September 22, 2017

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1672-P

Dear Ms. Verma:

The Medicare Payment Advisory Commission (MedPAC) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule entitled "Medicare and Medicaid Programs; CY 2018 Home Health Prospective Payment System Rate Update and Proposed CY 2019 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements," *Federal Register*, Vol. 82, No. 144, p. 35270 (July 28, 2017). We appreciate your staff's efforts to administer and improve the Medicare payment system for home health agencies (HHAs), particularly given the competing demands on the agency.

This rule proposes a payment update for HHAs in payment year 2018, and details a number of additional proposals. We comment on the impact of rebasing, the update for 2018, the proposed Home Health Groupings Model (HHGM) for 2019, changes to the Value-Based Purchasing program, and revisions to the Home Health Quality Reporting Program.

Monitoring for Potential Impacts—Affordable Care Act Rebasing Adjustments

CMS updates its analysis of the impact of the payment rebasing required under the Patient Protection and Affordable Care Act (PPACA). The Act included a provision to rebase home health payments from 2014 through 2017. Under this provision, CMS is required to adjust the home health payment rate based on its analysis of the adequacy of the rate compared to the average cost per episode. CMS determined that the adjustment would require a reduction at the maximum allowed rate of 3.5 percent of the base payment rate in effect in 2010 (or $80.95); under statute, this reduction would be offset by the annual payment update (indexed to the home health market basket).

In the proposed rule, CMS reviews the most recent data available on provider financial performance and benefit utilization. The review of costs indicates that the margin for the average full episode in 2015 was 21 percent, well in excess of providers' costs.[1] The review of utilization found that the number of beneficiaries using home health care and the number of episodes have declined since the peak in 2011, but the annual decline has slowed in recent years, with utilization falling by less than 1 percent in 2016 relative to the prior year. CMS notes that all utilization factors are well above the 2001 levels and concludes that there is no indication of access concerns in 2016.

Comment
The analysis of the cost and utilization data in the rule underscores the Commission's long-standing concern that the PPACA rebasing provision would not adequately reduce payments. The cost report data for 2015, reflecting the impact of two years of the reductions required by PPPACA, indicate that margins are well in excess of costs. Commission analyses have found that Medicare payments to home health agencies have consistently and substantially exceeded costs for more than a decade. These excess expenditures increase the fiscal pressure on the Medicare trust fund, and create financial incentives that may encourage agencies to provide low-value or unnecessary services.

CMS's review of utilization is consistent with the Commission's findings on access to care. In our March 2017 Report to Congress, we assessed the trends in utilization since 2011, the year of peak home health volume and spending. Since that year, episode volume has fallen 4.1 percent, but over 90 percent of that decrease occurred in 5 states (Florida, Illinois, Louisiana, Tennessee, and Texas) that experienced unusually high growth between 2002 and 2011. Volume in the other 45 states has increased. MedPAC examined the attributes of community-admitted and post-acute home health patients, and found that the clinical and demographic attributes of both groups of patients have not changed since 2011, indicating that for HHAs the severity of these populations did not change during the PPACA payment changes. The benefit continues to serve patients with severity similar to what it has served historically.

Proposed CY 2018 National Standardized 60-Day Episode Payment Rate

The proposed rule would implement the payment update for 2018. CMS proposes a 1 percent update to the base rate, as mandated by the Medicare Access and CHIP Reauthorization Act of 2015, offset by a 0.97 percent reduction for changes in coding. The 2018 coding reduction is the final adjustment under a policy implemented by CMS in the final rule for CY 2016. In that rule, CMS computed the total case-mix growth between 2012 and 2014, and applied the nominal growth factor developed from its prior research. CMS calculated that nominal growth accounted for 2.88 percentage points of the growth in case-mix over this period, and implemented a reduction of 0.97 percent per year from 2016 through 2018.

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[1] A full episodes includes 5 or more visits in a 60-day episode. Episodes with less than 5 visits are paid on a per visit basis.

Comment
Both the Commission and CMS have found that case-mix changes unrelated to patient severity occur frequently in Medicare PPSs. The Commission has long held that it is necessary for CMS to make adjustments to account for nominal case-mix change to prevent additional overpayments. CMS's proposed reduction is consistent with the agency's past findings on trends in case-mix change in the payment system and thus is warranted to ensure the accuracy of payments under the home health PPS. A reduction of 0.97 percent should not raise payment adequacy issues or significantly affect access to care. In fact, the Commission recommended in March 2017 that the Congress should reduce home health payment rates by 5 percent in 2018 and implement a two-year rebasing of the payment system beginning in 2019.

Proposed Implementation of the Home Health Groupings Model (HHGM) for CY 2019

CMS proposes major revisions to the home health PPS for CY 2019. The revisions are based on PPACA-mandated research, and are intended to address concerns cited by the Commission and others about incentives under the current system. In the proposed rule, CMS provides a summary of an alternative payment system, referred to as the Home Health Groupings Model (HHGM), that was developed from this research. The new system would end the use of the number of therapy visits provided in an episode as a payment factor in the PPS. CMS proposes to implement the new payment system with a non-budget neutral adjustment that would reduce payments by up to 4.4 percent.

Comment
The changes to the payment system would address the issues MedPAC identified in the home health PPS in our March 2017 report, which noted that both the incentives and the payment levels in the current payment system need to be addressed. The new unit of payment would lower aggregate payments, and eliminating the volume-rewarding incentives created by the use of therapy visits as a payment factor would address a problematic incentive in the current system. Though MedPAC will continue to analyze the proposed changes, the approach CMS has described has the potential to substantially improve the accuracy and efficiency of the home health PPS.

New unit of payment. The new approach would change the unit of payment from 60 days to 30 days. CMS's research indicates that most episodes last fewer than 60 days, with 25 percent of episodes in 2016 complete by 30 days. CMS found that, in general, the number of visits declines with time, with the first 30-day period of the episode having a higher average number of visits than the second 30-day period. In addition, CMS found that the predictive ability of case-mix factors was higher for 30-day periods than for the current 60-day episodes.

CMS proposes to set the base rate for the new 30-day episode by dividing the current 60-day payment (estimated to be \$3,091.46 in CY2018), in two.[2] This would result in a base payment rate of \$1,545.73 for a 30-day episode in for 2018.The base payment would be adjusted to account for whether the episode was the beneficiary's first or subsequent 30-day episode.

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[2] The rule calculates the rate for 2018 as an illustrative example. CMS is proposing that the new system be implemented in 2019.

Currently, many home health stays are shorter than 30 days. Under the new unit of payment, these stays in effect would not have a second 30-day period triggering payment. Under CMS's proposal, payment for these stays would be made only for the first 30-day period, reducing total payments for these stays (since these stays are currently paid as if services are furnished for the entire 60-day episode). CMS estimates that aggregate payments to home health agencies would fall by 4.4 percent if the full amount associated with the second 30-day period of these episodes were excluded from the payment system. CMS requests comments on whether fifty percent of the amount associated with the second 30-day period of these episodes should be excluded instead. Under this methodology, aggregate payments to home health agencies would fall by an estimated 2.2 percent

Comment

The proposed 30-day unit of payment offers some advantages over the current system, but MedPAC and CMS would need to monitor the impact of this change. As CMS notes, many episodes end before the 30th day. HHAs would now have an incentive to extend, when feasible, services past the 30th day to trigger an additional 30-day period and the resulting payment. Though CMS requires that agencies provide a certain number of visits to receive the full case-mix adjusted episode payment, agencies might need to provide only a few additional visits to surpass the threshold. Past experience has indicated that HHAs can be very responsive to payment incentives, and that some would extend services to increase reimbursement.

Because of CMS's proposed approach to stays that last fewer than 30 days, the rule would implement the new payment system in a non-budget neutral manner. This approach seems appropriate, as including expenditures for periods were no services were rendered would be wasteful. In addition, this reduction could address the significant overpayments in the PPS, which have exceeded 10 percent since the PPS was implemented.

However, the history of the home health PPS suggests that agencies can offset the effects of payment reductions through a variety of strategies, such as changes in coding practices or the provision of additional services. As noted earlier, the PPACA-mandated rebasing reduction has failed to markedly reduce home health margins or aggregate payments. Indeed, total home health expenditures and the average payment per episode in 2015 were both slightly higher than in 2013, the last year prior to rebasing. We estimate that the average Medicare margin for HHAs in 2015 was 15.6 percent, in line with the long-term average under the home health PPS. Though CMS's impact analysis assumes some behavioral response from providers, it is possible that the effect will be greater than assumed. If so, aggregate expenditures would not decline to the extent estimated by CMS.

Though the Commission has not yet completed our review of the proposed unit of payment, the reduction proposed by CMS should not significantly affect access to care. We estimated that HHA margins in 2017 will equal 13.6 percent. Current payment policy provides a flat market basket update for 2018 and a projected 1 percent increase in 2019. Given current cost trends, it is likely that margins will remain well above costs. If CMS proceeds with the new unit of payment, it

would be appropriate to exclude the full amount associated with the second 30-day periods of episodes that do not have services furnished after day 30, which CMS estimates would reduce aggregate payments by 4.4 percent. A reduction of this magnitude should not raise significant access to care issues.

Proposed case-mix system. CMS also investigated new case-mix factors for predicting home health resource use, and selected a range of prior service-use factors, clinical categories, functional indicators, and comorbidities for the proposed new system. The proposed system would end the use of therapy visits as a payment factor in the PPS. The proposed system would sort 30-day episodes into 144 payment groups based on the following categories:

- Episode timing. Services in the first 30 days of the 60-day episode would be classified as early, while services in the subsequent 30-day period would be classified as late. For example, if a beneficiary had two consecutive 60-day payment episodes under the current system, the first 30-day period would be classified as early, while the three subsequent 30-day periods would be classified as later 30-day periods.
- Referral source. Cases would be categorized based on the services received prior to the beginning of the episode: prior hospitalization, prior post-acute care, or admitted from the community.
- Clinical category. The new system would create six clinical categories based on patients' reported conditions: need for musculoskeletal rehabilitation, neuro/stroke rehabilitation, wound care, behavioral health care, complex care, and medication management, teaching, and assessment.
- Functional/cognitive level. Similar to the existing system, the HHGM would classify patients' cognitive and physical functioning using information from the OASIS home health patient assessment.
- Presence of comorbidities. CMS propose to adjust payment for commonly occurring comorbidities in home health care. There would be a single adjustment for all selected comorbidities.

The new case-mix system is intended to be less complex than the current system, while still more accurately describing a beneficiary's primary need for home health care. CMS's 2016 technical report noted the Commission's concerns that the home health benefit is ill-defined; the proposed new grouping system seeks to more accurately characterize a patient's need for home health care.

Comment
The Commission commends CMS for proposing to remove the number of therapy visits provided as a payment factor, and notes that we recommended eliminating the therapy adjustments in our March 2017 Report to the Congress. For many years, MedPAC has been concerned about the incentives created by the use of therapy as a payment adjuster.[3] This concern has been echoed by

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[3] Committee on Finance, United States Senate. 2011. Staff report on home health and the Medicare therapy threshold. 112th Congress, 1st Session S. PRT. 2011 112–24. Report prepared by the staff of the Committee on Finance, United States Senate. Committee print.

the Congress and federal oversight agencies. Including services, such as therapy, as payment factors in the PPS creates a financial incentive for providers to give less weight to certain patient needs and even to engage in selection favoring admitting those patients who need specific therapy services. The alternative system proposed by CMS would increase the role of patient characteristics in setting payment, thereby reducing a significant vulnerability in the current system. Below are our comments on specific elements of the proposed case-mix system.

Impact of new payment system for Medicare beneficiaries. The rule included an impact assessment for HHAs, but it does not discuss impacts for specific types of patients. The rule would benefit from a table that compares payments for patients with selected clinical characteristics under the proposed system with those under the current system. In a prior analysis, Abt Associates found that the proposed system would redistribute payments from therapy cases to non-therapy cases, consistent with MedPAC's previous findings regarding the elimination of therapy visits as a determinant of payment. For example, Abt reported that payments for non-therapy patients, who are less remunerative under the current system, were estimated to increase by over 20 percent under the proposed system. The Abt Associates report noted that this shift would also raise payments for patients with severe conditions, such as wounds, feeding difficulties, and poorly controlled vascular disease.

Medication Management, Training and Assessment clinical category. The six clinical categories include five that are characterized by reported diagnosis. A sixth category, Medication Management, Training, and Assessment (MMTA), would capture cases that do not fall into the other categories. The Commission is concerned that a residual group such as the MMTA category—which does not rely on reported diagnosis—would account for a significant share of home health cases. In 2016, about 60 percent of cases are assigned to the MMTA category. Assignment to this group would therefore not provide a clear rationale for the patient's need for home health care.

The coding incentives of this category may also be significant. Assignment to the MMTA category in many cases would result in lower payments relative to many of the other clinical category. In effect, providers will have an incentive to use coding practices that avoid the MMTA category to seek higher payment. Given the long history of changes in coding unrelated to patient severity that have been observed in this PPS, CMS may want to consider additional diagnosis-related clinical categories for these patients.

Use of prior hospitalization or institutional PAC use as a payment adjuster. The proposed changes would use hospital or institutional PAC use in the 14-day window before admission to home health care to set payment; Medicare would pay more for cases with prior use of these services than for cases without them. CMS notes that this adjustment is consistent with patterns of service in home health care, as patients coming from the hospital have higher use of services initially.

Adjusting payment to reflect prior use of these services would improve the accuracy of the payments in the revised system, but this adjustment would create incentives that need to be carefully considered. One advantage to such an adjustment is that it would encourage agencies to

serve post-hospital or post-PAC patients. In recent years, the Commission has been concerned that the number of episodes for patients with no prior hospital or PAC use has been rising. That pattern, combined with the longer average lengths of stay for community-admitted patients, raises concerns that the benefit is being used more like a long-term care service than a PAC service. The payment adjustment proposed by CMS would reduce current incentives for providers to avoid PAC patients in favor of community-admitted patients.

The disadvantage of the proposed adjustment arises for second or later 30-day periods in a spell of home health care. Under CMS's proposal, if an HHA's patient were hospitalized during the first 30-day period, payments to the HHA in the second 30-day period would be higher.[4] While we acknowledge that this proposed adjustment is intended to recognize the additional services a beneficiary is likely to receive during an episode following hospitalization, it could weaken other incentives to avoid hospitalization, such as those CMS is seeking to create through Value-Based Purchasing efforts. CMS may way want to consider shortening the window for hospitalizations to a shorter period, such as 5 days. This would reduce the potential vulnerability created by the adjustment.

Payment weight regression method. The proposed rule also would continue to derive the case-mix weights for payment groups using a statistical estimate of the cost of a case instead of the actual cost. This method, known as the payment weight regression, has been used since the advent of the PPS. CMS first assigns cases to 144 payment groups using the case-mix factors listed above. It then estimates a regression that uses a series of indicator variables representing a collapsed version of the payment groups to estimate the marginal cost associated with each.[5] The case-mix index for each group is then derived from the coefficients estimated in the regression. CMS contends that this approach has the effect of ensuring that marginal revenue increases between payment groups are more similar in size, effectively smoothing the change in payment as case-mix increases.

MedPAC is concerned that the proposed rule would use a statistical estimate of the cost associated with a payment group instead of the actual cost. This approach results in estimated payments that may not equal the actual costs experienced by HHAs. We understand that the approach attempts to "smoothen" the changes in marginal revenue between related payment groups in the PPS. However, the analysis in the rule does not specifically identify the problematic discontinuities that occur when the actual costs are used to compute the case-mix index. CMS should examine the effects for specific payment groups and indicate how the estimated weight is an improved measure of cost relative to using the actual reported costs of agencies. The use of the statistically derived weights has the effect of reducing the accuracy of the PPS, and CMS should provide better justification for this approach or not use this method.

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[4] Under the proposed rule, stays at institutional PAC providers would not be included as a payment factor in later cases.

[5] The regression uses 22 variables to represent the payment groups as the independent variable and the cost of a thirty-day case as the dependent variable. Some categories of independent variables are mutually exclusive, and in aggregate the possible combinations represents the 144 payment groups.

Changes to measure of resource use. The proposed system would also change how the costs of labor are computed in the case-mix system. Under the current system, CMS computes the cost of labor by multiplying the minutes of service provided in an episode by the estimated wage cost of a minute of labor. The estimated wages are derived from the hourly wages for home health care workers reported by the Bureau of Labor Statistics (BLS). In the proposed revision, CMS would compute the cost per minute from the cost per visit amounts reported by HHAs on the Medicare cost report. CMS contends that using the cost report better reflects agencies' actual costs, and includes other factors such as overhead costs and benefits that are not reflected in the BLS method. The use of cost report information from agencies likely better measures the relative costs of the different services provided by HHAs, and this change should improve the accuracy of the case-mix system.

Proposed provisions of the Home Health Value-based Purchasing (HH VBP) model

The Home Health Value-based Purchasing (HH VBP) model aims to improve the delivery of home health care services to Medicare beneficiaries by giving HHAs incentives to provide better quality care with greater efficiency. The HH VBP will adjust all HHAs' Medicare payments (upward or downward) based on their performance on a set of quality measures. The first HH VBP payment adjustment will begin January 1, 2018, applied to that calendar year based on 2016 performance data. The payment withhold will increase from 5 percent in 2018 to 8 percent in 2021. The initial rules of the program defined a starter set of measures that included outcomes measures collected in the Outcome and Assessment Information Set (OASIS) submitted by home health agencies, patient experience survey measures from the Home Health Consumer Assessment of Health Providers and Systems (HH CAHPS), claims calculated measures (e.g., Acute Care Hospitalization: Unplanned Hospitalization during First 60 Days of Home Health), and a number of agency submitted process measures.

Removal of measure and new measure concepts. In the CY 2018 proposed rule, CMS proposes to remove the Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care quality measure for the third performance year of the HH VBP. CMS has found that many providers have achieved full performance on this Drug Education measure. CMS also requested input on whether the agency should develop the following quality measure concepts for potential use in the HH VBP: composite total change in ADL/IADL measure; a composite functional decline measure; a measure to capture when an HHA correctly identifies the patient's need for mental and behavioral health supervision; and a measure to identify if a caregiver is able to provide the patient's mental or behavioral health supervision.

Comment
Over the past few years, the Commission has become increasingly concerned that Medicare's current quality measurement programs rely on too many clinical process measures that are, at best, weakly correlated with health outcomes of importance to beneficiaries and the program. Process measures are also burdensome on providers to report, while yielding limited information to support clinical improvement. Medicare quality programs should include outcomes, patient experience, and value (cost/low-value) measures. The Commission supports removing the "topped-out",

process Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care measure. The Commission does not support developing new process measures, such as the proposed measure concepts of correctly identifying the patient's need for mental and behavioral health supervision, and identifying if a caregiver is able to provide the patient's mental or behavioral health supervision. Further, CMS needs to be mindful that measures, when used for risk-adjustment or to move payments under a VBP, may be susceptible to inappropriate manipulation by providers. While we believe that improving a patient's functional ability is a goal of home health care, we have some degree of concern that the 'composite total change in ADL/IADL measure' and the 'composite functional decline measure' represent reporting elements completely within the control of the home health agency. If CMS includes these measures, the agency may also want to consider and propose ways that such data could be independently audited or otherwise verified.

Proposed updates to the Home Health Care Quality Reporting Program (HH QRP)

Beginning in 2007, the Home Health Quality Reporting Program (HH QRP) reduces an HHA's home health market basket percentage by two percentage points if they do not report a set of OASIS, HH CAHPS and other quality measures to CMS on a regular basis. For their own quality improvement work, HHAs also have access to home health quality measures that are part of the Home Health Quality Initiative (HHQI), but these measures only included in the HHQI are not tied to payment (e.g., pay-for-reporting or performance).

Defining standardized patient assessment data. The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 requires the Secretary to implement quality and resource use measures that are standardized and interoperable across PAC settings. The required quality measures include measures of function and cognition, skin integrity, medication reconciliation, incidence of major falls, the transfer of health information and care preferences, readmissions, and discharge to community. In the proposed rule, CMS proposes that "standardized" patient assessment data should be defined as patient assessment questions and response options that are identical across PAC providers (including skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals, as well as HHAs) and to which identical standards and definitions are applied.

Comment
The Commission supports this change in the definition of "standardized." Because the goal of cross-cutting measures is to gauge and compare care provided across PAC settings, it is critical that each measure use uniform definitions, specifications (such as inclusions and exclusions), and risk-adjustment methods. Otherwise, differences in rates across settings could reflect differences in the way the rates were constructed rather than underlying differences in the quality of care. Our work on the design of a unified PAC payment system and the work of others suggest considerable overlap in where beneficiaries are treated for similar PAC needs. These results indicate it is imperative that quality and resource use measures are directly comparable across settings so that Medicare can evaluate the value of its purchases and beneficiaries can make informed choices about where to seek care.

Standardized patient assessment data reporting. CMS proposes the addition of several elements to the OASIS tool beginning in FY2019. These elements relate to special services, treatments, and interventions that may be provided to HHA patients, including IV medications, dialysis, oxygen, and nutritional approaches (such as parenteral feeding and mechanically altered diets). Other elements relate to hearing and vision. The elements would be standardized (as defined above) to align with those collected in other PAC settings.

Comment
The Commission supports the addition of elements to the PAC assessment tools that are standardized across the PAC settings. However, CMS needs to be mindful that measures, when used for risk-adjustment, may be susceptible to provider manipulation. Of the items included in the proposed rule, the Commission is concerned about those that may induce service use, such as oxygen therapy, intravenous medications, and nutritional approaches. The Commission supports the inclusion of these care items when they are tied to medical necessity. For example, in prior Commission work developing a reformed payment system for SNFs, we required that patients be counted as needing oxygen services only if they have diagnoses that typically needing oxygen. We encourage CMS to take a similar approach in measuring use of services that are especially discretionary. For some elements, CMS may want to consider requiring a physician signature to attest that the reported service was reasonable and necessary and including a statement adjacent to the signature line warning that filing a false claim is subject to treble damages under the False Claims Act.

Items that were not proposed but which may warrant consideration include high-cost services such as cardiac monitoring and specialty bed/surfaces. Because patient assessment items are sometimes used for risk-adjustment, CMS may want to consider whether high-cost services such as these would be included in future collection efforts.

New measure concepts. CMS is requesting comments on whether the agency should develop several measures for potential future use in the HH QRP. Four measures under consideration would assess a change in functional outcomes such as self-care and mobility across a HH episode. These measures would be standardized to measures finalized in other PAC quality reporting programs, such as the IRF quality reporting program. They also proposed developing a claims-based within-stay potentially preventable hospitalization measures.

Comment
As described in our earlier comments, the Commission believes that Medicare quality programs should include outcomes, patient experience, and value (cost/low-value) measures. These measures should be claims or survey based. We support CMs developing the claims-based, potentially preventable hospitalization measure. Measuring potentially preventable hospitalizations holds providers accountable only for conditions that generally could have been managed by the HHA. The Commission also support measures that cut-across sectors, as long as they are standardized. Therefore, we would support CMS developing the self-care and mobility measure concepts for

HHAs based on the IRF measure specifications, as long as CMS ensures that the measures are aligned across PAC settings.

Accounting for social risk factors in quality measurement. CMS has been reviewing reports prepared by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academies of Sciences, Engineering, and Medicine on the issue of accounting for social risk factors in CMS's value-based purchasing and quality reporting programs. CMS has also been monitoring and awaiting results from the National Quality Forum's (NQF) 2-year trial period in which endorsement candidate quality measures seeking endorsement are assessed to determine whether risk adjustment for selected social risk factors is appropriate. At the end of the trial, NQF will issue recommendations on the future inclusion of social risk factors in risk adjustment for these quality measures. As CMS continues to consider the analyses from these reports and awaits the results of the NQF trial on risk adjustment for quality measures, the agency seeks public comment on whether and how to incorporate social risk factors in Medicare programs, including the HH QRP.

Comment
In December 2016, ASPE released the "Social Risk Factors and Performance under Medicare's Value-based Purchasing Programs" report to the Congress, which was mandated by the IMPACT Act. The report provides empirical analysis of the effects of six social risk factors (dual eligibility, residence in low-income areas, Black race, Hispanic ethnicity, rural residence, disability) on the nine Medicare quality payment programs including the Hospital Readmission Reduction (HRR) program. The report included two main findings:

1. Beneficiaries with social risk factors had worse outcomes on quality measures, regardless of the providers they saw, and dual eligibility status was the most powerful predictor of poor outcomes among the social risk factors.
2. Providers that disproportionately served beneficiaries with social risk factors tended to have worse performance on quality measures, even after accounting for their beneficiary mix.

ASPE simulated the effect of three different potential policy solutions to account for social risk factors in each of the Medicare programs:

- adjust quality and resource use measures,
- stratify providers into groups by proportion that are at-risk, and
- create separate payment adjustments.

MedPAC supports the second solution of using peer grouping or stratification.[6] This approach is straightforward to implement, since no additional measure-level research is needed (that is, working with measure developers to run new risk-adjustment models). The stratification approach also does not minimize incentives to improve for providers with high shares of beneficiaries that have social risk factors, and does not "mask" provider performance. Instead, providers would compare their unmasked performance (the rate would still have been adjusted for differences in

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[6] Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

patient age, sex, and comorbidities) with providers with similar risk factors. For example, risk-adjusted readmission performance would be compared for hospitals with similar shares of low-income patients, and payment would be adjusted based on whether hospitals met performance targets in their peer group.

Conclusion

The Commission appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. We also value the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact Mark E. Miller, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Francis J. Crosson, M.D.
Chairman