June 17, 2015

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

RE: Proposed 2015 Nursing Home Quality Initiative Methodology

Dear Mr. Roohan:

I am writing on behalf of LeadingAge New York to provide our comments on the Department of Health's (DOH's) proposed 2015 methodology for the Nursing Home Quality Initiative (NHQI) authorized in Section 2808 of the Public Health Law.

While recognizing that any revisions to this program are subject to approvals by the Centers for Medicare & Medicaid Services (CMS), we remain concerned about the timing of its implementation. Ideally, the methodology for each year should be finalized and distributed to facilities in advance of the reporting year, and the final results/payments should be distributed as close to the end of the reporting year as possible. Taken together, we believe this timing sequence would enhance the opportunity to realize quality improvements in any given year, more closely link the results to the feedback, and better fulfill the underlying intent of the program.

LeadingAge NY has consistently expressed concerns about the policy of funding the quality pool by commensurately reducing overall Medicaid payments by $50 million annually. This policy adds to the negative impacts many facilities are experiencing from the implementation of the statewide pricing methodology and the lack of a Medicaid inflationary adjustment over the last several years. In fact, we believe that funding this program out of the base could have the perverse effect of detracting from quality in an already underfunded system. Due to significant implementation delays, facilities will see two sets of NHQI payment adjustments in 2015 and this will contribute to revenue losses and cash flow issues for facilities not receiving awards. We maintain that quality funding should instead be derived from shared savings resulting from Medicaid redesign and/or other sources.

We are pleased to provide further input on the design of the NHQI for 2015, and offer the following comments:

Quality Measures

In general, the Quality Measures (QMs) used in the NHQI should be properly validated and risk adjusted, reflective of needed exclusions and manageable in number. With the ongoing transition of

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the nursing home Medicaid population and benefit into managed care, alignment of QMs between managed care and the NHQI will become more important as time goes on.

Our more specific comments on the 2015 QMs follow:

1. **We conditionally support the proposal on small sample size.** The apparent intent of the proposal is to reduce the number of QMs that are suppressed due to small sample size in instances when the sample size is sufficient for at least three-quarters of the year. We support this proposal, but reserve judgment on whether the Department should utilize the statewide quarterly average for the quarter with the small sample (as was proposed), or simply calculate a three-quarter average for the facility and use it in the NHQI results. We would be interested in seeing a statistical analysis that supports the DOH proposal in lieu of using only the facility's data.

2. **We support use of the quintile scoring method for the long stay resident pneumococcal vaccine QM.** However, we remain opposed to the policy of excluding from the numerator of both this QM and the long stay resident influenza vaccine QM those residents that are offered but refuse the vaccines. We believe this policy unfairly penalizes nursing homes with high numbers of residents who exercise their rights to refuse to receive one or both of these vaccines.

3. **An Antipsychotic (AP) measure focused on the dementia population is most appropriate, given the policy direction of federal and state governments.** We support the overall framework of the Pharmacy Quality Alliance (PQA) AP measure, which would focus on residents with dementia who have a history of receiving an AP medication. However, we would be interested in reviewing more information on the specifications of the PQA measure, validations that have been conducted, and whether/how the measure is currently being utilized for quality improvement purposes.

4. **We support the use of an annualized staffing measure.** LeadingAge NY supports a staffing level measurement based on the hours reported in nursing home cost reports rather than the less reliable CMS staffing measure which is based on the two-week "snapshot" of hours. We are concerned; however, that existing cost report instructions and guidance do not provide a clear framework for consistent allocation and reporting of hours between direct care and nursing administration. If it is possible to clarify the instructions prior to the due date for filing 2014 cost reports – and provided that facilities have been tracking the hours in a way that conforms to the clarified instructions – we support use and assignment of points to this measure for the 2015 NHQI. If standardization cannot be achieved for the 2014 hourly data, LeadingAge NY recommends publishing this measure as an informational one and utilizing on a one-time basis the current CMS measure for the 2015 NHQI.

5. **The proposed staff turnover measure should be further studied prior to use.** We agree that consistency and stability of direct care staffing can have a bearing on quality of care and quality of life. However, the proposed measure raises several questions and possible concerns that should be fully explored prior to use, such as: (1) what bearing, if any, the degree of reliance on contract and per diem staff has on employee turnover rates; (2) potential regional labor market variations; (3) the veracity of cost report data being reported for the first time in 2014; (4) level of reliance on part-time versus full- time employees; and (5) the employee classifications that should be included

in the measure. Given these questions and concerns related to utilizing an entirely new measure at this point in 2015, we recommend delaying implementation or publishing this measure as an informational one for the 2015 NHQI.

6. **The total weighting given to employee flu vaccinations is too great relative to that of the other measures.** Effectively, the proposed quality pool scoring matrix assigns 10 points – 10 percent of the entire score – to employee flu vaccinations. The Percent of Employees Vaccinated for Influenza QM is assigned 5 points, while timely submission of employee flu data is assigned 5 more points under "compliance." Regulations have been promulgated requiring employees who are not vaccinated to wear masks during time periods when the Commissioner determines that influenza is prevalent. We believe this addresses the underlying public health objective in a way that justifies reducing the associated scoring in the NHQI. Accordingly, we recommend eliminating the 5 points assigned under compliance, and instead subjecting facilities only to the loss of the 5 QM points if their vaccination rates cannot be measured based on non-submission of the required data by the due date.

Redistribution of Component Points/Incentive for High Performers

Inasmuch as we do not support assignment of points to the proposed staff turnover measure for 2015, we do not support the proposed redistribution of points from the Five-Star Quality Measure to the quality component.

LeadingAge NY had previously advocated for assignment of points for improvement in NHQI QMs, and is pleased to see that 94 percent of all facilities received at least one improvement point in the 2014 NHQI scoring. In an effort to ensure that top performers are properly incented to maintain their performance, LeadingAge NY recommends that DOH consider a new scoring incentive for those facilities that have achieved overall scores in the highest quintile for two or more consecutive years.

Potentially Avoidable Hospitalizations

Preventing potentially avoidable hospitalizations (PAHs) remains a policy imperative of both state Medicaid redesign and federal health reform efforts, and including an appropriate measure with a material weight in the NHQI framework seems well advised. Our more specific comments follow:

1. **We are unclear as to specifics of the risk adjustment formula that would be applied to the quarterly rates, and whether they would 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.

2. **Facilities should have access to the formulas and data elements utilized for this measure to be able to track their progress.** Previous iterations of this measure have been impossible for facilities and other stakeholders to replicate, making it much more difficult to validate the data and evaluate progress over time.

3. **The longer-term goal should be to align this measure with other relevant PAH measures planned for use.** For example, under the federal Protecting Access to Medicare Act of 2014, CMS is required to develop a risk-standardized re-hospitalization measure for the Medicare fee-for-service population in skilled nursing facilities for use beginning in 2018. With efforts underway to integrate care for dual eligible beneficiaries, efforts to reduce PAH would be reinforced by ensuring complementary approaches to re-hospitalization measures between the Medicare and Medicaid programs.

Conclusion

Thank you for the opportunity to provide input on the proposed 2015 NHQI methodology. LeadingAge NY remains interested in working with DOH and other stakeholders on the development and implementation of the NHQI program. 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

cc: Mark Kissinger, DOH
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