LeadingAge New York
formerly NYAHSA

March 18, 2013

Mr. Patrick Roohan
Director, Office of Quality and Patient Safety
NYS Department of Health
Corning Tower, Empire State Plaza
Albany, NY 12237

RE: Proposed NYS Nursing Home Quality Pool

Dear Mr. Roohan:

I am writing on behalf of LeadingAge New York to provide our comments on the Department of Health's (DOH's) most recent proposal for the Nursing Home Quality Pool authorized in Section 2808 of the Public Health Law.

For the record, LeadingAge NY remains concerned that the recommendation to fund the quality pool by commensurately reducing overall Medicaid payments by $50 million annually: (1) will add to the negative impacts many facilities are experiencing from the implementation of statewide pricing; and (2) could have the perverse effect of detracting from quality in an already underfunded system. We believe that quality funding should instead be derived from shared savings resulting from Medicaid redesign, the MRT waiver and/or Affordable Care Act funding enhancements.

Having said that, we are pleased to provide further input on the design of the quality pool and offer the following comments:

Quality Measures

We agree with DOH's intent to focus on quality measures (QMs) for long-stay residents, who are more likely to be Medicaid recipients and have different needs than short-stay patients. In general, the QMs used in the quality pool should be properly validated and risk adjusted, reflective of needed exclusions and manageable in number.

Our more specific comments follow:

1. **The list of QMs should include an appropriate antipsychotics quality measure.** The Prevalence of Long Stay Residents Who Received an Antipsychotic Medication QM should remain in the quality pool scoring matrix. Reducing off-label use of antipsychotic medication – particularly in the dementia population – has been a major CMS initiative; removing the measure from the NYS Quality Pool would most certainly send a mixed message to providers. However, we do agree that using the surveyor measure (which excludes residents with psychotic or related conditions) rather

13 British American Blvd. | Suite 2 | Latham, NY 12110-1431
P 518.867.8383 | F 518.867.8384 | leadingageny.org

than the CMS measure would be preferable, even if this is an interim step to developing an improved measure. In addition to the CMS exclusions, the surveyor measure excludes those with psychotic disorders, manic depression, hallucinations, and delusions. It may be beneficial at some point to also include a sub-measure which only looks at dementia residents who received an antipsychotic medication, since this is the population being targeted for reduction.

2. **The structure and application of the pain QM raise significant concerns.** The covariate for the Percent of Long Stay Residents who Self-Report Moderate to Severe Pain QM is cognition, which is based on the prior assessment. We believe that the covariate should be based on the target assessment rather than the prior assessment; cognition at the time of assessment affects the resident's response to pain, not his/her cognitive status as of the prior assessment. Another significant issue with this QM is that it only considers those residents who self-report pain, leaving out a large percentage of residents who cannot self-report due to dementia or other factors. Research has shown that pain in dementia residents is often under-reported and under-treated, validating this concern. Finally, a self-reported QM such as this one introduces a greater degree of subjectivity into measurement than most of the other QMs which are outcome-based.

3. **The weight loss QM includes some questionable covariates.** The Percent of Long Stay Residents who Lose Too Much Weight QM includes some covariates that we believe may be under the control of the facilities or could even be indicative of poor quality of care. For example, including hip fracture as a risk factor will tend to "reward" facilities that have a high rate of fractures where fractures themselves can be considered a sign of poor quality of care. The same argument applies to residents with malnutrition and depression.

4. **The QMs for influenza and pneumococcal vaccines of residents should be considered for elimination.** The overall compliance rates for both of these measures are very high, and the distribution of individual facility scores is narrow enough that meaningful distinctions in quality point assignments cannot be made. Given the exceedingly large number of QMs overall, we would suggest elimination of these QMs or, alternatively, establishing a minimal cutoff value (e.g., a set number or the 10^{th} percentile) for a combined measure and assigning minimal points.

5. **The total weighting given to employee flu vaccinations is too great.** Effectively, the proposed quality pool scoring matrix assigns nearly 10 points – about 10 percent of the entire score – to employee flu vaccinations. The Percent of Employees Vaccinated for the Flu QM is assigned 4.62 points, while timely submission of employee flu data is assigned 5 more points under "compliance." We would suggest eliminating the 5 points assigned under compliance, and instead subjecting facilities only to the loss of the QM points if their vaccination rates cannot be measured based on non-submission of the required data by the due date.

6. **The composite staffing measure should be given greater weight in the overall scoring.** There is a considerable body of research and literature linking the level of direct care staffing to quality of care and resident outcomes. Accordingly, a robust staffing measure should be included in the quality pool, and given a material weight in the overall scoring system. LeadingAge NY supports the staffing QM proposed by DOH, which is a composite of: (1) the level of temporary contract/agency staff use; and (2) an acuity-adjusted measurement of staffing hours, as reported in nursing home

cost reports and substituting for the less reliable CMS staffing measure which is based on the two-week "snapshot" of hours. We further recommend that the composite staffing measure be assigned a greater weight (perhaps 10 percent) in the overall scoring.

Compliance

We continue to maintain that survey performance should be based on each facility's most recent standard survey only, similar to the approach taken in the CMS Nursing Home Value-Based Purchasing (NHVBP) demonstration. If there are multiple levels of deficiencies cited in the standard survey, then performance should be measured by the most severe level assigned. With the ongoing implementation of the QIS process, while standard surveys continue to be completed, the only consistent evaluating factor is the scope and severity of the deficiencies cited.

If significant variations among survey regions are evident in the survey ratings, consideration should be given to ranking facilities within their respective survey regions for purposes of quality pool scoring.

Potentially Avoidable Hospitalizations

Preventing avoidable hospitalizations remains a policy imperative of both state Medicaid redesign and federal health reform efforts, and including an appropriate measure in the quality pool framework seems advisable. Our more specific comments follow:

1. **The definition of episode of care could lead to improper risk adjustment.** Based on the proposed methodology, an episode occurring within one year can have a duration of between 101 and 365 days. The probability of a resident being hospitalized within an episode will depend on length of stay. For example, a resident with an episode length of 110 days is much less likely to be hospitalized than a resident with a 350-day episode given similar resident characteristics and conditions. This will not be fair for facilities that have a longer stay resident population. Although the episode length is included as one of the covariates in the risk adjustment model, the effect will be understated. In addition, repeated hospitalizations will not be counted using the proposed method, as this methodology only counts the first hospitalization.

   We recommend that one of two methods be used to address this situation: (1) follow the CMS specification used in the NHVBP demonstration, which is the number of potentially avoidable hospitalizations (PAH) divided by 100 episode days; or (2) use a look-back scan (e.g. up to 100 days), similar to other CMS measures that have a look-back scan. The measure would then become "percent of long stay residents who were hospitalized in the last 100 days of target assessment." The second method is very commonly used in the literature and is consistent with other CMS QMs.

2. **Using SPARCS data for primary diagnosis raises concerns.** First, SPARCS data is based on hospital discharges. Primary diagnosis may be significantly different based on the hospital discharge information versus using primary diagnosis at time of admission from the nursing home. The diagnosis at the time of admittance from the nursing home is more relevant to the quality of the nursing home care that preceded it than a discharge diagnosis which also reflects what occurred during the hospital stay. Second, SPARCS data is only collected from hospitals in New York;

therefore, nursing home residents hospitalized out-of-state would not be counted in the calculations. As a result, nursing homes located near the state border may potentially have significant amounts of hospitalization data missing, and will likely be excluded from the calculations.

3. **The risk adjustment formula should properly account for specialty programs within nursing homes.** Certain facilities specialize in serving medically subacute patients, as well as specialty populations that are associated with higher rates of hospitalization. The comorbidity and functional indices that are used to risk adjust the predictive model should not inadvertently penalize nursing homes that offer these programs.

4. **The increased use of observation status could affect this measure**. Observation status refers to the classification of a patient in an acute care hospital as an outpatient, even though the person is placed in a bed in the hospital, stays overnight (potentially several nights), and receives medically necessary nursing and medical care, diagnostic tests, treatments, therapy, prescription and over-the-counter medications. CMS has reported that the number of hospital patients in observation for more than 48 hours nationally increased from 3 percent of hospital claims in 2006 to 7.5 percent in 2010. To the degree that observation stays do not trigger actual discharges to hospitals, we are unclear as to whether this dynamic is being captured. If not, this could significantly affect the stability of the potentially avoidable hospitalization measure and the ability to make valid comparisons across nursing homes based on variations in the use of observation status.

Conclusion

Thank you for the opportunity to provide input on the proposal. LeadingAge NY remains interested in working with DOH and other stakeholders on the development and implementation of the nursing home quality pool. If you have any questions on our comments, please contact me at (518) 867-8383 or dheim@leadingageny.org.

Sincerely,

Daniel J. Heim
Executive Vice President