Public Comment Report

Project Title:

Development, Implementation, and Maintenance of Quality Measures for the Programs of All-Inclusive Care for the Elderly (PACE).

Dates:

The Call for Public Comment ran from October 30, 2017 to November 30, 2017.
The Public Comment Summary was made on December 20, 2017.

Project Overview:

The Centers for Medicare and Medicaid Services (CMS) has contracted with Econometrica, Inc., to adapt, implement, and maintain quality measures for PACE nationwide. The contract name is Development, Implementation, and Maintenance of Quality Measures for the Programs of All-Inclusive Care for the Elderly. The contract number is HHSM-500-2013-13006I. The contract was awarded for a one (1)-year base period (or Base Year), with an option for three (3) additional years.

As part of the measure development process, CMS has requested interested parties to submit comments on the candidate or concept measures that may be suitable for this project. This comment request included the following four (4) measures.

- PACE Participants With an Advance Directive or Surrogate Decision Maker;
- PACE Participants With an Annual Review of Their Advance Directive or Surrogate Decision Maker;
- PACE Participants Not in Nursing Homes; and
- PACE Participants With Depression Receiving Treatment.

Project Objectives:

The primary objectives of this project are to:

- Analyze existing quality measure sets to determine the extent to which they can be uniquely modified, refined, or enhanced for PACE.
- Focus on new areas of measurement during each year of the project.
- Conduct field tests to assess the feasibility of data collection for proposed measures.

Information About the Comments Received:

- Public comments were solicited by announcements made during stakeholder group meetings, email notifications, and memos distributed to PACE Account Managers and PACE Organizations.
- The Call for Public Comment was posted on the CMS Call for Public Comment Web site: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/PC-Currently-Accepting-Comments.html.
- In total, 18 unique email responses were received through the PACEQMcomments@econometricainc.com address provided as part of the Call for Public Comment:
    - 12 email responses were from unique PACE Organizations.
    - Two (2) email responses were from unique nongovernmental organizations.
    - One (1) email response was from the National PACE Association (NPA).
    - One (1) email response was from a State organization.

- One (1) email response was from a private consulting firm.
- One (1) email response was from a physician, who is in private practice.

Stakeholder Comments—General

Six (6) email responses expressed support for the measurement topics included in Stream 2. However, six (6) email responses expressed concern over the burden of data collection. The specific concerns related to burden included the need for manual chart abstraction, potential for some data elements to be unavailable in their records, the number of data elements being collected, duplication of existing reporting that PACE Organizations (POs) participate in, and the lack of a common data set shared between these overlapping reporting requirements (e.g., Health Plan Management System (HPMS), National PACE Association's DataPACE).

TEP Recommendations

The Technical Expert Panel (TEP), which includes staff from multiple POs, was sensitive to the concerns over data collection burden. They suggested elimination or combination of quality measure data elements where possible. The TEP also discussed the need for clear information from CMS regarding the implementation of quality measures and how these new measures will impact current reporting, including HPMS reporting.

Response

We appreciate the comments in support of the effort to develop quality measures for PACE, and remain sensitive to issues surrounding data reporting burden. We describe specific data elements that have been combined or eliminated in response to public comment under the discussion of each measure below. We will also continue to refine data elements collected for each measure based on input and feedback from PACE Organizations that participate in reliability and feasibility testing.

It is important to note that, where possible, eMeasures will be developed for quality measures which pass testing and are approved for implementation by CMS. These eMeasures should reduce overall reporting burden for POs that have electronic medical records. Additionally, in cases where measures selected for implementation overlap with current Level 1 or Level 2 reporting, the new measures will replace the current reporting. That is, there will be no duplication between current and newly reported measures after implementation.

Stakeholder Comments—Advance Directive and Annual Review of Advance Directive

Stakeholders were generally supportive of the Advance Directive and Annual Review of Advance Directive measures, with only two (2) email responses expressing lack of support or alternative measures in this domain. Four (4) email responses requested clarification regarding specific portions of the measure specification, including clarification of types of documents which would be counted as advance directives for these measures, justification for excluding participants enrolled in PACE for less than six (6) months, and the choice of an annual timeframe for review. Four (4) email responses suggested changes or elimination of specific

data elements, including the collection of information regarding each participant's usual place of residence. Two (2) commenters expressed concerns about data collection burden for these measures.

TEP Recommendations

The TEP discussed data collection burden, and suggested eliminating the data element related to usual place of residence. The TEP also discussed the number of response choices for the data element documenting the presence of an advance directive or surrogate decision maker.

The TEP revisited their previous discussion and recommendations around the types of forms and documentation which will be counted as an advance directive for this measure (e.g., POLST, MOST, written or oral statement, living will, power of attorney, etc.). They still feel it is important to include all options presented rather than focusing on specific forms or state legal requirements.

The TEP also revisited previous discussion of the timing issues for this measure. A six (6) month exclusion was chosen based upon TEP and subject matter experts' opinions regarding the amount of time required to gain participant trust prior to engaging in end of life discussions. The annual timeframe for review was considered a minimum requirement, which does not preclude more frequent discussion due to change in condition or other factors. The TEP discussed the potential for requiring a review of the advance directive upon any significant change in the participant's condition (in response to a comment making suggesting this change). The TEP agreed that most PACE Organizations do operate under that practice, but that formalizing the measure to reflect that would likely lead to ambiguities in the data. Ultimately, they agreed that requiring an annual review, at minimum, is the most feasible approach for the measure.

Response

Based upon comments and TEP recommendations, we will remove the collection of usual place of residence from the data collection instrument prior to reliability and feasibility testing. The majority of requests for clarification of specific data elements are currently addressed in the existing data collection instructions, but the instructions will be reviewed for clarity prior to additional testing.

Based on feedback received from the TEP, the current list of documents accepted as advance directives for these measures, exclusions, and timeframes for review will be retained. Burden will be assessed using a post-data collection survey following reliability testing. Additional data elements may be reduced or combined based on results of Reliability and Feasibility testing.

Stakeholder Comments—Not in Nursing Homes

Five (5) email responses requested clarification regarding specific portions of the measure specification, including clarification of definition of being "in a nursing home" for the sake of this measure, either based on length of stay, or the type of facility the participant is staying in. Four (4) email responses addressed issues related to variations in housing availability, frailty,

age of the PO and other similar factors which might be expected to impact performance on this measure. The need for risk adjustment or other criteria to account for these issues was mentioned in three (3) email responses.

TEP Recommendations

The TEP revisited their previous discussion around defining a long-term nursing home placement for this measure, and continued to agree with a cutoff of 90 days as a long stay/placement. There was additional discussion regarding clarifying the measure specifications because there was confusion over whether this was intended to be a point in time measure, and how nursing home stays of greater than 90 days spanning multiple quarters should be counted.

Because a participant would need to be enrolled in PACE for at least 90 days to be counted as being in a nursing home for this measure, the TEP suggested that the specifications should be revised to include participants enrolled the entire quarter rather than "at least one (1) day" in the reporting quarter.

The issue of risk stratification or risk adjustment was also discussed, with the TEP acknowledging that all the factors mentioned by commenters could impact performance on this measure. The TEP acknowledged that they look forward to reviewing testing data to assess the extent to which risk adjustment is needed for this measure.

Response

We acknowledge that there is no perfect cut off point at which a nursing facility stay always becomes a permanent placement. We understand that while some participants will end up discharging home after very long stays, in other cases, the PO will know that a placement in a nursing home is permanent prior to the 90-day cutoff. Based upon the input and feedback received during the 30-day public comment period, and subsequent discussion with the TEP, we recommend that the cutoff for this measure remain 90 days.

The issues regarding risk adjustment must be balanced against the reporting burden required if additional adjustment variables are collected from POs. We will continue to explore the availability of data from other sources that might be used to risk adjust or risk stratify for this measure.

Based upon comments received and TEP input, we've identified the need to modify the measure exclusion criteria to include participants who were enrolled in PACE for the entire reporting quarter, rather than enrolled for at least one day.

Stakeholder Comments—Depression Treatment

A wide variety of comments were received regarding the Depression Treatment measure. Three (3) email responses requested clarification regarding the diagnostic codes included for the diagnosis of depression, and suggestions were made regarding changes to the International Classification of Disease (ICD)-10 codes selected for inclusion. Three (3) email responses

requested clarification of specific data elements, including the treatment options included in the measure. Three (3) email responses addressed data collection burden and the necessity of specific data elements, including place of residence and screening tests for depression and dementia. Two (2) email responses questioned the inclusion of participants with dementia in this measure, and one (1) email response questioned whether performance in this area is already, or would soon reach, 100%.

TEP Recommendations

The TEP discussed data collection burden, and again suggested eliminating the data element related to usual place of residence prior to Reliability and Feasibility testing. There was also discussion around the number of response choices for the data element documenting the type of depression treatment participants received. There was some concern expressed that some of the treatment options were alternative therapies, and do not have as strong an evidence base. The TEP also discussed the need to extend the timeframe POs have to screen participants and begin treatment for those diagnosed with depression. The TEP requested 90 days at minimum, and six (6) months at maximum, for the participant to settle into the PACE environment and adjust to an increased level of support and social interaction prior to formalizing the need for depression treatment.

Response

Based upon comments and TEP recommendations, the data element collecting usual place of residence will be removed from the data collection instrument for this measures. The majority of requests for clarification of specific data elements are currently addressed in the existing data collection instructions, but the instructions will be reviewed for clarity prior to additional testing. Additionally, the ICD-10 codes included as a diagnosis of depression will be reviewed with subject matter experts and adjusted, if needed. These subject matter experts will also be consulted on the treatment options included.

The current Depression Treatment specifications collect a large number of data elements, but we believe that all of these data elements (with the exception of place of residence) will provide useful information to guide improvement of the measure after reliability and feasibility testing. While some of the data elements may end up being unnecessary in the final specifications, it is less burden to collect them all during the first round of the reliability testing process than it would be to return to the participating POs and request additional data, which would require another round of chart review. Burden will be assessed using a post-data collection survey following reliability testing. Additional data elements may be reduced or combined based on testing results. We anticipate that the list of treatment options will be reduced to reflect the most common treatments seen during reliability testing. The reliability testing process will also provide data on the variation in depression treatment rates across POs.

Overall Analysis of the Comments and Recommendations

- Given the timing of this Public Comment Period, which was held prior to reliability and feasibility, there were many questions raised regarding burden and data collection

feasibility. Further testing will address these issues and assist with making decisions regarding appropriate revisions to the specifications.

- Specifications should be revised as needed based on the issues and clarifications raised during the Public Comment Period and from the results of upcoming reliability and feasibility testing.
- We will remove the data element regarding usual place of residence from the Advance Directive, Annual Review of Advance Directive, and Depression Treatment measures.
- Revisions and clarification to the exclusion criteria and data collections instructions are required prior to further testing of the Not in Nursing Homes measure.
    - We will modify the measure exclusion criteria to include PACE Participants enrolled for the entire quarter.
- The cut off for Not in Nursing Homes will remain 90 days.
- Reliability and feasibility testing will determine if any of the measures may be "topped out" (e.g., Depression Treatment).

Econometrica appreciates the input and feedback received from all commenters and values the public comment process. The comments and feedback received from these stakeholders provided meaningful and useful input into the Stream 2 measure specifications and data collection instructions. The TEP reviewed and discussed all Stream 2 comments received during the 30-day Public Comment Period. Some of the commenters submitted comments that can be responded to by highlighting specific areas of the provided measure specifications. There was general support for the intent of the measures, and concerns regarding the measures generally focused on data collection burden.

Public Comment Verbatim Report

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization	Responses
10/27/17	Depression Treatment	My comment has to do with the choice of DX (page 12): As it is in the document Depression Diagnosis ICD 10 Codes Abstract the data using these codes. You will not report the codes, just whether there had been a diagnosis of depression. • F32 Major depressive disorder, single episode. • F33 Major depressive disorder, recurrent. • F34.1 Dysthymic disorder. • F43.31 Adjustment disorder with depressed mood. • F06.31 Mood disorder due to known physiological condition with depressive features. • F06.02 Mood disorder due to known physiological condition with major depressive-like episodes. • F23.1 Schizoaffective disorder, depressive type. So we included Schizoaffective disorder (which is a psychotic disorder and not a mood disorder); however we did NOT include Bipolar Disorder, most recent episode depressive (F31.31,F31.32, F31.4, F31.5, F31.75, F31.76, F31.9), Bipolar D. II (F31.81)) or Adjustment D. with mixed anxiety and depressed mood (F43.23) or Psychoactive substance use/dependence with psychoactive substance-induced mood disorder (e.g. F19.14. F19.24, etc.) The logic is not quite clear to me. I would think we include all mood disorders and adjustment dx (using DSM as a classification guide), but exclude psychotic disorders. Current choice seems to be arbitrary.	Jay Luxenberg, MD, FACP, AGSF On Lok Lifeways	Thank you for your comments related to depression diagnosis codes. You are correct that you will not report ICD 10 codes. For pilot testing, we will ask PACE Organizations to report on a diagnosis of depression. We are reviewing and revising the ICD 10 codes to include all related mood and adjustment disorders.

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11/4/17	Advance Directives	Percentage of Participants With an Advance Directive or Surrogate Decision-Maker; This may need clarification about what constitutes an Advance Directive. Is it a MOLST, a HCP, a conversation about goals of care that is documented but does not have a form to go with it? And how will this be measured to capture the various forms advanced directives take across different states? Percentage of Participants With an Annual Review of Their Advance Directive or Surrogate Decision-Maker; Again a question about how this will be measured. If an EHR has a checkbox for "reviewed this visit," as many of them do, is that sufficient?	Rachel Broudy MD Mercy Life	Thank you for you clarifying questions related to the Advance Directive Measures. In the "Definitions" section, we define advance directives as "...An advance directive must include at least one of the following: A State-approved POST (Physician Order for Scope of Treatment), POLST (Physician Order for Life-Sustaining Treatment), MOST (Medical Orders for Scope of Treatment), or MOLST (Medical Orders for Life-Sustaining Treatment) form. Living Will (this is not the same as a Last Will and Testament that addresses estate issues) or Five Wishes document. 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." This definition was chosen to account for different forms and legal requirements across states. If your electronic health record (EHR) has a checkbox field for review of the advance directive or surrogate decision maker, and your providers use this checkbox to document their activities, it would be acceptable to use this field to collect data for the Annual Review measure.

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11/4/17	Not in Nursing Homes	Percentage of Participants Not in Nursing Homes; and I assume NHs means LTC placement, and not in a SNF for a temporary reason.	Rachel Broudy MD Mercy Life	Thank you for your clarification regarding the Not in NH measure. Yes, we will consider participants in a SNF for a temporary reason as Not in Nursing Homes. Only extended long-term stays > 90 days will be identified as "in nursing homes."
11/4/17	Depression Treatment	Percentage of Participants With Depression Receiving Treatment. I think it would be important to define what treatment means here. Major recurrent depression may need meds and therapy. Dysthymic depression may just need some monitoring and gentle support. What "kind" of depression are we talking about, how extensive, and what qualifies as treatment? And if patients refuse medications and therapy, though offered, do we still meet the quality measure since we have offered and encouraged this but in the end have to accept pt choice?	Rachel Broudy MD Mercy Life	Thank you for your questions about the Depression measure. The measure specifies ICD-10 codes which are included as a diagnosis of depression, and we are reviewing and revising the ICD 10 codes to include all related mood and adjustment disorders. The data collection form allows POs to indicate if treatment was NOT recommended by the healthcare provider. A list of treatments is also provided, and POs are able to select up to three (3) treatment options for each participant. We recognize that participant choice is important, so we have excluded participants who refuse treatment from both the numerator and denominator of this measure.
11/13/17	General	It is hard to interpret any indicator without description of the populations and PACE populations may be surprisingly different given that enrollment criteria are determined by the states. Consider adding descriptions including age, gender, frailty scores and dependencies in activities of daily living when comparing PACE sites.	Norman Desbiens, MD PACE Chattanooga Ascension Living	Thank you for your comments. We agree that there is variation across PACE Organizations, and continue to explore methods for risk stratifying measures to account for these variations.

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		Here are other indicators that are very important for PACE programs to monitor. % of participants who die at home or in the nursing home. % of participants who are DNR. Resuscitative efforts will hurt rather than help most PACE participants. % of participants receiving comfort care (with hospitalization only to promote this goal). Global question on satisfaction with PACE care (patient with decision-making capacity and surrogates for others) during quarterly surveys. Global question on satisfaction with PACE care at end-of-life. % of participants who died receiving care in keeping with their wishes (comfort care, no CPR, limited interventions, etc.).		We appreciate your recommendations for alternative measures, and will place them under consideration when considering future measure development.
11/13/17	Advance Directives	1. % of participants with advance directive or surrogate decision maker. To my mind, this is not a very informative indicator. Consider the following instead: Completed POST (POLST in some states) or POST questions within one month of PACE enrollment. While POSTs are not needed for patients who want full aggressive care, we use them for all patients to document that we have discussed the contained issues with all participants. Of course to meet this requirement all the state-required paper work for designation of decision maker or alternate decision maker must also be completed. Identification of alternate or surrogate decision maker by day one of enrollment. This is crucial for all participants because we must know who to turn to for decision making if a patient develops a critical health problem on day 1 of enrollment. We must know with	Norman Desbiens, MD PACE Chattanooga Ascension Living	Thank you for your comments regarding Advance Directives. The 6-month timeframe for this measure was decided upon after extensive discussions with providers at PACE Organizations. The rationale is that it takes time to develop a relationship with a participant and having a meaningful conversation about end-of-life wishes. During pilot testing, we will evaluate both the rate of participants who have an advance directive or surrogate decision maker, as well as how those PACE Organizations participating in the pilot testing feel about the 6-month timeframe.

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		whom to talk. 2. % of participants with annual review of their advance directive or surrogate decision maker. Surrogate decision makers do not change often enough to warrant this indicator. For patients who have (or whose designated decision makers) have elected DNR and comfort care, it is not necessary to review this. Things can change pretty quickly with PACE patients and once a year review may not be enough. As you know CMS requires care plan review for any significant worsening of condition. At a minimum care plans should be reviewed then. We review them after any hospitalization. Consider changing to: For patients who are not receiving comfort care (or who have refused hospitalization except for pain control), review of care plan in the last 6 months or after a significant deterioration in codition.		The annual review for the measure is a minimum. Participants with changing health or social situations may wish to change their advance directives or surrogate decision maker more frequently. We did not specify a review of the surrogate decision maker and/or advance directives when there is a change in condition because of the difficulty in capturing all the participants with a change in condition to include in the denominator. That would substantially increase the data collection burden for PACE Organizations. We appreciate your recommendations for alternative measures, and will place them under consideration when considering future measure development.
11/13/17	Not in Nursing Homes	% of participants not in nursing homes. Patients in SNFs after hospitalization should be excluded. To properly interpret this indicator, the frailty of the enrollment population and the caregivers should be known, so this indicator (true for most) is not entirely in the PACE program's control. Consider changing to: % of participants not in long-term nursing facilities	Norman Desbiens, MD PACE Chattanooga Ascension Living	Thank you for your comments regarding the Not in NHs measure. Participants in skilled nursing facilities (SNFs) after hospitalization, who have a stay of 90 days or less, will be counted as "Not in Nursing Homes." The focus of the measure is capturing long-term nursing facility placement. We agree that it could be beneficial to consider participant frailty for risk stratification or adjustment. The development of a participant-based

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				stratification or adjustment factor should be based on data analysis. Currently, we do not have sufficient data to develop reliable and valid stratification or adjustment factors. Instead, as a first step, we will provide risk stratification at the Organizational level to examine differences among types of PACE Organizations.
11/13/17	Depression Treatment	4. % of participants with depression receiving treatment. I would recommend deleting this indicator. Patients with depression who have dementia are a separate category and the database on the efficacy of treatment is of poorer quality.	Norman Desbiens, MD PACE Chattanooga Ascension Living	Thank you for your recommendation. You are correct that there is a complex relationship between depression and dementia, however our position is that participants with dementia who are depressed should be offered and receive treatment that may be beneficial.
11/13/17	Advance Directives	The POLST is not an advance directive. Use of the POLST in individuals who are not seriously ill contradicts the intent of the document to serve as a means to communicate patient preferences in an end of life setting. Otherwise healthy PACE patients with one or two chronic illnesses do not necessarily benefit from a POLST conversation, and it may creates an artificial end of life mandate for full CPR. I urge against use of the POLST as a single item definition for advance directive. Please consider reviewing CA law for POLST AB 3000 in your considerations.	John F. Randolph, MD	Thank you for your recommendation. We list the POLST as one type of documentation that a participant could have to address this measure. After discussions with PACE providers, we created a broad and inclusive definition of an advance directive to meet the needs of a wide variety of participants in different states. We encourage providers to discuss the strengths and limitations of different types of advance directives with participants as part of the discussion of end-of-life wishes.
11/17/17	General	1. Trinity Health PACE supports the proposed measures below:	Carrie Hays McElroy, MSN, RN, Gero-BC,	Thank you for your support.

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		a. Percentage of Participants With an Advance Directive or Surrogate Decision-Maker b. Percentage of Participants With an Annual Review of Their Advance Directive or Surrogate Decision-Maker c. Percentage of Participants Not in Nursing Homes	ACM Trinity Health PACE	
11/17/17	Not in Nursing Homes	We support and wish to emphasize the need for risk stratification, with particular relevance to the "Not in Nursing Homes" measure. As PACE Organizations age and mature it is possible that performance on this measure may actually worsen.	Carrie Hays McElroy, MSN, RN, Gero-BC, ACM Trinity Health PACE	Thank you for your recommendation. We agree that it could be beneficial to consider participant chronic conditions or demographic factors for risk/acuity stratification or risk/acuity adjustment. The development of a participant-based stratification/ adjustment factor should be based on data analysis. Currently, we do not have sufficient data to develop reliable and valid stratification or adjustment factors. Instead, as a first step, we will provide risk stratification at the organizational level to examine differences among types of PACE organizations.
11/17/17	Depression Treatment	With regards to the measure Percentage of Participants With Depression Receiving Treatment We have concerns regarding this measure being valid and reliable. Would it be possible to initially trial this measure as a demonstration indicator and a way to elicit best practices for treatment options of depression in the PACE population. We wish to stress the importance of capturing all the alternative modalities of treatment and ensuring that the list of options is inclusive enough. We wish to also emphasize the importance of the option	Carrie Hays McElroy, MSN, RN, Gero-BC, ACM Trinity Health PACE	Thank you for your comment. All measures developed for PACE will be tested for validity and reliability. Depression Treatment has already been tested for validity and found to be valid. Reliability testing will be conducted in the next stage of measure development. We anticipate that data on Depression Treatment will be analyzed during the first several quarters of reporting before any accountability decisions are linked to the measure, in essence, a demonstration period.

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		to document that participants refused treatment options. We are pleased that this is addressed in the measure specifications.		During reliability testing, we will examine a large number of treatment options. From this analysis, we will develop recommendations for the categorization of treatment types for measure implementation.
11/21/17	General	Centra PACE appreciates data driven initiatives and the desire by CMS to have consistent definitions. The measures selected here are relevant to our PACE organizations, however the amount of detail that is being required, does not appear to be of benefit, unless a stratified data analysis is being performed. Traditionally, PACE organizations have submitted data to CMS through HPMS but have not received any relevant comparative reports regarding the indicators. For example, currently, PACE organizations must submit detailed information on all non-level 2 falls, but we receive no fall rates or comparison data with similar PACE populations. To implement and maintain these measures will be an additional financial and time burden to PACE organizations already implementing and maintaining survey universes. Not all PACE organizations have an electronic medical record that can be queried and an Excel spreadsheet produced, so the amount of time to set up and maintain spreadsheets will be burdensome. Currently our organization does not have an electronic medical record that can be queried. (We are hopeful that this will become available within the next 18 months.) For our organization, with three (3) sites and approximately 225 participants, we estimate that it will take approximately	Kimberly Woodley Centra PACE	Thank you for your comments regarding PACE quality measures. We hope that the measures developed under this contract will be useful, both to individual PACE Organizations and to CMS. We anticipate that providing data reports will be an issue that is addressed during the implementation phase. We are also sensitive to the issue of data collection burden, and appreciate your insight into the burden of the Stream 2 measures. We will also assess burden during feasibility testing, and anticipate that we will be to condense or remove some data elements as the result of further testing. We agree that it takes time to develop new data collection processes. Training and support will be provided during both testing and implementation, and we anticipate that there will be a few quarters of data collection before a measure is used for accountability purposes.

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		112 hours to establish the Excel spreadsheets with the current definitions and populate them with participant information through chart review. Also it would take approximately 28 hours to update the spreadsheets quarterly. We calculate that this would be a minimum of $2800 to implement and $700 quarterly to maintain them. If a PACE organization does have an electronic medical record that can be queried, additional fields will need to be added and inquiries written to the specifications outlined in the measure. These additions to the medical record will incur an additional financial expenses for PACE organizations, because they will be done by the EMR contractor for a fee. Once the measures are finalized, please allow a minimum of six months for PACE organizations to implement the required data collection strategy.		
11/21/17	Advance Directives	Centra PACE supports the measures for advance directives. We currently track the number of participants who have an advance directive and a POA within the first month of enrollment, and we can easily change this measure to the final definition. Usually, our Providers have a discussion with the Participants at every annual/semiannual assessment. Although it is currently not tracked, it can be easily added and the Providers' process tightened to assure the measure is tracked. For our organization, we estimate that it will take approximately two (2) hours to establish the Excel spreadsheet with the current definitions and populate it with participant identifiers (which would be removed prior to submission). It would take a total of 22.5 (6 minutes per participant) hours to complete the initial chart review. This would be a minimum of $613 to	Kimberly Woodley Centra PACE	Thank you for expressing your concerns. During testing, we will assess the feasibility and burden of data collection for the measures, and eliminate or condense data elements where possible. We plan to drop the place of residence item prior to testing.

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		implement. Quarterly maintenance would be approximately 8 hours or $200 to add and review participants who have been in the program for six months, and to assure participants have had a review/discussion. The numerator, denominator, surrogate decision maker, review and discussion, exclusion, and inclusion criteria are clearly defined and reasonable. Our organization has concerns regarding the data reported on the spreadsheet: Auto-Generated Participant Number: This is a reasonable field however, it will require PACE organizations to include a patient identifier column for our internal tracking purpose, which will be removed prior to submission. Participant Residence: Based on the current definitions, a participant's residence does not have an impact on the measure. Therefore we would request that it be removed. If it cannot be removed, then the criteria needs to be modified. Additionally, if it cannot be removed, could the Not in Nursing Home Measure be calculated from this data? 1. Own home: remove the word "own" because it can be confusing with home ownership, and add the word alone. We find that the make-up of the participant's household is I important in the community (non-PACE) support that a participant receives. 2. Assisted Living Facility: no changes recommended. 3. Nursing Home: no changes recommended. 4. Residential Hospice: please remove. We currently do		

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		not utilize a residential hospice because in order for a participant to receive hospice benefits a participant must disenroll from the program (42 CFR § 460.154(i)) 5. Rehabilitation Facility: please remove. Our organization does not Rehabilitation Facilities, because many of the same services are offered at a skilled nursing facility. It could easily be combined with #6. 6. Skilled Nursing Facility: Add Rehabilitation facility. (It could read Skilled or Rehabilitation Facility.) 7. Other: no changes recommended 99. Not documented: No changes We would like to recommend additional residences be considered: a. Home with Spouse or Significant Other. b. Home with Child and/or Other Family Members c. Home with Non-Family Members. Participant has a documentation of an advance directive or surrogate decision makers or meets exclusionary criteria: This is reasonable and no changes are recommended at this time.		
11/21/17	Not in Nursing Homes	Centra PACE supports the measure for participants not in a Nursing Home. We currently track the number of who are residents of a nursing facility and we can easily change this measure to the final definition. To prevent duplication of data entry, if the participant residence cannot be removed from the Advance Directive Measures and Geriatric Depression Measure, could this measure be calculated using that data? For our organization, we estimate that it will take approximately one (1) hour to establish the Excel spreadsheet with the current definitions and populate it with participant identifiers (which would be removed	Kimberly Woodley Centra PACE	We are glad to hear that your organization currently tracks information relevant to this measure, and cost and burden will be low in your organization. In terms of the issue of data entry duplication, this Not in Nursing Homes measure cannot use participant residence data collected from other measures because each measure will use a different time frame to collect residence information. For example, the Not in Nursing Homes measure will use a 90-day threshold to identify

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		prior to submission). It would take approximately 1 hour enter the admission dates for our current nursing facility residents. This would be a minimum of $50 to implement. Quarterly maintenance would be approximately 1 hour or $25 to add participants enrolled/disenrolled and to enter admission dates. The numerator, denominator, exclusion, and inclusion criteria are clearly defined and reasonable. Our organization has concerns regarding the data reported on the spreadsheet: Total number of PACE participants enrolled at the site: Additional guidance is needed for this data. Would this be a single integer on Column A of the Spreadsheet or would this be a separate spreadsheet with only a single integer? Also wouldn't that be the same as the count of the Auto-Generated Participant Number, if so this number becomes duplicate data entry. Lastly, if I understand this number correctly, it is currently provided to HPMS via Level 1 reporting, so again wouldn't this be duplicate data reporting. Auto-Generated Participant Number: Again some clarification is needed for this data. My understanding is that it a count of this number will equal the same total number of participants. Date of Participant's Admission to the Nursing Home: Clarification is needed for this data. My understanding that only the participants who are residents of a nursing facility will have this field completed. If a participant is not a resident of a nursing home, will the field be left blank?		long-term placement in nursing homes; however, the depression measure identifies residence placement based on the majority days (>50%). In regard to the data entry, you don't need to provide any data if a participant is not a resident of a nursing home or stayed in a nursing home for less than 90 days in the reporting quarter.

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11/21/17	Depression Treatment	Centra PACE supports the measure for participants with depression receiving treatment. We currently track the participants who have an improvement of Geriatric Depression Screen (GDS) if they had a GDS of five (5) or greater the previous quarter. For our organization, we estimate that it will take approximately five (5) hours to establish the Excel spreadsheet with the current definitions and populate it with participant identifiers (which would be removed prior to submission). It would take approximately 75 hours complete the chart review and enter the required data. This would be a minimum of $2000 to implement. Quarterly maintenance would require 19 hours or $475 to add participants enrolled/disenrolled and update participants who had an annual/ semi-annual assessment during the quarter. The numerator, denominator, exclusion, and inclusion criteria are clearly defined and reasonable. Our requests that the additional variable be eliminated from the data collection as they are NOT used in the calculation of the measures. Our organization has concerns regarding the data reported on the spreadsheet: Auto-Generated Participant Number: This is a reasonable field however, it will require PACE organizations to include a patient identifier column for our internal tracking purpose, which will be removed prior to submission. Participant Residence: Based on the current definitions, a participant's residence does not have an impact on the	Kimberly Woodley Centra PACE	We commend your organization for identifying the mental health needs of participants. Reporting burden is an issue considered in the testing and implementation of the measure. Currently, we are in the measure testing phase. The publicly posted data collection instructions are for reliability and feasibility testing. We anticipate deleting some items as we transition into measure implementation, and appreciate your input on potential data elements to remove. The auto-generated participant number for reporting deidentifies the data. We will not track participants over time, so there is no need for PACE Organizations to develop a new identifier for each participant in their health records systems. We will eliminate the participant residence variable.

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		measure. Therefore we would request that it be removed. If it cannot be removed, then the criteria needs to be modified. Additionally, if it cannot be removed, could the Not in Nursing Home Measure be calculated from this data? 1. Own home: remove the word "own" because it can be confusing with home ownership, and add the word alone. We find that the make-up of the participant's household is important in the community (non-PACE) support that a participant receives. 2. Assisted Living Facility: no changes recommended. 3. Nursing Home: no changes recommended. 4. Residential Hospice: please remove. We currently do not utilize a residential hospice because in order for a participant to receive hospice benefits a participant must disenroll from the program (42 CFR § 460.154(i)) 5. Rehabilitation Facility: please remove. Our organization does not Rehabilitation Facilities, because many of the same services are offered at a skilled nursing facility. It could easily be combined with #6. 6. Skilled Nursing Facility: Add Rehabilitation facility. (It could read Skilled or Rehabilitation Facility._ 7. Other: no changes recommended 99. Not documented: No changes We would like to recommend additional residences be considered: d. Home with Spouse or Significant Other. e. Home with Child and/or Other Family Members f. Home with Non-Family Members. Participant Screened for Dementia using Validated Tool: Based on the current measure, the participants Dementia screening does not have an impact on the measure, therefore this variable should be eliminated. If it cannot be eliminated, it should be combined with the		

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		Dementia Screening Tool Used variable. Dementia Screening Tool Used: Based on the current measure, the participants Dementia screening does not have an impact on the measure, therefore this variable should be eliminated. If it cannot be eliminated it should be combined with the Participant Screened using Validated Tool variable, by simply changing the response to: 1. Mini Mental Status Exam 2. Montreal Cognitive Assessment 3. St. Louis University Mental Status 4. Please Add Allen Cognitive Level Screening Tool 5. Other 6. Participant Not Screened for Dementia Using a Validated Tool 99. Not documented Diagnosed with Dementia: Based on the current measure, the participants Dementia diagnosis does not have an impact on the measure, therefore this variable should be eliminated. If it cannot be eliminated, a clarification of the diagnosis using the ICD-10 codes would be helpful. Participant Screened for Depression: Although a diagnosis for depression does require a screening, the measure does not include “screening”, only if a participant has a diagnosis of depression. Therefore this is a non-value added variable and should be eliminated. Depression Screening Tools Used: Based on the current measure, the screening tool does not have an impact on the measure, therefore this variable should be removed. If it cannot be removed, it should be combined with		

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		Participant Screened for Depression. Recognizing the previous dementia variables would help to identify a participant who is unable to be screened for depression due to a cognitive impairment, if they are eliminated, it could be captured here. A proposed list is below: 1. Beck Depression Inventory 2. Center for Epidemiologic Studies Depression Scale (CESD)-10 3. CESD-20 4. Cornell Scale for Depression in Dementia 5. Geriatric Depression Scale (GDS)-5 6. GDS-15 7. GDS-30 8. Modified Depression Scale (MDS) 9. Patient Health Questionnaire (PHQ)-2 10. PHQ-9 11. Other Screening Tool 12. Participant Not Screened for Depression 13. Participant Unable to be Screened for Depression due to Cognitive Impairment 99. Not documented Diagnosed with Depression: No changes Depression Treatment During the Quarter: No changes Type of Treatment: Based on the current measure, the type of treatment does not have an impact on the measure, therefore this variable should be removed. If it cannot be removed, it should include a "treatment" of attending the PACE center as recommended by the plan of care. We have found that many of our participants respond positively by simply entering the program and participating in the activities in our day room.		

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11/21/17	Advance Directives	Percentage of Participants With an Advance Directive or Surrogate Decision-Maker; Data would be relatively easy to obtain. Percentage of Participants With an Annual Review of Their Advance Directive or Surrogate Decision-Maker; This could be more difficult to obtain, but could be done with effort and time.	Paige Harrington InnovAge - Lowry	Thank you for your input on data collection burden. During testing, we will assess the feasibility and burden of data collection for the measures.
11/21/17	Not in Nursing Homes	Percentage of Participants Not in Nursing Homes; We can get this data relatively easily. Although, the PACE population is rather fluid and living arrangements can change rather frequently.	Paige Harrington InnovAge - Lowry	Thank you for your input on data collection burden. We are glad to hear that there would be low burden to collect this measure at your Organization, and acknowledge that it is common for PACE participants to change living arrangements.
11/21/17	Depression Treatment	Percentage of Participants With Depression Receiving Treatment. We can get this data relatively easily. Although, a definition of what constitutes treatment would be necessary in order to get the most accurate data.	Paige Harrington InnovAge - Lowry	Thank you for your input on data collection burden. We are glad to hear that there would be low burden to collect this measure at your Organization.
11/23/17	General	Thank you for the opportunity to comment. The Center for Elder Care and Advanced Illness at Altarum Institute has a long history of working toward effective quality measures and efficient and reliable support for elders living with serious illnesses and disabilities. I am writing to comment that these metrics are quite disappointing.	Joanne Lynn, MD ALTARUM	Thank you for your comment.
11/23/17	General	So, this set of metrics will not help the consumer, will not guide quality improvement, and will not be adequate for accountability. We hope that the ongoing work is yielding more important and useful metrics. We'd especially like to see measures of confidence, measures of care planning, and measures of the congruence of the implemented care plan with the priorities and the situation of the elderly person.	Joanne Lynn, MD ALTARUM	Thank you for your recommendations for future measures. We will place them under consideration when additional measures are considered.

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11/23/17	Advance Directives	Surely PACE programs will quickly clean up any shortcomings in advance directive generation and review, so these two measures will be topped out at the onset or very quickly thereafter. Does Econometrica have any evidence that there is current substantial variation or that there is likely to be even a year before the compliance is nearly 100%?	Joanne Lynn, MD ALTARUM	Thank you for your comment. We developed this measure in consultation with the PACE Technical Expert Panel, which includes PACE providers and administrators. They provided us with anecdotal information that there may be variation across PACE Organizations. During testing, we will certainly evaluate both the rates (how close to 100% they are) and how much variation there is across sites.
11/23/17	Not in Nursing Homes	The measure of participants not being in nursing homes has a different set of problems. A new or newly expanding PACE program will have more people who are not yet overwhelmingly disabled and whose family is not yet exhausted, while an older program will have more such people. A PACE program that has very few nursing home beds in their area will have to place people needing nursing home care outside of the area and mostly those beneficiaries will leave PACE. A PACE program with a large number of participants living in assisted living can provide enough supports to keep nearly all PACE participants in assisted living settings rather than nursing homes. So, variations in the proportion of nursing home days will have ambiguous meaning. Furthermore, PACE programs already have strong incentives to keep most participants living in the community and not in a nursing home, because the PACE program is at risk for the costs.	Joanne Lynn, MD ALTARUM	Thank you for your input. We agree that this measure will be affected by the PACE Organization's residence placement options, its capacity, and other characteristics. As a first step, we will provide risk stratification at the Organizational level in order to examine differences among types of PACE Organizations.
11/23/17	Depression Treatment	In the VA's community living centers, a diagnosis of depression triggers the electronic record to expect a medical treatment. It appears that the response has been to diagnose "mood disorder" for persons who would not want or would not comply with treatment. As	Joanne Lynn, MD ALTARUM	Thank you for the information regarding the impact of similar measures in the VA setting. During testing, we will evaluate both the rates (how close to 100% they are)

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		this new measure is formulated, all sorts of "treatments" are allowed and the PACE participant can decline treatment. Again, this ensures that this measure will quickly be topped out as well. Does Econometrica have any evidence that there is current substantial variation or that there is likely to be even a year before the compliance is nearly 100%?		and how much variation there is across sites.
11/29/17	Advance Directives	Will a state-approved POLST form satisfy this measure, or do we need to have a specific advanced directive form in addition to the POLST? Currently we are tracking end of life wishes in the form of a POLST rather than an advanced directive. Though the proposed measure is trackable, these are two different forms that are required to fulfill this measurement. It would be useful to survey other PACE sites to see what form or forms they are using to track end of life wishes for their participants and share the findings amongst these sites with each other. With regards to the sub-measure on the proposed metric please see same comment as above.	Gisela Gómez Cuéllar CalOptima PACE	Thank you for your question. A state-approved POLST would satisfy this measure. We developed this measure in consultation with the PACE Technical Expert Panel, which includes PACE providers and administrators, and we also solicited input regarding the measure during site visits to PACE Organizations. The information they provided regarding forms which are currently in use was used to construct this measure.
11/29/17	Not in Nursing Homes	Can you define what is meant by "usual place of residence" and how do we account for participants that have been residing in a nursing home for 90 days or greater but are then discharged to another level of care such as Board and Care given that they are no longer residing in a nursing home? The proposed measure is something we can track as we are currently tracking number of participants in a nursing home internally on a monthly basis.	Gisela Gómez Cuéllar CalOptima PACE	Thank you for your question. This measure will capture long-term nursing home stays for a specific reporting quarter. Thus, if a participant had been residing in a nursing home in the previous quarter, but was discharged to another level of care (i.e., assisted living) in less than 90 days for the current reporting quarter, they will be captured as "Not in Nursing Homes" in the reporting quarter.

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11/29/17	Depression Treatment	In the context of this measure, does any member on the Interdisciplinary Team (IDT) including PACE Social Work, Occupational Therapy or Recreational Therapy qualify as a clinician? Treatment for depression varies among each participant and currently only 3 categories can be accounted for under the proposed data abstraction measure which can be limiting. Can we expand the data abstraction categories to include up to 5 categories vs. 3 categories? With any measure, it is imperative that all PACE sites get more specific data-pull information in order to align with each other. If CMS/DHCS can define these is advance, it would assist in determining factors related to the tracking of these metrics. The proposed measure is something we can track.	Gisela Gómez Cuéllar CalOptima PACE	Thank you for your comments and questions. Any member of the IDT may recommend that a participant be assessed for depression. The diagnosis of depression should be made by a physician, advanced practice nurse, or licensed clinical social worker, in accordance with their legal scope of practice. The categories of treatment listed in the public record will be included in reliability and feasibility testing. We anticipate that number of treatment categories will be reduced for measure implementation and that specific instructions will be issued for PACE organizations to use in preparing their data pull.
11/30/17	General	On behalf of the NJ Division of Aging Services we are pleased to have the opportunity to submit comments on the proposed quality measures referenced as Stream 2 and includes, the percentage of participants with an advance directive or surrogate decision-maker; the percentage of participants with an annual review of their advance directive or surrogate decision-maker; the percentage of participants not in nursing homes; and the percentage of participants with depression receiving treatment. The state has reviewed the proposed measures; the numerators and denominators for each, the inclusions and exclusions criteria and the data entry measures and supports these measures as written. The state believes these measures will provide valuable information to the	Paul S. Sullivan Kevin Murphy New Jersey Department of Human Services Division of Aging Services	Thank you for your support.

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		PO in NJ as well as to the Centers for Medicaid. NJ believes that these measures will strengthen the person-centered-planning process and will encourage family involvement and participant engagement in areas of long term care planning that is difficult for families and the participant to discuss unless facilitated by a third party.		
11/30/17	General	Referring to NPA's comment letter on which CentraCare had significant opportunity to provide input, we believe that measuring the quality of health care is a necessary step in the process of improving health care quality. We support the utilization of performance indicators, as it is a critical component of continuous performance measurement and improvement. We anticipate that the implementation of PACE quality measures will support initiatives specifically targeted to improve PACE participant outcomes and would expect that CMS will be transparent in communicating the intended purposes of measure reporting. CentraCare 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, as well as, other service delivery options (e.g., managed care). We reinforce the point that currently PACE lacks a common assessment instrument and data standard. As referenced in NPA's comment letter, NPA has developed a common data platform across all PACE Organizations referred to as the Common Data Set (CDS). We	Alexandria Lueth, CPA CentraCare PACE	Thank you for your comments. We agree that performance indicators are key to guiding performance improvement. We anticipate that CMS will provide guidance to PACE Organizations regarding the purpose and intended use of new measures as they are implemented. We agree that there is variation amongst PACE Organizations in terms of PO, community and participant characteristics. As a first step, we will provide risk stratification at the Organizational level, in order to examine differences among types of PACE Organizations. Preliminary stratification variables include caseload size, metropolitan status, years in operation and academic affiliation. Additional options for risk stratification or adjustment will continue to be explored. We agree that lack of harmonization could result in reporting errors. As new quality measures are implemented, they will replace

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		encourage Econometrica to seek alignment with those efforts currently underway to address these limitations. We encourage CMS to harmonize the measure definitions of the proposed measure set with the definitions and reporting requirements associated with current PACE Quality Monitoring reporting requirements (i.e., Level I and Level II reporting) to mitigate the use of varying definitions for the same data element, assure consistency amongst data reporting requirements, and eliminate duplication in reporting. While we understand the overall intent, and are in support of the proposed measures, we offer the following general concerns and/or recommendations. Feasibility of Data Collection We request that further consideration be given to the data collection and reporting burden that POs will incur in implementing these measures. Currently, many POs have significant limitations on the ability to effectively and efficiently abstract many of the data elements required for the proposed measures. We strongly encourage CMS to provide adequate time for POs to establish a strategy to accommodate implemented quality measures and applicable reporting requirements. The rationale for the reporting of many required data elements is unclear and appears to provide no meaningful information as it relates to the applicable measures. This includes “participant residence” for Percentage of Participants with an Advance Directive or Surrogate Decision-Maker, Percentage of Participants with an Annual Review of Their Advance Directive or Surrogate Decision-Maker, and Percentage of		analogous Level I or II reporting where there is overlap. Thank you for your input on data collection feasibility and burden. During testing, we will assess the feasibility and burden of data collection for the measures. We anticipate that some data elements may be eliminated or condensed based on the results of this testing.

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		Participants with Depression Receiving Treatment measures. We believe 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 the determination is made to adapt this data element, we recommend that the descriptions be modified as outlined in NPA's comment letter. We suggest that it is also the case with many of the data elements requested for the Percentage of Participants with Depression Receiving Treatment measure. We therefore recommend that "Depression screening", "Depression screening tool used" and "Type of treatment" data elements be eliminated from data collection and reporting requirements for this measure. Calculation Methodology Within the supplemental documents distributed with the CMS call for comment, it is noted that initially risk stratification will be used rather than risk adjustment, and that stratification will be based on PACE organization characteristics. We request that CMS specifically delineate what specific PACE organization characteristics will be considered and the anticipated methodology to be utilized. We also encourage CMS to consider the use of participant characteristics for stratification purposes, while it further examines risk adjustment and alternative adjustment methodologies.		
11/30/17	Advance Directives	The exclusionary criteria for this measure requires clarification, specifically as it relates to a participant's inability to provide an advance directive or identify a surrogate decision maker. It is unclear what criteria CMS expects POs to consider for exclusionary purposes.	Alexandria Lueth, CPA CentraCare PACE	Thank you for your comment. The ability of the participant to provide and advance directive or identify a surrogate decision maker was left undefined to not limit PACE providers' judgement. We will clarify

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		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.		that in the definitions. We will also clarify the response choices for #5, #6, and #7.
11/30/17	Not in Nursing Homes	While the expectation is that PACE participants residing in nursing homes should be low, natural age progression may require a long-term nursing home stay—as a result, we recommend exclusion criteria that considers the natural progression of chronic conditions and the related impact on the participant's functional status. We also recommend, for measure stratification and risk adjustment purposes, 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.	Alexandria Lueth, CPA CentraCare PACE	Thank you for your comments. We agree that some participants need nursing home care due to their functional status, health conditions, cognitive status, or other conditions outside the control of the PO, so this measure may not be a direct reflection of the performance of PACE Organizations. We also agree that it will be beneficial to take into account participant chronic conditions or demographic factors for risk/acuity stratification or risk/acuity adjustment. The development of a participant-based stratification/ adjustment factor should be based on data analysis. Currently, we do not have sufficient data to develop

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				reliable and valid stratification or adjustment factors. Instead, as a first step, we will provide risk stratification at the organizational level in order to examine differences among types of PACE Organizations.
11/30/17	Depression Treatment	Based on the current measure definitions, the participants' Dementia diagnosis does not have an impact on the measure. We recommend that this measure be limited to the evaluation of the diagnosis and treatment of depression.	Alexandria Lueth, CPA CentraCare PACE	Thank you for your comment. The diagnosis of depression among persons with dementia is complex. Because PACE participants can have both diagnoses, special assessment tools are required for the identification of depression. The need for these data elements in the final measure will be assed based on the results of testing.
11/30/17	General	Overall, we appreciate CMS's efforts to improve quality measures for PACE. However, we continue to emphasize the importance of patient-reported outcomes, including measures relating to quality of life and community inclusion. We note that the proposed measures are all administrative measures, and we believe that patient-reported outcome measures are critical to a more consumer-centered approach to quality measurement.	Ann Hwang, MD Community Catalyst	Thank you for your recommendation. We agree that patient reported outcome measures are important, and will consider this recommendation when new measures are selected.
11/30/17	Advance Directives	We appreciate the intent of these measures and agree with the focus on improving quality of care and life, and ensuring that care is provided according to participants' goals, values and preferences. We note that this quality measure is a reasonable first step, but over time, it would be helpful to have a fuller picture of patient and family member experiences with end of life care, such as through family reported outcomes.	Ann Hwang, MD Community Catalyst	Thank you for your comment. We agree that this measure does not fully capture the participant and family experience and will consider this issue as an area for further development in the future.
11/30/17	Not in Nursing Homes	We agree with the goal of supporting people to live independently in their homes or communities if that is	Ann Hwang, MD Community Catalyst	Thank you for your comments. We agree that some participants need

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		their wish. Therefore, the number of PACE participants who need nursing home care should be low. However, there are still circumstances in which nursing home care is needed, whether that is due to age, functional limitations or loss of a caregiver, and we suggest that approaches to risk adjustment be considered that would appropriately take into account the acuity of the population. We are also concerned by the exclusion of institutional stays less than 90 days. From a consumer perspective, a 90-day nursing facility stay is significant in terms of its impact on a consumer's life, and omitting these stays does not give a full picture of community tenure. Finally, we note the limits of administrative data in identifying whether a participant is living in the setting of their choice, experiencing good quality of life, and is integrated into community living, domains that can and should be measured through patient-reported outcomes.		nursing home care due to their functional status, health conditions, etc., so this measure may not be a direct reflection of the performance at PACE Organizations. We agree that it could be beneficial to take into account participant chronic conditions or demographic factors for risk/acuity stratification or risk/acuity adjustment. The development of a participant-based stratification/adjustment factor should be based on data analysis. Currently, we do not have sufficient data to develop reliable and valid stratification or adjustment factors. Instead, as a first step, we will provide risk stratification at the organizational level to examine differences among types of PACE Organizations. 90 days was selected in consultation with the TEP, which is made up of PACE Organization staff and administrators. We do agree that stays shorter than 90 days can have a significant impact, and we will collect additional feedback on the appropriateness of the 90-day criteria during testing. We agree that quality of life and participant experience would be good measures for future development.

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11/30/17	Depression Treatment	While we support the importance of screening and treating depression, we note that the measure as proposed assesses whether a patient received at least one of a defined set of treatments, not whether the treatment was appropriate or effective. We suggest that what is missing is an approach that would measure whether the patient feels that their symptoms have improved, and we believe that this approach would better measure what is actually important to patients.	Ann Hwang, MD Community Catalyst	Thank you for the suggestion for development of a patient-centered measure reflecting the perceived benefit of depression treatment. We will take this under consideration when considering future measure development.
11/30/17	General	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	Shawn Bloom National PACE Association	Thank you for your comments. We will continue to assess data collection burden, feasibility, and refinements to specific measure specifications during reliability and feasibility testing. Thank you for your recommendations around the Common Data Set. Harmonization is an important issue in measure development, as is reducing unnecessary data collection and reporting burden. We will continue to consider how to construct useful measures that serves the needs of PACE Organizations, their participants, and CMS, while allowing comparison to other settings. We anticipate that CMS will provide additional information regarding implementation and intended use of PACE quality measures as we move closer to the implementation phase.

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		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		

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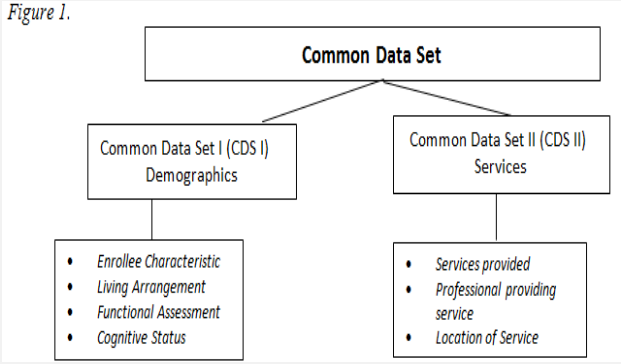
		instrument and data standard. To address this need, NPA has developed a common data platform across all PACE Organizations referred to as the Common Data Set (CDS) [see Figure 1]. The CDS contains a standardized dictionary of definitions for data elements to be collected by POs – demographics (CDS I) 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.		

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		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.		

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		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).		
11/30/17	Advance Directives	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	Shawn Bloom National PACE Association	Thank you for your comments regarding Advance Directives. We will add wording that documents, as well as documentation of oral statement, must meet the state's legal requirements. The ability of the participant to provide an advance directive or identify a surrogate decision maker was left undefined to not limit PACE providers' judgement. We will clarify that in the definitions. The 6-month timeframe was decided upon after extensive discussions with providers at PACE sites. The rationale is that it takes time to develop a relationship with a participant and having a meaningful conversation about end-of-life wishes. During testing, we will evaluate both the rate of participants who have an advance directive or surrogate decision maker, as well as how those PACE Organizations participating in the testing feel about the 6-month timeframe.

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		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.		Thank you for your input on data collection feasibility and burden. During testing, we will assess the feasibility and burden of data collection for the measures. We anticipate that some data elements may be eliminated or condensed based on the results of this testing. Thank you for the comment about place of residence. This item will be dropped. We understand that there is variation amongst PACE Organizations in terms of PO and participant characteristics. As a first step, we will provide risk stratification at the Organizational level, in order to examine differences among types of PACE Organizations. Preliminary stratification variables include caseload size, metropolitan status, years in operation and academic affiliation. Additional options for risk stratification or adjustment will continue to be explored.

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		• 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.		
11/30/17	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	Shawn Bloom National PACE Association	Thank you for your comments regarding Not in NHs. We agree that some participants need nursing home care due to their functional status, health conditions, etc., so this measure may not be a direct reflection of the performance at PACE Organizations. We agree that it could be beneficial to take into

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		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.		account participant chronic conditions or demographic factors. Rather than exclusions, this could be accomplished through risk/acuity stratification or risk/acuity adjustment. The development of a participant-based stratification/adjustment factor should be based on data analysis. Currently, we do not have sufficient data to develop reliable and valid stratification or adjustment factors. Instead, as a first step, we will provide risk stratification at the organizational level in order to examine differences among types of PACE Organizations. In regard to the exclusion criteria for both the numerator and denominator, we are planning to modify the criteria based on comments and feedback from TEP members to include participants who were enrolled in PACE for the entire reporting quarter, rather than those enrolled for at least one day. 90 days was selected in consultation with the TEP, which is made up of PACE Organization staff and administrators. We do agree that stays shorter than 90 days can have a significant impact, and we will collect additional feedback on the

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		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.		appropriateness of the 90-day criteria during testing. We recognize that there is variation amongst PACE Organizations in terms of PO, community and participant characteristics. As a first step, we will provide risk stratification at the Organizational level, in order to examine differences among types of PACE Organizations. Preliminary stratification variables include caseload size, metropolitan status, years in operation and academic affiliation. Additional options for risk stratification or adjustment will continue to be explored.
11/30/17	Depression 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	Shawn Bloom National PACE Association	Thank you for your helpful comments. To be comprehensive, PACE Organizations will be asked to include participants who expire during the reporting period in order to fully capture depression treatment at the PACE Organization level. Participants who are receiving comfort care only are excluded from the measure. We recognize the issue of reporting burden. We will request a larger amount of data for reliability and feasibility testing for this measure. One purpose of this is to determine

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		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		how participants with dementia should be handled when calculating this measure. We will collect a wider range of data used in analyses that will inform measure implementation, and data elements that are determined to be unnecessary will be removed or revised. Based on feedback and TEP recommendations, we will remove place of residence as a data element. We recognize that there is variation amongst PACE Organizations in terms of PO, community and participant characteristics. As a first step, we will provide risk stratification at the Organizational level, in order to examine differences among types of PACE Organizations. Preliminary stratification variables include caseload size, metropolitan status, years in operation and academic affiliation. Additional options for risk stratification or adjustment will continue to be explored.

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		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.		
11/30/17	General	UnityPoint Health (UPH) and Siouxland PACE are pleased to provide input in response to the Centers for Medicare & Medicaid Services' (CMS) comment request via its contractor, Econometrica, Inc., relating to proposed Stream 2 measures for the Programs of All-Inclusive Care for the Elderly (PACE) program. Siouxland PACE started in 2008 with assistance from a CMS Rural PACE	Cathy Simmons, JD, MPP Randy Ehlers, MSW Siouxland PACE	Thank you for your comments and general support of these measures. We appreciate your concern regarding burden. We will request a larger amount of data for reliability and feasibility testing for the measures to be used in analyses that

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		Development grant. Since 2011, Siouxland PACE has been under the ownership of UnityPoint Health – St. Luke's, a UPH senior affiliate in northwest Iowa. Currently, there are 179 Participants receiving PACE services from four northwest Iowa counties. In Stream 2, four new quality measures are being proposed: · Percentage of Participants With an Advance Directive or Surrogate Decision-Maker; · Percentage of Participants With an Annual Review of Their Advance Directive or Surrogate Decision-Maker; · Percentage of Participants Not in Nursing Homes; and · Percentage of Participants With Depression Receiving Treatment. Siouxland PACE is extremely supportive of initiatives to provide and track quality care. The Stream 2 draft measures appear appropriate and relevant for a PACE population. That said, we have two basic concerns: (1) administrative burden; and (2) overall scope. In terms of burden, we are concerned about the time and effort needed to track and report these new measures as it is unlikely that capitation rates will increase to reflect this added burden. While we track some of these efforts, we do not track in the manner specified by these measures. For the most part, this will involve manual collection until we can eventually convert some to an electronic platform (at added expense). Prior to any measure adoption, we encourage piloting these measures with several PACE organizations at varying degrees of EHR integration / adoption to determine level of effort and providing an additional comment period related to testing efforts and resulting time and effort studies.		will inform measure implementation. Data elements that are determined to be unnecessary will be removed or revised. We acknowledge your comments regarding the need to understand the overall process and plans for the final measure set. We anticipate that CMS will provide further information and guidance as we move closer to measure implementation. Additionally, both testing and implementation will include training and support which will provide additional information regarding the measure development and/or implementation process.

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		Second, it is difficult to comment on individual measures without understanding the totality of this quality measure project. We do not know how many total measures will ultimately be included within the final measure set nor how they are intended to be risk adjusted and impact our rates. While we are pleased that CMS is aligning these measures within the "Meaningful Measures" constructs, we lack an overall understanding of the final collection and reporting ask. We urge more transparency in the overall process so that we have better context in which to comment. On behalf of our PACE Participants, Siouxland PACE and UnityPoint Health appreciates the opportunity to provide comments to the Stream 2 proposed measures. In addition, Siouxland PACE is a member of the National PACE Association (NPA). We generally support the comments submitted by NPA and are committed to participating with the NPA to further strengthen services and supports for the PACE population. Siouxland PACE and UnityPoint Health look forward to participating in future PACE measure development and other stakeholder forums.		
11/30/17	General	Overall, Providence ElderPlace supports the move toward quality measurements for PACE organizations and the general categories of measures proposed. Providence ElderPlace appreciates CMS' efforts to update PACE data elements and measures that are intended to better serve PACE participants. However, we are deeply concerned that these proposals would add administrative burden on our caregivers without increasing the value of care provided to our participants. In addition, we find some of these proposals to be ambiguous with difficult to understand intent. Providence ElderPlace asks CMS to provide more clarity	Ellen Garcia, MPH Providence ElderPlace Oregon Susan Tuller, MHA Providence ElderPlace Washington	Thank you for your comments. We appreciate your concern regarding burden. We will request a larger amount of data for reliability and feasibility testing for the measures to be used in analyses that will inform measure implementation. Data elements that are determined to be unnecessary will be removed or revised.

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		and guidance on how the data will be reported, such as participant specific data versus aggregate data. In an effort to reduce administrative burden, Providence ElderPlace suggests CMS use aggregate data elements and functional upload capabilities. We request CMS: Clarify if the PACE quality measures are in addition to or a replacement for the current HPMS Level 1 quarterly data reporting. There are several areas of redundancy between the current reporting system and the streams of proposed quality measures, such as falls and immunizations. Providence ElderPlace strongly urges CMS to provide more information on the PACE quality data measures and provide clarity on how CMS intends to implement these measures without unnecessary duplication by PACE organizations to report events as both Level I and PACE quality data. Clarify if data will be collected by PACE contract number or by PACE center. We recommend data submission by contract number. Change data collection to aggregate data rather than participant specific data. As a large PACE organization, participant specific data collection will create large spreadsheets with, at times, limited data relevant to the measure. For example, the current proposal for data collection for the Percentage of Participants not in Nursing Homes would produce a spreadsheet for our Portland PACE program with 1414 lines, 29 of which would contain data (the date of nursing home admission). Our Seattle PACE program has 627 participants with 4		Data reporting will vary somewhat based on the individual measure, but we anticipate data elements will be provided at the participant level in most cases. We acknowledge your comments regarding the need to understand the overall process and plans for the final measure set. Where there is overlap, new measures will replace their analogous Level 1 or 2 measures when they are implemented. We also anticipate that CMS will provide further information and guidance as we move closer to measure implementation. Additionally, both testing and implementation will include training and support which will provide additional information regarding the measure development and/or implementation process.

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		participants living in skilled/sub-acute stay, 7 participants in non-permanent custodial stay, and 16 participants who permanently live at a nursing home. The same data could be submitted in an aggregate fashion, thus reducing staff burden for the PACE center and CMS. Limit data collection to the information relevant to the measure. For example, the proposed data collection plan for the measures related to Advanced Directives and Depression treatment includes the participant's living situation. This data point is not necessary to the data calculation of these measures.		
11/30/17	Advance Directives	Data collection category should be changed to "Yes/No". The type of Advanced Directive is not needed for measure calculation and creates undue administrative burden.	Ellen Garcia, MPH Providence ElderPlace Oregon Susan Tuller, MHA Providence ElderPlace Washington Health	Thank you for your comment regarding Advance Directives. We may change the measure to be yes/no after testing. For pilot testing, the items are more detailed to inform the measure definitions.
11/30/17	Not in Nursing Homes	We urge CMS to clarify if this is a point in time measure at the end of the quarter, or if the intention is for PACE programs to report any nursing facility stay over 90 days that overlaps with any part of the reporting quarter. For consistency of data reporting, we recommend a point in time measure for the final day of the quarter. We also request clarification on qualifying stays. Does CMS intend for PACE programs to include all levels of nursing facility stays (sub-acute, skilled, intermediate, custodial, or any combination of the above)? Or is the intention only for long-term custodial or intermediate stays to be reported for this measure?	Ellen Garcia, MPH Providence ElderPlace Oregon Susan Tuller, MHA Providence ElderPlace Washington	Thank you for your questions. This measure is a point-in-time measure that will capture data on the final day of the reporting quarter, rather than counting or capturing extended nursing home stays across multiple quarters. This measure is only for long-term placement (> 90 days) in nursing homes. Skilled nursing facilities and other types of short-term care will be defined as "Not in Nursing Homes."
11/30/17	Depression Treatment	Additionally, there are multiple unnecessary data points listed in the proposed data collection plan for the	Ellen Garcia, MPH Providence ElderPlace	Thank you for your comments regarding Depression Treatment. We

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		measure of Percentage of Participants with Depression receiving Treatment. The data collection proposal for the measure asks for: o whether the participant was screened for dementia o the dementia screening tool used o whether the participant was diagnosed with dementia o whether the participant was screened for depression o which depression screening tool was used Based on the measure definitions and inclusion/exclusion criteria, none of these requested data points are relevant to the calculation of the measure. The only relevant data points are the number of participants with a depression diagnosis and whether or not they are receiving or were offered treatment. Requesting unnecessary data creates an administrative burden for PACE and CMS and takes away resources from the people we serve. Providence ElderPlace recommends that data collected be limited to the relevant data points and, when possible, be reported as "Yes/No" and as aggregate data.	Oregon Susan Tuller, MHA Providence ElderPlace Washington	recognize the issue of reporting burden. We will request a larger amount of data for reliability and feasibility testing for this measure. One purpose of this is to determine how participants with dementia should be handled when calculating this measure. We will collect a wider range of data used in analyses that will inform measure implementation, and data elements that are determined to be unnecessary will be removed or revised.
11/30/17	Depression Treatment	Percentage of Participants with Depression Receiving Treatment. If the data collection points related to screening are maintained, there needs to be a category added for "screening is not due" and "screening is not clinically indicated/ appropriate". We also recommend changing data collection categories of Depression Diagnosis and treatment to "Yes/ No". The type of treatment and diagnostic codes are not needed for measure calculation, again adding an administrative burden.	Ellen Garcia, MPH Providence ElderPlace Oregon Susan Tuller, MHA Providence ElderPlace Washington	Thank you for your comments; we will address them in the instructions for both reliability and feasibility testing and for measure implementation. We are sensitive to PACE organizations' reporting burden and can assure you that several categories of data that prove to be problematic or not meaningful in measure testing will be eliminated for measure implementation. The larger amount of data collected for the reliability/feasibility testing will be

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				analyzed to inform the measure specifications for implementation. For example, we will provide PACE organizations with ICD-10 codes to be programmed into your data-pull. But you will not be asked to report data for each code.
11/30/17	General	Justice in Aging appreciates the opportunity to provide comments on the above-referenced proposed PACE measures. Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries and populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency. We appreciate the value of the PACE program to providing an integrated care option to older adults and people with disabilities, including especially those who qualify for both Medicare and Medicaid. We also have appreciated the many innovations in care developed through PACE and the pioneering work of many PACE programs in providing culturally competent care to older adults in limited-English proficient communities and communities of color. Overall, we support the inclusion of all the measures proposed in Stream 2, as each measure addresses needs	Jennifer Goldberg, JD Justice in Aging	Thank for your comments supporting the Stream 2 measures.

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		for Medicare and Medicaid beneficiaries that should be prioritized.		
11/30/17	Advance Directives	We believe that the measures addressing the Percentage of Participants with an Advance Directive or Surrogate Decision-Maker and Percentage of Participants with an Annual Review of Their Advance Directive or Surrogate Decision-Maker are valuable as important elements of determining the extent to which person-centered care is delivered. We have concerns, however, about the framing in the introduction with its emphasis on cost reduction as a major benefit for offering beneficiaries opportunities to express their choices. We urge that care be taken to ensure that the message to programs and to participants is clear: participant choice, whether or not that choice results in savings, should be honored. We also offer one additional suggestion related to this measure. In the definitions section, there is a statement that the documentation of an advance directive "must be reviewed using terms the participant can understand." We urge that there be more explicit reference to the needs of participants with limited English proficiency or with communications disabilities. We urge adding a sentence such as: "This may require use of interpreters, including sign language interpreters, translated documents, materials in alternate formats or other accommodations to ensure that the participant or, if appropriate, the surrogate decision-maker can fully understand explanations and express preferences or concerns."	Jennifer Goldberg, JD Justice in Aging	We greatly appreciate the recommendation to emphasize participant-choice and participant-centered care, regardless of cost, and will revise the measure introduction to further highlight those very important points. We also agree with the need for the review to be at a level and in a manner the participant can understand. Thank you for the wording suggestion; we will add this to the measure guidelines.
11/30/17	Not in Nursing Homes	We believe that the measure of Percentage of Participants Not in Nursing Homes is a key indicator of the program effectiveness and success at promoting	Jennifer Goldberg, JD Justice in Aging	Thank you for your feedback. We are glad to hear that you find the

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		community integration for participants. PACE programs are designed to allow participants to continue to live in the community, even at the high care need level that characterizes PACE participants. It is appropriate and necessary to measure the extent to which programs achieve those goals.		measure to be an important indicator of PACE's effectiveness.
11/30/17	Depression Treatment	We also support the measure of Percentage of Participants with Depression Receiving Treatment. The evidence that depression is under-diagnosed and under-treated among older adults is overwhelming, including the studies cited in the announcement. Measuring the extent to which PACE programs address depression among participants will encourage programs to prioritize providing appropriate treatment and help identify promising practices.	Jennifer Goldberg, JD Justice in Aging	Thank you for your comment.
11/30/17	Advance Directives	Current electronic medical system records advanced directives/surrogate decision-maker and discussions with participant. Flags are set on facesheet of electronic records based on directives. There is no computer report to exclude specifically for refusals. Current electronic health record pulls a report specifying emergency directives on one report as a total summary (ex. category 1 shows on one report). These categories of 1 - 7 would be manually entering on a spreadsheet by participant to break it down into 7 separate categories. Current electronic health record pulls a report listing most recent date of advance directive. Signatures on scanned in documents occur at enrollment, annually and sooner as needed. The current electronic report only shows the most recent date data was entered, no listing of enrollment date as it pulls currently active participants only. Manually adding back deceased/dis-enrolled participants will be required as well as	Wendy Stanton Rocky Mountain PACE	We appreciate the comments about how your electronic record system captures (or does not capture the data elements). This is an important aspect of feasibility that we will assess during testing. We will clarify and add examples for the anchor dates. We will drop the place of residence item.

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		enrollment dates. Current electronic medical system selects all active participants. There is no computer report to calculate enrollment tied to advanced directives. Manual merging of countable census based on annual criteria would be required. Clarification of anchor dates requested. Ex. 6 months include versus 5 months 30 days exclude. Would the anchor dates change if the directive is updated sooner than annually? Suggest combining 3. Nursing Home and 6. Skilled Nursing Facility as current electronic health record is set for this parameter. Suggest reviewing PACE sites to see if majority of SNF and/or ALF are contracted to provide rehabilitation services. Current electronic health record is set to pull ALF and SNF, and not rehabilitation. Would single patient agreements that are not with a current contracted facility (ALF/SNF) be counted as 7. Other? Suggest using current location based on 1st day of last month of reporting quarter or last day of the month of the reporting quarter. Current calculations would be manual by participant because electronic medical system does not have capability to sort data with this limitation of 50% or greater.		
11/30/17	Depression Treatment	RM PACE administers a MOCA first upon enrollment, not a dementia screening first. Based on enrollment assessments, further diagnostic tools are used to screen for dementia as relevant as well as a tool, such as the GDS. Regarding depression diagnosis codes:	Wendy Stanton Rocky Mountain PACE	Thank you for your comments about assessment procedures in newly enrolled PACE participants. We are revising the list of ICD-10 codes to be used in identifying participants diagnosed with depression so that

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		Is this a range? Is this a range from F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.8, F32.9? Coding requires a fourth digit. F06.3 would be the code for definition listed. F06.02 does not exist 2017-2018 ICD10-CM Manual. This manual is through the AMA. F06.31 If utilized, this is normally used as a second code after coding Depression first. Something cognitively is wrong such as Brain Trauma. It will not be coded often at RM PACE as participants do not often present with this - less than 5 participants. F23.1 This code does not exist according to the 2017-2018 ICD10-CM Manual F25.0, F25.1, F25.8, F25.9 are possible. F34.1 does not exist in 2017-2018 ICD10-CM Manual. This manual is through the AMA. Adjustment disorders start at F43.2 Regarding exclusions: Should dis-enrolled participants be included too? Thinking Out Loud: Active participants for at least 30 days (set standard for administering the tool) and the person cannot be deceased within the first 30 days of enrollment nor dis-enrolled the following month of new enrollment. The reason being, staff need time to assess participant and also administer the tool for depression and then the participant needs to be seen as appropriate for follow-up.		they include mood and some adjustment disorders. Depression treatment reporting should include participants who became dis-enrolled during the reporting period. Thank you for the suggesting regarding allowing 30 days to complete an assessment tool. This criteria will be considered further as we test the measure.

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		Would it be possible to list the relevant ICD10 codes that are included for depression (32.0 - mild depression) and dementia? CO State has a list that is being used for dementia (F03.90, F03.91 - CO State note utilizing at this time but recommended by coder, F01.50, F01.51, F10.27, F02.80, F02.81, G31.83, G31.09) What about Alzheimer's disease - G30.0, G30.1, G30.8, G30.9 Pick's Disease G31.01 Regarding whether participant is receiving treatment: Electronic computer system does not have a way of coding 1-6, 99. This would be manual. Are you going to identify ICD10 code F32.4, F32.5, F33.40, F33.41, F33.42 for remission? Regarding type of treatment: This would be a manual process of looking at the medical record by participant.		
11/30/17	General	We appreciate the opportunity to comment on the measures. A concern with our growing program, is the ability to pull data from the electronic medical record. Collecting data manually leaves much room for error and is inefficient. Our electronic health record will not pull data unless it is entered on a form. We do not currently have forms for any of this data. There will be a cost to adding forms. There are some restrictions on certain screening tools and Mediture cannot always get permission to use screening tools. None of the listed measures can be retrieved from our current electronic medical record. We will have to manually collect this information.	Tracey Diroff PACE Southeast Michigan	Thank you for your comments regarding the feasibility and burden of collecting the required data elements. We will continue to assess these issues during feasibility testing.
11/30/17	Not in Nursing Homes	I question the need for the percentage of participants not in a nursing home. The reason for our existence is to keep elderly in the community and independent.	Tracey Diroff PACE Southeast Michigan	Thank you for your comment. We agree that one of the primary goals of PACE is to care for the elderly in the

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				community. As such, this measure will provide important information about how PACE is meeting that goal. PACE Organizations may be able to use this measure to compare PACE with other related types of care programs.