

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 July 17, 2015, to August 17, 2015.
- Additional questions based on the initial public comments received are **bolded** and included within this report. We are asking that you please send responses/comments to these questions using the following address: PACEQMcomments@econometricainc.com. Your responses/comments are due by **11:59PM EST on September 24, 2015**.

Project Overview

The Centers for Medicare & 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-year base period (or Base Year), with an option for three additional years. For the Base Year of this project, CMS and Econometrica are developing four quality measures:

- (1) Falls,
- (2) Falls with injury,
- (3) 30-day hospital readmissions, and
- (4) Pressure ulcers (prevention and outcomes).

These four measures are under review and adaptation to the best suit the PACE Organizations and participants.

As part of its measure development process, CMS requires contractors to convene groups of stakeholders and experts who contribute direction and thoughtful input to the measure contractor during measure development and maintenance. To date, CMS and Econometrica have informed the development of these proposed quality measures for the PACE program by:

- Conducting an Environmental Scan of the white and grey literature,
- Engaging the input of experts in the field by convening a technical expert panel,
- Developing a Business Case that aims to reveal potential value to the PACE program from these measures, and
- Engaging PACE organizations to both test and comment on the draft quality measures.

As part of the public comment period, CMS and Econometrica developed the following documents for the draft quality measures:

- Public Description of Measures,
- Measure Information and Measure Justification forms for all proposed measures, and
- A Measure Evaluation Report.

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 four areas of measurement—30-Day Readmissions, Falls, Falls With Injury, and Pressure Ulcers (inclusive of a prevention measure) —within the Base Year of the project.
- Conduct field tests to assess the feasibility of data collection for these four proposed adapted measures.

Information About the Comments Received

- Public comments were solicited by announcements made during stakeholder group meetings and by email notifications.
- 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/CallforPublicComment.html>.
- In total, 148 comments were received from 17 unique email submissions through the PACEQMcomments@econometricainc.com address provided as part of the Call for Public Comment:
 - 108 comments were from PACE organizations.
 - 34 comments were from the National PACE Association.
 - Three comments were from State organizations.
 - One comment was from a nongovernmental organization.
 - One comment was from a private consulting firm.
 - One comment was from a hospital.

Purpose of Preliminary Public Comment Report

The purpose of this Preliminary Public Comment Report is to provide an overall summary of public comments received, identify all comments received through the public comment period, and provide an overall set of preliminary recommendations regarding the next steps for the draft

four measures. CMS and Econometrica, Inc. continue to review all individual comments and will provide final recommendations as part of the Final Public Comment Report, which will be posted at a later date.

In addition, the CMS and Econometrica expect this preliminary report to generate additional feedback prompted by the submitted public comments as well as recent results from the testing phase, which weren't included in the Initial Public Comment Period. This feedback is being solicited in the form of seven questions posed in the "Additional Feedback" subheadings included, where applicable, in the sections below. CMS and Econometrica are requesting that responses to these comments be submitted by **11:59pm EST on September 24, 2015**.

This preliminary report organizes the summary of each comment under two main headings: Stakeholder Comments – General and Stakeholder Comments – Measure Specific.

Stakeholder Comments – General

Two comments expressed the uniqueness of the PACE environment as opposed to other health care settings. PACE environments are not as well controlled to mitigate risk as much as a more controlled environment, such as a hospital or a nursing home facility. Seven comments addressed how census numbers should be used and supported instead of caseload, which is a term better suited to other care environments.

We thank submitters for all comments. One of the important aspects of pilot testing is the identification of the need for clarification, including census vs. caseload. Due to the nature of the PACE organization and the capitation payment system, we agree that census is a better term. Furthermore, considering the fact that disenrollments rarely occur during a given month, we are proposing to use the census as of the first day of the month.

Additional Feedback

Based on our testing results, CMS and Econometrica are trying to consider all factors when implementing quality measures across PACE organizations, such as differences in the PACE participant population influenced by health status and geography. We believe an overarching acuity methodology application may be a necessary component for all measures, and are seeking feedback from stakeholders on this application in the question below.

- 1. CMS and Econometrica are considering an acuity methodology, which would include a geographic and participant health status component. Should a substitute measure include acuity adjustment? Recognizing there is no standard measure of acuity, please suggest an acuity assessment specific to PACE Organizations.**

Stakeholder Comments – Measure-Specific

Summary of Falls and Fall with Injury Comments:

Seven comments questioned assisted falls and the difficulty in determining who assisted a participant to reduce injury from a fall. Three comments promoted parsimony within the falls measure set (i.e., Falls and Falls With Injury).

Additional Feedback

Following the review of the comments and accounting for the results of our testing phase, CMS and Econometrica encourage the public to provide additional feedback on the Falls and Falls With Injury rates based on the questions posed below.

- 2. Our testing results suggest that a monthly reporting timeframe for the Falls and Falls with Injuries measures is not sufficient in order to produce meaningful results. We believe that a larger “look-back” data reporting period would produce more reliable, valid data across the PACE Organizations. Currently, our intent is to shift the reporting period from monthly to quarterly. Is quarterly reporting an appropriate timeframe for reporting falls? Do you believe that a different reporting period should be used?**
- 3. Would a paired (or composite) measure combining falls and falls with injury be more appropriate? How could a paired or composite measure be accomplished?**
- 4. The comments received suggest that many falls go unreported. CMS and Econometrica are considering ways of involving PACE participants or their caregivers in order to promote effective data reporting. For example, we could develop and implement a form-like process to document falls in the home by the PACE participant or caregiver. What are the benefits of developing a form-like process for PACE participants to track falls that would assist with recall/reporting? Are there other more effective ways of involving PACE participants and their caregivers on reporting falls?**
- 5. Based on comments received and our testing results, CMS and Econometrica are considering the development of a fall prevention measure in future contract years. What factors should CMS consider in developing a prevention measure for falls within PACE?**

Summary of Pressure Ulcers Comments:

Four comments pointed out that Pressure Ulcer assessments are conducted every 60 days in home care, but only every six months in the PACE programs, unless there is a change of status. We received seven comments requesting a tool for risk assessment. Six comments asked for measures to be associated with Level II reporting in order to harmonize the measure definitions. Three comments addressed concerns around the measure capturing pressure ulcers acquired by participants in their homes versus those acquired in settings outside of PACE.

Additional Feedback

Review of the comments and accounting for the initial testing phase results prompted the CMS and Econometrica to request the following additional feedback on the pressure ulcer prevention measure.

6. CMS and Econometrica believe that preventative measures are vital to ensuring quality of care for PACE participants. Through our testing and the public comments, we understand that current processes are prohibitive in terms of capturing data for a pressure ulcer prevention measure. CMS and Econometrica would like to invite feedback on how we can direct and/or incorporate processes in order to promote effective reporting on such a process measure. For example, **should CMS adapt a pressure ulcer scoring system (e.g., Braden) and/or a bundling pressure ulcer prevention system to capture data effectively and consistently across PACE organizations?**

Summary of 30-Day Readmission Comments

Four comments were received regarding the timing for defining the window for 30-day all-cause readmissions. Six comments were received regarding clarification of what constitutes a 30-day all-cause readmission and the related exclusion criteria. There also were three comments expressing that high performing PACE organizations may have low admission rates (i.e., index admissions), which reduces the denominator.

Additional Feedback

All of the comments were appreciated, including the illustrative examples with sample dates. Comments related to the performance of PACE organizations and low admission rates are well considered and also appreciated. Review of the comments and accounting for the initial testing phase results prompted CMS and Econometrica to request the following additional feedback on the readmissions measure:

7. **Is admission a more appropriate quality measure for PACE than 30-day Readmissions or is there a more appropriate measure for use in the context of PACE?**

Preliminary Recommendations

- Given the timing of the Public Comment Period—held concurrently with the Feasibility Testing—the comments were focused primarily on the measure intent and specifications. The PACE Quality Measures Testing Summary contains suggestions regarding the feasibility of data collection that was not known at the time of this round of public comment.
- Specifications should be revised as needed based on the issues and clarifications raised during the Public Comment Period and from the results of Feasibility Testing reported above.
- Responses to the seven questions posed above will better inform Quality Measure development and implementation.

Overall Analysis of the Comments and Recommendations

All of the comments and feedback received from these stakeholders provided meaningful and useful input into the core data element specifications. There was broad support for the intent of the measures, with four commenters/organizations supporting the intent of Falls, Falls With Injury, Pressure Ulcers (outcomes), and 30-Day Readmissions. The draft Pressure Ulcer

Prevention measure was not unanimous among commenters, with one stating they agreed with the intent “as is” and two stating that they agreed with the intent only after considering the comment. With the initial validity and feasibility testing completed, changes to the specifications can be made to the relevant measures. Crucial conversations regarding a path forward for all measures will be held following analysis and review of the findings from the feasibility testing.

Public Comment Verbatim Report

Note: All identifiable information have been removed from the comments section. All comments, however, represent the complete, verbatim comments provided during the public comment period. Repeated comments were submitted by multiple commenters and the repetition is intentional.

| No. | Date Posted | Measure Set or Measure | Text of Comments |
|-----|-------------|------------------------|---|
| 1. | 8/11/2015 | General | <p>1) Attention must be given to the ability of PACE Organizations (PO's) to easily extract data from the medical records either from paper or electronic. If electronic, vendors must be held accountable for meeting reporting requirements and deadlines to assure the PO's are well supported.</p> <p>2) Special attention must be given to the unique aspects of PACE population particularly when considering how to define in numerators and denominators.</p> <p>3) Another unique aspect of the PACE population and the services and care we provide is based on individual preferences. There are three goals of care categories in PACE: Longevity, Functionality and comfort care. Services are provided to our participants based on an individual participant's goals of care and are not population specific.</p> <p>4) Claims are generally not generated for services which should be taken into account when developing measures</p> <p>5) As a measure testing site, numerators and denominators must have unambiguous definitions</p> |
| 2. | 8/13/2015 | General | If CMS decides to implement the overall hospital star rating system will each individual measure continue to be posted on the Hospital Compare website, or will the star rating only be displayed? |
| 3. | 8/13/2015 | General | <p>As a long-time advocate for and provider of services to persons living with advanced illness or disability in old age, I am quite disheartened by the proposed quality metrics for PACE. Having some quality metrics applied to PACE is a good step, especially as many of the new PACE programs are sponsored by for-profit businesses, so more variation in quality is likely to arise. However, the initial five metrics are really a pallid reflection of the core issues of importance to beneficiaries and families who use PACE. These people look for elements like continuity, reliability, prudent medical services, and comfort. They may be looking to relieve an overwhelmed family caregiver or mainly to avoid placement in a Medicaid-supported nursing home. Indeed, they may have quite personal goals and priorities, and one of the sterling characteristics of PACE has been its commitment to patient-and family-driven comprehensive care plans, enabling the care plan to help the beneficiary and family to live as well as possible with their situation, as measured by their own yardstick.</p> <p>Yet these proposed measures do not even begin to ask about person-driven care plans, or care plans at all. They don't touch on medical care quality or symptoms or reliability of back-up for care at home. It is undoubtedly important to all to avoid falls and pressure ulcers, but even these</p> |

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| | | | <p>have varying importance, depending upon the particular PACE participant's concerns and aspirations.</p> <p>The specific metrics that are proposed pose certain practical problems. Pressure ulcers at stage 1 should not be counted as adverse indicators. They are variably detected, easily healed, and it is prudent to encourage them to be reported and treated quickly. None of the other CMS metrics for other types of providers tally Stage 1 pressure ulcers (though they did in the past, before the adverse consequences of doing so were recognized). Falls will have the persistent problem of under-reporting for people who are living on their own. But these can probably be rectified (for pressure ulcers) and managed (for falls).</p> <p>However, the 30-day readmission rate will have the same "shrinking denominator" problem that the CMS readmission rates have had in all other applications or the readmission rate. A very good PACE program will have a low admission rate, and their readmission RATE (if calculated as proposed) may well be high, because the only people being admitted to hospitals are people for whom hospitals actually offer substantial gains and whose health is very fragile, and for whom achieving stability is challenging. On the other hand, a weak PACE program might well still hospitalize a larger number of elders who really could have been served in other settings, whether for conventional medical care or for more palliative goals; but their readmission RATE might be low because their admission rate is so high. In short, the readmission rate, defined as some form of readmissions/discharges, is singularly useless as an indicator of care quality. Perhaps PACE would be a good setting in which to start evolving toward more useful metrics -- perhaps process measures like having root cause analyses in place with responses to identified opportunities, or overall hospital utilization measures. In the meantime, CMS should not propagate this seriously dysfunctional metric to yet one more setting.</p> <p>In conclusion, CMS should not implement the readmission rate metric, should delete Stage 1 pressure ulcers from the numerator in that measure, and should commit to developing and deploying metrics that are of more use in distinguishing better and worse PACE programs in the future.</p> |
| 4. | 8/13/2015 | General | <p>Thank you for the opportunity to comment on the proposed quality measures for the Programs of All- Inclusive Care for the Elderly (PACE) program. We strongly support publically reported quality measure for this valuable program but encourage consideration of how quality measures can be used across programs. There is a need for quality measures reflecting the unique needs of PACE participants but also allow comparison across programs serving this frail and often dual-eligible population, including Special Needs Plans and the CMS Medicare Medicaid Plans.</p> <p>In developing measures proposed here, we encourage CMS to consider how measures used by Special Needs Plans and Medicare-Medicaid Plans can be adapted for PACE before developing de-novo measures. For example, this project proposes to develop a 30 day all-cause readmission measure.</p> <p>However Special Needs Plans and Medicare-Medicaid plans already report on a readmissions</p> |

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| | | | <p>measure. A de-novo measure not aligned with existing measures would prevent CMS and beneficiaries from making apples-to-apples comparison among plans in the other programs. Without comparable measures across programs, beneficiaries cannot make truly informed choices.</p> <p>We also recognize that those of us who develop measures have a responsibility to do so with an eye to the importance of comparability and harmonization. This is especially important for the many beneficiaries have both serious health concerns and limited health literacy. They and their families must be able to make direct comparisons across programs. It is also essential for providing policymakers and practitioners the tools they need to measure quality, identify the most effective models of care, direct patients to the most appropriate options and drive improvements throughout the health care system.</p> |
| 5. | 8/14/2015 | General | <p>1. XXXX strongly encourages that definitions be considered from the perspective that the PACE population is always “at-risk”.</p> <p>2. Regarding readmissions – XXXX suggests that more criteria be defined and that consideration be given to readmissions for the same reason/condition.</p> <p>3. What is the baseline that is being developed/used for comparison for these measures? Best practices should be published and encouraged based on the benchmarks/findings.</p> <p>4. Risk stratification based on PACE characteristics should be more defined.</p> <p>5. XXXX has suggestions for additional quality measures that we would like to share.</p> |
| 6. | 8/14/2015 | General | <p>We respectfully request that in this pursuit, measures are designed with minimal burden in data collection and high value for our participant’s care. For example, XXXX supports the areas of focus for the proposed measures: Fall and Injury Prevention, Pressure Ulcer Prevention, and Reducing Hospital Readmissions. However, we are concerned about the level of data entry proposed on a monthly basis. As a large PACE Organization serving over 1100 enrollees, we believe that the administrative burden of monthly data entry without a mechanism for uploading spreadsheets or reports is very significant. We recommend that only the data elements needed to calculate the measures be submitted and that data be submitted on a quarterly basis. Further, we strongly urge you to explore data reporting that is done on an aggregate basis versus per participant data entry.</p> |
| 7. | 8/14/2015 | General | <p>XXXX represents 11 PACE programs which serve approximately 1,400 frail, elderly individuals. On their behalf, we offer the following in response to the Centers for Medicare & Medicaid Services’ (CMS) request for comment on proposed PACE quality measures. XXXX supports CMS’ efforts to improve the quality of health care for PACE participants in the United States. As the PACE population is dynamically evolving, we are aware of the increasingly complex nature of measuring quality accurately and providing this information so that it is reliable, valid, and meaningful. We offer the following comments related to the potential implementation of these measures. As a member of the National PACE Association, we have drawn heavily upon their</p> |

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| | | | findings and comments, which were developed by a participatory process. |
| 8. | 8/14/2015 | General | XXXX appreciates CMS' efforts to develop, adapt, and implement quality measures for PACE. It will be vital to consider the unique aspects of PACE that allow for PACE-specific comparison, while balancing the needs of the National Quality Forum, states, and other stakeholders to compare PACE to other service delivery options (e.g., managed care). Given the variability in PACE size, participant needs and abilities, and programmatic differences compared to other settings of care (i.e., nursing facilities), simply adapting existing quality measures may not be advisable. For example, the denominator of National Database of Nursing Quality Indicators <i>Falls</i> quality measure is based on patient days in a facility which is not applicable to PACE. We recommend that Econometrica review PACE regulations and guidance documents to glean insight regarding how to best define and identify the PACE participant. We encourage CMS/Econometrica to harmonize the measure definitions of the proposed measure set with the definitions and reporting requirements associated with Level II reporting. This will mitigate the use of varying definitions for the same data element. |
| 9. | 8/14/2015 | General | Additionally, PACE quality measures should reflect participants' individual preferences and goals. In PACE, the goals of care for participants are categorized into three broad areas: promotion of longevity, optimization of function, and comfort care. Given the heterogeneity of the PACE population, we encourage to CMS/Econometrica to consider the impact of differences in participant care goals, as well as the characteristics of participants on the measure results. |
| 10. | 8/14/2015 | General | Lastly, as part of the measure testing phase, XXXX recommends that CMS/Econometrica explore and attempt to understand the degree to which standardized and complete data is available from PACE organizations (POs) needed to calculate valid and reliable measures. Unlike nursing homes, home health care agencies and many other provider-based care options for frail elderly, PACE lacks a common assessment instrument and data standard. We have struggled with this within our own state boundaries, and are deeply appreciative of the work done by the National PACE Association to address this need. The National PACE Association has developed a common data platform across all PACE organizations referred to as the <i>Common Data Set (CDS)</i> [see Figure 1]. The CDS contains a standardized dictionary of definitions for data elements to collected – demographics (CDS I) and services (CDS II). The creation of a standardized participant specific data set for 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. |

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|------------------|--|------------------------|--|------------------|------------------------------|--------|--|------|--|
| | | | <p>Figure 1.</p> <div><div>Common Data Set</div><div><div>Common Data Set I (CDS I) Demographics</div><div><ul style="list-style-type: none">Enrollee CharacteristicLiving ArrangementFunctional AssessmentCognitive Status</div></div><div><div>Common Data Set II (CDS II) Services</div><div><ul style="list-style-type: none">Services providedProfessional providing serviceLocation of Service</div></div></div> | | | | | | |
| 11. | 8/14/2015 | General | <p>Additionally, PACE organizations may not generate claims for all services their employees render to PACE enrollees because PACE is a provider-based managed care model. This lack of data may fundamentally impede the ability to calculate certain measures. Much of this data will need to be captured and reported electronically, so it will be important to understand the degree to which POs use and can generate data from their electronic health record (EHR) systems. We encourage CMS to consider the data collection and reporting burden that POs will incur in implementing these measures. We request that CMS be transparent in communicating the purpose of measure reporting (i.e., quality improvement; accountability; public reporting). We also encourage that CMS share trend data and PO-specific performance results that can be used to inform service delivery.</p> | | | | | | |
| 12. | 8/14/2015 | General | <p>The following table, prepared by the XXXX, presents a list of settings in which PACE participant’s reside, attend, obtain medical treatment, and/or visit that has been standardized across PACE. As CMS/Econometrica finalizes the measure specifications, we request that consideration be given to the locations identified on the <i>Place of Service</i> list in order to promote consistency in data reporting and use of existing standardized definitions used in PACE.</p> <p>Table 1. Place of Service</p> <table><tr><th>Place of Service</th><th>Place of Service Description</th></tr><tr><td>Office</td><td>Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.</td></tr><tr><td>Home</td><td>Location, other than a hospital or other facility, where the patient receives care in a private residence.</td></tr></table> | Place of Service | Place of Service Description | Office | Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis. | Home | Location, other than a hospital or other facility, where the patient receives care in a private residence. |
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| | | | Assisted Living Facility | Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services. |
| | | | Group Home | A residence, with shared living areas, where participants receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration). |
| | | | Temporary Lodging | A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code. |
| | | | Inpatient Hospital | A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions. |
| | | | Outpatient Hospital | A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. |
| | | | Emergency Room - Hospital | A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided. |
| | | | Skilled Nursing Facility | A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital. |
| | | | Nursing Facility | A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals. |
| | | | Custodial Care Facility | A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component. |
| | | | Hospice | A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided. |

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|-----|-------------|------------------------|---|---|
| | | | Independent Clinic | A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. |
| | | | Federally Qualified Health Center | A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician. |
| | | | Inpatient Psychiatric Facility | A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician. |
| | | | Psychiatric Facility - Partial Hospitalization | A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility. |
| | | | PACE Day Center | A facility which includes a primary care clinic, and areas for therapeutic recreation, restorative therapies, socialization, personal care, and dining, and which serves as the focal point for coordination and provision of most PACE services. |
| | | | Inpatient Substance Abuse Facility / Behavioral Care Facility | Including, but not limited to, detox lockdown. |
| | | | Rehabilitation Unit/Facility | A free-standing rehabilitation hospitals and rehabilitation units in acute care hospitals that provides an intensive, multi-disciplinary physical or occupational therapy. |
| | | | In Transport | Use of vehicle to transport participants to/from locations to obtain PACE-related services. |
| | | | Community | Parks, concert halls, theatres, etc. |
| 13. | 8/17/2015 | General | General Comments These measures appear to be existing nursing home measures that have only been slightly tweaked to fit the PACE model of care. We feel CMS and Econometrica should look at what quality looks like in PACE vs. other healthcare delivery systems such as ACOs and MCOs and not compare to nursing home populations. We cannot reiterate enough the concept that unlike nursing homes or acute care hospitals – the majority of POs do not have physical custody of the participants who live at home. Many times bad outcomes occur at homes that are associated with poor judgment on part of the participant or caregiver in spite of many educational attempts. We would be in favor of referring to the CDC for some guidance in falls in the community that is more | |

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| | | | akin to our population and the many challenges we face. Thank you for allowing us input on these measures. |
| 14. | 8/17/2015 | General | XXXX appreciates CMS' efforts to develop, adapt, and implement quality measures for PACE. XXXX cautions CMS and its contractors as they seek to adapt existing quality measures given the variability in PACE size, participant needs and abilities, and programmatic differences compared to other settings of care (i.e., nursing facilities). For example, the denominator of National Database of Nursing Quality Indicators <i>Falls</i> quality measure is based on patient days in a facility and which is not applicable to PACE. It will be vital to consider the unique aspects of PACE that allow for PACE-specific comparison, while balancing the needs of the National Quality Forum, states, and other stakeholders to compare PACE to other service delivery options (e.g., managed care). We recommend that Econometrica review PACE regulations and guidance documents to glean insight regarding how to best define and identify the PACE participant. We encourage CMS/Econometrica to harmonize the measure definitions of the proposed measure set with the definitions and reporting requirements associated with Level II reporting. This will mitigate the use of varying definitions for the same data element. |
| 15. | 8/17/2015 | General | Additionally, PACE quality measures should reflect participants' individual preferences and goals. In PACE, the goals of care for participants are categorized into three broad areas: promotion of longevity, optimization of function, and comfort care. Given the heterogeneity of the PACE population, we encourage to CMS/Econometrica to consider the impact of differences in participant care goals, as well as the characteristics of participants on the measure results. |
| 16. | 8/17/2015 | General | Lastly, as part of the measure testing phase, XXXX recommends that CMS/Econometrica explore and attempt to understand the degree to which standardized and complete data is available from PACE organizations (POs) needed to calculate valid and reliable measures. Unlike nursing homes, home health care agencies and many other provider-based care options for frail elderly, PACE lacks a common assessment instrument and data standard. We have struggled with this within our own state boundaries, and are deeply appreciative of the work done by the National PACE Association to address this need. The National PACE Association has developed a common data platform across all PACE organizations referred to as the <i>Common Data Set (CDS)</i> [see Figure 1]. The CDS contains a standardized dictionary of definitions for data elements to collected – demographics (CDS I) and services (CDS II). The creation of a standardized participant specific data set for 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. |

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| | | | <p>Figure 1.</p> <div><div>Common Data Set</div><div><div>Common Data Set I (CDS I) Demographics</div><div><ul style="list-style-type: none">• Enrollee Characteristic• Living Arrangement• Functional Assessment• Cognitive Status</div></div><div><div>Common Data Set II (CDS II) Services</div><div><ul style="list-style-type: none">• Services provided• Professional providing service• Location of Service</div></div></div> | | |
| 17. | 8/17/2015 | General | <p>Further, as a provider-based managed care model, PACE organizations do not generally generate claims for all services rendered by their employees to PACE enrollees. As such, 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 use and can generate data from their electronic health record (EHR) systems. We encourage CMS to consider the data collection and reporting burden that POs will incur in implementing these measures. We request that CMS be transparent in communicating the purpose of measure reporting (i.e., quality improvement; accountability; public reporting). We also encourage that CMS share trend data and PO-specific performance results that can be used to inform service delivery.</p> | | |
| 18. | 8/17/2015 | General | <p>The following table presents a list of settings in which PACE participant's reside, attend, obtain medical treatment, and/or visit that has been standardized across PACE. As CMS/Econometrica finalizes the measure specifications, we request that consideration be given to the locations identified on the <i>Place of Service</i> list in order to promote consistency in data reporting and use of existing standardized definitions used in PACE.</p> <p>Table 1. Place of Service</p> <table><tr><th>Place of Service</th><th>Place of Service Description</th></tr></table> | Place of Service | Place of Service Description |
| Place of Service | Place of Service Description | | | | |

| No. | Date Posted | Measure Set or Measure | Text of Comments | |
|-----|-------------|------------------------|----------------------------------|--|
| | | | Office | Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis. |
| | | | Home | Location, other than a hospital or other facility, where the patient receives care in a private residence. |
| | | | Assisted Living Facility | Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services. |
| | | | Group Home | A residence, with shared living areas, where participants receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration). |
| | | | Temporary Lodging | A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code. |
| | | | Inpatient Hospital | A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions. |
| | | | Outpatient Hospital | A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. |
| | | | Emergency Room - Hospital | A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided. |
| | | | Skilled Nursing Facility | A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital. |

| No. | Date Posted | Measure Set or Measure | Text of Comments | |
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| | | | Nursing Facility | A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals. |
| | | | Custodial Care Facility | A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component. |
| | | | Hospice | A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided. |
| | | | Independent Clinic | A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. |
| | | | Federally Qualified Health Center | A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician. |
| | | | Inpatient Psychiatric Facility | A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician. |
| | | | Psychiatric Facility - Partial Hospitalization | A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility. |
| | | | PACE Day Center | A facility which includes a primary care clinic, and areas for therapeutic recreation, restorative therapies, socialization, personal care, and dining, and which serves as the focal point for coordination and provision of most PACE services. |
| | | | Inpatient Substance abuse Facility / Behavioral Care Facility | Including, but not limited to, detox lockdown. |
| | | | Rehabilitation Unit/Facility | A free-standing rehabilitation hospitals and rehabilitation units in acute care hospitals that provides an intensive, multi-disciplinary physical or occupational therapy. |

| No. | Date Posted | Measure Set or Measure | Text of Comments | |
|-----|-------------|------------------------|---|--------------------------------------|
| | | | In Transport | Community |
| | | | Use of vehicle to transport participants to/from locations to obtain PACE-related services. | Parks, concert halls, theatres, etc. |
| 19. | 8/17/2015 | General | <p>We concur with the comment document put together on our behalf by XXXX. We write to offer our additional feedback in response to the Centers for Medicare & Medicaid Services' (CMS) request for comment on its four proposed PACE quality measures. We are aware of the increasingly complex nature of measuring quality accurately and providing this information so that it is reliable, valid, and meaningful. XXXX has carefully reviewed the draft quality measures and all related materials provided and provided comments related to the potential implementation of these measures.</p> <p>XXXX program would like to supplement XXXX's position from the perspective of a non-profit and as an independent organization which is not an aligned part of a health care system.</p> | |
| 20. | 8/17/2015 | General | <p>XXXX agrees with the general comments XXXX made but would like to highlight the following: We recommend that Econometrica review PACE regulations and guidance documents to glean insight regarding how to best define and identify the PACE participant. We encourage CMS/Econometrica to harmonize the measure definitions of the proposed measure set with the definitions and reporting requirements associated with Level II reporting. This will mitigate the use of varying definitions for the same data element.</p> | |
| 21. | 8/17/2015 | General | <p>PACE quality measures should reflect participants' individual preferences and goals. In PACE, the goals of care for participants are categorized into three broad areas: promotion of longevity, optimization of function, and comfort care. Given the heterogeneity of the PACE population, we encourage to CMS/Econometrica to consider the impact of differences in participant care goals, as well as the characteristics of participants on the measure results.</p> | |
| 22. | 8/17/2015 | General | <p>The last comment section has particular resonance with XXXX. Due to financial limitations, we originally adopted an EHR which had been adapted from a clinical office perspective. This has not been efficacious for us, does not fit the PACE model needs and we cannot obtain needed quality measure statistics. Pulling data for the current HPMS and DataPACE 2 reports is cumbersome. The ability to benchmark with current HPMS measures is restricted by the use of different definitions across different CMS regions and even within regions. XXXX is in the process of transitioning to a PACE supported EHR. Do we at PACE, believe a standardized common assessment tool similar to MDS is needed or do we use the Common Data Set (CDS) which is evolving into CDS III? XXXX believes, as the market of certified PACE EHR systems has expanded and with the evolution of CDS III, NPA is moving in a direction from which data will be easily assessable, reportable and standardized for comparisons.</p> | |
| 23. | 8/17/2015 | General | <p>The ability to benchmark with current HPMS measures is restricted by the use of different definitions across different CMS regions and even within regions. XXXX believes unless this</p> | |

| No. | Date Posted | Measure Set or Measure | Text of Comments |
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| | | | systemic problem is addressed the proposed measures will suffer the same fate. |
| 24. | 8/17/2015 | General | XXXX appreciates the opportunity to publicly comment on the proposed Quality Measures for PACE programs. We recognize the importance of consistency of approach to the measurement of key performance indicators related to falls, pressure ulcers, and hospital readmissions. Additionally, we acknowledge the utility of benchmark data when trying to determine the efficacy of our internal quality improvement initiatives. After reviewing the information provided by Econometrica, Inc. as well as the descriptions and calculation methods for the proposed measures, we respectfully offer the following comments and questions for your consideration. Many PACE programs have monitored quality performance using self-designed measures. It may be challenging for organizations to switch to new measures whose results cannot be mapped or compared to internal historical results. |
| 25. | 8/17/2015 | General | Several of the proposed measures require PACE plans to collect detailed data from hospitals, skilled nursing facilities (SNF), and other settings that do not fall within the direct governance of the program. This may be challenging for PACE organizations, particularly those who have not established interoperability between electronic systems. |
| 26. | 8/17/2015 | General | The inclusion of data from hospital, emergency department, and SNF may not be as impactful to care planning; including data on events that occur in these settings may (have) a negative trend that cannot be directly affected by PACE efforts. |
| 27. | 8/17/2015 | General | From a technical perspective, the calculation formulas for several of the measures do not match the narrative descriptions for the numerator and denominator. |
| 28. | 8/17/2015 | General | The data collection forms contain more demographic information than is required to compute measure performance. We would like clarification on how this data will be used and what the risk stratification process entails. The measure guidance indicates " <i>The need and type of case mix adjustment that could be applied to these measures will be addressed at a later stage.</i> " |
| 29. | 8/17/2015 | General | Since PACE is significantly different from other care based options for the elderly, and as CMS/Econometrica develops and reviews the comments please keep in mind the various programs size and differences as compared to other settings of care. |
| 30. | 8/17/2015 | General | XXXX supports XXXX's view of recommending that Econometrica review PACE regulations and guidance documents to glean insight regarding how to best define and identify the PACE participant. To avoid duplication and confusion we also encourage CMS/Econometrica to harmonize the measure definitions of the proposed measure set with the definitions and reporting requirements associated with Level II reporting. This will mitigate the use of varying definitions for the same data element. |
| 31. | 8/17/2015 | General | We also recommend that CMS/Econometrica understand the degree to which standardized and complete data is available from PACE organizations. Unlike nursing homes, home health care agencies and many other care options for frail elderly, PACE lacks a common assessment instrument and data standard. |

| No. | Date Posted | Measure Set or Measure | Text of Comments |
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| 32. | 8/17/2015 | General | Continuous enrollment specifies the minimum amount of time that a person must be enrolled in a health plan before becoming eligible for a measure. Continuous enrollment allows the health plan enough time to render services in which to be evaluated; it ensures that the quality performance measurement is of the entity that had sufficient time to affect the outcome. Continuous enrollment criteria is applied throughout the quality performance measurement realm and it should also be applied to the quality measures related to the PACE population. A minimum duration of continuous enrollment should be identified. |
| 33. | 8/17/2015 | General | Extending the collection of falls and pressure ulcer data to settings such as hospital and nursing homes for PACE participants should be qualified within the impact of adverse outcomes. Those settings have their own licensures and survey requirements, should consider that PACE influence from a quality perspective could have limitations. |
| 34. | 8/11/2015 | Falls | <p>1) I want to point out that since falls are collected regardless of location of the fall, i.e., home, out shopping in the community, etc., PO's do their best to mitigate the risk of falls, however, it needs to be taken into account the fact that the PACE environments are not as well controlled to mitigate risk as much as a more controlled environment such as a hospital or even a nursing home facility.</p> <p>2) With that said, it may make more sense to report on a more catastrophic injury related to a fall, consistent with a reporting Level IV or V under the CMS Level II reporting guidelines since falls with that level of injury would require a level II submission and may neutralize for the differences in the populations and living situations</p> <p>3) One other comment regarding falls is that in PACE, participants come to us with compromised functionality and we work with our rehab departments to provide them with therapy to improve their function. As function improves, falls risk may also increase as a previously non-ambulating participant might now be walking short distances with say an assistive device, but may still be at a higher risk for a fall due to that increased mobility.</p> <p>4) Calculation methodology: Caseload size should be replaced with census size as we do not have caseloads</p> |
| 35. | 8/14/2015 | Falls | Measure Intent XXXX supports the intent of the Fall measures as injury from falls can create serious outcomes for our participants. In that light, we encourage that the measures used by CMS focus on preventing or reducing injury from falls, rather than overall rate of falls. We believe PACE programs will be better served by a second measure that addresses serious injury from falls (Rating of 3-5) or rate of fracture from falls rather than an overall fall rate measure. PACE serves a frail population with the intent of maximizing their independence. In the course of supporting participant autonomy, falls are likely to occur in the population we serve. Preventing injury is what enhances Quality of Life for our participants. In addition, we believe that there may be inherent differences in reporting across States. By focusing on rate of serious injuries or fractures, we presume that there will be more consistency in rates between PACE organizations. |
| 36. | 8/14/2015 | Falls | Measure Definitions For Fall rate, it would be more appropriate in the PACE setting to use |

| No. | Date Posted | Measure Set or Measure | Text of Comments |
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| | | | Number of Participants served in a quarter or Members per Month rather than participant days, which is more of an acute or nursing home approach to population measurement. |
| 37. | 8/14/2015 | Falls | For the inclusion criteria - The list of locations included is not inclusive and levels of definitions vary from state to state. This bullet point should be further defined, or should state only "ALL PACE participant falls with injury in any location". Additionally, all PACE sites do not track falls in the inpatient setting. Falls in the inpatient acute setting should be considered an exclusion from the measure. |
| 38. | 8/14/2015 | Falls | <p>Feasibility of Data Collection The original Data Entry instructions and plan are very cumbersome and would create significant burden for the PACE sites. Several unnecessary data elements were listed such as:</p> <ul style="list-style-type: none"> • Participant age • Participant gender • Who documented the fall • Location of the fall • If the fall was assisted or unassisted <p>None of these elements contribute to the calculation of the proposed measure but would take significant staff time to gather and input, using resource that could be used for other participant care needs or improvement projects. We again request that only the data elements needed to calculate the Quality Measures be required for entry. PACE Organizations typically track this information in their Unusual Occurrence Reporting systems and we feel these additional data elements represent a duplication of effort.</p> |
| 39. | 8/17/2015 | Falls | Lastly, the specifications indicate that PACE organizations document whether a fall was assisted by clinician or trained family member. XXXX concurs with XXXX in requests insight on what value is offered by reporting an <i>assisted fall</i> . |
| 40. | 8/17/2015 | Falls | <p>We want to thank CMS and Econometrica in the work you have done on developing some valid quality metrics for PACE organizations. We appreciate the time and effort it takes to undertake such an important and vital project. I think all PACE quality directors want good solid metrics that we can have confidence as well as resources for benchmarking.</p> <p>Here at XXXX we had our medical director, Dr. D. review these metrics as he is a geriatrician with a vast amount of experience with research. He is one of the principal investigators in the SUPPORT study (JAMA, NOV 1995) as well as several other studies in the field of geriatrics. Below is a list of concerns about the measures we have identified and their unintended impact on PACE organizations.</p> <p>Falls</p> <ul style="list-style-type: none"> • Not sure it is feasible to assess who documented the fall as within PACE several different |

| No. | Date Posted | Measure Set or Measure | Text of Comments |
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| | | | <p>disciplines would be responsible for documenting the fall. Many of the front line staff in PACE (Drivers, home health aides, etc.) does report falls so we feel this element is confusing.</p> <ul style="list-style-type: none"> We feel that an average monthly census would be better to ascertain on a quarterly basis. Perhaps a better defined method would be use the census on the first day of the month. PACE does not see a lot of variation in census during the month due to enrollments being limited to the first of the month and disenrollment at the end of the month. The difference between actual census and average census is statistically insignificant. The purpose of determining if the fall was assisted by clinician or trained family member. The participants may live or be with a variety of people in the community so it would be impossible to train everyone who may be with that participant at the time. CMS/Econometrica must realize that the PO does not have physical custody of the participant at all times. Also the definition of clinician implies this role is more akin to a nurse or member of rehab rather than a C.N.A. or driver. Would like to see if fall was assisted or not in this metric. |
| 41. | 8/17/2015 | Falls | <p><u>Feasibility of Data Collection</u></p> <p>XXXX is unclear of the rationale for documenting who reported the fall (e.g., MD, RN, etc.). It is our sense that this data element does not provide meaningful information and should be removed as it creates an undue administrative burden. We recommend that date and time be reported rather than who reported the fall as these elements will aid in quality improvement efforts (i.e., trending and identification of frequent fallers).</p> |
| 42. | 8/17/2015 | Falls | <p>Given the number of participants living alone in the community, it is likely that incidental falls will be underreported due to participant concern of relinquishing independence and potential placement in an institutional setting of care. If CMS elects to maintain this reporting requirement, XXXX recommends that "participant/caregiver" be added to the list of <i>documented by</i> to promote reporting of falls in the home.</p> |
| 43. | 8/17/2015 | Falls | <p>XXXX perceives an administrative burden associated with calculating the daily participant census for PACE organizations. This proposed calculation approach is often used for nursing home measures and should not be applied in PACE. We recommend that CMS/Econometrica consider a feasible method for determining the quarterly census value (i.e., per member per month OR total participants served in quarterly).</p> |
| 44. | 8/17/2015 | Falls | <p>Lastly, the specifications indicate that PACE organizations document whether a fall was assisted by clinician or trained family member. Inclusion of these data elements may encourage a clinician and/or family member to aid in a participant fall rather than mitigate/prevent a fall occurrence as an unintended consequence. XXXX requests insight on what value is offered by reporting an <i>assisted fall</i>.</p> |
| 45. | 8/17/2015 | Falls | <p><u>Calculation Methodology</u></p> |

| No. | Date Posted | Measure Set or Measure | Text of Comments |
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| | | | With regard to the stratification variables, we request insight on how CMS will operationalize the term “caseload size.” We recommend that “caseload size” be replaced with “census size”. Given the varying size of POs census, stratifying based on census size may ensure comparable results. |
| 46. | 8/17/2015 | Falls | As CMS/Econometrica finalizes the stratification variables, we recommend stratifying the measure results by location of fall and injury level. |
| 47. | 8/17/2015 | Falls | <p>Feasibility of Data Collection</p> <p>XXXX is unclear of the rationale for documenting who reported the fall (e.g., MD, RN, etc.). It is our sense that this data element does not provide meaningful information and should be removed as it creates an undue administrative burden. We recommend that date and time be reported rather than who reported the fall as these elements will aid in quality improvement efforts (i.e., trending and identification of frequent fallers).</p> <p>XXXX additional comment: We believe the root cause analysis includes date, time (can be problematic, especially time, as each participant has their own living patterns including sleeping, napping, and medication schedules) and location among other variables. We do not believe it is appropriate when reporting a statistical measure for quality/benchmarking purposes that root cause variables be included. For stratification I do agree with location and believe a table as done with PU would be user friendly.</p> |
| 48. | 8/17/2015 | Falls | <p>XXXX perceives an administrative burden associated with calculating the daily participant census for PACE organizations. This proposed calculation approach is often used for nursing home measures and should not be applied in PACE. We recommend that CMS/Econometrica consider a feasible method for determining the quarterly census value (i.e., per member per month OR total participants served in quarterly).</p> <p>Lastly, the specifications indicate that PACE organizations document whether a fall was assisted by clinician or trained family member. Inclusion of these data elements may encourage a clinician and/or family member to aid in a participant fall rather than mitigate/prevent a fall occurrence as an unintended consequence. XXXX requests insight on what value is offered by reporting an assisted fall. XXXX believes this is another example of a Root Cause Analysis variable.</p> |
| 49. | 8/17/2015 | Falls | Given the number of participants living alone in the community, it is likely that incidental falls will be underreported due to participant concern of relinquishing independence and potential placement in an institutional setting of care. If CMS elects to maintain this reporting requirement, XXXX recommends that “participant/caregiver” be added to the list of <i>documented by</i> to promote reporting of falls in the home. |
| 50. | 8/17/2015 | Falls | Lastly, the specifications indicate that PACE organizations document whether a fall was assisted by clinician or trained family member. Inclusion of these data elements may encourage a clinician and/or family member to aid in a participant fall rather than mitigate/prevent a fall occurrence as an unintended consequence. XXXX requests insight on what value is offered by reporting an assisted fall. XXXX believes this is another example of a Root Cause Analysis variable. |

| No. | Date Posted | Measure Set or Measure | Text of Comments |
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| 51. | 8/17/2015 | Falls | As CMS/Econometric finalizes the stratification variables, we recommend stratifying the measure results by location of fall and injury level. XXXX strongly concurs with this last statement. |
| 52. | 8/17/2015 | Falls | Measure Intent XXXX supports the intent of the Fall Rate measure as evidence suggests that falls are one of the most common adverse patient events. We also support the intent of the Falls with Injury Rate measure to prevent the occurrence of falls that result in fatal and non-fatal injuries among PACE participants. In the future, we recommend that CMS/Econometrica consider developing a Fall Risk Assessment & Prevention measure that can be paired with this measure to assess POs ability to mitigate falls among those at risk. |
| 53. | 8/17/2015 | Falls | To promote parsimony within the measure set, we recommend that the data elements required for the Falls Rate and Falls with Injury measures be combined and that the results be reported as a single measure – Falls with Injury. |
| 54. | 8/17/2015 | Falls | Measure Definitions In reviewing the definition of “fall”, we note that CMS/Econometrica has broadened the definition compared to the Level II reporting guidance definition. Given the health status and complexity of PACE participants, we recommend that when analyzing the measure results that CMS/Econometrica considers confounding conditions and/or circumstances which may increase the risk of participant falls (i.e., ADLs, cognition, and medical complexity). An assessment of the impact of these characteristics will inform the need for the future risk adjustment. Additionally, we recommend that CMS/Econometrica reference the CMS-funded report Outcome-based Continuous Quality Improvement System and Core Outcome and Comprehensive Assessment (COCOA-B) Data Set for the Program of All-Inclusive Care for the Elderly (PACE) report as it describes a preliminary method for risk adjusting outcome data so comparisons can be made among PACE programs. |
| 55. | 8/17/2015 | Falls | Feasibility of Data Collection XXXX is unclear of the rationale for documenting who reported the fall (e.g., MD, RN, etc.). It is our sense that this data element does not provide meaningful information and should be removed as it creates an undue administrative burden. We recommend that date and time be reported rather than who reported the fall as these elements will aid in quality improvement efforts (i.e., trending and identification of frequent fallers). |
| 56. | 8/17/2015 | Falls | Given the number of participants living alone in the community, it is likely that incidental falls will be underreported due to participant concern of relinquishing independence and potential placement in an institutional setting of care. If CMS elects to maintain this reporting requirement, XXXX recommends that “participant/caregiver” be added to the list of <i>documented by</i> to promote reporting of falls in the home. |

| No. | Date Posted | Measure Set or Measure | Text of Comments |
|-----|-------------|-----------------------------|--|
| 57. | 8/17/2015 | Falls | XXXX perceives an administrative burden associated with calculating the daily participant census for PACE organizations. This proposed calculation approach is often used for nursing home measures and should not be applied in PACE. We recommend that CMS/Econometrica consider a feasible method for determining the quarterly census value (i.e., per member per month OR total participants served in quarterly). |
| 58. | 8/17/2015 | Falls | Lastly, the specifications indicate that PACE organizations document whether a fall was assisted by clinician or trained family member. Inclusion of these data elements may encourage a clinician and/or family member to aid in a participant fall rather than mitigate/prevent a fall occurrence as an unintended consequence. XXXX requests insight on what value is offered by reporting an <i>assisted fall</i> . |
| 59. | 8/17/2015 | Falls | Calculation Methodology With regard to the stratification variables, we request insight on how CMS will operationalize the term “caseload size.” We recommend that “caseload size” be replaced with “census size”. Given the varying size of POs census, stratifying based on census size may ensure comparable results. |
| 60. | 8/17/2015 | Falls | As CMS/Econometrica finalizes the stratification variables, we recommend stratifying the measure results by location of fall and injury level. |
| 61. | 8/17/2015 | Falls | There is an apparent discrepancy between the measure formula and the numerator statement. The measure formula states (<i>Number of falls * 1000</i>) whereas the numerator statement indicates <i>Participants in the PACE program who experienced a fall during the month</i> . It is unclear if the numerator is counting distinct participants or distinct falls. |
| 62. | 8/13/2015 | Falls and Falls With Injury | Falls verses falls with injuries: We already address all falls including those with injuries, will we be doing something different with the falls now. I am unclear on what differently is wanted. Will there be another in-service before this is rolled out? |
| 63. | 8/17/2015 | Falls and Falls With Injury | <u>Measure Intent</u> XXXX supports the intent of the <i>Fall Rate</i> measure as evidence suggests that falls are one of the most common adverse patient events. We also support the intent of the <i>Falls with Injury Rate</i> measure to prevent the occurrence of falls that result in fatal and non-fatal injuries among PACE participants. In the future, we recommend that CMS/Econometrica consider developing a <i>Fall Risk Assessment & Prevention</i> measure that can be paired with this measure to assess POs ability to mitigate falls among those at risk. To promote parsimony within the measure set, we recommend that the data elements required for the <i>Falls Rate</i> and <i>Falls with Injury</i> measures be combined and that the results be reported as a single measure - <i>Falls with Injury</i> . |
| 64. | 8/17/2015 | Falls and Falls With Injury | <u>Measure Definitions</u> In reviewing the definition of “fall”, we note that CMS/Econometrica has broadened the definition compared to the Level II reporting guidance definition. Given the health status and complexity of |

| No. | Date Posted | Measure Set or Measure | Text of Comments |
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| | | | <p>PACE participants, we recommend that when analyzing the measure results that CMS/Econometrica considers confounding conditions and/or circumstances which may increase the risk of participant falls (i.e., ADLs, cognition, and medical complexity). An assessment of the impact of these characteristics will inform the need for the future risk adjustment. Additionally, we recommend that CMS/Econometrica reference the CMS-funded report <i>Outcome-based Continuous Quality Improvement System and Core Outcome and Comprehensive Assessment (COCOA-B) Data Set for the Program of All-Inclusive Care for the Elderly (PACE)</i> report as it describes a preliminary method for risk adjusting outcome data so comparisons can be made among PACE programs.</p> |
| 65. | 7/21/2015 | Falls and Falls With Injury | <p>Measure Information Form:</p> <p>There are concerns with information that is NOT captured in Table 3 under Section B. "Measure Information Form for Falls With Injury Rate".</p> <ul style="list-style-type: none"> • The data captures the status of the participant 24 hours after the fall/injury. • Injuries to the head may not produce immediate effects that are visible on a CT scan. Thus, a participant who suffered a trauma to the head may receive a fall "injury level" captured as "None=1", particularly if no one was there to observe the event or the participant has no memory for the events related to the fall. • However, the aftermath of inflammation, diffuse axonal injury, and intracellular response to a fall injury, that includes trauma to the brain, may not happen until days or weeks <u>after</u> the injury. • The American Heart Association has determined that there is a 10-fold increased risk of stroke within 3 months of a single traumatic brain injury (TBI), indicating that the brain's vasculature is in a highly vulnerable state following injury to the head/brain. This increased risk is still significant 1 year and 5 years post-injury. http://stroke.ahajournals.org/content/early/2011/07/28/STROKEAHA.111.620112.abstract • For the frail elderly, who live with weakened vasculature, these rates may be even higher and are not necessarily being captured, reported, or related back to a previous fall injury. • Current research indicates that repetitive trauma to the head increases the risk of developing chronic traumatic encephalopathy and other forms of dementia. http://www.bu.edu/cte/about/frequently-asked-questions/. A previous fall, history of falls, or any repetitive or cumulative injuries (e.g. domestic violence, assaults, MVAs) may be factors that trigger the degeneration of brain tissue. A single fall in an individual with a history of cumulative injuries to the brain may contribute to the sudden onset of "dementias of unknown origin". • Data Collection on Injury Level provides an excellent opportunity to better capture individuals who have had an impact to the head that may lead to more serious complications. |

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| | | | <ul style="list-style-type: none"> The inclusion criteria MUST be expanded to include the following information to assist in more intensive medical monitoring and treatment, as appropriate: <ul style="list-style-type: none"> <i>"Incident involved an observed, reported, noticeable or suspected trauma or impact to the head"</i> (regardless of CT findings within 24 hours of injury and an Injury Level of None=1). Adding this additional level of analysis opens avenues for capturing data related to complications due to head trauma. <p>Measure Justification Form: Clinical Practice Guideline Recommendations</p> <p>Overall, the discussion of "Rationale" was helpful in providing a context for injuries to the head, including potential cognitive impairment, emotional distress related to a fall and subsequent increased risk of future falls and the need for safety and prevention.</p> <p>Prevention measures were noted to include fall safety education programs; exercise to improve mobility, strength and balance; medication reviews and management; and home safety assessments and modifications.</p> <p>However, one other important recommendation by the CDC (http://www.cdc.gov/HomeandRecreationalSafety/images/CDC_Guide-a.pdf) was not included:</p> <ul style="list-style-type: none"> Vision Exams and Vision Improvement, specifically, having eyes checked at least once a year and routinely updating eyeglasses or other assistive devices. |
| 66. | 8/14/2015 | Falls and Falls With Injury | <u>For Falls with Injury</u> , XXXX supports the Injury Level definitions. |
| 67. | 8/17/2015 | Falls and Falls With Injury | In conjunction with XXXX, XXXX also supports the intent of the <i>Falls with Injury Rate</i> measure to prevent the occurrence of falls that result in fatal and non-fatal injuries among PACE participants. |
| 68. | 8/17/2015 | Falls and Falls With Injury | We concur with their recommendation that the data elements required for the <i>Falls Rate</i> and <i>Falls with Injury</i> measures be combined and that the results be reported as a single measure. |
| 69. | 8/17/2015 | Falls and Falls with Injury | We also request that the definition of a "fall" be in agreement with that of the Level II reporting to decrease confusion among plans as CMS/Econometrica has broadened the definition. XXXX is unclear on why who reported the fall is important. This presents an undue administrative burden and that information is irrelevant to the prevention and care planning of the occurrence. Reporting the falls with injury provides more concrete data on adverse patient events. |
| 70. | 8/3/2015 | Pressure Ulcers | It appears that the measure is based upon current OASIS Home Care assessments that are performed every 60 days since the measure asked if a Risk Assessment had been conducted within the past 60 days. We do not perform every 60 day assessments. Assessments are completed every 6 months unless there is a change of status. |
| 71. | 8/11/2015 | Pressure Ulcers | <p>1) The numerator and denominator are ambiguous. It is not clear which participants and at what time a PU should be collected.</p> <p>2) There should be a consistent risk measurement tool recommended PO's use so there is</p> |

| No. | Date Posted | Measure Set or Measure | Text of Comments |
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| | | | consistency with how PO's are measuring risk. 3) Only newly acquired PU's should be collected once enrolled in our program. 4) Only information from the most recent risk assessment should be used in the calculation |
| 72. | 8/13/2015 | Pressure Ulcers | I have some concerns with the Rate and preventions of pressure ulcers. Will we take in consideration that someone has a debilitating disease and due to poor intake skin status may change? |
| 73. | 8/14/2015 | Pressure Ulcers | <u>Measure Intent</u> XXXX supports the intent of the <i>Pressure Ulcer (PU) Prevalence Rate</i> measure to determine the number of PACE participants with the presence of a PU. |
| 74. | 8/14/2015 | Pressure Ulcers | <u>Measure Definitions</u> XXXX has concerns about how to operationalize the definition of a documented pressure ulcer of any stage across PACE. Is this defined as a documented pressure ulcer that has been diagnosed? Is this a point in time measure of a Pressure Ulcer that is present at end of quarter? Or a Pressure Ulcer Documented at any time in the quarter but may have resolved? For the Denominator, XXXX has concerns about the use of the term "average Number of PACE participants"? We suggest that this should be further defined as "Total Participants served in the Quarter" if we are capturing all Pressure Ulcers from the Quarter or "Number of Participants served on the last day of the quarter" if we are capturing active Pressure Ulcers at the end of the Quarter. The later Denominator is defined as "Number of PACE Participants whose medical records were reviewed for evidence of a PU at the end of month". Please clarify if this is a total population measure or a targeted population measure. |
| 75. | 8/14/2015 | Pressure Ulcers | XXXX supports the removal of DTI as reportable event. |
| 76. | 8/14/2015 | Pressure Ulcers | <u>Feasibility of Data Collection</u> This is difficult to determine until the measure is more clearly defined. XXXX would again like to encourage development of quarterly measurements and reporting. |
| 77. | 8/14/2015 | Pressure Ulcers | We would also recommend requiring only necessary data elements to decrease the significant burden for the PACE sites. Several unnecessary data elements were listed such as: <ul style="list-style-type: none"> • Participant age • Participant gender • Total number of Pressure Ulcers acquired after PACE enrollment None of these elements contribute to the calculation of the proposed measure but would take significant staff time to gather and input, using resource that could be used for other participant care needs or improvement projects. We again request that only the data elements needed to calculate the Quality Measures be required for entry. |
| 78. | 8/14/2015 | Pressure Ulcers | <u>Measure Intent</u> XXXX supports the intent of the <i>Pressure Ulcer Risk Assessment measure</i> to determine |

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| | | | appropriate care planning for PACE participants at risk of a PU. |
| 79. | 8/14/2015 | Pressure Ulcers | As written, the denominator appears to represent participants with pressure ulcers after the exclusions are factored. XXXX has concerns that this definition does not address the intent of the measure. |
| 80. | 8/14/2015 | Pressure Ulcers | <u>Measure Definitions</u> XXXX has concerns about how to operationalize the definition of a documented pressure ulcer risk assessment across PACE. To ensure the consistency of the measure results, XXXX supports the NPS recommendation of a structured, systematic pressure ulcer risk assessment tool be specified (e.g. Braden risk assessment tool). Additionally, the measure would need to define what score indicates that a participant is at risk and how we would determine that a plan is in place. |
| 81. | 8/14/2015 | Pressure Ulcers | For the Numerator statement, the second point of “participants who are at risk have a pressure ulcer prevention plan of care” is the best definition for the PACE population. |
| 82. | 8/14/2015 | Pressure Ulcers | For data integrity, the denominator should be changed from participants with a documented PU to participants who are documented as being at risk for a PU. With the current definitions, there is misalignment between the numerator and the denominator. In some cases, a participant may be at risk and have a skin care plan of care in place but not have a PU at this time. This scenario (which is common to PACE) would create an invalid percentage based on the current definitions. |
| 83. | 8/14/2015 | Pressure Ulcers | We would appreciate clarification on the value of determining the number of days since last Pressure Ulcer Risk assessment. Once a participant is deemed to be at risk for Pressure Ulcers, what is to be gained by repeated risk screenings? A more meaningful measure might be that all participants have had risk screening at least every six months (or within some other time frame). |
| 84. | 8/14/2015 | Pressure Ulcers | <u>Feasibility of Data Collection</u> XXXX has concerns about the burden of data collection in this area. It is not possible to run automated reports off a plan of care in most EHR's. For most PACE sites, determining plan of care would require manual chart audits which are cumbersome and time-consuming. Any time taken in this effort takes away from direct patient care. Assessing implementation of the plan would require manual chart review for documentation of plan <u>and</u> documentation of home visits to ensure interventions and devices are in place. Most prevention plans require multiple elements. Would all interventions need to be assessed as implemented to count? For example: If a therapeutic support surface were ordered but the participant did not always agree to using it, would that count as implemented or not? Or if a turning and positioning or toileting schedule were recommended but the caregiver did not chart it, would that be considered implemented or not? |
| 85. | 8/14/2015 | Pressure Ulcers | XXXX would offer that measuring the number of participants who are at risk for Pressure ulcer (Braden score 16 or less) who have a prevention plan in place may be a valuable quality measure to report although manual chart reviews to determine this would be an onerous undertaking for |

| No. | Date Posted | Measure Set or Measure | Text of Comments |
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| | | | PACE organizations. |
| 86. | 8/17/2015 | Pressure Ulcers | <p>Pressure Ulcer Prevention Rate</p> <ul style="list-style-type: none"> We feel a PU incidence rate may be a more appropriate measure than prevalence rate. We do not feel it is feasible to collect this information as suggested; we have read and agree with XXXX's position on this measure. We feel there has been some misunderstanding in the development of the measure concerning Pressure Ulcer risk assessments. PACE participants are not mandated by regulation to conduct monthly assessments like a nursing home. We do not feel it is appropriate to conduct a risk assessment monthly – these should follow a scheduled re-assessment at 6 month intervals (some POs will do more often if they have this as a care plan intervention but would be hard to tease this information out for measurement across all POs) The Braden scale is a valid and reliable tool for hospitals and nursing homes. There is currently no valid tool for frail elders living in the community. Many pressure ulcers that occur in the community have causes so widely and varied (caregiver not following recommended plan of care, footwear, sitting surfaces, etc.) We would support a measure of participant's who scored high risk on Braden scale (etc.) having a care plan but otherwise this would be hard to measure |
| 87. | 8/17/2015 | Pressure Ulcers | <p>Measure Intent</p> <p>XXXX supports the intent of the Pressure Ulcer (PU) Prevalence Rate measure to determine the number of PACE participants with the presence of a PU.</p> |
| 88. | 8/17/2015 | Pressure Ulcers | <p>Measure Definitions</p> <p>We are unable to determine the target population of this measure due to the ambiguity of the numerator and denominator statements. We request that CMS/Econometrica clarify the denominator. In the denominator, which participants comprise the population available for review? Does the denominator include "all the participants" or "participants whose time it is to be reviewed in the month based on some pre-determined criteria"? Lastly, we seek clarity regarding the criteria on which the number of participants is selected each month for review (e.g., PU risk assessment, problem list, clinical visit). The measure's lack of specificity regarding frequency/method of assessment limits POs ability to consistently collect and report the necessary data elements.</p> |
| 89. | 8/17/2015 | Pressure Ulcers | <p>The Measure Evaluation Report notes that the PU definitions of numerator and denominator had content validity indices of .44 and .57, respectively. We recognize Econometrica's efforts to revise the definitions; however, it is our recommendation that CMS/Econometrica perform additional steps to clarify the numerator and denominator statements.</p> |
| 90. | 8/17/2015 | Pressure Ulcers | <p>Feasibility of Data Collection</p> <p>XXXX suggests that POs also report the location of the PU on the body as this will aid POs in delivering optimal participant care and improving quality of life.</p> |

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| 91. | 8/17/2015 | Pressure Ulcers | <p>We request that CMS/Econometrica consider including the following PU anatomic location codes.</p> <p>Table 2. Pressure Ulcer Location Codes</p> <table><tr><th>Pressure Ulcer Location Codes</th></tr><tr><td>Unspecified</td></tr><tr><td>Elbow</td></tr><tr><td>Upper Back</td></tr><tr><td>Lower Back</td></tr><tr><td>Hip</td></tr><tr><td>Buttock</td></tr><tr><td>Ankle</td></tr><tr><td>Heel</td></tr><tr><td>Other Site</td></tr></table> | Pressure Ulcer Location Codes | Unspecified | Elbow | Upper Back | Lower Back | Hip | Buttock | Ankle | Heel | Other Site |
| Pressure Ulcer Location Codes | | | | | | | | | | | | | |
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| Heel | | | | | | | | | | | | | |
| Other Site | | | | | | | | | | | | | |
| 92. | 8/17/2015 | Pressure Ulcers | <p>Calculation Methodology</p> <p>Given the ambiguity of the numerator and denominator statements, we do not understand the logic of the calculation algorithm.</p> | | | | | | | | | | |
| 93. | 8/17/2015 | Pressure Ulcers | <p>There is an apparent discrepancy between the measure formula and the denominator statement. The measure formula states <i>(Average number of PACE participants)</i> whereas the denominator statement indicates <i>Number of PACE participants whose medical records were reviewed for evidence of PU at the end of the month</i>. It is unclear if the denominator is counting average number of participants active during the month or total number of participants whose charts were reviewed.</p> | | | | | | | | | | |
| 94. | 8/17/2015 | Pressure Ulcers | <p>The proposed measure does not exclude pressure ulcers that were acquired prior to enrollment, that are recurring in nature, or that were acquired in settings including inpatient hospital, emergency department, and SNF. These exclusion criteria help create a measure that better identifies PU's that developed while the participant was in the care of PACE staff.</p> | | | | | | | | | | |
| 95. | 8/17/2015 | Pressure Ulcers | <p>It is not clear if "medical record reviewed for evidence of PU" requires chart abstraction or if data from any tracking method may be used (i.e. wound log or electronic medical record report).</p> | | | | | | | | | | |
| 96. | 8/17/2015 | Pressure Ulcers | <p>XXXX supports XXXX's position on the intent of the <i>Pressure Ulcer (PU) Prevalence Rate</i> measure to determine the number of PACE participants with the presence of a PU. However, we also seek clarity regarding the criteria, on which the number of participants are selected each month for review and given the ambiguity of the numerator and denominator statements, we do not understand the logic of the calculation algorithm. We also concur with XXXX regarding what is the purpose conducting a risk assessment on participants who already have a pressure ulcer. The use of a specific pressure ulcer assessment tool (Braden, etc.) is essential in providing consistency across plans for reporting on risk. Further, we request clarity on the calculation algorithm and measure logic.</p> | | | | | | | | | | |

| No. | Date Posted | Measure Set or Measure | Text of Comments |
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| 97. | 8/17/2015 | Pressure Ulcers | <u>Measure Intent</u> As written, the denominator appears to represent participants with pressure ulcers after the exclusions are factored. What is the purpose of conducting a pressure ulcer risk assessment on participants who already have a pressure ulcer? |
| 98. | 8/17/2015 | Pressure Ulcers | <u>Measure Definitions</u> To ensure the consistency of the measure results, XXXX recommends that a structured, systematic pressure ulcer risk assessment tool be specified (e.g. Braden risk assessment tool, Waterlow risk assessment tool, Ramstadius risk screening tool). |
| 99. | 8/17/2015 | Pressure Ulcers | <u>We offer the following measurement approach for CMS' consideration:</u> Measure: Percent of participants at risk with preventative skin care plan Numerator: Number participants at risk for developing a pressure ulcer that have a documented preventative skin care plan. Denominator: Number of participants at risk (determined by Braden score <16). Data frequency: Quarterly To lower the administrative burden, it is recommend that only the most recent assessment be captured if a participant has more than one Braden score during the course of the quarter. |
| 100. | 8/17/2015 | Pressure Ulcers | <u>Feasibility of Data Collection</u> No comments. |
| 101. | 8/17/2015 | Pressure Ulcers | <u>Calculation Methodology</u> In the <i>PU Prevalence Rate</i> measure, the review is conducted on a monthly basis from which the numerator is derived. Assuming that the numerator from the previous measure forms the denominator in the current measure, the time period of the numerator is out of sync as it accounts for assessments conducted in the current or preceding month. We request clarity on the calculation algorithm/measure logic. |
| 102. | 8/17/2015 | Pressure Ulcers | <u>Measure Definitions</u> To ensure the consistency of the measure results, XXXX recommends that a structured, systematic pressure ulcer risk assessment tool be specified (e.g. Braden risk assessment tool, Waterlow risk assessment tool, Ramstadius risk screening tool). XXXX comment: If this is done effectively with affiliated preventative interventions then the PU Stage 1 is a redundant measure. |
| 103. | 8/17/2015 | Pressure Ulcers | <u>Measure Intent</u> As written, the denominator appears to represent participants with pressure ulcers after the exclusions are factored. What is the purpose of conducting a pressure ulcer risk assessment on |

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| | | | participants who already have a pressure ulcer? |
| 104. | 8/17/2015 | Pressure Ulcers | Measure Definitions To ensure the consistency of the measure results, XXXX recommends that a structured, systematic pressure ulcer risk assessment tool be specified (e.g. Braden risk assessment tool, Waterlow risk assessment tool, Ramstadius risk screening tool). |
| 105. | 8/17/2015 | Pressure Ulcers | We offer the following measurement approach for CMS' consideration: Measure: Percent of participants at risk with preventative skin care plan Numerator: Number participants at risk for developing a pressure ulcer that have a documented preventative skin care plan. Denominator: Number of participants at risk (determined by Braden score <16). Data frequency: Quarterly To lower the administrative burden, it is recommend that only the most recent assessment be captured if a participant has more than one Braden score during the course of the quarter. |
| 106. | 8/17/2015 | Pressure Ulcers | Feasibility of Data Collection No comment. |
| 107. | 8/17/2015 | Pressure Ulcers | Calculation Methodology In the PU Prevalence Rate measure, the review is conducted on a monthly basis from which the numerator is derived. Assuming that the numerator from the previous measure forms the denominator in the current measure, the time period of the numerator is out of sync as it accounts for assessments conducted in the current or preceding month. We request clarity on the calculation algorithm/measure logic. |
| 108. | 8/17/2015 | Pressure Ulcers | Measure Definitions We are unable to determine the target population of this measure due to the ambiguity of the numerator and denominator statements. We request that CMS/Econometrica clarify the denominator. In the denominator, which participants comprise the population available for review? Does the denominator include "all the participants" or "participants whose time it is to be reviewed in the month based on some pre-determined criteria"? Lastly, we seek clarity regarding the criteria on which the number of participants is selected each month for review (e.g., PU risk assessment, problem list, clinical visit). The measure's lack of specificity regarding frequency/method of assessment limits POs ability to consistently collect and report the necessary data elements. XXXX Comment: Inclusion of participants with PU prior to PACE admission? Also, on the numerator my experience has been an underreporting of PU Stage 1. At this time |

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| | | | unable to collect information through our EHR system. Please demonstrate the reasoning behind the PU Stage 1 reporting. The other concern is differentiating the hospice/end of life participant subset from the functional/longevity/palliative groups. | | | | | | | | | | |
| 109. | 8/17/2015 | Pressure Ulcers | <p>We request that CMS/Econometrica consider including the following PU anatomic location codes. XXXX sees the need for Coccyx to be added.</p> <p>Table 2. Pressure Ulcer Location Codes</p> <table><tr><th>Pressure Ulcer Location Codes</th></tr><tr><td>Unspecified</td></tr><tr><td>Elbow</td></tr><tr><td>Upper Back</td></tr><tr><td>Lower Back</td></tr><tr><td>Hip</td></tr><tr><td>Buttock</td></tr><tr><td>Ankle</td></tr><tr><td>Heel</td></tr><tr><td>Other Site</td></tr></table> | Pressure Ulcer Location Codes | Unspecified | Elbow | Upper Back | Lower Back | Hip | Buttock | Ankle | Heel | Other Site |
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| 110. | 8/17/2015 | Pressure Ulcers | <p><u>Measure Intent</u> XXXX supports the intent of the <i>Pressure Ulcer (PU) Prevalence Rate</i> measure to determine the number of PACE participants with the presence of a PU.</p> | | | | | | | | | | |
| 111. | 8/17/2015 | Pressure Ulcers | <p><u>Measure Definitions</u> We are unable to determine the target population of this measure due to the ambiguity of the numerator and denominator statements. We request that CMS/Econometrica clarify the denominator. In the denominator, which participants comprise the population available for review? Does the denominator include “all the participants” or “participants whose time it is to be reviewed in the month based on some pre-determined criteria”? Lastly, we seek clarity regarding the criteria on which the number of participants is selected each month for review (e.g., PU risk assessment, problem list, clinical visit). The measure’s lack of specificity regarding frequency/method of assessment limits POs ability to consistently collect and report the necessary data elements.</p> | | | | | | | | | | |
| 112. | 8/17/2015 | Pressure Ulcers | <p>The <i>Measure Evaluation Report</i> notes that the PU definitions of numerator and denominator had content validity indices of .44 and .57, respectively. We recognize Econometrica’s efforts to revise the definitions; however, it is our recommendation that CMS/Econometrica perform additional steps to clarify the numerator and denominator statements.</p> | | | | | | | | | | |
| 113. | 8/17/2015 | Pressure Ulcers | <p><u>Feasibility of Data Collection</u> XXXX suggests that POs also report the location of the PU on the body as this will aid POs in delivering optimal participant care and improving quality of life.</p> | | | | | | | | | | |

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| 114. | 8/17/2015 | Pressure Ulcers | <p>We request that CMS/Econometrica consider including the following PU anatomic location codes.</p> <p>Table 2. Pressure Ulcer Location Codes</p> <table><tr><th>Pressure Ulcer Location Codes</th></tr><tr><td>Unspecified</td></tr><tr><td>Elbow</td></tr><tr><td>Upper Back</td></tr><tr><td>Lower Back</td></tr><tr><td>Hip</td></tr><tr><td>Buttock</td></tr><tr><td>Ankle</td></tr><tr><td>Heel</td></tr><tr><td>Other Site</td></tr></table> | Pressure Ulcer Location Codes | Unspecified | Elbow | Upper Back | Lower Back | Hip | Buttock | Ankle | Heel | Other Site |
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| Other Site | | | | | | | | | | | | | |
| 115. | 8/17/2015 | Pressure Ulcers | <p><u>Calculation Methodology</u></p> <p>Given the ambiguity of the numerator and denominator statements, we do not understand the logic of the calculation algorithm.</p> | | | | | | | | | | |
| 116. | 8/17/2015 | Pressure Ulcer Prevention | <p><u>Measure Intent</u></p> <p>Please indicate the intent of the <i>Pressure Ulcer Prevention Plan of Care</i> measure. Is the denominator defined as all participants enrolled with the additional criteria or a subset of the previous measure? Is measure intended to prevent the development of a PU among participants at risk or prevent worsening and/or recurrence of a PU among participants with an existing PU? As Kennedy Terminal Ulcers are highly prevalent among PACE participants, we request that CMS/Econometrica consider how to account for this type of pressure ulcer.</p> | | | | | | | | | | |
| 117. | 8/17/2015 | Pressure Ulcer Prevention | <p><u>Measure Definitions</u></p> <p>No comment.</p> | | | | | | | | | | |
| 118. | 8/17/2015 | Pressure Ulcer Prevention | <p><u>Feasibility of Data Collection</u></p> <p>No comment.</p> | | | | | | | | | | |
| 119. | 8/17/2015 | Pressure Ulcer Prevention | <p><u>Calculation Methodology</u></p> <p>We request clarity on the calculation algorithm/measure logic.</p> | | | | | | | | | | |
| 120. | 8/17/2015 | Pressure Ulcer Prevention | <p><u>Measure Intent</u></p> <p>The intent of this is clear. As this measure is a subset of the preceding measures, it our sense that the process to compute this measure will become clear once the aforementioned issues are resolved.</p> | | | | | | | | | | |
| 121. | 8/17/2015 | Pressure Ulcer Prevention | <p><u>Measure Intent</u></p> <p>Please indicate the intent of the Pressure Ulcer Prevention Plan of Care measure. Is the denominator defined as all participants enrolled with the additional criteria or a subset of the</p> | | | | | | | | | | |

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| | | | previous measure? Are measure intended to prevent the development of a PU among participants at risk or prevent worsening and/or recurrence of a PU among participants with an existing PU? As Kennedy Terminal Ulcers are highly prevalent among PACE participants, we request that CMS/Econometrica consider how to account for this type of pressure ulcer. |
| 122. | 8/17/2015 | Pressure Ulcer Prevention | Measure Definitions No comment. |
| 123. | 8/17/2015 | Pressure Ulcer Prevention | Feasibility of Data Collection No comment. |
| 124. | 8/17/2015 | Pressure Ulcer Prevention | Calculation Methodology We request clarity on the calculation algorithm/measure logic. |
| 125. | 8/17/2015 | Pressure Ulcer Prevention | Measure Intent The intent of this is clear. As this measure is a subset of the preceding measures, it our sense that the process to compute this measure will become clear once the aforementioned issues are resolved. |
| 126. | 8/17/2015 | Pressure Ulcer Prevention | The pressure ulcer risk assessment window is too narrow. The minimum required assessment interval for PACE participants is every 6 months. Participants with an existing pressure ulcer may have had a risk assessment performed within the last 6 months but not within the last 60 days. |
| 127. | 8/17/2015 | Pressure Ulcer Prevention | The guidance indicates that the target population is “all participants in the PACE site census during the month”. This denominator conflicts with the denominator for the PACE- acquired pressure ulcer rate because it requires a record review of all PACE participants to establish the presence of an ulcer. |
| 128. | 8/3/2015 | Readmission Rate | In the Environmental Scan, page 18 has the following definition: The Final Rule defines readmissions for the PACE program as “PACE participants readmitted to an acute care hospital within 31 days.” This rule includes emergency (unscheduled) care, defined as “PACE participants seen in the hospital emergency room (including care from a PACE physician in a hospital emergency department) or an outpatient department/clinic emergency” (CMS PACE User’s Guide, 2008). However, that is not correct. PACE participants seen in an emergency setting within 30 days of hospital discharge are not considered readmissions. |
| 129. | 8/14/2015 | Readmission Rate | <u>Measure Intent</u> XXXX supports the intent of the <i>30-day All-Cause Readmission Rate</i> measure to examine avoidable 30-day hospital readmissions among PACE participants. |
| 130. | 8/14/2015 | Readmission Rate | <u>Measure Definitions:</u> XXXX also supports the defined exclusion criteria. |
| 131. | 8/14/2015 | Readmission Rate | We do request clarification of the exclusion criteria, “Admission to one acute hospital directly after discharge from another acute hospital” as a hospital to hospital transfer. |
| 132. | 8/14/2015 | Readmission Rate | <u>Feasibility of Data Collection</u> No comment. |

| No. | Date Posted | Measure Set or Measure | Text of Comments |
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| 133. | 8/17/2015 | Readmission Rate | 30 Day All Cause Readmission Rates <ul style="list-style-type: none"> We support this measure as is. |
| 134. | 8/17/2015 | Readmission Rate | <u>Measure Intent</u> XXXX supports the intent of the <i>30-day All-Cause Readmission Rate</i> measure to examine avoidable 30-day hospital readmissions among PACE participants. XXXX also supports the Technical Expert Panel's recommendation to consider a future measure which examines "days in the community" as such a measure can assess changes in setting from home to SNF, acute care, emergency department, etc. |
| 135. | 8/17/2015 | Readmission Rate | <u>Measure Definitions</u> Examining 30-day all-cause readmission in isolation may not provide an accurate indication of quality. For example, a "high-performing" PACE program may have a low admission rate, and their readmission rate (calculated as proposed) may well be high, because the only participants being admitted to hospitals are individuals for whom hospitals actually offer substantial gains and whose health is fragile and finding stability is challenging. On the other hand, a "low-performing" PACE program might have a high hospital admission rate due to the number of elders who could have been served in other settings, but their readmission rate may be low since its admission rate is so high. We recommend that CMS consider examining the 30-day all-cause readmission rate in conjunction with the hospital admission rate. |
| 136. | 8/17/2015 | Readmission Rate | There is a lack of clarity on how admissions will be captured in these measures. We have created the following scenario to understand how the measure will be computed. Please confirm whether our understanding is correct. Scenario – the following admits are for the same patient after all exclusion/inclusion criteria have been factored. <ul style="list-style-type: none"> Admit 2/15 – Discharge 2/22 Admit 3/10 – Discharge 3/15 Admit 3/20 – Discharge 3/24 Admit 3/27 – Discharge 3/31 The following depicts our understanding of how the measure will be compute for the month of February. <ul style="list-style-type: none"> The 1st discharge associated with the Admit 2/15 – Discharge 2/22 constitutes the index discharge. The 2nd discharge associated with the Admit 3/10 – Discharge 3/15 is counted as a re-admit for February because the discharge date of 3/15 is within 30 days of the prior |

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| | | | <p>discharge (which occurred in February). And, the following depicts our understanding of how the measure will be computed for the month of March.</p> <ul style="list-style-type: none"> The 2nd discharge associated with the Admit 3/10 – Discharge 3/15 above becomes the index discharge (therefore the same occurrence which is counted as a re-admit for the prior month is now the index for the current month). The 3rd discharge associated with the Admit 3/20 – Discharge 3/24 is counted as a re-admit for the month of March because it is within 30 days of the index discharge of 3/15. The 4th discharge associated with the Admit 3/27 – Discharge 3/31 is also counted as a re-admit for the month of March because it is also within 30 days of the index discharge of 3/15. <p>Therefore in the scenario above, there will be one (1) re-admit for February and two (2) for March. To ensure consist interpretation and implementation of the measure, we request that CMS consider revising the denominator statement as follows: <i>Denominator statement:</i> <i>Number of PACE participants admitted to an acute care hospital during the reporting month.</i></p> |
| 137. | 8/17/2015 | Readmission Rate | <p><u>Feasibility of Data Collection</u> No comment.</p> |
| 138. | 8/17/2015 | Readmission Rate | <p><u>Calculation Methodology</u> No comment.</p> |
| 139. | 8/17/2015 | Readmission Rate | <p><u>Calculation Methodology</u> No comment. XXXX has no further comments on this quality measure.</p> |
| 140. | 8/17/2015 | Readmission Rate | <p>Measure Intent XXXX supports the intent of the 30-day All-Cause Readmission Rate measure to examine avoidable 30-day hospital readmissions among PACE participants. XXXX also supports the Technical Expert Panel's recommendation to consider a future measure which examines "days in the community" as such a measure can assess changes in setting from home to SNF, acute care, emergency department, etc.</p> |
| 141. | 8/17/2015 | Readmission Rate | <p>Measure Definitions Examining 30-day all-cause readmission in isolation may not provide an accurate indication of quality. For example, a "high-performing" PACE program may have a low admission rate, and their readmission rate (calculated as proposed) may well be high, because the only participants being admitted to hospitals are individuals for whom hospitals actually offer substantial gains and whose health is fragile and finding stability is challenging. On the other hand, a "low-performing" PACE program might have a high hospital admission rate due to the number of elders who could have been served in other settings, but their readmission rate may be low since its admission rate</p> |

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| | | | is so high. We recommend that CMS consider examining the 30-day all-cause readmission rate in conjunction with the hospital admission rate. |
| 142. | 8/17/2015 | Readmission Rate | <p>There is a lack of clarity on how admissions will be captured in this measure. We have created the following scenario to understand how the measure will be computed. Please confirm whether our understanding is correct.</p> <p>Scenario – the following admits are for the same patient after all exclusion/inclusion criteria have been factored.</p> <ul style="list-style-type: none"> • Admit 2/15 – Discharge 2/22 • Admit 3/10 – Discharge 3/15 • Admit 3/20 – Discharge 3/24 • Admit 3/27 – Discharge 3/31 <p>The following depicts our understanding of how the measure will be compute for the month of February.</p> <ul style="list-style-type: none"> • The first discharge associated with the Admit 2/15 – Discharge 2/22 constitutes the index discharge. • The second discharge associated with the Admit 3/10 – Discharge 3/15 is counted as a re-admit for February because the discharge date of 3/15 is within 30 days of the prior discharge (which occurred in February). <p>And, the following depicts our understanding of how the measure will be computed for the month of March.</p> <ul style="list-style-type: none"> • The second discharge associated with the Admit 3/10 – Discharge 3/15 above becomes the index discharge (therefore the same occurrence which is counted as a re-admit for the prior month is now the index for the current month). • The third discharge associated with the Admit 3/20 – Discharge 3/24 is counted as a re-admit for the month of March because it is within 30 days of the index discharge of 3/15. • The fourth discharge associated with the Admit 3/27 – Discharge 3/31 is also counted as a re-admit for the month of March because it is also within 30 days of the index discharge of 3/15. <p>Therefore in the scenario above, there will be one (1) re-admit for February and two (2) for March. To ensure consistent interpretation and implementation of the measure, we request that CMS consider revising the denominator statement as follows:</p> <p>Denominator statement: <i>Number of PACE participants admitted to an acute care hospital during the reporting month.</i></p> |

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| 143. | 8/17/2015 | Readmission Rate | Feasibility of Data Collection No comment. |
| 144. | 8/17/2015 | Readmission Rate | Calculation Methodology No comment. |
| 145. | 8/17/2015 | Readmission Rate | The proposed measure methodology may understate the volume of readmissions. The numerator is based on <i>distinct participants</i> instead of <i>distinct admissions</i> . It is possible that one participant may have more than one readmission within the 30-day window. |
| 146. | 8/17/2015 | Readmission Rate | The denominator may be overstated using the proposed methodology. The denominator includes all discharges for the prior month including those for participants who were not readmitted within 30 days. Measure performance could vary widely based on fluctuations in discharges from month to month. |
| 147. | 8/17/2015 | Readmission Rate | PACE programs may find it challenging to collect data related to the exclusion criteria, as they contain non-standard data points that are not typically seen on hospital discharge aggregate reports (i.e. left against medical advice). |
| 148. | 8/17/2015 | Readmission Rate | XXXX supports the intent of the <i>30-day All-Cause Readmission Rate</i> measure to examine avoidable 30-day hospital readmissions among PACE participants; however, as XXXX points out in their comments, examining this in isolation may not provide an accurate indication of quality. There is a lack of clarity on how admissions will be captured in this measure. XXXX agrees with XXXX in ensuring consistent interpretation and implementation of the measure, we request that CMS consider revising the denominator statement as follows: Denominator statement: <i>Number of PACE participants admitted to an acute care hospital during the reporting month.</i> |