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DATE: August 17, 2015
TO: Centers for Medicare & Medicaid Services
FROM: North Carolina PACE Association
RE: **NCPA Comments to CMS on Development, Implementation, and Maintenance of Quality Measures for the Programs of All-Inclusive Care for the Elderly (PACE®)**

The North Carolina PACE Association (NCPA) represents 11 PACE programs throughout North Carolina 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. NCPA 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 findings and comments, which were developed by a participatory process.

GENERAL COMMENTS

NCPA 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 *Falls* 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.

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.

Lastly, as part of the measure testing phase, NCPA 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

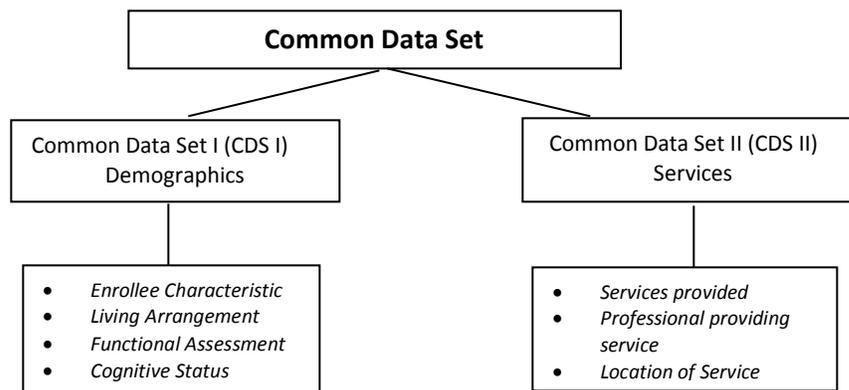
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assessment instrument and data standard. We have struggled with this within our own state boundaries, and are deeply appreciative of the work done by the National PACE Association to address this need. The National PACE Association has developed a common data platform across all PACE organizations referred to as the *Common Data Set (CDS)* [see Figure 1]. The CDS contains a standardized dictionary of definitions for data elements to be collected – demographics (CDS I) and services (CDS II). The creation of a standardized participant specific data set will allow for better defining the PACE population; create opportunities to measure the value and performance of PACE; support improved and more efficient benchmarking; distinguish PACE from emerging delivery models; and foster the evolution and adoption of EHRs for PACE.

Figure 1.



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.

The following table, prepared by the National PACE Association, 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 *Place of Service* list in order to promote consistency in data reporting and use of existing standardized definitions used in PACE.

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Table 1. Place of Service

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.
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.
INCPatient 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 INCPatient 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.
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.

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Place of Service	Place of Service Description
INCPatient Psychiatric Facility	A facility that provides iNCPatient 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.
INCPatient 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.

FALL RATE & FALLS WITH INJURY RATE

Measure Intent

NCPA 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.

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.

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 consider 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

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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.

Feasibility of Data Collection

NCPA 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).

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, NCPA recommends that “participant/caregiver” be added to the list of *documented by* to promote reporting of falls in the home.

NCPA 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).

Lastly, the specifications indicate that PACE organizations document whether a fall was assisted by clinician or trained family member. Inclusion of this 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. NCPA requests insight on what value is offered by reporting an *assisted fall*.

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.

As CMS/Econometrica finalizes the stratification variables, we recommend stratifying the measure results by location of fall and injury level.

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PRESSURE ULCER PREVALENCE RATE

Measure Intent

NCPA supports the intent of the Pressure Ulcer (PU) Prevalence Rate measure to determine the number of PACE participants with the presence of a PU.

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.

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.

Feasibility of Data Collection

NCPA 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.

We request that CMS/Econometrica consider including the following PU anatomic location codes.

Table 2. Pressure Ulcer Location Codes

Pressure Ulcer Location Codes
Unspecified
Elbow
Upper Back
Lower Back
Hip
Buttock
Ankle
Heel
Other Site

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Calculation Methodology

Given the ambiguity of the numerator and denominator statements, we do not understand the logic of the calculation algorithm.

PRESSURE ULCER RISK ASSESSMENT CONDUCTED IN CURRENT OR PRECEDING MONTH

Measure Intent

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?

Measure Definitions

To ensure the consistency of the measure results, NCPA 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).

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.

Feasibility of Data Collection

No comment.

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.

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PRESSURE ULCER PREVENTION PLAN OF CARE

Measure Intent

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 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.

Measure Definitions

No comment.

Feasibility of Data Collection

No comment.

Calculation Methodology

We request clarity on the calculation algorithm/measure logic.

PERCENT OF PARTICIPANTS AT RISK OF PRESSURE ULCERS WHOSE PREVENTION PLAN OF CARE HAD BEEN IMPLEMENTED

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.

30-DAY ALL-CAUSE READMISSION RATE

Measure Intent

NCPA supports the intent of the 30-day All-Cause Readmission Rate measure to examine avoidable 30-day hospital readmissions among PACE participants. NCPA 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.

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

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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.

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.

Scenario – the following admits are for the same patient after all exclusion/inclusion criteria have been factored.

- 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.

- 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).

And, the following depicts our understanding of how the measure will be computed for the month of March.

- 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.

Therefore in the scenario above, there will be one (1) re-admit for February and two (2) for March.

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To ensure consistent interpretation and implementation of the measure, we request that CMS consider revising the denominator statement as follows:

Denominator statement: Number of PACE participants admitted to an acute care hospital during the reporting month.

Feasibility of Data Collection

No comment.

Calculation Methodology

No comment.

CONCLUSION

Thank you again for the opportunity to share comments on the quality measures. As a minimally staffed organization, we greatly appreciate the collective thinking and professional wisdom provided primarily by the National PACE Association on this critical issue. We support their work and the recommendations outlined herein, and encourage you to give these comments your most serious consideration. Thank you again, and please do not hesitate to contact me if you have any questions at linda.shaw@ncpace.org.

Sincerely,

Linda S. Shaw
Executive Director