



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare and Medicaid Services

Survey and Certification Group

Center for Medicaid and State Operations

7500 Security Boulevard

Baltimore, MD 21244-1850

Mr. William L. Minnix, Jr.
President and CEO
American Assn of Homes & Services for the Aging

April 17, 2009

Mr. Bruce Yarwood
President and CEO
American Health Care Association

Mr. Alan G. Rosenbloom
President
Alliance for Quality Nursing Home Care

Dear Mr. Minnix, Mr. Yarwood, and Mr. Rosenbloom:

I wish to thank your many members who made the considerable effort to travel to Baltimore and participate with us in our three-hour discussion session on January 22, 2009 regarding the nursing home *Five-Star Quality Rating System*. The session was very helpful in understanding some of the members' concerns. We agreed at the meeting that we would examine four areas: the health surveys, the staffing data, the quality measures, and the potential for resident and consumer satisfaction data to be incorporated into the ratings.

We also agreed that you would follow-up with a letter providing recommendations for those changes to the system that you believe could be made by CMS in the short-term, as well as goals and objectives for a process that would address longer-term issues. I therefore appreciate your follow-up letter of March 28, 2009 that contained those recommendations.

Attached are specific responses to your letter, to the extent that we can make commitments at this time. We will follow-up this letter with a timeline for some of the next steps to get the process moving. In the meantime, I would appreciate (a) any feedback if you believe we have not understood any of your recommendations and (b) clarification of some recommendations where we have posed questions in the attachment.

Attachment 1 contains responses to the items you recommended for immediate action. Attachment 2 includes items you recommended for a longer term process. Most of the issues require analysis and an identification of pros, cons, and implications. We look forward to development of issue papers and an open process that must include consumer groups in the dialogue process and be transparent to the public. I look forward to working with you on these issues.

Sincerely,

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Thomas E. Hamilton, Director
Survey & Certification Group

I. Response to Recommendations for Immediate Actions

A. Actions That We Will Implement Now or Very Soon

1. ***Helpline:*** *Maintain and extend Helpline operations to assure access to assistance as needed. (Recommendation of the Nursing Home Associations)*

We will extend the Helpline operations through the rest of the calendar year, but convert to a quarterly availability that coincides with the quarterly Quality Measure updates when the major new data sets are integrated into the system (April, July, and October). We will reevaluate the process at that time before making plans for CY 2010. We will also continue taking individual provider questions and issues at any time via email through the BetterCare@cms.hhs.gov email box, or referral through your associations.

B. Actions That We Will Explore Soon

1. ***Pear-Shaped Percentile Distribution:*** *Eliminate the use of the forced distribution of facilities (the skewed bell curve) which predetermines that 20% of the facilities will receive 1 star, 70% of the facilities will receive 2, 3, or 4 stars, and 10% of the facilities will receive 5 stars. Implement defined cut points as the basis for the assignment of facilities' star ratings in the respective domains. (Recommendation of the Nursing Home Associations)*

We will analyze the potential and the implications of converting the ratings for health survey results from the current percentile distribution system to one that involves fixed boundary values between the star categories within States.

Percentile rankings are used only in the health inspection ratings and in 2 out of 10 quality measures. The other 8 of 10 quality measures, and the staffing domain, all involve fixed numerical, national boundary values between the star categories. The overall composite rating, by extension, involves a mix of national, fixed values and percentile rankings as the 3 domains (surveys, QMs, staffing) are brought to bear on the overall composite rating.

The current within-State percentile distribution system for health surveys was adopted in response to concerns from you and others regarding variation between States. The current *Five-Star* system controls for State-to-State variation in the survey process and other State-unique variables by comparing nursing homes only to other nursing homes in the same State, and arraying those nursing home scores across percentile rankings for the State.

These statistical controls for health surveys mean that consumers are provided with a basis for “comparison shopping” – each nursing home can be compared with all other nursing homes in the State. Comparison shopping is well-understood by consumers and is commonly used in rating systems. And it is easy for consumers to understand that a facility rated at five-stars was among the top 10%-12% of nursing homes in that State. When college students say they graduated in the top 10% of their class, for example, people well understand the meaning. The State-by-State statistical controls mean that nursing homes can improve their health survey ratings by doing better than their peers in the same State.

At the same time, we appreciate that many nursing homes may wish to see fixed, numerical boundary points between star categories rather than percentile boundaries. In theory, it may be possible to continue to control for State-to-State variation by having specific star category boundary points that are in the form of fixed values based on each individual State's historical pattern. Once established, the boundary values would remain fixed over time unless there were significant changes in regulations, survey practices, or other factors that would require a later "re-basing" of the boundary points. Nursing homes would need to accept, in such situations, that a re-basing could involve an abrupt change in a star rating over a short period of time.

There is no absolute "right or wrong" way to address these issues, simply advantages and disadvantages. The issues therefore will require analysis, data modeling, dialogue, and ultimately an agreement if such change were to be adopted. We will undertake development of issue papers, invite review and input from you and others, and engage in dialogue with you regarding these issues.

- 2. **Hospital-Based SNFs:** Rate hospital-based skilled nursing facilities against each other, separate from free-standing nursing facilities. The current pooling of data for the purpose of the 5-Star rating system fails to recognize the distinctions in the populations served. (Recommendation of the Nursing Home Associations)*

We will develop a discussion paper, analyze the implications of making such a change, and discuss these ideas with you. We agree that we should look distinctly at the hospital-based facilities, particularly with regard to the quality measures.

- 3. **Appeals Process:** Develop and implement an appeals process for the Five Star Rating System when questionable, inaccurate, or incomplete data has been identified. A process similar to that currently used for Hospital Compare, with more advance notice of data, should also be considered to provide greater opportunity for prospective correction. Include provision for deferral of ratings pending resolution, citing, e.g., "Data under review." "Data under review" should be applied as well when survey determinations remain under appeal. (Recommendation of the Nursing Home Associations)*

We will explore with you the various options for addressing individual concerns of nursing homes and the best methods of providing responses to everyone is aware of CMS' response and rationale. The exact form such a process should take is a topic worth discussing.

So far, we have adopted a "no wrong door" approach that involves us receiving inquiries and appeals from you, requests first received by our Helpline and passed on to us, email and phone requests.

- 4. **Advancing Excellence Campaign:** Develop a plan to integrate Advancing Excellence (AE) into the 5-Star Rating System since, according to CMS' own experts, AE is demonstrating "Extraordinary Results." (Recommendation of the Nursing Home Associations)*

We are not sure what you mean by "integrate," but we are willing to explore options for aligning the efforts. We will rely on you to start the process of identifying options for aligning

D. Actions That We Are Not Pursuing

1. **Composite Rating:** *Eliminate the composite star rating in favor of a multi-dimensional system; assign star ratings to each individual domain. (Recommendation of the Nursing Home Associations)*

We appreciate that quality is “multi-dimensional.” For that reason we display on the *Nursing Home Compare* website the ratings for each of the three informational domains (surveys, QMs, and staffing). The website affords consumers with the capability to click on any of the domains and have the listing of nursing homes re-sorted so as to focus on the particular domain of greatest interest.

While consumers can use any of the three domains to calculate their own best sense of overall quality, we believe there is added value in offering consumers our best estimate of how the three domains of detailed information are most appropriately organized to convey - in a readily understandable way - a sense of overall quality.

2. **Use of In-State Comparisons:** *Use in-state comparisons for all components within all domains (Recommendation of the Nursing Home Associations)*

We do not believe that residents in one State deserve a different staffing level compared to residents of other States. National data and research exist to establish thresholds for optimum staffing. In addition, the *Five-Star Quality Rating System* improved the staffing measure by adjusting for the case-mix represented by the population of residents in each individual nursing home. We recently began publishing on the CMS website the expected case-mixed staffing values for each nursing home for each of the star categories. With this added information nursing homes are in a better position to discern the staffing level that would be needed to move to another star category. See the “downloads” section of the CMS website at: http://www.cms.hhs.gov/CertificationandCompliance/13_FSQRS.asp.

We therefore believe that the best and most appropriate approach for the staffing domain is to maintain the existing system of fixed, boundary points for the star categories based on national metrics and adjusted for differences in the acuity level of each nursing home’s residents through the use of case-mix adjusters.

Similarly, for most of the quality measures we believe that national metrics are the most appropriate. We do not believe, for example, that there should be different expectations with regard to the use of daily restraints or prevalence of pressure ulcers depending on the State within which a nursing home resident resides. Historically there have been significant differences between States on these measures, possibly attributable to cultural differences. However, there has been much progress in this area in the past few years through such efforts as the *Advancing Excellence* campaign for which your associations, nursing home members, and many others deserve great credit. Much of the success from those efforts has been due to a focus on those States with the highest levels of restraint or pressure ulcers.

With these observations in mind, we remain willing to examine non-cultural differences between States (such as Medicaid policy differences that affect case-mix), with a view to

identifying the best methods to enlarge upon the statistical controls through the QM risk adjusters.

3. ***Weighting of Standard Surveys:*** *Revisit the weighting methodology to consider weighting the standard survey more heavily than the complaint survey. The standard survey is a comprehensive review of all requirements of participation while complaint surveys focus on individual issues; determine how the accuracy of information to the consumer is impacted under the two approaches.*

The current weighting system treats all deficiencies as a deficiency regardless of whether it was identified in a standard survey or complaint investigation. The scope and seriousness of each deficiency is individually scored. While the standard survey is a comprehensive review of all requirements, the complaint survey is also an effective method for identifying serious problems. The findings of a complaint survey are no less real than those of a standard survey. In addition, the standard survey, by virtue of its broader scope, has the potential to identify more deficiencies. Given that the current system scores each deficiency individually and then sums the result, we believe that the current Five-Star methodology already weights the standard survey more heavily.

4. ***Staffing and Funding at the Five-Star Level:*** *Revisit the appropriateness of expected staffing levels as the basis for a 5-star rating, i.e., the 5-star rating based on 4.08 hours of nursing staff and .55 hours of RN staff, given that this level of staffing has never been funded. If determined appropriate, evaluate the cost of adequately funding facilities to at these levels and incorporate into the RUGs update on October 1.*

The *Five-Star* system is designed to rate quality rather than funding. To achieve a five-star rating, a nursing home's staff level must cross the research-based threshold that identifies the level at which further staff increases were no longer associated with significant increases in quality. Thus, a five-star rating is not an "expected" level based on level of funding, but a proxy for the actual level of quality of care present. It may be useful to calculate the level of funding that would result in a five-star rating for all nursing homes, but that is not the purpose of the quality rating system.

II. Processes to Examine Key Areas Over a Longer Timeframe

We will implement processes to examine each of the areas identified in your letter and summarized below. While your letter uses the term “stakeholder workgroup,” we cannot specify the exact form that the work will involve due to the need to observe the limitations of various federal regulations and the need to ensure public transparency. We can, however, commit to an analysis and dialogue process that will involve the identification of specific individuals who will serve as expert resource persons for the relevant areas, and periodic dialogue involving a variety of such stakeholder experts, particularly your association experts and the knowledgeable representatives of consumer groups.

The elements below derive primarily from your suggestions for the content of each examination. Before finalizing, we will need to solicit input from consumer groups and others. We agree that these elements constitute a useful starting point.

A. Quality Measures

1. Carefully review evidence-based research to evaluate the use of the quality measures for the purpose of the *Five-Star Quality Rating System*.¹ Analyze the methodologies presented to adjust the quality measures, taking into account and applying the relationship of resident characteristics. Examine the potential for additional quality measures and risk adjusters that would expand the dimensions and appropriateness of the QMs.
2. Examine the disparate weighting of the quality measures and determine the appropriateness of this weighting.

B. Survey & Certification

1. Review and assess the impact of the differences in weightings between the *Special Focus Facility* formula and the *Five Star Quality Rating System* to identify whether they should be identical.

C. Staffing

1. Provide consultation to CMS regarding:
 - The directions and definitions included on form 671, to assure uniformity of interpretation nationwide.
 - Revision of staff definitions and expansion of the categories recorded to better reflect current practice and staffing patterns.
 - The best approach to providing information on agency and contract staff.
 - How to reflect turn-over rates on form 671 and on Nursing Home Compare.

1. Including Dr. Christie Teigland’s white paper (*5 Star Quality Measures – Are the risk adjusted to “level the playing field” and allow fair/accurate comparisons across facilities?*)

2. Provide consultation to CMS on moving to a system of quarterly, electronic reporting of staffing based on payroll information.
3. Examine the case-mix adjustment methodology used for staffing to determine if adjustments are advisable and feasible.

D. Resident Satisfaction/Consumer Needs

1. Examine how best to determine and represent resident / consumer satisfaction. Identify options and associated costs related to different methods to do so. Examples of different approaches that involve different levels of efficacy and cost include:
 - ***Measure Process but not Results:*** Indicate on the *NH Compare* website the extent to which a nursing home has an effectively-working resident satisfaction feedback system that provides assurance that the resident feedback will reach accountable parties in the nursing home organization and will be used in facility's quality improvement efforts.
 - ***Use Certified Private Systems with National Reporting:*** Establish a system to certify private sector systems, ensure that such systems maintain comparable processes and certain key questions, and report the results on *NH Compare*.
 - ***Adopt a National Public System:*** Adopt a single national system administered by objective third-parties with national reporting of the results.
2. Identify and investigate approaches to obtaining and reporting facility-specific characteristics that will allow consumers to search by and better identify those that will meet their particular and overall needs.
3. Recommend ways to enhance *Nursing Home Compare* to better emphasize the importance of on-site facility visits as a critical component of decision-making.