2024 Measure Set Review (MSR): Final Preliminary Assessment

The following information was sourced in June of 2024 from the Centers for Medicare & Medicaid Services Measures Inventory Tool (CMIT), discussions with CMS program leads, and publicly available CMS datasets (see links below).

I. Measure Information

CMIT ID	Title
00210-02-C-SNFQRP	Discharge to Community (DTC) - Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
Measure Steward	**CMS Program**
Centers for Medicare & Medicaid Services (CMS)	Skilled Nursing Facility Quality Reporting

Measure Overview
Rationale: Discharge to a community setting is an important health care outcome for many residents for whom the overall goals of post-acute care include optimizing functional improvement, returning to a previous level of independence, and avoiding institutionalization. Returning to the community is also an important outcome for many residents who are not expected to make functional improvement during their PAC stay and for residents who may be expected to decline functionally due to their medical condition. Also, providers have found that successful discharge to community was a major driver of their ability to achieve savings, where capitated payments for post-acute care were in place.
Description: This measure assesses successful discharge to the community from a PAC setting, with successful discharge to the community including no unplanned rehospitalizations and no death in the 31 days following discharge. Specifically, this measure reports a SNF's risk-standardized rate of Medicare fee-for-service (FFS) residents who are discharged to the community following a SNF stay, and do not have an unplanned readmission 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. Community, for this measure, is defined as home or self-care, with or without home health services, based on Patient Discharge Status Codes 01, 06, 81, and 86 on the Medicare FFS claim.
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 estimate of the number of patients/residents 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 discharges to community and is risk-adjusted for patient/resident characteristics and a statistical estimate of the facility effect beyond case mix.
Denominator: The denominator for the discharge to community measure is the risk-adjusted expected number of discharges to community. This estimate includes risk adjustment for patient/resident 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/residents were treated at the average facility appropriate to the measure.

Exclusions: 1. Age under 18 years; 2. No short-term acute care stay within the 30 days preceding an inpatient rehabilitation facility (IRF), SNF, or LTCH admission; 3. Discharges to psychiatric hospital; 4. Discharges against medical advice; 5. Discharges to disaster alternative care sites or federal hospitals; 6. Discharges to court/law enforcement; 7. Patients/residents discharged to hospice and those with a hospice benefit in the post-discharge observation window; 8. Patients/residents not continuously enrolled in Part A FFS Medicare for the 12 months prior to the post-acute admission date, and at least 31 days after post-acute discharge date; 9. Patients/residents whose prior short-term acute care stay was for non-surgical treatment of cancer; 10. Post-acute stays that end in transfer to the same level of care; 11. Post-acute stays with claims that are problematic (e.g., anomalous records for stays that overlap wholly or in part, or are otherwise erroneous or contradictory); 12. Planned discharges to an acute or LTCH setting; 13. Baseline NF residents; 13. Medicare Part A benefits exhausted; 14. Patients/residents who received care from a facility located outside of the United States, Puerto Rico, or a U.S. territory; 15. Swing Bed Stays in Critical Access Hospitals (SNF setting only).	
Measure type: Outcome	**Measure is a composite:** No **Measure is digital and/or an eCQM:** No
Level(s) of analysis/measured entity: Facility/Hospital/Agency	**Care setting:** • Inpatient rehabilitation facility (IRF) • Long-term care hospital • Skilled nursing facility (SNF)/Nursing Home
Risk adjustment and/or stratification: Yes, risk adjusted for variables including age, sex, comorbidities, and other variables outlined here.	**Data source(s):** Claims data
Data collection method: Claims data, routinely collected	**Reporting frequency:** Annually
All required data are collected as part of clinical workflow: Yes	**Reporting overlap with similar/related measures:** Discharge to Community-Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP).
Does this measure fill a statutorily required category for the program? Yes, this topic area is required by IMPACT Act.	**Is this measure included in upcoming rulemaking?** No

Measure Status	
Current CBE Endorsement Status: Not Endorsed	**CBE Endorsement History:** None

II. Measure Performance

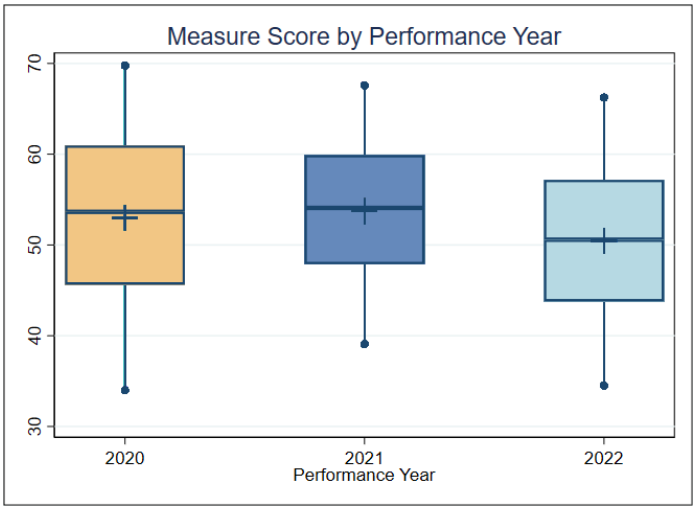
00210-02-C-SNFQRP Performance in 2020-2022

For this measure, the MSR evaluation and analysis team reviewed the publicly available dataset Skilled Nursing Facility Quality Reporting Program - Provider Data and archived Nursing Homes and Rehab Services.

Figure 1 is a boxplot that shows the distribution of the performance over the past 3 years (where available). For each performance year, the dots indicate the lower 5th and upper 95th percentiles, and the vertical line is the range between these values (90% of the measure scores are between the dots). The box spans the lower 25th to the upper 75th percentile (50% of the measure scores are within the box). The horizontal line in the box indicates the median score, and the "+" indicates the mean score. This plot can be used to assess overall trends in the score over time.

Interpretation: In the plot below the median score decreases slightly from about 54 in 2020-2021 to about 51 in 2022. There was a wide range in performance across entities during each of the three years.

Figure 1. Boxplot of Measure Score by Year



Importance Table

This table shows the relative spread of the scores and how many patients are impacted. Often the lowest or highest deciles (which, by definition, each represent 10% of the entities) may represent a disproportionately higher or lower percentage of patients. If the lowest decile contains only 5% of the patients for example, it suggests that low patient population may be related to low scores.

Interpretation of measure scores: The table can also be used to evaluate the impact of improving the score. It is common practice to use the performance of the top 20% of the entities as a benchmark. Here, 20% of the entities perform better than the 8th Decile (57.2), which could be considered the benchmark. The number of positive events for each decile can be estimated by multiplying the total patients by the corresponding rate. Here the estimated total number of positive events across all deciles is about 803,057. If Deciles 1-7 performed at the benchmark of 57.2, there would be an estimated 9.6% increase in positive events (about 880,551).

Table 1. Importance (Decile by measure score, 2022)

Data Type	Overall	Min	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Max
Mean Score	50.4 (9.63)	10.7	33.4	40.1	43.8	46.8	49.3	51.8	54.3	57.2	60.8	66.9	82.0
Entities	11,453	1	1,146	1,145	1,145	1,146	1,145	1,145	1,146	1,145	1,145	1,145	1
Total Patients	1,475,505	323	76,260	83,452	93,145	103,283	122,036	139,153	161,957	179,329	222,553	294,337	177

Reliability Table

Two tables are used to summarize reliability. For Table 2, entities are sorted by patient volume, and the average reliability is reported along with the number of entities and average number and total patients for each decile. These tables can be used to assess the impact of population size on the reliability of an entity's measure score. In cases where reliability has a strong relationship to population size, reliability will be the lowest at Decile 1 and progressively increase up to Decile 10.

For Table 3, entities are sorted by reliability, and the average reliability by decile is reported. Mean, standard deviation, minimum and maximum reliability, and inter-quartile range (IQR) are also included. This table can be used to see the distribution of the reliability of the entities. A measure score is generally considered reliable when the reliability for at least 70% of the individual entities is above 60%.

Table 2. Reliability (Decile by denominator – target population size)

Data Type	Overall	Min	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Max
Mean Target Population Size	129	25	29	39	50	63	78	96	122	161	222	430	1,839
Mean Reliability	78.8	61.6	63.6	67.5	71.2	74.5	77.6	80.3	83.3	86.4	89.7	93.8	98.8
Entities	11,453	137	1,146	1,145	1,145	1,146	1,145	1,145	1,146	1,145	1,145	1,145	1
Total Patients	1,475,505	3,425	33,219	44,424	56,790	71,997	88,938	110,388	140,231	183,908	253,704	491,906	1,839

Table 3. Mean Reliability (By reliability decile)

Mean	SD	Min	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Max	IQR
78.8	9.8	35.6	61.6	67.6	71.4	74.6	77.7	80.6	83.6	86.7	89.9	94.1	98.8	15.3

Interpretation: The overall variation between entities (as estimated by the variance of the measure scores) is high relative to the variation within each entity. All entities have an estimated reliability of greater than 60%, suggesting that this measure is effective in differentiating entities by quality of performance.