June 12, 2014

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

**RE: Proposed 2014 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 methodology for the Nursing Home Quality Initiative (NHQI) authorized in Section 2808 of the Public Health Law.

For the record, LeadingAge NY remains concerned that the policy of funding the quality pool by commensurately reducing overall Medicaid payments by $50 million annually: (1) adds 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 and/or other sources.

While recognizing that initiation of this program and any modifications to it are subject to approvals by the Centers for Medicare & Medicaid Services (CMS), we are nonetheless concerned about the timing of 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 and more closely link the results to the feedback.

With that said, we are pleased to provide further input on the design of the NHQI and offer the following comments:

**Quality Measures**

We agree with maintaining a 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. With the impending transition of the nursing home Medicaid population and benefit into managed care, alignment (or at least avoiding misalignment) of QMs between managed care and the NHQI will become more important as time goes on.


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Our more specific comments on the 2014 QMs follow:

1. **The composite staffing measure needs refinement.** The level of direct care staffing is a critically important structural determinant of quality of care and resident outcomes. Accordingly, robust staffing measures should be included in the quality initiative, and given a material weight in the overall scoring system. LeadingAge NY supports continued use of the level of temporary contract/agency staff use and an acuity-adjusted measurement of staffing hours as measures. However, we recommend refining these measures as follows: (1) the temporary contract/agency staff measure would more effectively promote quality if the points were assigned based on quintiles or other ranges rather than on a single cut-off value (i.e., 10 percent); and (2) the staffing level measurement should be modified to reflect 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. For this purpose, the 2013 cost report data should be reviewed and incorporated for the 2014 quality initiative, if at all possible.

2. **The total weighting given to employee flu vaccinations is too great in relation 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 the Flu QM is assigned 5 points, while timely submission of employee flu data is assigned 5 more points under "compliance." Subsequent to the development of the 2013 NHQI methodology, regulations were 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 quality initiative. 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.

3. **The QMs for influenza and pneumococcal vaccines of residents should be eliminated.** 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. Furthermore, we do not support the proposal to modify these QMs to exclude from the numerator those residents that are offered but refuse the vaccine, since we believe this would undermine resident choice. Given the exceedingly large number of QMs overall, we would suggest elimination of these QMs and reassignment of the points.

4. **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.

5. **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.

6. **We are unclear as to the calculation of the scores for attainment and improvement.** Specifically, will attainment scoring be calculated based on average rates from four quarters of MDS 3.0 data (i.e., four data points)? If yes, which quarters are included for the 2014 NHQI? Similarly, will the improvement score be calculated based on improvement from average rates for four quarters (i.e., Q1-4 of 2013) and the following four quarters (i.e., Q1-4 of 2014)? In each instance, a rate calculated based on a full year of data is likely to be different than an average of the average rates for each of the respective four quarters of data.

**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, DOH should strongly consider ranking facilities within their respective survey regions for purposes of NHQI scoring.

**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. **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.

2. **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 PAH 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 proposed 2014 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

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