



UnityPoint Health

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December 15, 2017

Centers for Medicare and Medicaid Services
Attention: Econometrica, Inc. (HHS-500-2013-13006I)

RE: Development, Implementation, and Maintenance of Quality Measures for the Programs of All-Inclusive Care for the Elderly (PACE) – Stream 3

Submitted electronically via PACEQMcomments@econometricainc.com

Dear PACE Stream 3 Quality Measures Development Team:

UnityPoint Health (UPH) and Siouxland PACE are pleased to provide input in response to the Centers for Medicare & Medicaid Services' (CMS) comment request via its contractor, Econometrica, Inc., relating to proposed Stream 3 measures for the Programs of All-Inclusive Care for the Elderly (PACE) program. Siouxland PACE started in 2008 with assistance from a CMS Rural PACE Development grant. Since 2011, Siouxland PACE has been under the ownership of UnityPoint Health – St. Luke's, a UPH senior affiliate in northwest Iowa. Currently, there are 179 Participants receiving PACE services from four northwest Iowa counties.

In Stream 3, three new quality measures are being proposed:

- Participant Influenza Immunization;
- PACE Staff Influenza Immunization; and
- Participant Emergency Department (ED) Utilization Without Hospitalization.

Siouxland PACE is extremely supportive of initiatives to provide and track quality care. The rationale for the Stream 3 concepts appear appropriate and relevant for a PACE population; although the measures themselves should be revisited. We have two general concerns: (1) administrative burden; and (2) overall scope. In terms of burden, we are concerned about the time and effort needed to track and report these new measures as it is unlikely that capitation rates will increase to reflect this added burden. While we track these efforts, we do not track in the manner specified by these measures. For the most part, this will involve manual collection until we can eventually convert some to an electronic platform (at added expense). Prior to any measure adoption, we encourage piloting these measures with several PACE organizations at varying degrees of EHR integration / adoption to determine level of effort and providing an additional comment period related to testing efforts and resulting time and effort studies. Second, it is difficult to comment on individual measures without understanding the totality of this quality measure

project. We do not know how many total measures will ultimately be included within the final measure set nor how they are intended to be risk adjusted and impact our rates. While we are pleased that CMS is aligning these measures within the “Meaningful Measures” constructs, we lack an overall understanding of the final collection and reporting ask. We urge more transparency in the overall process so that we have better context in which to comment.

Applying the above general concerns to the proposed measures, we will specifically discuss the Participant Influenza Immunization measure (e.g., a process measure) as an example. While we appreciate the efforts to attempt to control or recognize various exclusionary criteria, we question whether the added reporting burden results in meaningful quality distinctions and reiterate our need to understand the quality context for this measure. In support of this, we point to the recent revisions of a similar immunization measure within the Home Health setting.¹ For home health, this measure is simplified - percentage of home health episodes of care during which patients received influenza immunization for the current flu season. Rather than revising the measure to take into account each exclusion, the measure was simply removed from the Quality of Patient Care STAR rating methodology, but not from Home Health Compare reporting. As proposed, we are concerned with the multi-level reporting, whether these results provide meaningful differentiation among programs, and that the ultimate purpose of, and audience for, the reporting is unclear.

In response to your specific questions, we urge a balance between administrative burden and definition accuracy. We also encourage measure standardization with existing CMS measures in other settings, including Medicare Advantage measures. The more that PACE measures deviate from similar quality measures, the less likely that PACE will be able to be compared holistically and the greater the administrative expense that will be borne by relatively small PACE Provider Organizations to create customized reporting.

- For Participant and Staff Influenza Immunization Measures:
 1. Definition of “reporting influenza season” to expand the date range or substitute a date reference with a start date to “begin with vaccine availability.” We encourage the adoption of language common to other CMS immunization measures. For a tracking perspective, it is easier to monitor a date certain than a fluctuating date.
 2. Denominator of the Participant Influenza measure to expand the trigger date from 1 day to 2 days or 14 days. Again, we encourage the use of common requirements. For a tracking perspective, it is easier to run reports with a single date trigger than a date range trigger.
 3. Definition of Contraindications to identify exclusionary criteria. As mentioned above, we question whether this level of specificity it needed, without truly understanding how CMS intends to use this measure.
- For the ED Utilization Without Hospitalization Measure:
 4. Observation Stays counted as a hospitalization. While we generally agree that ED visits are distinguishable from observation stays and should be excluded, the proposed ED utilization

¹ Home Health Star Ratings, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIHomeHealthStarRatings.html>

measure itself does not necessarily equate to avoidable/preventable/unnecessary ED use, which is the rationale for this measure. The fact that an inpatient stay or observation stay followed the ED visit should not be confused with situations where ED care is medically necessary. With a frail elderly population, the ED should not be de-legitimized as a necessary level of care. In addition, this measure seems to fly in the face of patient and caregiver care preference. While Siouxland PACE has initiatives to address misutilization and/or overutilization of ED services, these efforts should be targeted interventions and not applied to the PACE population as a whole to discourage medically necessary care. This deference to patient/caregiver preferences was referenced by CMS as part of the rationale for excluding this measure from the Home Health Quality of Patient Care STAR rating methodology.

On behalf of our PACE Participants, Siouxland PACE and UnityPoint Health appreciates the opportunity to provide comments to the Stream 3 proposed measures. In addition, Siouxland PACE is a member of the National PACE Association (NPA). We generally support the comments submitted by NPA and are committed to participating with the NPA to further strengthen services and supports for the PACE population. Siouxland PACE and UnityPoint Health look forward to participating in future PACE measure development and other stakeholder forums. To discuss Siouxland PACE comments or for additional information, please contact Cathy Simmons, Executive Director of Regulatory Affairs at cathy.simmons@unitypoint.org or 319-361-2336.

Sincerely,



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Executive Director
Siouxland PACE



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