

March xx, 2009

Mr. Thomas Hamilton  
Director, Survey and Certification Group  
Centers for Medicare and Medicaid Services  
7500 Security Blvd.,  
Mailstop S2-12-25  
Baltimore, MD 21244-1850

Dear Mr. Hamilton:

This letter is in follow-up to our meeting on January 22, 2009. We appreciated the opportunity to discuss our concerns with CMS' Nursing Home Five Star Quality Rating System and we reiterate our support for ensuring that accurate, understandable information about nursing homes is available to the public.

As promised, we are providing our recommendations for those needed changes to the system that can be made by CMS in the short-term, as well as goals and objectives for four CMS/Stakeholder workgroups to address longer-term issues and modifications. In turn, as agreed, we await your response to our concerns and recommendations, including those issues that CMS views as short-term changes/modifications that can be achieved.

Following are the issues we've identified as needing immediate modification.

#### **Immediate Actions**

- Eliminate the composite star rating in favor of a multi-dimensional system; assign star ratings to each individual domain.
- 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.
- Use in-state comparisons for all components within all domains.
- 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.
- 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.
- Maintain and extend Helpline operations to assure access to assistance as needed.
- 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."

Following are the charges to each of the work groups:

### **Quality Measures**

- Carefully review evidence-based research to evaluate the use of the quality measures for the purpose of the 5-Star rating system, 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?*
- Analyze the validated methodologies presented to adjust the quality measures, taking into account and applying the relationship of resident characteristics.
- Evaluate the disparate weighting of the quality measures and determine the appropriateness of this weighting.

### **Survey & Certification Workgroup**

- 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.
- Review and assess the impact of the disparate weightings between the Special Focus Facility formula and the Five Star Rating System.

### **Staffing Workgroup**

- We understand that a Technical Expert Panel (TEP) has been convened to work on/modify the CMS form 671. The staffing workgroup should provide consultation to the TEP 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.
- Revisit and evaluate the case-mix adjustment methodology used for staffing to determine if it is appropriate.
- 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.

### **Resident Satisfaction/Consumer Needs**

- Evaluate how best to determine and represent resident / consumer satisfaction.
- 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.

- Recommend ways to enhance Nursing Home Compare to better emphasize the importance of on-site facility visits as a critical component of decision-making.

### **Moving the 5-Star System from Unintended Consequences and Perverse Incentives to a Consumer-Friendly Alignment of Common Objectives**

Addressing the above-cited concerns and revisiting the 5-Star Rating System methodologies is becoming increasingly imperative. Current implementation has resulted in unintended consequences and perverse incentives for consumers and providers alike. Providers are, in fact, being penalized for superior clinical practice, such as better identification of pain. Facilities are also having to respond to misleading information resulting from inaccurate or missing data, a problem further compounded by use of the current 5-Star system by insurance companies as a basis for determining coverage. At least 19 States already have established quality ratings systems. Consumers in these States are confused by unexplained disparities in ratings and/or the lack of “crosswalks” between the State and Federal systems. The meaning of the stars in-and-of-themselves is also confusing as exemplified by a consumer’s recent statement that the family “...would have to look for a 2-star facility because [they] could not afford a 5-Star facility.” Taken together, the end result can be a system that creates incentives for facilities’ to seek “5-Star residents” rather than one where consumers seek 5-Star facilities.

Prior to national implementation of any of the workgroup-determined changes, we strongly recommend that they be piloted in a limited number of states to avoid future glitches or any additional unintended consequences that may result.

We look forward to our continued work with you on this and related issues and look forward to your prompt response.

Sincerely,



**William L. Minnix, Jr.  
President and CEO  
American Association of Homes  
and Services for the Aging**