DA: November 29, 2017

TO: Centers for Medicare and Medicaid Services
FR: National PACE Association

RE: **NPA Comments to CMS on Development, Implementation, and Maintenance of Quality Measures for the Programs of All-Inclusive Care for the Elderly (PACE) – Stream 2**

On behalf of the National PACE Association (NPA), our 119-member PACE organizations (POs) in 30 states, and the 38,000 medically complex, functionally and/or cognitively impaired individuals we serve, we write to offer our feedback in response to the Centers for Medicare and Medicaid Services' (CMS) request for comment on its four proposed PACE quality measures (Stream 2). NPA supports CMS' efforts to improve the quality of health care for PACE participants in the United States. We are aware of the formidable challenges to measuring quality effectively and providing this information in a manner that is reliable, valid, and meaningful. NPA has carefully reviewed the draft quality measures and all related materials provided and offers the following comments related to the potential implementation of these measures.

GENERAL COMMENTS

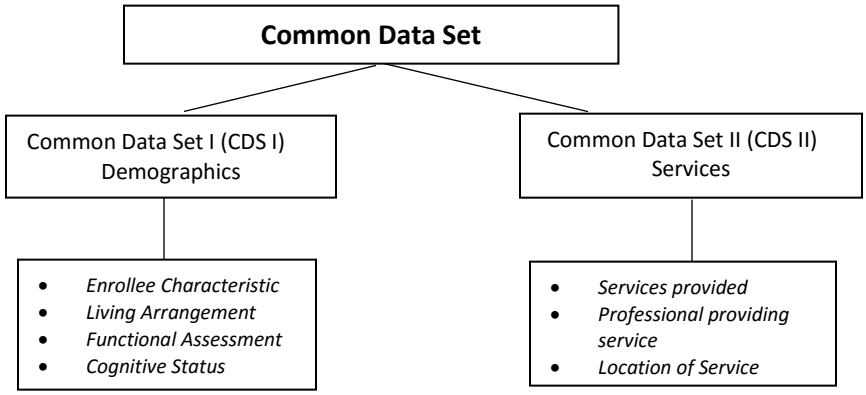
NPA appreciates CMS' efforts to develop, adapt, and implement quality measures for PACE. NPA cautions CMS and its contractors as they seek to adapt existing quality measures to PACE given the variability in POs' size, PACE participants' needs and abilities, and programmatic differences between PACE and other providers of care (e.g., nursing facilities). It is vital to consider the unique characteristics of PACE in considering the potential to make comparisons between POs, while balancing the needs of the National Quality Forum, states, and other stakeholders in comparing PACE to other service delivery options (e.g., managed care). We recommend that Econometrica continue to reference PACE regulations and guidance documents to glean insight regarding how to best define and identify measures that will meet the needs of PACE participants. We encourage CMS/Econometrica to harmonize the measure definitions of the proposed measure set with the definitions and reporting requirements associated with current Level I and II reporting. This will mitigate the use of varying definitions for the same data element, assure consistency amongst data reporting requirements, and eliminate duplication in reporting.

Additionally, POs' performance on quality measures should reflect their ability to respond to participants' individual preferences and goals. In PACE, participants' goals for care can be categorized into three broad areas: promotion of longevity, optimization of function, and comfort care. Given the heterogeneity of the PACE population, we encourage CMS/Econometrica to consider the impact of differences in participant care goals, as well as the characteristics of participants, on the measure results.

Lastly, as part of the measure testing phase, NPA recommends that CMS/Econometrica explore and attempt to understand the degree to which standardized and complete data needed to calculate valid and reliable measures are available from POs. Unlike nursing homes, home health care agencies and many other provider-based care options for PACE-like populations, PACE lacks a common assessment instrument and data standard. To address this need, NPA has developed a common data platform across all PACE Organizations referred to as the *Common Data Set (CDS) [see Figure 1].* The CDS contains a standardized dictionary of definitions for data elements to be collected by POs – demographics (CDS I)

and services (CDS II). The creation of a standardized participant-level data set will allow for better defining the PACE population; create opportunities to measure the value and performance of PACE; support improved and more efficient benchmarking; distinguish PACE from emerging delivery models; and foster the evolution and adoption of EHRs for PACE.

Figure 1.



Further, as a provider-based managed care model, PACE organizations do not generally generate claims for services rendered by their direct-care staff to PACE enrollees. Consequently, this lack of data may fundamentally impede the ability to calculate certain measures. For the purpose of reporting, since much of the data will need to be captured electronically, it will be important to understand the degree to which POs may use and/or can generate data from their electronic health record (EHR) systems.

It should be noted that not all POs have an electronic health record (EHR) system and therefore would be required to establish manual processes to maintain data tracking logs which will be quite burdensome. If a PO does have an electronic health record that can be queried, system enhancements may be required to meet expected data collection and reporting requirements. These enhancements will result in additional financial expenses incurred by the PO.

Many POs may also have data requested stored across multiple systems within their organizations—making data collection a challenge. The absence of financial means, capacity, and time to support the development of a large data warehouse to aggregate the data from each system and generate reports are significant challenges faced by our membership.

We request CMS to consider the data collection and reporting burden that POs will incur in implementing these measures. Requiring data collection and reporting that may not be relevant to the measure calculation not only increases the administrative burden to the PACE program, but may also result in the inappropriate use of resources.

We encourage CMS to share trend data and PO-specific performance results that may be used to evaluate the performance of POs against recognized quality standards, with a recognition that measuring the quality of health care is a necessary step in the process of improving health care quality. NPA supports effective utilization of performance indicators, as it is a critical component of continuous performance measurement. We anticipate that the implementation of PACE quality measures will support initiatives specifically targeted to improve patient outcomes. We request that CMS be

transparent in communicating the purpose of measure reporting (i.e., quality improvement; accountability; public reporting).

PERCENTAGE OF PARTICIPANTS WITH AN ADVANCE DIRECTIVE OR SURROGATE DECISION-MAKER DOCUMENTED & PERCENTAGE OF PARTICIPANTS WITH ANNUAL REVIEW OF THEIR ADVANCE DIRECTIVE OR DECISION-MAKER DOCUMENT

Measure Intent

NPA supports the intent of the *Percentage of Participants with an Advance Directive or Surrogate Decision-Maker Documented in the Medical Record* measure. We also support the intent of the *Percentage of Participants with Annual Review of their Advance Directive or Surrogate Decision-Maker Document* measure.

Measure Definitions

The measure definitions indicate that an *advance directive* includes "a written or oral statement by a participant about treatment preferences documented in the electronic medical record or recorded on a paper copy and placed in the medical record." It is recommended that specific criteria be delineated to assure that both written and oral statements encompass all elements necessary to meet legal requirements.

We request clarity on the exclusion criteria, specifically related to a participant's inability to provide an advance directive or identify a surrogate decision maker. It is recommended that the definition be expanded to include specific details regarding the circumstances in which a participant may not be able to provide an advance directive or identify a surrogate decision maker. We also request clarity on the rationale to exclude participants enrolled in PACE for less than six (6) months. Is the intent to limit this measure to those participants enrolled in PACE for greater than six (6) to provide PACE Organizations sufficient time to engage in an end of life discussion with participants?

Feasibility of Data Collection

NPA is unclear of the rationale for documenting the participant residence for these measures. It is our sense that this data element does not provide meaningful information as it relates to these measures and should be removed as it creates an undue administrative burden.

If a final determination is made to report this data element, we offer the following recommendations to better align the types of participants' residence with descriptions currently utilized by POs.

- **Own home**: Modify to align with CMS PACE Quality Indicator: Emergency Room Visits data reporting requirements:
    a. *Private Home/Apartment – Alone*
    b. *Private Home/Apartment – with family/caregivers*
    c. *Private Home/Apartment – with roommate*
- **Assisted Living Facility:** No modification.
- **Residential Hospice:** Remove this place of residence.
- **Rehabilitation Facility**: Combine with Skilled Nursing Facility and align with CMS PACE Quality Indicator: Emergency Room Visits data reporting requirements – *Nursing Facility – Short Term.*
- **Skilled Nursing Facility**: Align with CMS PACE Quality Indicator: Emergency Room Visits data reporting requirements – *Nursing Facility – Short Term.*
- ***Nursing Facility – Long Term:*** Include to align with CMS PACE Quality Indicator: Emergency Room Visits data reporting requirements.
- **Other**: No modification.

- **Not documented**: No modification.

We request clarification on data reporting requirements for participants meeting the exclusionary criteria for these measures. According to the exclusion criteria noted, participants with written documentation in the medical record that reflects that the participant did not wish or was unable to provide an advance directive or identify a surrogate decision-maker are excluded from both the numerator and denominator. Furthermore, the "Auto-Generated Participant Number" is reflected as the total number of non-excluded participants. This appears to conflict with the available responses for "Participant has documentation of an advance directive or surrogate decision-maker, or meets exclusionary criteria", specifically #5 #6, and #7.

Calculation Methodology

Regarding stratification, we request insight on how CMS will utilize PACE Organization characteristics for stratification purposes. As CMS/Econometrica finalizes the stratification variables, we recommend stratifying the measure results by variables, including participant characteristics, that may directly influence measure results.

PERCENT OF PARTICIPANTS NOT IN NURSING HOMES

Measure Intent

NPA supports the intent of the *Percent of Participants Not in Nursing Homes* measure, given the mission of PACE is to reduce the need for and utilization of nursing home care, although not to avoid it all together. It should also be noted that the proportion of PACE participants who reside in nursing homes is also a function of access to alternative residential setting. Taking this into account will be very important in comparing performance on this measure across POs.

Measure Definitions

While the number of PACE participants residing in nursing homes should be low, the fact that some PACE participants need nursing home care as they age, and their functional status deteriorates due to the natural progression of illness is not a direct reflection of the performance of the PACE program. We therefore recommend exclusion criteria that considers the natural progression of chronic conditions and the related impact on the participant's functional status.

As it relates to exclusion criteria for both the numerator and denominator, clarification is requested for the difference between the exclusion of persons who were not enrolled as PACE participants in the reporting quarter as opposed to the exclusion of persons who were enrolled as PACE participants for less than one (1) day in the reporting quarter.

We request further clarification of the measure description, specifically as it relates to the 90-day threshold utilized to classify the nursing home as a participant's "usual place of residence." The current measure definitions do not take into consideration nursing home stays that may exceed 90 days, yet don't meet the criteria for long-term nursing home placement. For example, a PO may need to admit a participant to a nursing home for a temporary stay that may exceed 90-days, with the intent to transition the participant back to the community.

Feasibility of Data Collection

No comments.

Calculation Methodology
Regarding stratification, we request insight on how CMS will utilize PACE Organization characteristics for stratification purposes. As CMS/Econometrica finalizes the stratification variables, we recommend that consideration be given to participant characteristics, as well as POs access and use of alternative residential settings, which may be limited due to geographic area, state specific guidelines, or other uncontrollable factors.

PERCENTAGE OF PARTICIPANTS WITH DEPRESSION RECEIVING TREATMENT

Measure Intent
NPA supports the intent of the *Percentage of Participants with Depression Receiving Treatment* given the prevalence of depression among the geriatric population.

Measure Definitions
NPA has no significant concerns with the definitions outlined for the *Percentage of Participants with Depression Receiving Treatment* measure, yet requests clarification on the rationale to include expired participants in both the numerator and denominator.

Feasibility of Data Collection
NPA is unclear as to why Econometrica/CMS is proposing to have POs report so much data in support of this measure. Given the uncertainty of the rationale behind the reporting of the data variables delineated in support of this measure, we offer the following observations.

Participant residence - It is our sense that this data element does not provide meaningful information as it relates to this measure and should be removed as it creates an undue administrative burden. If a final determination is made to report this data element, we offer following recommendations to better align the types of participant residence with descriptions currently utilized by POs.

- **Own home**: Modify to align with CMS PACE Quality Indicator: Emergency Room Visits data reporting requirements:
    a. *Private Home/Apartment – Alone*
    b. *Private Home/Apartment – with family/caregivers*
    c. *Private Home/Apartment – with roommate*
- **Assisted Living Facility:** No modification.
- **Residential Hospice:** Remove this place of residence.
- **Rehabilitation Facility**: Combine with Skilled Nursing Facility and align with CMS PACE Quality Indicator: Emergency Room Visits data reporting requirements – *Nursing Facility – Short Term.*
- **Skilled Nursing Facility**: Align with CMS PACE Quality Indicator: Emergency Room Visits data reporting requirements – *Nursing Facility – Short Term.*
- ***Nursing Facility – Long Term:*** Include to align with CMS PACE Quality Indicator: Emergency Room Visits data reporting requirements.
- **Other**: No modification.
- **Not documented**: No modification.

Dementia screening, Dementia screening tool used, and Dementia diagnosis - It appears that the intent is to review the process by which POs identify depression among their participant populations, distinguishing between participants with and without dementia in this regard. We request clarification on the rationale behind this distinction for the PACE program, which is inconsistent with existing NQF

measures for other care settings (i.e., NQF #3148 - Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan and NQF #3132 Preventive Care and Screening: Screening for Depression and Follow-Up Plan).

Depression screening, Depression screening tool used, Depression diagnosis, and Treatment for depression, and Type of treatment - We request clarification on the applicability of the "Depression screening", "Depression screening tool used" and "Type of treatment" data elements as it relates to this measure and recommend that they be removed as it will create an undue administrative burden. To reduce the administrative burden, it is recommended that only "Depression diagnosis" and "Treatment for depression" data elements be reported, as these are the only elements that are utilized for the measure calculations.

Calculation Methodology

Regarding stratification, we request insight on how CMS will utilize PACE Organization characteristics for stratification purposes.

Thank you for taking the time to consider our feedback, concerns, and recommendations. Please direct any questions to Mia Phifer, vice president of Quality at miap@npaonline.org.

Sincerely,

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