

March 14, 2011

National Quality Forum

Re: National Voluntary Consensus Standards for Nursing Homes

To the Committee:

First I want to thank the NQF for their efforts to endorse quality measures for the nursing home industry that are consistent across the industry utilizing standard data for comparison. The nursing home industry has always supported methods to present their quality standards.

I was privileged to be a member of the National Quality Forum's Steering Committee for the National Voluntary Consensus Standards for Nursing Homes project that had the opportunity to review and comment on the proposed quality measures as a representative of my profession and my peers. I feel that even though I did express my concerns during the meetings and during the public comment period, I feel I must comment one more time on some of the measures that the NQF has approved for endorsement or for time limited endorsement.

In the responses to the comments posted on the NQF website, many of the responses from CMS indicated that the comments will be considered as they analyze the MDS 3.0 data as well as for further refinement of the quality measures. My hope is that this consideration and refinement will occur prior to the measures becoming public record and allow the industry to fully understand and prepare for the publishing of the quality measures.

NH-003-10 Physical Therapy or Rehabilitation/Restorative Care for Long-Stay Patients with New Balance Problem.

I appreciate RAND's response to the comments received in correcting the original title to recognize long stay patients and for their addition of the BIMS in the definition of "advanced dementia" for exclusion from the measure.

RAND did not fully explain how they were going to be able to capture those patients who meet the denominator definition of a balance problem and received physical therapy in the prior 4 months to one month after paid by funds not recorded or submitted to CMS. Private pay patients, private insurance, many managed health care organizations and in some cases, State Medicaid programs, do not provide their therapy billing to CMS. If a patient received therapy in the administrative data look-back period paid by funds not reported to CMS, these patients would meet the requirement to be included in the numerator but would not be included in the measure. This would result in a false lower percentage being published.

As an example – 100 patients meet the denominator requirement. 20 patients meet the physical therapy administrative data in the 4 month look-back, 10 patients meet the numerator from O5f of the MDS 3.0, and 20 patients received physical therapy in the administrative data look back period but from private or insurance payors. According to the specifications for this measure – the reportable percentage would be 30% rather than the actual 50%.

I strongly urge NFQ, CMS and RAND to research the variances in the percentage reported verses actual prior to making this measure public and provide information to the industry on how all applicable therapy billing for this measure will be captured. This will lessen the burden to the nursing homes to have to explain the actual percentage verses the percentage reported on Nursing Home Compare.

NH-013-10 Percent of High Risk Residents with Pressure Ulcers (Long Stay)

I appreciate CMS recognizing the need to examine the comments to include ICD-9 codes for Malnutrition in I8000 in the calculation of the denominator and hope this information will be provided to the industry prior to the measures becoming public record.

NH-014-10 and NH-015-10 Percent of Nursing Home Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (Long Stay)

I appreciate NQF noting the concern regarding the accuracy of the title from the original title; however, I still feel the current title remains unclear to the consumer based upon the specifications of the measure. The measure includes in the numerator and denominator residents who refuse and resident who are medically ineligible to receive the vaccine. Adding the word “appropriately” to the title does not make the percentage clearer. When consumers see “appropriately given” – their first reaction is that the percentage represents the percentage actually given.

For example; 100 patients meet the denominator, if that number 20 received the vaccine, 20 declined the vaccine and 40 were medically ineligible. The measure would be presented as 80% of residents were assessed and appropriately given the influenza vaccine when in actuality – only 20% of the residents actually received the vaccine.

Would the NQF and CMS ever consider handling the influenza vaccine measures like the pneumococcal vaccine measures – reporting each of the areas as separate measures to reduce confusion?

NH-022-10 Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long Stay)

I appreciate CMS responses to the comments and excluding the discharge assessment from the denominator and also recognizing an ADL score of 7 will equate to a score of 4 in the numerator.

CMS failed to explain in their responses their rationale in not providing any risk adjustments for late loss ADL loss based upon geriatric aging syndrome. Commenters referenced Katz, who indicated that late loss ADLS are lost in opposite order from which they are acquired from infancy. Late loss functional decline is considered a component of geriatric aging syndrome and there is no evidence that late loss ADLs can be prevented. Considering that the purpose of the measure is to measure decline as a measure relating to quality, CMS should research and recognize risk adjustments based upon the aged aging. Although the exclusions recognize when a resident is totally dependent in all 4 late loss ADLS, there is no risk adjustment for the aged aging during the ADL loss cycle.

NH-024-10 Percent of Residents Who Lose Too Much Weight (Long Stay)

I appreciate CMS response to the comments regarding the omission of the discharge assessment in the specifications – however – the specifications posted with the October 2010 responses to the public comment still did not address that the discharge assessment would be included in the measure.

Many comments were submitted regarding including hospice and “life expectancy of less than 6 months” as an exclusion for this measure. No clinician has a goal for a resident who is end of life and/or receiving hospice services to lose weight and I agree that it is not associated with all residents who are at end of life but it is an outcome of many end of life residents. CMS responded that a prognosis in J1400 of having less than 6 months to live is likely subject to substantial measurement error given it is very difficult to predict when someone will die. Since this MDS item requires physician documentation in order to code and hospice services must have supporting physician documentation, it is not a subjective decision of center clinicians. The exclusion of hospice/end of life residents has been part of the prior Quality Measure # 13 and it revised Quality Measure 7.1. for years.

CMS stated in their response that they plan “to analyze the MDS 3.0 data regarding refinement in the measures and in particular, for residents receiving hospice care and those with a prognosis of less than 6 months to live”. I appreciate this response and look forward to having to opportunity along with the industry to review any revisions prior to the measure becoming public record.

NH—026-10 CAHPS Nursing Home Survey: Discharged Resident Instrument

I appreciate AHRQ analyzing the questions “how often did you feel worried”; “how often did you feel happy” and “Think about how you felt about your life when you were in the nursing home, Use any number from 0-10 where 0 is the worst possible and 10 is the best possible, what number would you use to rate your life then?” and their impact as potential case mix adjusters. I believe it will be very important to involve the nursing home industry in their review of the data and consideration of the impact of these questions to the survey.

Again, I appreciate the efforts of the NQF in assisting the nursing home industry with their quality standards and the collaborative efforts to identify consistent and meaningful quality measures for the community.

Thank you

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March 24, 2011

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Re: National Voluntary Consensus Standards for Nursing Homes – Appeal

Dear Ms. Theberge,

The American Health Care Association (AHCA) appreciates the work of the National Quality Forum (NQF) on the National Voluntary Consensus Standards for Nursing Homes Steering Committee's work in identifying measures for quality improvement and public reporting. As the nation's leading long term care organization, AHCA and our members agree that measures are needed to monitor and improve care. However, we are concerned that the quality measures most recently approved by the board fall short in their ability to measure processes and outcomes for all our patients and thus we are appealing the measures. Our appeal is based on the following issues:

1. The announcement for the appeal is premature,
2. The number of measures for the Medicare Program is inadequate; and
3. Existing measures may not be sensitive enough to the various patient populations being served in nursing facility care centers.

Appeal is Premature

While we appreciate the opportunity to appeal some or all of the measures, we believe this offer is premature since the measures will not be available to the public (blacked-out) for one year. Currently, one third of the measures have been given provisional approval; meaning that CMS will, during the black-out period, test the measure definitions and the performance of the provisional measures. These measures have not been previously tested or validated. Since the definition of "short-stay" and "long-stay" measures has been newly defined, AHCA believes that NQF must designate all the measures with provisional approval. It is difficult to appeal any measure until testing is completed and measure performance results have been analyzed, validated and published. By signifying all the MDS 3.0 measures as having time-limited approval, this will allow NQF the opportunity to reexamine the performance of the quality measures when they are actually used and calculated using the MDS 3.0 data.

Recommendation: NQF request that CMS offer a second appeal opportunity this Fall after testing is completed and when all the needed measure changes and refinements have been made.

Inadequate Measures for Medicare Program

Among the 21 endorsed measures, only 5 measures are directly intended for the Medicare, short-stay, patient population. These measures include:

1. The percent of residents on a scheduled pain medication regimen on admission who report a decrease in pain intensity or frequency;
2. Percent of residents who report moderate to severe pain;
3. Percent of residents with pressure ulcers that are new or worsening;
4. Percent of residents assessed and appropriately given the seasonal influenza vaccine;
5. Percent of residents assessed and appropriately given the pneumococcal vaccine; and,
6. CAHPS Discharge Resident Instrument.

It is apparent that the short-stay measures for pain, pressure ulcer, influenza, pneumonia and experience of care survey do not cover the care issues experienced by the Medicare patient and the scope of care provided by nursing facility care centers. These measures also fall short in measuring quality associated with the growing short-stay population. In 2004, Grabowski published a study entitled *Medicaid Payment and Risk-Adjusted Nursing Home Quality Measures*. The researchers looked at the relationship between payment rates and quality outcomes for pressure ulcers, physical restraints and pain, and they found that higher payment was associated with lower incidents of pressure ulcers and physical restraints. The researchers concluded that nursing facility care may suffer as a result of State Medicaid budget shortfalls. The study also found that higher payment rates were associated with higher quality.¹

This study leads to questions and concerns about nursing facility care funding adequacy and the quality measures currently being proposed. Two questions that need to be raised and considered include:

- If Medicare funding leads to better quality and yet there is an inadequate number of Medicare Program quality measures, are nursing facility quality and policy decisions unintentionally being negatively biased by the predominance of the long-stay (underfunded Medicaid population) measures?
- Are MDS-based quality measures, currently categorized by long-stay and short-stay patients (Medicaid and Medicare), in reality measuring the quality of the nursing facility payment systems?

Privacy of information is an issue that restrains the development of quality measures for the Medicare Program. Measuring structure, process and outcomes is impacted by the numbers of managed care, private insurance and self-pay patients receiving care in the facility. Patient information is withheld from Federal and State agencies when the payer of the nursing facility services is not Medicare and Medicaid. The purpose of the restriction relates to the need to protect patient information as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

¹ Grabowski, David C., Joseph, J., Angelelli and Vincent Mor, *Health Affairs*, 23(5):243-252 (2004).

As a result, managed care, private insurance and self-pay patient data is excluded from the reported measures. Adding to this problem, more and more nursing facilities are admitting managed care patients.

MDS 3.0 coding addresses the information exclusions in Section A, 0410, Submission Requirement. This section lists the following instructions:

Code 1, neither Federal nor State required submission: if the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, and the State does not have authority to collect MDS information for residents on this unit. If the record is submitted, it will be rejected and all information from that record will be purged.

Code 2, State but not Federal required submission: if the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, but the State has authority, under State licensure or other requirements, to collect MDS information for these residents.

Code 3, Federal required submission: if the MDS record is for a resident on a Medicare and/or Medicaid certified unit. There is CMS authority to collect MDS information for residents on this unit.²

An important outcome resulting from the MDS Submission Requirements is the reduction in the number of assessment files used in the calculation of the nursing facility's quality measures that mostly impacts the short-stay patient population. This means the measure's denominator size is reduced and may be too small to produce a valid result, resulting in a measure not appropriate for public reporting. This situation further restricts the availability and use of short-stay measures and inadvertently may lead to a biased assessment of nursing facility quality. As previously recommended, having a second appeal will allow the quality measure performance to be evaluated during the black-out period and will help better understand the impact of the denominator size, exclusions, and reliability (which could not be adequately tested since MDS 3.0 was not in use when the measures were developed.) This latter point is demonstrated by the fact that the NQF panel asked the measure developers for a number of changes to the measure specifications during the NQF review process.

Fixing quality measures for the Medicare Program is not simple and the previously cited Grabowski study findings beg the question of whether the current framework for measuring nursing facility quality is the most appropriate approach. More analysis is needed. In the interim, Medicare Program quality measurement remains a necessity and efforts are needed to develop, as best as possible, more measures that are accurate and valid and that can be implemented with the rest of the quality measures. Having an equal number of measures for both the Medicaid and Medicare Programs will help eliminate the unintended biased and negative care setting impression conveyed to consumers and others about the quality of nursing facility care.

Recommendation: Work with CMS to identify and test additional measures for the Medicare Program and include those measures and their testing findings in a second public appeal opportunity.

² MDS 3.0 RAI Manual, December 2010. MDS 3.0 Chapter 3, Section A, *available at* http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage

Long Term Care Patient Populations

As previously discussed, long-stay patients are those predominantly paid by Medicaid and short-stay patient are those patients funded by Medicare.

In an article entitled *Using Population Segmentation to Provide Better Health Care for All: The “Bridges to Health” Model*, the authors Lynn, Straube, Bell, Jencks and Kambic divide the population into eight groups; people in good health, in maternal/infant situations, with an acute illness, with stable chronic conditions, with a serious but stable disability, with failing health near death, with advanced organ system failure, and with long-term frailty. They propose that each group has its own definitions of optimal health and its own priorities among services. The authors interpreted what they called “population-focused priorities” in the context of the Institute of Medicine’s (IOM), *Crossing the Quality Chasm* report. The report identified six goals of quality (safety, effective, efficient, patient centered, timely and equitable) and from this framework recognize that a better approach to care arrangements, resource planning and services could be realized.³

AHCA finds the *Bridges to Health Model* discussion enlightening with regard to its potential use in providing the framework for the next generation of healthcare quality measurements. At least half of the identified population groups are currently found in nursing care facilities. Since each patient needs different services for the attainment of optimal health; building a measurement system based on population segments, not funding approaches, may allow for measures to be used across provider settings and compared. This approach potentially offers a more appropriate method to measure quality for like-patients across care settings, tie payment to quality, and in implementing a bundled or value-based purchasing payment system.

NQF has incorporated the IOM’s *Crossing the Quality Chasm* work in the National Priority Partnership initiative. It is logical, if not already underway, that NQF look at patient classification methodologies and test all-setting quality measures based on a patient classification system.

Recommendation: CMS and NQF members must work together with stakeholders to explore other methodologies that improve the current quality measurement framework and recommend an alternative approach that is patient-focused and not care setting or payment focused.

AHCA understands that the NQF is an independent CMS contractor in the endorsement of MDS 3.0 quality measures for quality improvement and public reporting and that any organization whether Federal, State, Insurance, etc. can use the measures. Being the CMS designated entity to recommend the measures, in essence bounds CMS to use the NQF measures. It also infers that NQF is an acting arm of CMS. Therefore, a premature approval of the NQF endorsed measures results in the possible release of less than optimal measures. In fact, some States are currently using NQF MDS endorsed measures for their serious reportable event payment programs. CMS also is recommending the adoption of NQF hospital, healthcare acquired conditions (HAC) for consideration for use in other settings. It is important to note that a HAC or never-event program can be crafted for long term care if it is done in an appropriate fashion with specific nursing facility criteria and measures and not warmed-over hospital never-events.

³ Lynn, J., Straube, B., Bell, K., Jencks, S., Kambic, R. Using Population Segmentation to provide Better Health Care for All: The “Bridges to Health” Model. *The Milbank Quarterly*, Vol. 85(2):185-208 (2007).

Payment policy initiatives cannot just adopt the hospital never event program and expect it to work properly or work at all in nursing facilities. Due to the open use of NQF adopted measures, we strongly urge the NQF to consider how other groups are using or proposing to use NQF products. We also urge NQF to work with CMS to ensure that all MDS measures are tested after all changes and refinements are made, that a second public appeal is offered, measure exclusions are considered, and measure construction does not hamper public reporting.

Again, AHCA appreciates the opportunity to appeal the nursing home quality measures and to offer our thoughts and recommendations.

Sincerely,



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Senior Director of Clinical Services

April 1, 2011

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Re: Endorsed Quality Measures for Nursing Homes

Dear Ms. Theberge:

On behalf of more than 100 not-for-profit and public long term care organizations that make up the membership of Continuing Care Leadership Coalition (CCLC), an affiliate of the Greater New York Hospital Association (GNYHA), we appreciate the opportunity to comment upon the National Quality Forum endorsed quality measures for nursing homes.

CCLC strongly supports the use of quality measures for quality improvement and quality assurance activities in long-term care. CCLC appreciates the ability to represent our deeply engaged members in this opportunity for comments on these quality measures.

The following issues have been identified as problematic for our members:

NH-003-10: Physical therapy or nursing rehabilitation/restorative care for long-stay patients with new balance problem (RAND).

CCLC members indicate that this measure lacks sensitivity to transient balance problems (caused by medications, for example) that may not be resolved by physical therapy or restorative nursing care. In using MDS 3.0 assessments, this measure has potential to miss capturing certain new balance problems that normally respond to physical therapy or restorative nursing care.

For example, an initial quarterly MDS might have captured in the 7-day lookback period transient balance problems previously noted for which a resident was coded as "2". During the next quarter, the resident exhibits a new balance problem, which normally responds to physical therapy or restorative nursing care, coded in the second quarterly MDS as "2" or "1." As a result, this case would incorrectly capture a "new balance" problem under this measure.

Additionally, the measure does not capture a resident's refusal of offered services. CCLC recognizes that researchers found such refusals to be minimal in the 10/4/2010 draft report comments; however, CCLC members question the populations studied (e.g., were HIV/AIDS facilities or other specialty population facilities included in this study), and contend that the measure should be risk-adjusted for even small numbers of refusals.

NH-009-10: The percentage of residents on a scheduled pain medication regimen on admission who report a decrease in pain intensity or frequency (short stay).

For facilities that have frequent unscheduled transfers to emergency departments (e.g., facilities caring for high acuity patients), this measure does not accurately reflect the residents who might have experienced an improvement in pain, as this measure relies on the MDS discharge

assessment. CCLC recommends that NQF use an alternative to the MDS discharge assessment as the basis for the denominator for this measure.

NH-026-10: Consumer Assessment of Health Providers and Systems (CAHPS) Nursing Home Survey: Discharged Resident Instrument (Agency for Healthcare Research and Quality).

NH-027-10: Consumer Assessment of Health Providers and Systems (CAHPS) Nursing Home Survey: Long-Stay Resident Instrument (Agency for Healthcare Research and Quality).

NH-028-10: Consumer Assessment of Health Providers and Systems (CAHPS) Nursing Home Survey: Family Member Instrument (Agency for Healthcare Research and Quality).

As a strong proponent of person-centered care, CCLC recognizes the value of a standard satisfaction survey; however, CCLC strongly urges the NQF to clarify how providers and States may use alternative satisfaction surveys, pursuant to AHRQ's response to concerns about the Federal government's survey tool as the only tool eligible to meet requirements. CCLC also recognizes the difficulty involved with obtaining results from cognitively impaired nursing home residents and the resources needed to seek feedback from them and their loved ones. Whether a provider can use an existing satisfaction survey and what the parameters are surrounding the threshold number of required returned surveys will have a significant impact on the cost of administering satisfaction surveys, which could potentially become overburdensome for financially fragile providers.

If you would like to follow up, please do not hesitate to contact me (212-506-5412 or tena-nelson@cclcnyc.org) or Kathryn Santos, Manager of Quality Improvement Initiatives (212-506-5413 or ksantos@cclcnyc.org), at CCLC.

Sincerely,



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April 4, 2011

Dear NQF Nursing Home Group,

Uniform Data System for Medical Rehabilitation (UDSMR) appreciates the opportunity to submit comments on the National Quality Forum's (NQF) proposed nursing home measurers.

UDSMR offers post-acute care providers a range of products and services they can use to document the severity of patient disability and the results of medical rehabilitation. Since 1994, we have maintained a national database for short-term rehabilitation programs in skilled nursing facilities and have provided severity-adjusted benchmark data to our subscribers.

After careful consideration, we have concluded that the proposed nursing home measures are predisposed to long-term patients and do not adequately address clinical and rehabilitative objectives for short-stay patients. Given the propensity of Medicare payments to nursing homes for skilled nursing and therapy services, it seems appropriate that the Centers for Medicare and Medicaid Services (CMS) would be most interested in quality and efficacy data related to the patient population it is ultimately financially responsible for. The recommended measures do not allow facilities to substantiate the quality of their short-term restorative care program to CMS.

The average length of stay in short-term rehabilitation programs, coupled with the expectation for a community-based discharge, results in a concentrated effort to maintain or restore function. In 2010, the average length of stay in UDSMR's skilled nursing database was 23 days. The mix and intensity of services provided in this abbreviated time frame differ greatly from those of the long-term patient population. The emphasis on restoration or maintenance of function affected by the patient's illness or injury is paramount in this episode of care. Yet the proposed measures do not adequately capture function or functional improvement. The result is an incomplete picture of the short-term episode that doesn't help purchasers. The measures would be much improved if they identified the burden of care at admission, the functional improvement achieved, and the percentage of patients returned to community settings.

Our most respected instrument, the FIM[®] instrument, is used across the post-acute care continuum. The FIM[®] instrument has a high overall internal consistency, captures significant functional gains during rehabilitation, has high discriminative capabilities for rehabilitation patients, and is a good indicator of the patient's burden of care. Measures of effectiveness, efficiency, timeliness, resource use, and safety are integral parts of the FIM[®] instrument. CMS endorses the FIM[®] instrument as part of the Inpatient Rehabilitation Facility Prospected Payment System (IRF PPS) used to capture functional health in patients seen at IRFs—a patient set similar to, yet with differing severity than, the patients seen at skilled nursing facilities.



University at Buffalo
The State University of New York

Although incorporating the FIM[®] instrument into your measures would certainly be a valid approach, UDSMR does not necessarily advocate it. We merely question the absence of functional measures in a quality tool used when medical rehabilitation is predominant. We recommend that you strongly consider adding functional measures beyond pain and incidence of vaccination.

We thank NQF for the opportunity to share our comments on this important initiative. If you have any questions about these comments, please contact us at 716-817-7800.

Sincerely,

A handwritten signature in black ink that reads "Carl V. Granger". The signature is written in a cursive style with a large initial 'C'.

Carl V. Granger, MD
Executive Director, UDSMR