March 17, 2017

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

RE: Proposed 2017 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 2017 methodology for the Nursing Home Quality Initiative (NHQI) authorized in Section 2808 (2-c) of the Public Health Law.

Overall Feedback

While recognizing that DOH has accelerated the release of the draft NHQI methodology relative to prior years, we remain concerned about the timing of its implementation. Ideally, the methodology for each year should be finalized and distributed to facilities at the beginning 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 since 2008. 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 that are in large part due to outstanding NHQI litigation, when payment adjustments are finally able to be made, facilities could see multiple years of NHQI payment adjustments implemented in a short timeframe which will contribute to significant revenue losses and cash flow issues for facilities not receiving awards. For all of these reasons, 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 specific input on the design of the NHQI for 2017, as follows:

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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 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.

1. **The 2016 results of the staff hours per day measure should be carefully reviewed.** LeadingAge NY remains supportive of a staffing level measurement based on the hours reported in nursing home cost reports rather than the less reliable Centers for Medicare and Medicaid Services (CMS) staffing measure. We are concerned; however, that the 2016 results display greater overall variation among quintile values than the 2015 baseline results. This variation could be the result of inconsistent allocation and reporting of hours in the cost report which, if validated, suggests that modifications to the cost report instructions and/or facility education may be warranted. We do not support revising the scoring of this measure from a quintile basis to a threshold basis – as was suggested during the NHQI Workgroup meeting – precisely because there is a high degree of variation in the results. We would also encourage DOH to closely monitor CMS efforts to gather staffing data through the Payroll-Based Journal and potential resulting staffing measures for possible adoption in the NHQI.

2. **We remain opposed to the policy of excluding from the numerator of the long stay resident influenza and pneumococcal vaccine QMs those residents that are offered but refuse the vaccines.** While we understand that making this change would narrow the distribution of results, we believe this policy unfairly penalizes nursing homes with high numbers of residents who validly exercise their rights to refuse to receive one or both of these vaccines.

3. **The total weighting given to employee flu vaccinations remains too high 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." DOH regulations require 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.

4. **The new CMS functional status measure should be further evaluated following additional use.** We agree with DOH's decision to not incorporate the new CMS functional status measure (#451) in the NHQI at this time, but would recommend that its potential future use be further evaluated. Unlike the existing functional QM (Measure #401), the new measure incorporates risk adjustments for resident characteristics that may have a significant bearing on functional status and are largely outside of the control of the facility.

Potentially Avoidable Hospitalizations

Preventing potentially avoidable hospital use 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 is well-advised. Our more specific comments follow:

1. **We are unclear as to whether the risk adjustment formula for the current measure properly accounts for specialty programs offered 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 the CMS potentially preventable readmission measure.** CMS is implementing the Skilled Nursing Facility 30-Day Potentially Preventable Readmission Measure (SNFPPR) for the Medicare fee-for-service population in skilled nursing facilities beginning in 2018. With efforts underway to integrate care for dual eligible beneficiaries, efforts to reduce avoidable hospital use would be reinforced by ensuring complementary approaches to hospitalization measures between the Medicare and Medicaid programs. We understand the Department's decision to not use the SNFPPR or a similar measure in the NHQI at this time, but would encourage further evaluation of the measure for future years.

Conclusion

Thank you for the opportunity to provide input on the proposed 2017 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
Raina Josberger, DOH
Emily Bean, DOH