



January 29, 2016

Acumen, LLC  
500 Airport Boulevard  
Suite 365  
Burlingame, CA 94010  
E-mail: [mspb-pac-measures-support@acumenllc.com](mailto:mspb-pac-measures-support@acumenllc.com)

RE: Draft Specifications for the Medicare Spending Per Beneficiary – Post-Acute Care (MSPB-PAC) Resource Use Measures, Provided for Public Comment

To Whom It May Concern:

The Alliance for Home Health Quality and Innovation (the “Alliance”) appreciates the opportunity to comment on the draft specifications for the Medicare Spending Per Beneficiary—Post-Acute Care (MSPB-PAC) resource use measures.

By way of background, the Alliance is a non-profit 501(c)(3) organization with the mission to lead and support research and education on the value of home health care to patients and the U.S. health care system. Working with researchers, key experts and thought leaders, and providers across the spectrum of care, we strive to foster solutions that will improve health care in America. The Alliance is a membership-based organization comprised of not-for-profit and proprietary home health care providers and other organizations dedicated to improving patient care and the nation’s healthcare system. For more information about our organization, please visit: <http://ahhqi.org/>.

The Alliance has the following comments regarding the proposed measures.

First, the Alliance appreciates the importance of developing measures to better understand Medicare cost and resource use associated with post-acute care, but is concerned that when viewed in isolation, cost information alone can be a confusing measure because it does not necessarily correlate with quality of care. The Alliance believes that spending alone is not an indicator of quality, nor is it an indicator of efficiency. The measure will be most useful when paired with quality outcome measures. If outcome measures are not linked to this cost measure, there may be an incentive for providers not to refer patients for reasonable and necessary services, including post-acute care services that can be used to reduce rehospitalization rates and improve patient experience. As various stakeholders make use of MSPB-PAC measures

and apply them in various ways, it will be critical to ensure that adequate quality outcome measures are coupled with measures of the cost of care to discourage underuse.

Moreover, there is a need for the development of measures of patient access to care. Reforms that are aimed at improving efficient, cost-effective delivery of care are needed, as are measures that will help to encourage efficiency. However, patient access should not be compromised as a means to lower cost. Unfortunately, this measure alone cannot be used to assess whether patients have access to quality care. The Alliance is not aware of any measures at present that would address access to care and would support development of such measures.

Second, the Alliance is concerned about the episode length for the MSPB-home health measure as it relates to standard HHA and HHA-LUPA episodes. Whereas for SNF, LTCH, IRF and HHA-PEP episodes, the treatment period ends at discharge, for standard HHA and HHA-LUPA episodes the treatment period ends after 60 days. For standard HHA episodes, there are cases when a beneficiary is discharged prior to the end of the 60 day episode. For example, a beneficiary may be discharged at the 25<sup>th</sup> day for a variety of reasons (e.g., the patient may no longer be homebound, or the patient's goals have been met). In such cases when the standard HHA episode ends before the 60<sup>th</sup> day, the treatment period should end at discharge instead of running a full 60 days. Similarly, for HHA-LUPA episodes, the treatment period should end at discharge because in many cases patients may be discharged before the 60<sup>th</sup> day.

By making this change, the home health treatment periods will be better aligned with the way the other PAC provider treatment periods are constructed in terms of approach and methodology.

Third, the Alliance is concerned that for the MSPB-home health measure, the home health costs will be double counted because of the way the episode length is constructed. In cases where there is a home health episode followed by recertification and a second home health episode, the second home health episode of care would be counted twice: once as part of a treatment period associated with the second home health episode and another as part of the first home health episode's associated services period. The Alliance urges the measure developer to ensure that home health episode costs will not be counted twice. This is an issue that may be unique to home health care and the Alliance recommends that the episode length be tailored to prevent overlap and over-counting.

Fourth, the Alliance supports the overall approach to focusing on MSPB within each PAC setting. This will enable providers in each PAC setting the opportunity to test the measures and assess whether refinements to the measures are needed. After an appropriate period of testing, it may make sense over time to consider development of a measure that will enable comparisons across post-acute care settings. If the policy

interest in post-acute care payment reform results in a unified post-acute care payment system across settings, a cross-setting MSPB measure might be considered in the future to align with such a system.

Fifth, the Alliance is concerned about use of the national median as the benchmark for the MSPB-PAC measures. At present, there is considerable geographic variation in health care that is often outside the control of any given provider. For example, in some areas, there is a high penetration of Medicare Advantage plans and the patients in traditional Medicare tend to be older and more sick or frail than MA plan beneficiaries; in these areas, resource use per beneficiary in traditional Medicare may be higher than expected. Notwithstanding, the Alliance recognizes that it is a reasonable policy goal to achieve greater consistency in practice where variation is inefficient.

The Alliance recommends using regional medians as benchmarks. It is worthy of note that in the CMS comprehensive care for joint replacement model, CMS is using a phased in approach for its cost benchmarks that are blended provider-specific costs and regional medians for the first four years, and shifting to straight regional medians in year five. A similar approach could be used for the MSPB-PAC measures. Alternatively if a national median must be attained CMS should use a similar blended approach using regional and national medians for the transition period and ultimately shifting to straight national median.

Sixth, it is interesting to note the varying approaches to risk adjustment that have been used by the measure developers of the different IMPACT Act domain measures. The Alliance supports recognition of prior PAC setting as a factor relating to risk adjustment and appreciates this approach. Regarding the six different groupings for risk adjustment specified in the measure specifications, the Alliance respectfully requests that data be made available to enable stakeholders to assess whether such categories are effective in terms of predicting clinical similarity and cost. The Alliance also recommends the use of approaches to risk adjustment that make use of data (including assessment data) collected on functional status and behavioral and mental health. It will also be critical to pursue and invest in ways to risk adjust for socioeconomic status.

Finally, the Alliance urges testing, validating and self-reporting of this measure before it is finalized. Testing and validation should be no less than six months with an opportunity to modify the measure prior to finalizing it. A similar approach was used for many of the OASIS-based measures that CMS uses for home health agencies. The information on performance against this measure should not be made public if there are any concerns about validity and accuracy of the measure.

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The Alliance appreciates the opportunity to comment on the draft MSPB-PAC measure specifications. Please contact me at [tlee@ahhqj.org](mailto:tlee@ahhqj.org) or 703-863-2382 if you have any questions.

Sincerely,

/s/

Teresa L. Lee, JD, MPH  
Executive Director