week 1 of fieldwork will be performed off-site through desk review or webinar and will include the review of the Service Delivery Requests, Appeals and Grievances (SDAG) element. CMS may also review other elements remotely when necessary or feasible. During week 2 of fieldwork, the audit team will conduct an in-person review of the onsite element, and any elements not reviewed or completed in week one. By spreading audit fieldwork out over the course of two weeks, we anticipate reducing burden on PACE Organizations by allowing organizations additional time to review and respond to audit findings and documentation requests.

- The review and issuance of engagement letters, ICAR notifications, draft reports, and final reports will now be done by MOEG's Division of Analysis, Policy and Strategy (DAPS) to further centralize the audit process and review of audit deliverables.

- Core audit leads have been identified. These audit leads will be responsible for managing the CMS audit team, ensuring the audit protocol is followed, and reporting conditions to the PACE Audit Consistency Team (PACT) following the audit fieldwork. They will also be responsible for communicating with PACE Organizations both before and during the audit. Additionally, Account Managers (AMs) will no longer participate as an audit lead or audit team member for any organization they oversee; however, AMs will be responsible for monitoring the implementation and release of all corrective action plans (CAPs) following the audit.

- All CMS audit elements, samples, and supporting documentation will be reviewed and collected by the CMS audit team. We will continue to share all information, data, and documentation received and reviewed by CMS during the audit process. While CMS is ultimately responsible for collecting and documenting all findings related to the CMS protocol, SAAs may be onsite with the CMS team and may choose to review the information collected by CMS. The SAAs may also choose to conduct any State specific reviews of the PACE Organization that the State determines necessary.

- The Health Plan Management System (HPMS) requirements have been updated to allow for easier navigation and response to CMS requests within the audit module. These updates include: allowing organizations to upload and download multiple files at the same time (excluding universe files); entering draft audit report comments and responses directly into the HPMS; and allowing for ICAR notification directly from the HPMS.

Conclusion

We hope PACE Organizations will utilize the information contained in this report to inform their organization in making process improvements and ensuring that participants receive appropriate care and services. CMS continues to strive for increased transparency in relation to audit materials, performance, results, and enforcement actions, and looks forward to continued collaboration with the industry in developing new approaches to assist in achieving compliance.

Appendix

Table 14: Number of POs by State[36]

State	Number of POs	State	Number of POs
Alabama	1	New Jersey	6
Arkansas	2	New Mexico	1
California	11	New York	9
Colorado	4	Ohio	1
Delaware	1	Oklahoma	3
Florida	4	Oregon	1
Iowa	2	Pennsylvania	19
Indiana	1	Rhode Island	1
Kansas	3	South Carolina	3
Louisiana	2	Tennessee	1
Massachusetts	8	Texas	3
Maryland	1	Virginia	8
Michigan	12	Washington	1
North Carolina	11	Wisconsin	1
North Dakota	1	Wyoming	1
Nebraska	1		

[36] States omitted from this table did not have active PACE Organizations in 2017.

Table 15: Audit Scores by PACE Organization

PACE Organization	2017 Audit Score
VIA CHRISTI HEALTHCARE OUTREACH FOR ELDERS, INC.	9
RIVERSIDE RETIREMENT SERVICES, INC.	8.4
COMPLETE HEALTH WITH PACE	5.8
TOTAL LONGTERM CARE, INC. (CO)	5.2
ROCKY MOUNTAIN HEALTH CARE SERVICES	4.6
VOANS SENIOR COMMUNITY CARE OF MICHIGAN, INC.	4.4
NORTHLAND PACE PROGRAM	4.4
THE WASHTENAW PACE	4
TOTAL LONGTERM CARE, INC. (CA)	4
CAROLINA SENIORCARE	4
LIFE PACE	3.8
INDEPENDENT LIVING FOR SENIORS, INC.	3.8
HOPE HOSPICE AND COMMUNITY SERVICES, INC.	3.6
LIFE AT ST. FRANCIS HEALTHCARE, INC.	3.2
PACE SOUTHEAST MICHIGAN	3
GENESYS REGIONAL MEDICAL CENTER, INC.	3
HUMBOLDT SENIOR RESOURCE CENTER, INC.	3
LUTHERAN SENIOR HEALTHCARE, INC.	3
TOTAL LIFE HEALTHCARE	2.8
SIOUXLAND PACE, INC.	2.8
LUBBOCK REGIONAL MENTAL HEALTH MENTAL RETARDATION	2.8
VIECARE BEAVER, LLC	2.8
FRANCISCAN ACO, INC.	2.8
VALIR PACE FOUNDATION	2.8
HARBOR HEALTH SERVICES	2.6
COMMUNITY ELDERCARE OF SAN DIEGO	2.6
PACE NEBRASKA	2.6
CENTER FOR ELDERS INDEPENDENCE	2.6
PACE IOWA	2.6
BLUESTEM PACE, INC.	2.4
MIDLAND CARE CONNECTION	2.4
SUTTER HEALTH SACRAMENTO SIERRA REGION	2.4
THE METHODIST OAKS	2.4
SENIOR CARE CONNECTION, INC.	2.2
FLORIDA PACE CENTERS, INC.	2.2
LIFE ST. MARY	2.2
APPALACHIAN AGENCY FOR SENIOR CITIZENS, INC.	2.2
MERCY LIFE, INC.	2.2

PACE Organization	2017 Audit Score
NEWCOURTLAND LIFE PROGRAM	2.2
PENNSYLVANIA PACE, INC.	2
CENTRAL VALLEY MEDICAL SERVICES CORPORATION	2
MERCY LIFE OF ALABAMA	2
TOTAL SENIOR CARE, INC.	2
PACE OF SOUTHWEST MICHIGAN, INC.	2
THE CASCADE PACE, INC.	1.8
SENIOR LIFE YORK, INC.	1.8
BIENVIVIR SENIOR HEALTH SERVICES	1.8
SAINT JOSEPH PACE	1.8
CAMBRIDGE PUBLIC HEALTH COMMISSION	1.6
SENIORLIFE WASHINGTON, INC.	1.6
ELDERHAUS INC.	1.6
CENTRO DE SALUD DE LA COMUNIDAD DE SAN YSIDRO	1.4
MOUNTAIN EMPIRE OLDER CITIZENS, INC.	1.4
FRANCISCAN PACE, INC.	1.2
PITTSBURGH CARE PARTNERSHIP, INC.	1.2
PIEDMONT HEALTH SERVICES, INC.	1.2
SERENITY CARE, INC.	1.2
COMMUNITY CAREPARTNERS, INC.	1.2
FALLON HEALTH WEINBERG, INC.	1.2
SPIRITTRUST LUTHERAN LIFE	1.2
COMMUNITY CARE, INC.	1.2
SENIOR TOTAL LIFE CARE, INC.	1
INOVACARES	1
GEISINGER COMMUNITY HEALTH SERVICES	1
STAYWELL SENIOR CARE, INC.	1
A&D CHARITABLE FOUNDATION, INC.	1
TRINITY HEALTH LIFE PENNSYLVANIA, INC.	0.8
PACE ORGANIZATION OF RHODE ISLAND	0.8
VOANS SENIOR COMMUNITY CARE OF COLORADO, INC	0.8
MCGREGOR PACE	0.8
VIECARE ARMSTRONG, LLC	0.8
UPHAMS CORNER HEALTH COMMITTEE, INC.	0.8
ACUTE CARE HEALTH SYSTEM, LLC	0.6
PACE @ HOME, INC.	0.6