May 11, 2012

Mr. Patrick Roohan
Director, Division of Quality Improvement and Evaluation
Office of Health Insurance Programs
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 initial comments on the Department of Health's (DOH's) proposal for the Nursing Home Quality Pool authorized in Section 2808 of the Public Health Law.

Founded in 1961 and formerly known as the New York Association of Homes and Services for the Aging, LeadingAge NY is the only statewide organization representing the entire continuum of not-for-profit and publicly-sponsored continuing care providers including nursing homes, adult day health care programs, home care agencies, managed long term care plans, senior housing, continuing care retirement communities, adult care facilities and assisted living.

For the record, LeadingAge NY supports efforts to link quality to payment and is supportive of the establishment of a quality pool for nursing home services to provide an incentive to encourage quality of care and quality of life. However, we remain concerned that the apparent decision to fund the pool by commensurately reducing overall Medicaid payments by $50 million or more 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.

Having said that, we are pleased the Department has convened the stakeholder group and given us the opportunity to provide input on the design of the quality pool. To that end, we offer the following comments:

Quality Measures – Clinical

We agree with the Department's intent to focus on quality for long-stay residents, who are more likely to be Medicaid recipients and have different needs than short-stay patients. We also agree that, where possible, quality measures (QMs) should rely on existing data and reporting mechanisms in lieu of untested and potentially time-consuming and expensive collection of additional data. A mixture of process and outcome indicators also makes sense, given the inexact science of quality measurement.

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In general, the set of QMs used in the quality pool should be properly validated and risk adjusted, reflective of needed exclusions and manageable in number. Without proper risk adjustment, facilities may be ranked as "top performers" simply because they have many residents with few/no risk factors. Indeed, these measures could result in rewarding facilities providing worse care than expected, based on their resident population.

The selected QMs should also properly distinguish between short-stay and long-stay individuals and tie in with broader Medicaid quality measures as outlined in the final report of the Medicaid Redesign Team, *A Plan to Transform the Empire State's Medicaid Program.* Our more specific comments follow:

1. **To avoid inconsistency, DOH should utilize the new CMS definitions of short-stay and long-stay.** The new CMS definition described on page 3 of the MDS 3.0 QMs user's manual is as follows:
   - Short-stay: an episode with cumulative days in facility (CDIF) less than or equal to 100 days as of the end of the target period.
   - Long-stay: an episode with CDIF greater than or equal to 101 days as of the end of the target period.

   Episode and CDIF are defined as follows:
   - Episode: an episode begins with an admission and ends with either (a) a discharge assessment with return not anticipated, (b) a discharge assessment with return anticipated but the resident did not return within 30 days of discharge, (c) a death in facility, or (d) the end of the target period, whichever comes first.
   - CDIF: the total number of days within an episode during which the resident was in the facility. It is the sum of the number of days within each stay included in an episode. If an episode consists of more than one stay separated by periods of time outside the facility (e.g., hospitalizations), only those days within the facility would count towards CDIF. Any days outside of the facility (e.g., hospital, home, etc.) would not count towards the CDIF total.

2. **The list of QMs should include an antipsychotics quality measure.** Atypical antipsychotic drugs are FDA-approved only for treatment of schizophrenia and bipolar mania. However, they are frequently used "off-label" as the first-line treatment for agitation and other dementia-related behavioral disturbances (e.g., anxiety, aggression and obsessive behaviors). As part of CMS's new Behavioral Health Initiative, they will soon release an MDS 3.0-based long-stay and short-stay antipsychotics measure. We recommend that DOH incorporate at least the long-stay antipsychotics measure into the proposed quality pool, using the same specifications as CMS.

3. **A pressure ulcer (PU) measure should also be considered.** PU rates are an important measure of overall quality of care, indicative of appropriate staffing, leadership, adherence to evidence-based processes and protocols of care and prevention of adverse outcomes. PU reduction in nursing homes is a high state and national priority. We recommend that DOH look at the specifications of the pressure ulcer QMs from the MDS 3.0 QMs user's manual (see p. 10 for short-stay and p. 21 for long-stay) to evaluate the possibility of including a new risk-adjusted PU measure in the quality pool specifically based on the state's nursing home population. See the attached document for a detailed description of the methodology used for New York's 2010 Pay for Performance PU initiative developed by LeadingAge NY researchers, using MDS 2.0 data. A new risk-adjusted model

would need to be developed for an MDS 3.0-based risk-adjusted QM since the data elements have changed.

4. **Other QMs included in the proposal may need to be excluded.** It was suggested in the meeting, and we would agree, that adding more QMs should result in other suggested QMs being excluded from the list. For this purpose, the Department should examine the distribution of values for each QM across facilities and over time to assess the levels of stability and outlier values. This should also include an analysis of the size of the denominator relative to the total number of residents; the relative subjectivity of the MDS items used in the calculation of the measure; the risk-adjustments and exclusions applied; the use of standardized scales and thresholds (e.g., PHQ-9 for depression); and the presence of facility interventions related to reported conditions. In addition, we also recommend that DOH review the literature to determine the advantages and drawbacks of each measure (e.g., measures related to reimbursement might not be reliable in measuring quality of care).

5. **Improvement and performance can both be recognized and methodically measured.** We agree that it is more complicated to measure improvement than performance. As discussed in our recent meeting, it is more difficult to lower a QM rate, for example, from 40% to 35% than from 60% to 55%. In addition, from our experience analyzing MDS data, changes in QM rates are more likely to occur in smaller facilities than in larger facilities, either due to random variation or systematic variation attributed to improvement in care. A possible solution to these problems is to adjust the changes in the overall score similar to a risk adjustment method where the covariates include, but are not limited to, facility size and initial score. In addition, facilities considered for an award based on improvement should meet some reasonable minimum threshold (e.g., a post-improvement score more favorable than the median).

6. **The equal weightings given to each of the QMs should be re-evaluated in the future.** Based on the distributions of facility-specific scores, overall changes in performance, changes in priorities and other factors, it may make sense to reweight the QM scores making up the overall QM component to achieve more optimal total scoring for quality of care.

7. **Certain MDS data should not be used.** As referenced in the presentation, MDS 3.0 data are available from October 2010 forward fur use in quality measurement. However, we strongly recommend against using assessments that were conducted in the 4th quarter of 2010 as nursing home staff were new to the MDS 3.0 and still in the learning process. Data collected during this time period (October 1, 2010 – December 31, 2010) may be unreliable for use as quality pool baseline information.

Quality Measures – Staffing

Staffing is a critical part of nursing home quality, and a staffing measure should be included in the factors used to allocate quality incentive pool payments and given a material weight in the overall scoring system. The measures that are used to gauge quality in this domain must be meaningful and should be based on valid and accurate data. Lacking this, there is a danger of excluding intended recipients and of establishing perverse incentives.

While staff retention has been found to be related to quality of care, the recommended percentage of turnover measure has some inherent limitations including: (1) giving the same weighting to occasional per diems and part-time employees as to full-time employees; (2) failing to account for differential turnover rates among different regional labor markets and between unionized and non-unionized facilities; (3) failing to distinguish between voluntary and involuntary turnover; (4) degree of reliance on, and turnover within the category of, contractual staff workers; and (5) inconsistent reporting within the cost report. Furthermore, turnover is also a poor proxy for consistent staff-resident assignments. A facility can have low employee turnover even though it does not practice consistent assignment.

There is a considerable body of research and literature linking the level of direct care staffing to quality of care and resident outcomes. Accordingly, LeadingAge NY recommends that the Department utilize the staffing measure advanced by the Joint Association Task Force on Nursing Home Reimbursement (JATF), which is a composite of two measures: (1) the level of temporary contract/agency staff use; and (2) the acuity-adjusted Nursing Home Compare 5-Star staff ranking, with the more robust annual cost report hours (which are based on payroll data) substituted for the snapshot staffing data received during the survey process.

Satisfaction

LeadingAge NY agrees that resident satisfaction is an important indicator of quality of life, and should be incorporated if a standardized, validated measure can be identified and applied uniformly across facilities. While many facilities gather satisfaction data using tools developed/administered by third parties, there are multiple such tools and no consistently administered satisfaction measurement system in use. As noted in the presentation, the Quality Indicator Survey (QIS) process includes interview questions aimed at identifying satisfaction levels. However, 40% of facilities have yet to be surveyed under QIS and there are timing issues inherent in the survey process in general.

We agree with DOH’s recommendation to not include satisfaction results in year one of the quality incentive program. CMS development of a satisfaction measure should be monitored and examined for possible application in future quality pool scoring.

Compliance

As recommended by the JATF, survey performance should be based on each facility’s most recent standard survey only. 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.

Once the QIS process has been implemented statewide, the survey component of the compliance domain should be revisited. If significant variations among survey regions manifests in the QIS process (as it has in the traditional process), consideration should be given to ranking facilities within their respective survey regions for purposes of quality pool scoring.

As recommended by the JATF, those facilities receiving a survey outcome of Immediate Jeopardy or Substandard Quality of Care during any survey in the target year, or that are deemed a Special Focus Facility at any time during the target year, should be ineligible to participate in the quality pool for the target year.

For purposes of the pay for reporting phase in 2012; however, a facility that would otherwise be ineligible to receive additional funding through the quality pool should not have its Medicaid rate reduced in 2012, unless it does not comply with the data reporting requirements.

Avoidable Hospitalizations

Preventing avoidable hospitalizations is 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 definitions of episodes of care need to be standardized.** As recommended above in the first point under "Quality Measures – Clinical," the CMS definitions of short-stay and long-stay should be utilized for purposes of the avoidable hospitalizations measure.

2. **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 (e.g., ventilator dependent individuals). The comorbidity and functional indices that are used to risk adjust the predictive model should not inadvertently penalize nursing homes that offer these programs.

3. **Additional variables that may explain differential rates of hospitalization should also be examined.** These include resident race, the type of location of the facility (I.e., rural, suburban and urban) and bed size of the facility. The hospitalization measure may need to be refined if significant variances in hospitalization rates are observed based on these or other demographic variables.

Scoring and Qualification

In the initial year of quality pool payments, top performing facilities should be identified and be eligible for funding. In subsequent years, the highest scorers as well as those showing significant improvement should be allocated funding. While adding improvers to the funding matrix introduces further complexity, significant improvement should be encouraged among facilities that would not be included among the top performers.

Among the facilities that would be excluded from receiving quality pool funding are those for which there has been a determination of fraud or abuse. This criterion should be clearly distinguished from the results of audit findings by the Office of the Medicaid Inspector General. We would recommend instead that a facility be excluded if it was subject to a mandatory suspension of Medicaid payments based on a "credible allegation of fraud" and the results of any associated fraud investigation by the Medicaid Fraud Control Unit of the Office of the Attorney General.

Conclusion

Thank you for the opportunity to provide input on the proposal. LeadingAge NY remains interested in working with the Department 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

Attachment