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PROPOSED CMS RULE A GOOD FIRST STEP TO LEVELING THE VALUE-BASED CARE PLAYING FIELD

Would Warrant a Re-examination of Financial Risk

On April 14, the Centers for Medicare and Medicaid Services (CMS) [proposed a rule](#) that would create a more level playing field for safety-net hospitals under the value-based Hospital Readmissions Reduction Program (HRRP).

The rule, which would take effect in FY 2019, would require Medicare to consider social risk factors when calculating hospital penalties under the HRRP, as mandated by the 21st Century Cures Act.

DETAILS

Under the proposed rule, CMS would group hospitals according to their overall proportion of dual-eligible Medicare-Medicaid patients.

Defining dual-eligible

The rule defines a dual-eligible patient as any individual identified as having full-benefit dual status in the State Medicare Modernization Act during the month he/she was discharged from the hospital.

"The State MMA file is considered the most current and most accurate source of data for identifying dual-eligible beneficiaries since it is also used for operational purposes related to the administration of Part D benefits," the rule explains.

Calculating a hospital's proportion of dual-eligibles

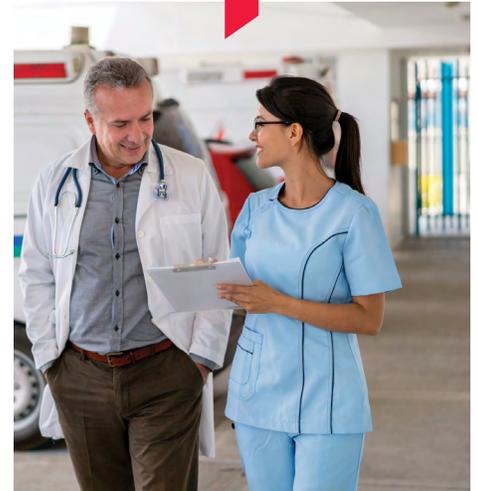
It offers two methodologies for calculating a hospital's proportion of dual-eligible patients.

The first—and preferred, by CMS—methodology defines the proportion of full-benefit dual-eligible beneficiaries as the proportion of dual-eligible patients among all Medicare fee-for-service (FFS) and Medicare Advantage inpatient visits. This method, the CMS states, provides more of an apples-to-apples comparison of social risk factors among hospitals, as it "represents the proportion of dual-eligible patients served by the hospital, particularly for hospitals in states with high managed care penetration rates."

The second, alternative methodology defines the proportion of full-benefit dual-eligibles as solely Medicare FFS hospital episodes of care. The CMS included this option since the HRRP payment adjustment applies only to Medicare FFS payments and is based on excess readmissions among only those cases.

Determining the best data source

Under both methodologies, the CMS suggests using data from the Medicare



HOW DO I GET MORE INFORMATION?

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Provider and Analysis Review (MedPAR) to identify total hospital stays, as that data is the most readily available to the public. CMS said, however, it will also consider using data from the CMS integrated data repository.

Accurately grouping hospitals

Using the definitions above, the rule then proposes stratifying hospitals into five peer groups, broken down by their proportion of dual-eligible patients. The CMS recommends five, rather than two or 10 as aligned with previous industry-standard methodologies for comparing hospital performance, because quintiles create "peer groups that accurately reflect the relationship between the proportion of dual-eligibles in the hospital's population without the disadvantage of establishing a larger number of peer groups."

Accounting for social risk factors

CMS also said it continues to seek public comment on whether—and how—to account for social risk factors in the HRRP and other value-based initiatives.

"We are concerned about holding providers to different standards for the outcomes of their patients with social risk factors because we do not want to mask potential disparities or minimize incentives to improve the outcomes for disadvantaged populations," the rule said.

The comment period is open through June 13.

INSIGHTS

Dual-eligible patients are historically more expensive for hospitals, skewing the readmissions figures for safety-net hospitals, leading to unfair penalties against them and inhibiting their ability to provide the best quality of care to populations that need it the most. Such patients "constituted 18 percent of beneficiaries yet accounted for nearly one-third of total Medicare fee-for-service spending in 2012," reported [Modern Healthcare](#).

The suggestions put forth in the CMS rule allow safety-net hospitals to control for variables often out of their control as they relate to dual-eligibility. But when it comes to high readmission rates and the associated penalties, other population factors are often also at play regardless of a hospital's quality scores:

1. **Proportion of patients who are linguistic minorities.** These patients, less likely to access the social programs often needed to attain dual-eligibility because of language barriers, are often at a higher risk for readmission.
2. **Proportion of patients who have behavioral health diagnoses.** Patients with behavioral health diagnoses, which have higher associations with other medical diagnoses, are at a higher risk for readmission.

3. **Proportion of patients with minimal social support.** These types of patients, for example those who live alone or have little familial support, too are associated with higher readmission rates.

Others have argued for grouping hospitals according to simple income by census tract data, allowing hospitals in low socioeconomic status areas penalty adjustments based on income quintiles alone.

Although the rule needs fine tuning and is likely to go through multiple iterations before finalization, correcting hospitals' penalties based on their proportion of dual-eligible patients is a welcome change and a step in the right direction if value-based reimbursement is to be realistically replicable across all providers—and all populations.

Providers, especially those that serve a higher proportion of dual-eligible patients, should keep abreast of how the rule evolves ahead of its proposed FY 2019 effective date, and adjust financial risk management accordingly.

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