NATIONAL QUALITY FORUM

Comment Report for Patient Experience and Function Project

Post-Evaluation Comments received March 18 - April 16

All Comments received during the Member and Public Comment Period have been included in this table, as well as the pre-evaluation public comment period.

Important Links

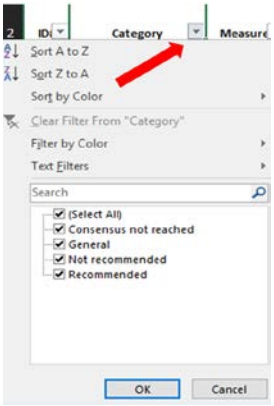
Patient Experience and Function Measures Project Page

List of Measures that were Recommended

3455 Timely Follow-Up After Acute Exacerbations of Chronic Conditions
3477 Discharge to Community-Post Acute Care Measure for Home Health Agencies
3479 Discharge to Community-Post Acute Care Measure for Inpatient Rehabilitation Facilities (IRF)
3481 Discharge to Community-Post Acute Care Measure for Skilled Nursing Facilities (SNF)

Council Acryonms

HPL	Health Plan
HPR	Health Professions
PRO	Providers
SPI	Supplier/Industry
QMRI	Quality Measurement, Research, and Improvement
CON	Consumers
PUR	Purchasers
PCHA	Public/Community Health Agency



National Quality Forum - Comment Report for Patient Experience and Function Fall 2018 Cycle

Comments received December 5, 2018 through April 16, 2019

ID#	Category	Measure	Comment	Commenter	Council/ Public	Response	Theme
7175	Recommended	3479: Discharge to Community-Post Acute Care Measure for Inpatient Rehabilitation Facilities (IRF)	The Federation of American Hospitals (FAH) supports measures that encourage appropriate discharge planning and transitions of care to minimize undesirable outcomes such as readmissions and death but continues to have the same concerns regarding the measure and its intended use for accountability purposes as expressed in our comments prior to the Standing Committee's evaluation. FAH agrees with the conclusion that some of the Scientific Methods Panel members made regarding the lack of inclusion of dual eligible status in the risk model. If the developer's statement noted under the discussion for measure #3477 on pages 9 and 19 of the report also applies to this measure, FAH is extremely concerned to see that what is included or excluded in a measure is based on CMS policy rather than empiric evidence and we do not believe that policy decisions should impact an NQF committee's evaluation of whether a measure adequately meets the Measure Evaluation Criteria. Measures must be specified to ensure that they produce results that are reliable and valid and enable fair comparisons. By not including dual eligible status in the risk model nor examining additional factors, there is increased risk that an entity's true performance will be misrepresented and could provide inaccurate information to patients and their families. FAH strongly urges CMS and its developer to continue to identify new sources that offer more robust data on these factors and be open to new adjustment approaches to better answer the question. As a result, the FAH does not believe that this measure is appropriate for use for accountability purposes. FAH encourages the committee to not recommend this measure for endorsement at this time.	Submitted by Dr. Claudia A. Salzberg, PhD, Federation of American Hospitals (FAH)	PRO	CMS, RTI International and Abt Associates Inc. thank the Federation of American Hospitals (FAH) for their comments. We agree that quality measures must be specified to ensure reliable and valid comparisons of providers. We believe we have empirically demonstrated a high level of reliability and validity of the Discharge to Community (DTC) measures. In addition to policy considerations impacting our approach, we conducted an extensive and thoughtful empirical assessment of the need for social risk factor adjustment. We first assessed the impact of dual status adjustment on provider scores. We found that dual-adjusted and non-dual—adjusted DTC scores were very strongly associated in all post-acute care (PAC) settings, both for providers with low and high proportions of dual eligible beneficiaries with full Medicaid benefit (full-dual). Pearson and Spearman correlations between dual-adjusted and non-dual—adjusted DTC scores were close to 1, while intraclass correlation coefficients were between 0.9 and 1, with most being close to 1. Further, we found that amongst providers with the highest proportions of full-dual beneficiaries, nearly 71% of home health agencies (HHAs), nearly 50% of inpatient rehabilitation facilities (IRFs), over 25% of long-term care hospitals (LTCHs), and over 10% skilled nursing facilities (SNFs) had DTC measure scores above the national rate. The strong association between dual-adjusted and non-dual—adjusted scores demonstrates that the measure provides reliable and valid assessment of provider performance without adjustment for dual status. The presence of high performing providers amongst those with high proportions of full-dual beneficiaries shows that it is possible for providers serving dual eligible beneficiaries to achieve high DTC rates, without adjustment for dual status. Based on these findings, we do not believe that dual status risk adjustment is indicated at this time. On the contrary, dual status adjustment poses the risk of disincentivizing providers from working towards successfully discharging dual eligible beneficiaries to the community. In addition to dual eligibility, we assessed the impact of three other social risk factors: race, urbanicity of beneficiary residence, and socioeconomic status (SES) of beneficiary residence area (Agency of Healthcare Research and Quality (AHRQ) SES Index) (see Appendix). We found an inconsistent impact of these social risk factors across PAC settings. We also found that these additional social risk factors had little impact on scores beyond dual status adjustment (i.e., there was little difference in scores based on dual adjustment only vs. adjustment for all four social risk factors) (data not shown). We will continue to monitor outcomes of dually eligible beneficiaries and those with other social risk factors as part of measure monitoring and evaluation and will assess the need for social risk factor adjustment in the future.	Concern with risk adjustment model
7176	Recommended	3477: Discharge to Community-Post Acute Care Measure for Home Health Agencies	The Federation of American Hospitals (FAH) supports measures that encourage appropriate discharge planning and transitions of care to minimize undesirable outcomes such as readmissions and death but continues to have the same concerns regarding the measure and its intended use for accountability purposes as expressed in our comments prior to the Standing Committee's evaluation. FAH agrees with the conclusion that some of the Scientific Methods Panel members made regarding the lack of inclusion of dual eligible status in the risk model. If the developer's statement noted under the discussion for measure #3477 on pages 9 and 19 of the report also applies to this measure, FAH is extremely concerned to see that what is included or excluded in a measure is based on CMS policy rather than empiric evidence and we do not believe that policy decisions should impact an NQF committee's evaluation of whether a measure adequately meets the Measure Evaluation Criteria. Measures must be specified to ensure that they produce results that are reliable and valid and enable fair comparisons. By not including dual eligible status in the risk model nor examining additional factors, there is increased risk that an entity's true performance will be misrepresented and could provide inaccurate information to patients and their families. FAH strongly urges CMS and its developer to continue to identify new sources that offer more robust data on these factors and be open to new adjustment approaches to better answer the question. As a result, the FAH does not believe that this measure is appropriate for use for accountability purposes. FAH encourages the committee to not recommend this measure for endorsement at this time.	Submitted by Dr. Claudia A. Salzberg, PhD, Federation of American Hospitals (FAH)	PRO	CMS, RTI International and Abt Associates Inc. thank the Federation of American Hospitals (FAH) for their comments. We agree that quality measures must be specified to ensure reliable and valid comparisons of providers. We believe we have empirically demonstrated a high level of reliability and validity of the Discharge to Community (DTC) measures. In addition to policy considerations impacting our approach, we conducted an extensive and thoughtful empirical assessment of the need for social risk factor adjustment. We first assessed the impact of dual status adjustment on provider scores. We found that dual-adjusted and non-dual—adjusted DTC scores were very strongly associated in all post-acute care (PAC) settings, both for providers with low and high proportions of dual eligible beneficiaries with full Medicaid benefit (full-dual). Pearson and Spearman correlations between dual-adjusted and non-dual—adjusted DTC scores were close to 1, while intraclass correlation coefficients were between 0.9 and 1, with most being close to 1. Further, we found that amongst providers with the highest proportions of full-dual beneficiaries, nearly 71% of home health agencies (HHAs), nearly 50% of inpatient rehabilitation facilities (IRFs), over 25% of long-term care hospitals (LTCHs), and over 10% skilled nursing facilities (SNFs) had DTC measure scores above the national rate. The strong association between dual-adjusted and non-dual—adjusted scores demonstrates that the measure provides reliable and valid assessment of provider performance without adjustment for dual status. The presence of high performing providers amongst those with high proportions of full-dual beneficiaries shows that it is possible for providers serving dual eligible beneficiaries to achieve high DTC rates, without adjustment for dual status. Based on these findings, we do not believe that dual status risk adjustment is indicated at this time. On the contrary, dual status adjustment poses the risk of disincentivizing providers from working towards successfully discharging dual eligible beneficiaries to the community. In addition to dual eligibility, we assessed the impact of three other social risk factors: race, urbanicity of beneficiary residence, and socioeconomic status (SES) of beneficiary residence area (Agency of Healthcare Research and Quality (AHRQ) SES Index) (see Appendix). We found an inconsistent impact of these social risk factors across PAC settings. We also found that these additional social risk factors had little impact on scores beyond dual status adjustment (i.e., there was little difference in scores based on dual adjustment only vs. adjustment for all four social risk factors) (data not shown). We will continue to monitor outcomes of dually eligible beneficiaries and those with other social risk factors as part of measure monitoring and evaluation and will assess the need for social risk factor adjustment in the future.	Concern with risk adjustment model
7177	Consensus Not Reached	3480: Discharge to Community-Post Acute Care Measure for Long-Term Care Hospitals (LTCH)	The Federation of American Hospitals (FAH) supports measures that encourage appropriate discharge planning and transitions of care to minimize undesirable outcomes such as readmissions and death but continues to have the same concerns regarding the measure and its intended use for accountability purposes as expressed in our comments prior to the Standing Committee's evaluation. FAH agrees with the conclusion that some of the Scientific Methods Panel members made regarding the lack of inclusion of dual eligible status in the risk model. If the developer's statement noted under the discussion for measure #3477 on pages 9 and 19 of the report also applies to this measure, FAH is extremely concerned to see that what is included or excluded in a measure is based on CMS policy rather than empiric evidence and we do not believe that policy decisions should impact an NQF committee's evaluation of whether a measure adequately meets the Measure Evaluation Criteria. Measures must be specified to ensure that they produce results that are reliable and valid and enable fair comparisons. By not including dual eligible status in the risk model nor examining additional factors, there is increased risk that an entity's true performance will be misrepresented and could provide inaccurate information to patients and their families. FAH strongly urges CMS and its developer to continue to identify new sources that offer more robust data on these factors and be open to new adjustment approaches to better answer the question. As a result, the FAH does not believe that this measure is appropriate for use for accountability purposes. FAH encourages the committee to not recommend this measure for endorsement at this time.	Submitted by Dr. Claudia A. Salzberg, PhD, Federation of American Hospitals (FAH)	PRO	CMS, RTI International and Abt Associates Inc. thank the Federation of American Hospitals (FAH) for their comments. We agree that quality measures must be specified to ensure reliable and valid comparisons of providers. We believe we have empirically demonstrated a high level of reliability and validity of the Discharge to Community (DTC) measures. In addition to policy considerations impacting our approach, we conducted an extensive and thoughtful empirical assessment of the need for social risk factor adjustment. We first assessed the impact of dual status adjustment on provider scores. We found that dual-adjusted and non-dual—adjusted DTC scores were very strongly associated in all post-acute care (PAC) settings, both for providers with low and high proportions of dual eligible beneficiaries with full Medicaid benefit (full-dual). Pearson and Spearman correlations between dual-adjusted and non-dual—adjusted DTC scores were close to 1, while intraclass correlation coefficients were between 0.9 and 1, with most being close to 1. Further, we found that amongst providers with the highest proportions of full-dual beneficiaries, nearly 71% of home health agencies (HHAs), nearly 50% of inpatient rehabilitation facilities (IRFs), over 25% of long-term care hospitals (LTCHs), and over 10% skilled nursing facilities (SNFs) had DTC measure scores above the national rate. The strong association between dual-adjusted and non-dual—adjusted scores demonstrates that the measure provides reliable and valid assessment of provider performance without adjustment for dual status. The presence of high performing providers amongst those with high proportions of full-dual beneficiaries shows that it is possible for providers serving dual eligible beneficiaries to achieve high DTC rates, without adjustment for dual status. Based on these findings, we do not believe that dual status risk adjustment is indicated at this time. On the contrary, dual status adjustment poses the risk of disincentivizing providers from working towards successfully discharging dual eligible beneficiaries to the community. In addition to dual eligibility, we assessed the impact of three other social risk factors: race, urbanicity of beneficiary residence, and socioeconomic status (SES) of beneficiary residence area (Agency of Healthcare Research and Quality (AHRQ) SES Index) (see Appendix). We found an inconsistent impact of these social risk factors across PAC settings. We also found that these additional social risk factors had little impact on scores beyond dual status adjustment (i.e., there was little difference in scores based on dual adjustment only vs. adjustment for all four social risk factors) (data not shown). We will continue to monitor outcomes of dually eligible beneficiaries and those with other social risk factors as part of measure monitoring and evaluation and will assess the need for social risk factor adjustment in the future.	Concern with risk adjustment model
7178	Recommended	3481: Discharge to Community-Post Acute Care Measure for Skilled Nursing Facilities (SNF)	The Federation of American Hospitals (FAH) supports measures that encourage appropriate discharge planning and transitions of care to minimize undesirable outcomes such as readmissions and death but continues to have the same concerns regarding the measure and its intended use for accountability purposes as expressed in our comments prior to the Standing Committee's evaluation. FAH agrees with the conclusion that some of the Scientific Methods Panel members made regarding the lack of inclusion of dual eligible status in the risk model. If the developer's statement noted under the discussion for measure #3477 on pages 9 and 19 of the report also applies to this measure, FAH is extremely concerned to see that what is included or excluded in a measure is based on CMS policy rather than empiric evidence and we do not believe that policy decisions should impact an NQF committee's evaluation of whether a measure adequately meets the Measure Evaluation Criteria. Measures must be specified to ensure that they produce results that are reliable and valid and enable fair comparisons. By not including dual eligible status in the risk model nor examining additional factors, there is increased risk that an entity's true performance will be misrepresented and could provide inaccurate information to patients and their families. FAH strongly urges CMS and its developer to continue to identify new sources that offer more robust data on these factors and be open to new adjustment approaches to better answer the question. As a result, the FAH does not believe that this measure is appropriate for use for accountability purposes. FAH encourages the committee to not recommend this measure for endorsement at this time.	Submitted by Dr. Claudia A. Salzberg, PhD, Federation of American Hospitals (FAH)	PRO	CMS, RTI International and Abt Associates Inc. thank the Federation of American Hospitals (FAH) for their comments. We agree that quality measures must be specified to ensure reliable and valid comparisons of providers. We believe we have empirically demonstrated a high level of reliability and validity of the Discharge to Community (DTC) measures. In addition to policy considerations impacting our approach, we conducted an extensive and thoughtful empirical assessment of the need for social risk factor adjustment. We first assessed the impact of dual status adjustment on provider scores. We found that dual-adjusted and non-dual—adjusted DTC scores were very strongly associated in all post-acute care (PAC) settings, both for providers with low and high proportions of dual eligible beneficiaries with full Medicaid benefit (full-dual). Pearson and Spearman correlations between dual-adjusted and non-dual—adjusted DTC scores were close to 1, while intraclass correlation coefficients were between 0.9 and 1, with most being close to 1. Further, we found that amongst providers with the highest proportions of full-dual beneficiaries, nearly 71% of home health agencies (HHAs), nearly 50% of inpatient rehabilitation facilities (IRFs), over 25% of long-term care hospitals (LTCHs), and over 10% skilled nursing facilities (SNFs) had DTC measure scores above the national rate. The strong association between dual-adjusted and non-dual—adjusted scores demonstrates that the measure provides reliable and valid assessment of provider performance without adjustment for dual status. The presence of high performing providers amongst those with high proportions of full-dual beneficiaries shows that it is possible for providers serving dual eligible beneficiaries to achieve high DTC rates, without adjustment for dual status. Based on these findings, we do not believe that dual status risk adjustment is indicated at this time. On the contrary, dual status adjustment poses the risk of disincentivizing providers from working towards successfully discharging dual eligible beneficiaries to the community. In addition to dual eligibility, we assessed the impact of three other social risk factors: race, urbanicity of beneficiary residence, and socioeconomic status (SES) of beneficiary residence area (Agency of Healthcare Research and Quality (AHRQ) SES Index) (see Appendix). We found an inconsistent impact of these social risk factors across PAC settings. We also found that these additional social risk factors had little impact on scores beyond dual status adjustment (i.e., there was little difference in scores based on dual adjustment only vs. adjustment for all four social risk factors) (data not shown). We will continue to monitor outcomes of dually eligible beneficiaries and those with other social risk factors as part of measure monitoring and evaluation and will assess the need for social risk factor adjustment in the future.	Concern with risk adjustment model

7164	Consensus Not Reached	3480: Discharge to Community-Post Acute Care Measure for Long-Term Care Hospitals (LTCH)	The American Medical Association (AMA) appreciates the opportunity to comment and vote on this measure. We are not able to support endorsement of this measure at this time due to our concerns outlined below. In addition, due to the limited information provided in the measure evaluation beginning on page 28 of the report, we were unable to truly understand what led to the committee being unable to reach consensus and additional background on the rationale for the preliminary recommendation would be useful. We believe that given our concerns with the validity of this measure, it is not suitable for endorsement at this time. Regarding our concerns with validity and more specifically risk adjustment, we do not believe that the measure is adequately tested and adjusted for social risk factors. We assume that the developer's statement that 'it was a CMS policy decision not to include dual eligibles'; discussed under Measure #3477 applies to this measure as well and we are extremely concerned that the decision to include this variable was made based on policy rather than the testing results. We do not believe that CMS policy decisions should play a role in determining whether the risk adjustment model meets the NQF Measure Evaluation Criteria requirements. On review of the testing attachment, we note that the responses provided on social risk factors (2b3.3a) did not specifically address the question nor did the developer provide a conceptual and statistical analysis of social risk factors. As a result, the AMA is unable to support the endorsement of this measure, as we do not believe that the measure meets the validity subcriterion. We encourage the Standing Committee to not recommend this measure for endorsement.	Submitted by Ms. Koryn Y. Rubin, MHA, American Medical Association (AMA)	HPR	CMS, RTI International and Abt Associates Inc. thank the American Medical Association (AMA) for their comments. We agree that quality measures must be specified to ensure reliable and valid comparisons of providers. We believe we have empirically demonstrated a high level of reliability and validity of the Discharge to Community (DTC) measures. In addition to policy considerations impacting our approach, we conducted an extensive and thoughtful empirical assessment of the need for social risk factor adjustment. We first assessed the impact of dual status adjustment on provider scores. We found that dual-adjusted and non-dual—adjusted DTC scores were very strongly associated in all post-acute care (PAC) settings, both for providers with low and high proportions of dual eligible beneficiaries with full Medicaid benefit (full-dual). 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We will continue to monitor outcomes of dually eligible beneficiaries and those with other social risk factors as part of measure monitoring and evaluation and will assess the need for social risk factor adjustment in the future. We provide a conceptual model for social risk factors in section 2b3.3b of the testing form and statistical results of social risk factor testing in section 2b3.4a.	Concerns with risk adjustment model; consensus not reached status
7161	Recommended	3479: Discharge to Community-Post Acute Care Measure for Inpatient Rehabilitation Facilities (IRF)	The American Medical Association (AMA) appreciates the opportunity to comment and vote on this measure. We are not able to support endorsement of this measure at this time due to our concerns with the validity of this measure. Based on our review of the submission, we do not believe that the measure is adequately tested and adjusted for social risk factors. We assume that the developer's statement that "it was a CMS policy decision not to include dual eligibles" discussed under Measure #3477 applies to this measure as well and we are extremely concerned that the decision to include this variable was made based on policy rather than the testing results. We do not believe that CMS policy decisions should play a role in determining whether the risk adjustment model meets the NQF Measure Evaluation Criteria requirements. On review of the testing attachment, we note that the responses provided on social risk factors (2b3.3a) did not specifically address the question nor did the developer provide a conceptual and statistical analysis of social risk factors. As a result, the AMA is unable to support the endorsement of this measure, as we do not believe that the measure meets the validity subcriterion. We encourage the Standing Committee to not recommend this measure for endorsement.	Submitted by Ms. Koryn Y. Rubin, MHA, American Medical Association (AMA)	HPR		Concern with risk adjustment model
7162	Recommended	3481: Discharge to Community-Post Acute Care Measure for Skilled Nursing Facilities (SNF)	The American Medical Association (AMA) appreciates the opportunity to comment and vote on this measure. We are not able to support endorsement of this measure at this time due to our concerns with the validity of this measure. Based on our review of the submission, we do not believe that the measure is adequately tested and adjusted for social risk factors. We assume that the developer's statement that "it was a CMS policy decision not to include dual eligibles"; discussed under Measure #3477 applies to this measure as well and we are extremely concerned that the decision to include this variable was made based on policy rather than the testing results. We do not believe that CMS policy decisions should play a role in determining whether the risk adjustment model meets the NQF Measure Evaluation Criteria requirements. On review of the testing attachment, we note that the responses provided on social risk factors (2b3.3a) did not specifically address the question nor did the developer provide a conceptual and statistical analysis of social risk factors. As a result, the AMA is unable to support the endorsement of this measure, as we do not believe that the measure meets the validity subcriterion. We encourage the Standing Committee to not recommend this measure for endorsement.	Submitted by Ms. Koryn Y. Rubin, MHA, American Medical Association (AMA)	HPR	CMS, RTI International and Abt Associates Inc. thank the American Medical Association (AMA) for their comments. We agree that quality measures must be specified to ensure reliable and valid comparisons of providers. We believe we have empirically demonstrated a high level of reliability and validity of the Discharge to Community (DTC) measures. In addition to policy considerations impacting our approach, we conducted an extensive and thoughtful empirical assessment of the need for social risk factor adjustment. We first assessed the impact of dual status adjustment on provider scores. We found that dual-adjusted and non-dual—adjusted DTC scores were very strongly associated in all post-acute care (PAC) settings, both for providers with low and high proportions of dual eligible beneficiaries with full Medicaid benefit (full-dual). Pearson and Spearman correlations between dual-adjusted and non-dual—adjusted DTC scores were close to 1, while intraclass correlation coefficients were between 0.9 and 1, with most being close to 1. Further, we found that amongst providers with the highest proportions of full-dual beneficiaries, nearly 71% of home health agencies (HHAs), nearly 50% of inpatient rehabilitation facilities (IRFs), over 25% of long-term care hospitals (LTCHs), and over 10% skilled nursing facilities (SNFs) had DTC measure scores above the national rate. The strong association between dual-adjusted and non-dual—adjusted scores demonstrates that the measure provides reliable and valid assessment of provider performance without adjustment for dual status. The presence of high performing providers amongst those with high proportions of full-dual beneficiaries shows that it is possible for providers serving dual eligible beneficiaries to achieve high DTC rates, without adjustment for dual status. Based on these findings, we do not believe that dual status risk adjustment is indicated at this time. On the contrary, dual status adjustment poses the risk of disincentivizing providers from working towards successfully discharging dual eligible beneficiaries to the community. In addition to dual eligibility, we assessed the impact of three other social risk factors: race, urbanicity of beneficiary residence, and socioeconomic status (SES) of beneficiary residence area (Agency of Healthcare Research and Quality (AHRQ) SES Index) (see Appendix). We found an inconsistent impact of these social risk factors across PAC settings. We also found that these additional social risk factors had little impact on scores beyond dual status adjustment (i.e., there was little difference in scores based on dual adjustment only vs. adjustment for all four social risk factors) (data not shown). We will continue to monitor outcomes of dually eligible beneficiaries and those with other social risk factors as part of measure monitoring and evaluation and will assess the need for social risk factor adjustment in the future. We provide a conceptual model for social risk factors in section 2b3.3b of the testing form and statistical results of social risk factor testing in section 2b3.4a.	Concern with risk adjustment model
7158	Recommended	3477: Discharge to Community-Post Acute Care Measure for Home Health Agencies	The American Medical Association (AMA) appreciates the opportunity to comment and vote on this measure. We are not able to support endorsement of this measure at this time due to our concerns with the validity of this measure. Based on our review of the submission, we do not believe that the measure is adequately tested and adjusted for social risk factors. The measure evaluation includes a statement from the developer that "it was a CMS policy decision not to include dual eligibles";. We are extremely concerned that the decision to include this variable was made based on policy rather than the testing results. We do not believe that CMS policy decisions should play a role in determining whether the risk adjustment model meets the NQF Measure Evaluation Criteria requirements. On review of the testing attachment, we note that the responses provided on social risk factors (2b3.3a) did not specifically address the question nor did the developer provide a conceptual and statistical analysis of social risk factors. As a result, the AMA is unable to support the endorsement of this measure, as we do not believe that the measure meets the validity subcriterion. We encourage the Standing Committee to not recommend this measure for endorsement.	Submitted by Ms. Koryn Y. Rubin, MHA, American Medical Association (AMA)	HPR	CMS, RTI International and Abt Associates Inc. thank the American Medical Association (AMA) for their comments. We agree that quality measures must be specified to ensure reliable and valid comparisons of providers. We believe we have empirically demonstrated a high level of reliability and validity of the Discharge to Community (DTC) measures. In addition to policy considerations impacting our approach, we conducted an extensive and thoughtful empirical assessment of the need for social risk factor adjustment. We first assessed the impact of dual status adjustment on provider scores. We found that dual-adjusted and non-dual—adjusted DTC scores were very strongly associated in all post-acute care (PAC) settings, both for providers with low and high proportions of dual eligible beneficiaries with full Medicaid benefit (full-dual). Pearson and Spearman correlations between dual-adjusted and non-dual—adjusted DTC scores were close to 1, while intraclass correlation coefficients were between 0.9 and 1, with most being close to 1. Further, we found that amongst providers with the highest proportions of full-dual beneficiaries, nearly 71% of home health agencies (HHAs), nearly 50% of inpatient rehabilitation facilities (IRFs), over 25% of long-term care hospitals (LTCHs), and over 10% skilled nursing facilities (SNFs) had DTC measure scores above the national rate. The strong association between dual-adjusted and non-dual—adjusted scores demonstrates that the measure provides reliable and valid assessment of provider performance without adjustment for dual status. The presence of high performing providers amongst those with high proportions of full-dual beneficiaries shows that it is possible for providers serving dual eligible beneficiaries to achieve high DTC rates, without adjustment for dual status. Based on these findings, we do not believe that dual status risk adjustment is indicated at this time. On the contrary, dual status adjustment poses the risk of disincentivizing providers from working towards successfully discharging dual eligible beneficiaries to the community. In addition to dual eligibility, we assessed the impact of three other social risk factors: race, urbanicity of beneficiary residence, and socioeconomic status (SES) of beneficiary residence area (Agency of Healthcare Research and Quality (AHRQ) SES Index) (see Appendix). We found an inconsistent impact of these social risk factors across PAC settings. We also found that these additional social risk factors had little impact on scores beyond dual status adjustment (i.e., there was little difference in scores based on dual adjustment only vs. adjustment for all four social risk factors) (data not shown). We will continue to monitor outcomes of dually eligible beneficiaries and those with other social risk factors as part of measure monitoring and evaluation and will assess the need for social risk factor adjustment in the future. We provide a conceptual model for social risk factors in section 2b3.3b of the testing form and statistical results of social risk factor testing in section 2b3.4a.	Concern with risk adjustment model