National PACE Association Model State Reporting Framework Project

Gap Analysis

Compiled by IBM Watson Health

Introduction:

The purpose of this gap analysis was to identify metrics reported by Managed Long-Term Services and Supports (MLTSS) plans to states and compare them to metrics reported by PACE organizations. The analysis resulted in the development of two distinct gaps: Gap 1 is defined as MLTSS reporting requirements that may not be reported by or may not be applicable or appropriate to PACE organizations; and Gap 2 is defined as unique attributes of PACE programs that are not captured in typical MLTSS reporting.

Approach:

Gap 1

The research team worked with NPA and a work group comprised of PACE organizations to select a total of eight MLTSS programs from five states, representing a range of MLTSS model types and level of prescriptiveness in reporting requirements. The team reviewed reporting requirements for MLTSS plans using contract language, supplemental materials such as program or reporting manuals, and other resources contributed by PACE organizations. Each measure collected was categorized into one of three domains: cost, outcomes, and utilization. Work group members assessed whether or not these or similar measures are currently reported by PACE, and the appropriateness of the measures for PACE.

The rows in the Gap 1 tab are color-coded to indicate what is typically reported by PACE organizations:

Green rows indicate metrics that many PACE organizations currently report to states;

Yellow rows indicate metrics that may be reported by PACE to states in part, are being reported by PACE to CMS, or are currently proposed by CMS for federal reporting; and

Red rows indicate metrics that PACE organizations generally do not report.

Gap 2

The research team conducted two focus groups of PACE organizations, 11 key informant interviews with PACE and state officials, and seven work group meetings. The team analyzed information collected and identified unique attributes of the PACE model that are not captured in standard MLTSS reporting. These PACE attributes represent additional value of the PACE model that should be captured in any measurement and reporting of the PACE model.

The rows in the Gap 2 tab describe the unique attributes of PACE that are not captured in standard MLTSS reporting.

Gap Analysis 1: Data Elements Reported in MLTSS, and Their Reporting Status in PACE

KEY:
Yes- reported in many states (green)
In Part- reported in few states; or similar data reported; or reported to CMS (yellow)
No- not reported (red)

No.	Domain	Reported in MLTSS	Comments
2	Cost	Adequate working capital	Other items to note for PACE: there are CMS fiscal soundness criteria for managed care; PACE capital reserve requirements are different than those required of MCOs.
3	Cost	Audit reports	Some PACE orgs complete fully audited financial reporting; others do not. Duplicative with item 4 below.
4	Cost	Financial reviews and independent audits	Duplicative with item 3 above.
11	Cost	Part D revenue and expenditure	PACE orgs report Part D revenue and expenditures to CMS.
13	Cost	Program Expenditures	All PACE orgs report this data but not standardized; some programs also complete voluntary PMPM reports to NPA.
14	Cost	Provider Payment	All PACE orgs report this data, but not standardized; included in annual audited financial statements.
16	Cost	Revenue and costs broken out by delegated networks	PACE orgs report revenue/costs by internal expenses, PACE center expenses, external medical and service expenses; voluntary PMPM reports to NPA; included in annual audited financial statements
19	Cost	Total dollars recovered from third party payors for MMP members; and total dollars recovered through subrogation, coordination of benefits and worker's compensation.	Standard PACE reporting; financial ration benchmarking reports but not uniformly reported
25	Outcome	Consumer satisfaction with HCBS	Most PACE orgs report, but not standardized; duplicative with item 31
31	Outcome	Enrollee satisfaction	Most PACE orgs report, but not standardized; iSAT performed by Vital Research and employed in California; duplicative to item 25 above.
100	Utilization	Nursing Facility Utilization Measures	Most PACE orgs report, but not standardized; good to measure PACE's ability to keep participants in the least restrictive environment
1	Cost	Adequate provision against the risk of insolvency	Duplicative to measure 2 above
5	Cost	Financial soundness of rates	PACE provides extensive cost reporting that should enable the state to determine actuarial soundness of rates.
6	Cost	Incurred claims and the amount paid per month	
17	Cost	Revenue and costs broken out by demonstration population	PACE reports costs for its population; voluntary PMPM reports submitted to NPA
18	Cost	Risk corridors and reinsurance	Reinsurance is relevant to PACE but not risk corridors
20	Cost	Total dollars recovered from Third Party Liability or claims not paid due to other insurance coverage or Medicare coverage.	
24	Outcome	CAHPS data (HEDIS)	PACE orgs report experience of care, but not standardized. Existing CAHPS surveys (e.g., HCBS CAHPS) have not been tested in PACE
63	Utilization	Annual flu vaccine (HEDIS)	Similar measure reported to CMS via HPMS
64	Utilization	Care for Older Adults -- Advanced care planning (HEDIS)	Similar measure is coming in future publicly reported CMS measures.
65	Utilization	ED utilization (HEDIS)	ED utilization is reported but not HEDIS.
75	Utilization	Potentially Preventable Hospital Admissions (HEDIS)	Reported in some states; but "potentially preventable" not well-defined.
80	Utilization	Number of beneficiaries using LTSS, by service	Reported in some states by some PACE orgs.
102	Utilization	Percent of High-Risk Patients with Pressure Ulcers (Long-Stay)	This is coming in future publicly reported CMS measures; currently reported as part of CMS PACE Quality Monitoring
103	Utilization	Rate of nursing home admissions from community	
104	Utilization	Rate of nursing home admissions from hospital	
107	Utilization	Access to behavioral health services and counseling	BH utilization is reported by some Pace orgs via Data PACE 3
108	Utilization	All pharmacy encounter data plus all adjustments made by MMP	PACE reports Part D encounters to CMS
116	Utilization	Encounter data	Challenges include how to capture PACE extras not recognized on 837; how to account for IDT and other day center services; infrastructure needed-- involves both claims and EMR. Requires significant infrastructure.
121	Utilization	Medication utilization	PACE reports Part D encounters to CMS; OTC and excluded prescriptions generally not reported
124	Utilization	Pneumococcal vaccine	Reported to CMS via HPMS
7	Cost	Medicaid capitation payments	States already know what capitation payments they are making to PACE orgs
8	Cost	Medicaid only MLR	MLR may be different than other MLTSS programs; may not be specifically comparable.
9	Cost	Medical loss ratio (MLR)	Need to ensure all PACE services are in the formula
10	Cost	Overpayment recoveries	
12	Cost	Payment Discrepancy	
15	Cost	Reconciliation of the year-to-date paid claims reported in the Financial Statistical Reports to the appropriate paid dollars.	
21	Outcome	Adherence for Hypertension (ACEI or ARB)	May not be directly applicable to PACE, may need to be adjusted for the PACE population
22	Outcome	All HEDIS measures related to Medicaid (HEDIS)	HEDIS measures may need to be risk adjusted, or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants
23	Outcome	Avoidance of Antibiotic Medication for People with Acute Bronchitis (HEDIS)	HEDIS measures may need to be risk adjusted, or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants
26	Outcome	Controlling Blood Pressure (HEDIS)	HEDIS measures may need to be risk adjusted, or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants
27	Outcome	Diabetes care: blood sugar controlled (HEDIS)	HEDIS measures may need to be risk adjusted, or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants

28	Outcome	Diabetes Long-Term Complications Admission Rate	May not be directly applicable to PACE, may need to be adjusted for the PACE population
29	Outcome	Diabetes short-term Complications Admission Rate (CMS Core Set -- AHRQ)	May not be directly applicable to PACE, may need to be adjusted for the PACE population
30	Outcome	Employment report	May not be directly applicable to PACE, may need to be adjusted for the PACE population
32	Outcome	Getting Appointments and Care Quickly	Challenges in how this would be measured for PACE, given delivery of services in Center
33	Outcome	Getting Needed Care	Challenges in how this would be measured for PACE, given delivery of services in Center
34	Outcome	Getting Needed Prescription Drugs	Challenges in how this would be measured for PACE, given delivery of services in Center
35	Outcome	Improving or Maintaining Mental Health	
36	Outcome	Improving or Maintaining Physical Health	
37	Outcome	LDL-C controlled	May not be directly applicable to PACE, may need to be adjusted for the PACE population
38	Outcome	Lower Extremity Amputation among Patients with Diabetes Rate	May not be directly applicable to PACE, may need to be adjusted for the PACE population
39	Outcome	Medication Adherence for Cholesterol (statins) (HEDIS)	HEDIS measures may need to be risk adjusted, or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants
40	Outcome	Medication Adherence for Oral Diabetes medications	May not be directly applicable to PACE, may need to be adjusted for the PACE population
41	Outcome	Medication Management for People with Asthma (HEDIS)	HEDIS measures may need to be risk adjusted, or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants
42	Outcome	Mortality data	May not be directly applicable to PACE, may need to be adjusted for the PACE population
43	Outcome	Number of individuals who went from community to hospital to nursing home and remained in nursing home	Not directly aligned with existing PACE metrics that collect information on percent of active participants at quarter end with permanent placement living situation
44	Outcome	Nursing Facility and ICF/IID transition to Community	Not directly aligned with existing PACE metrics that collect information on percent of active participants at quarter end with permanent placement living situation
45	Outcome	Participants using consumer direction in HCBS	This is MLTSS specific; different model of care than PACE.
46	Outcome	Percent of Enrollees with documented discussions of care goals.	This is coming in future publicly reported CMS measures.
47	Outcome	Percent of Enrollees with initial health assessments completed within 90 days of enrollment	Shorter timeframe (30 days) required for PACE, so measure would need to be modified.
48	Outcome	Potentially Harmful Drug-Disease Interactions in the Elderly (HEDIS)	HEDIS measures may need to be risk adjusted or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants.
49	Outcome	Potentially Preventable Complications	
50	Outcome	Provider preventable conditions	
51	Outcome	Rand Health Medical Outcomes Study	
52	Outcome	Reducing the Risk of a Fall (HEDIS)	HEDIS measures may need to be risk adjusted, or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants; not directly aligned with existing PACE reporting as this focuses on total falls.
53	Outcome	Reduction in Emergency Department Use for seriously mentally ill and substance use disorder enrollees	
54	Outcome	Rheumatoid arthritis management (HEDIS)	HEDIS measures may need to be risk adjusted, or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants.
55	Utilization	Access to Primary Care Physician (HEDIS)	Currently measuring primary care encounters for physicians, physician assistants and nurse practitioners.
56	Utilization	Access to routine care	Much routine care is provided in the PACE center
57	Utilization	Access to service coordination	Challenges in how this would be measured for PACE
58	Utilization	Access to special therapies	Challenges in how this would be measured for PACE
59	Utilization	Access to Specialists	Currently information collected on specialist encounters including audiologist, dentist, optometrist, podiatrist, psychiatrist, medical outpatient specialist
60	Utilization	Adult BMI Assessment (HEDIS)	HEDIS measures may need to be risk adjusted or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants.
61	Utilization	Adult Weight Screening and Follow-Up (HEDIS)	HEDIS measures may need to be risk adjusted or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants.
62	Utilization	Angina w/o Procedure Admission Rate	Challenges in how this would be measured for PACE
66	Utilization	Eye examination every 2 years	
67	Utilization	Hearing examination every 2 years	
68	Utilization	Medication Review -- Older Adults (HEDIS, 66 yrs+)	
69	Utilization	Osteoporosis Management in Women who had a Fracture (HEDIS)	HEDIS measures may need to be risk adjusted or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants.
70	Utilization	Perforated Appendix	
71	Utilization	Persistence of Beta-Blocker Treatment after Heart Attack (HEDIS)	HEDIS measures may need to be risk adjusted or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants.
72	Utilization	Pharmacotherapy Management of COPD Exacerbation (HEDIS)	HEDIS measures may need to be risk adjusted or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants.
73	Utilization	Plan All-Cause Readmissions (HEDIS)	Can currently report this if diagnosis code is provided at time of admission; some POs report % 30 day admission rate
74	Utilization	Potentially Preventable Emergency Department Visits	Currently can collect information on the number of emergency room visits; potentially preventable is not well-defined

76	Utilization	Potentially Preventable Hospital Readmissions (HEDIS)	HEDIS measures may need to be risk adjusted or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants.
77	Utilization	Urinary Tract Infection Admission Rate	
78	Utilization	Use of high risk medications in the elderly (HEDIS)	
79	Utilization	Use of spirometry testing in the assessment and diagnosis of COPD (HEDIS)	HEDIS measures may need to be risk adjusted or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants.
81	Utilization	Adult Asthma Admission Rate (HEDIS)	HEDIS measures may need to be risk adjusted or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants.
82	Utilization	Annual Monitoring for Persistent Medications (HEDIS, 18+yrs)	Duplicative to measure 68 above.
83	Utilization	Bacterial Pneumonia Admission Rate	
84	Utilization	Comprehensive Diabetes Care (HEDIS)	HEDIS measures may need to be risk adjusted or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants.
85	Utilization	Congestive Heart Failure Admission Rate	Disease-specific admission rates may be challenging for PACE to collect
86	Utilization	COPD or Asthma in Older Adults Admission Rate (AHRQ CMS Core)	Disease-specific admission rates may be challenging for PACE to collect
87	Utilization	Dehydration Admission Rate	Disease-specific admission rates may be challenging for PACE to collect
88	Utilization	Diabetes Blood Pressure Controlled	Challenges in how this would be measured for PACE
89	Utilization	Diabetes Care -- HbA1c Control	Challenges in how this would be measured for PACE
90	Utilization	Diabetes Care -- HbA1c Testing	Currently can collect information on the % of Medicare participants with Diabetes who receive a A1C test within 12 months.
91	Utilization	Diabetes Care -- LDL Screening	Challenges in how this would be measured for PACE
92	Utilization	Diabetes care: eye exam	Challenges in how this would be measured for PACE
93	Utilization	Diabetes care: kidney disease monitoring	Challenges in how this would be measured for PACE
94	Utilization	Diabetes Care; Reducing the risk of falling	Challenges in how this would be measured for PACE
95	Utilization	Diabetes kidney function test	Challenges in how this would be measured for PACE
96	Utilization	High Risk Medication, Diabetes Treatment	Challenges in how this would be measured for PACE
97	Utilization	Hypertension Admission Rate	Disease-specific admission rates may be challenging for PACE to collect
98	Utilization	Home care utilization	Very important to PACE; currently can collect skilled home care encounters
99	Utilization	Medical Attention for Nephropathy	Challenges in how this would be measured for PACE
101	Utilization	Percent of enrollees who had a pain screening or pain management plan at least once per year (HEDIS)	HEDIS measures may need to be risk adjusted or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants.
105	Utilization	Rebalancing from Institutional to Community Settings	Duplicative to measure 44
106	Utilization	Uncontrolled Diabetes Admission Rate	Disease-specific admission rates may be challenging for PACE to collect
109	Utilization	Antidepressant Medication Management (HEDIS)	HEDIS measures may need to be risk adjusted or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants. Additionally, may be more applicable to measure outcomes related to IP psych admits.
110	Utilization	Breast Cancer screening (HEDIS)	HEDIS measures may need to be risk adjusted or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants.
111	Utilization	Cervical Cancer screening (HEDIS)	HEDIS measures may need to be risk adjusted or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants.
112	Utilization	Chlamydia Screening (HEDIS)	HEDIS measures may need to be risk adjusted or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants.
113	Utilization	Participants who have entered or exited a community living placement	Additional measures can enhance this metric
114	Utilization	Cholesterol screening	Challenges in how this would be measured for PACE
115	Utilization	Colorectal Cancer screening (HEDIS)	HEDIS measures may need to be risk adjusted or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants.
117	Utilization	Enrollee-specific prescription data (MDS 2.0)	Currently can track prescription drug encounters for the Medicare population
118	Utilization	Follow-up visit after hospitalization for mental illness (HEDIS)	HEDIS measures may need to be risk adjusted or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants.
119	Utilization	Individuals using the nursing facility for short stays	Currently can collect information on the days spent by participants in a short term nursing facility placement
120	Utilization	Initiation and engagement of AOD treatment (HEDIS)	HEDIS measures may need to be risk adjusted or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants.
122	Utilization	Mental Health Utilization (HEDIS)	HEDIS measures may need to be risk adjusted or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants.
123	Utilization	Multiple Psychotropic Medications	
125	Utilization	Post-Discharge Services Report	Challenges in how this would be measured for PACE
126	Utilization	Prescription patterns for selected medications	Challenges in how this would be measured for PACE
127	Utilization	Prevention/Intervention Services for participants with I/DD	Generally not relevant in the PACE population
128	Utilization	Psychiatric bed days	Currently can collect information on inpatient psychiatric days
129	Utilization	Psychiatric/RTF Readmission Report	
130	Utilization	Screening for Clinical Depression and Follow-up Care (CMS Core)	Currently can collect information on % of Medicare eligible participants with a diagnosis of depression; data obtained from PDAC.
131	Utilization	Screening for Dementia	
132	Utilization	Services utilized with Out of Network providers	Challenges in how this would be measured for PACE

133	Utilization	Tobacco Use Assessment and Tobacco Cessation Intervention (HEDIS)	HEDIS measures may need to be risk adjusted or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants.
134	Utilization	Unhealthy alcohol use: Screening and Brief Counseling (HEDIS)	HEDIS measures may need to be risk adjusted or developed separately for older adults in order to be meaningful; currently as written, they are not generalizable to PACE participants.

	A	B	C	D
1	**Gap Analysis 2: Key PACE Attributes Not Captured by Common MLTSS Reporting**			
2	**No.**	**Domain**	**PACE Attribute**	**Comments**
3	G2-1	Cost	Capital expenses and building costs: furniture; equipment; construction; modernization; leasehold improvements; land and related costs; facility operations	MLTSS plans may have expenses related to their office space, but PACE provides care onsite at their Centers. PACE is typically required to meet square footage requirements and safety standards for Adult Day Care. Additionally, PACE programs may have dental chairs, IV units, bladder scanner, and other equipment found in an urgent care setting.
4	G2-2	Cost	Transportation costs, including but not limited to transportation coordinators, drivers, dispatchers, supplies, and repairs	PACE transportation is integral to the model of care and more extensive than in MLTSS, where typically it is a benefit limited to getting members to appointments. PACE centers typically have operational costs related to transportation.
5	G2-3	Utilization	Utilization of services at PACE centers, including direct support professionals, therapists, palliative care and nutritionists	The intensity and types of services at PACE centers surpasses a typical adult day center.
6	G2-4	Utilization	Interdisciplinary team utilization	The PACE IDT process is far more extensive than in MLTSS. It is in-person and involves many clinical and non-clinical staff. In MLTSS, care coordination is reported, but this generally includes only the time of the care coordinator. MLTSS IDTs are usually virtual and involve few providers. PACE reporting in this area should capture intensity and broad participation in the IDT process.
7	G2-5	Utilization	Utilization of services not traditionally covered by Medicaid or Medicare, such as, but not limited to, spiritual care/chaplain services outside of hospice, pet care, pest control services, reminder calls, staff to escort clients to appointments, housing support and other social services.	Non-traditional, flexible services are a hallmark of PACE, and are not captured through encounters or other utilization reporting. MLTSS plans may offer and report on "value-added" services; however, PACE has more flexibility in the breadth of non-traditional services provided. Typically, value-added services must be defined for the MLTSS benefit year and offered to all members.