CBE ID

3477

Title

Discharge to Community-Post Acute Care Measure for Home Health Agencies

Endorsement Status

Endorsed

Is Under Review

No

Next Maintenance Cycle

Fall 2026

Previous Endorsement Cycle

Fall 2018

Initial Endorsement

Mon, 06/10/2019 - 09:02

Steward

Centers for Medicare & Medicaid Services

1.0 New or Maintenance

Maintenance

1.1 Measure Structure

Single Measure

1.3 Electronic Clinical Quality Measure (eCQM)

No

1.6 Measure Description

The Discharge to Community-Post Acute Care Measure for Home Health Agencies (DTC-PAC HHA) measure was developed to address the resource use and other measures domain of Discharge to the Community, a domain mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). The measure was developed using calendar year 2012-2013 data.

This Medicare claims-based outcome measure assesses successful discharge to community from an HHA, with successful discharge to community including no unplanned hospitalizations and no death in the 31 days following discharge. Specifically, this measure reports an HHA's risk-standardized rate of Medicare fee-for-service (FFS) patients who are discharged to the community following an HHA stay, and do not have an unplanned admission to an acute care hospital or long-term care hospital (LTCH) in the 31 days following discharge to community, and who remain alive

during the 31 days following discharge to community. The measure is based on Medicare FFS claims data and is calculated using two consecutive years of data. This measure submission is based on CY 2015-2016 data; i.e., HHA discharges from January 1, 2015 through December 31, 2016.

The measure was adopted by the Centers for Medicare & Medicaid Services (CMS) for the HH Quality Reporting Program finalized in the Calendar Year (CY) 2017 HH Quality Reporting Program (QRP) Final Rule and implementation began October 2016. Confidential feedback reports on measure performance were distributed to HH providers in early 2018. The measure will be publicly reported on the Home Health Compare website (https://www.medicare.gov/homehealthcompare) in January 2019 using CY 2016-2017 data. Four claims-based discharge to community measures were developed for IRF, LTCH, skilled nursing facility, and home health agency settings, respectively to meet the mandate of the IMPACT Act. These measures were conceptualized uniformly across the four settings, in terms of the definition of the discharge to community outcome, the approach to risk adjustment, and the measure calculation.

1.7 Measure Type

Outcome

1.8 Level of Analysis

Facility

1.14 Numerator

The measure does not have a simple form for the numerator and denominator—that is, the risk-adjustment method does not make the observed number of community discharges the numerator, and a predicted number the denominator. The measure numerator is the risk-adjusted predicted estimate of the number of patients who are discharged to the community, do not have an unplanned readmission to an acute care hospital or LTCH in the 31-day post-discharge observation window, and who remain alive during the post-discharge observation window. This estimate starts with the observed number of discharges to community, defined as (i) discharges to home or self-care based on Patient Discharge Status Codes 01, 81, the Medicare FFS claim [1]; and (ii) no unplanned acute or LTCH hospitalizations in the 31-day post-discharge window; and (iii) no death in the 31-day post-discharge window. Discharges to community are risk-adjusted for patient characteristics and a statistical estimate of the facility effect beyond case-mix (described below).The numerator uses a model estimated on full national data specific to the PAC setting; it is applied to the HHA's patient stays included in the measure and includes the estimated effect of that HHA. The prediction equation is based on a logistic regression model with a two-level hierarchical structure. The patient stays in the model have an indicator of the HHA they are discharged from; the effect of the HHA is measured as a positive or negative shift in the intercept term of the equation. The HHA effects are modeled as belonging to a normal (Gaussian) distribution centered at 0 and are estimated along with the effects of patient characteristics in the model. The risk adjustment logistic model is re-estimated for every measurement period and model coefficients corresponding to the measurement period are used for measure calculation. Results of the hierarchical logistic regression model presented in this submission are based FY 2016-2017 data.

1.15 Denominator

The target population for the measure is the group of Medicare HH FFS beneficiaries who are discharged from an HHA during the measure time window and are not excluded based on the measure exclusion criteria (see S.8. and S.9.). The measure denominator is the risk-adjusted expected number of discharges to community. This estimate includes risk adjustment for patient characteristics with the facility effect removed. The “expected” number of discharges to community is the predicted number of risk-adjusted discharges to community if the same patients were treated at the average facility. The hierarchical logistic regression model used to calculate the denominator is developed using all non-excluded facility stays in the national data.

1.20 Types of Data Sources

Claims Data, Other

6.1.2 Current or Planned Use(s)

Public Reporting, Quality Improvement (Internal to the specific organization)

6.1.3 Current Use(s)

Public Reporting, Quality Improvement (Internal to the specific organization)

Exclusions

Measure exclusion criteria are based on administrative data from Medicare claims and eligibility files. Exclusion criteria were selected to maintain clinical validity of the measure by excluding stays for which discharge to community would not be appropriate, to ensure data availability and completeness, to exclude stays with problematic claims data, and to maintain relevance to the HH Quality Reporting Program (e.g., excluding HHAs not included in the HHA QRP based on regional location). Stays ending in transfers to the same level of care (i.e., HHA-to-HHA discharge) are excluded, because the HHA episode of care had not ended. We also excluded certain discharge status codes on the HHA FFS claim that indicated that the patient was not appropriate for community discharge (e.g., discharges against medical advice).

Measure exclusion criteria are as follows:
• Age under 18 years;
• Discharges to a psychiatric hospital;
• Discharges against medical advice;
• Discharges to disaster alternative care site or a federal hospital;
• Discharges to court/law enforcement;
• Discharges to hospice or patient stays with a hospice benefit in the 31-day post-discharge window;

• Stays for patients without continuous Parts A and B FFS Medicare enrollment during the 12 months prior to the HHA admission date and the 31 days after the HHA discharge;

• HHA stays preceded by a short-term acute care or psychiatric stay for non-surgical treatment of cancer;

• Stays ending in transfer to a HHA; and

• Stays with problematic claims data (e.g. anomalous records for stays that overlap wholly or in part, or are otherwise erroneous or contradictory).

• Medicare Part A benefits exhausted

Planned Use

Quality Improvement (Internal to the specific organization)

Risk Adjustment

Statistical risk model

The measure developer is different from the measure steward

No

Steward Organization

Centers for Medicare & Medicaid Services