Harmonization of SNFRM (NQF #2510) and OnPoint-30 (NQF#2375)

Summary

NQF criteria point to two considerations before multiple related measures may be endorsed in a single area.

1. Do the measures address the same measure topic or target population?
    a. The measures address the same topic: Readmissions of SNF patients following discharge from an acute care hospital
    b. The target population of the two measures is different
        i. OnPoint -30: All payor
        ii. SNFRM: Medicare FFS
2. In that case, the related must be harmonized, or the differences in specification must be justified.

These measures are related and complementary, and should not be viewed by the committee in competition with one another. We believe that the differences in specification are justified. In anticipation of the NQF endorsement process, CMS and AHCA have collaborated to ascertain the suitability of their respective SNF-based readmission measures for harmonization and coexistence. In doing so, we have concluded that the claims-based and MDS-based measures possess distinct strengths and weaknesses, rendering each one more suitable to different specific needs. For example, while the OnPoint-30 measure addresses facility care by assessing readmissions for current SNF patients, the SNFRM measure focuses on coordination of care at SNFs by measuring readmissions within 30 days of discharge from the hospital that may occur after discharge from the SNF. We address these distinctions below in response to the NQF's questions.

I. What are the key differences between the 2 measures?

Data Source: Use of two different data sources leads to many of the differences in the two measures that make harmonization difficult or impossible. The OnPoint-30 Re-hospitalization Metric uses MDS data to identify patient characteristics and comorbidities for all patients in SNFs. In contrast, the SNFRM identifies patient characteristics using Medicare FFS claims, and is therefore limited to the data available for this population, namely diagnoses and procedures performed during prior hospitalizations. The data source imposes several important limitations on each measure, including the lag in calculation, the inclusivity of the discharge population, and available data elements for risk adjustment and exclusions. Neither data source is able to meet all data needs ideally.

Patient Population: The OnPoint-30 measure assesses readmissions for all patients in SNFs, regardless of payor. The SNFRM is limited to Medicare FFS patients for whom claims have been submitted.

Readmission Definition: The OnPoint-30 measure is limited to capturing readmissions that occur while the patient is being treated at the SNF. The SNFRM captures readmissions for a full 30 days following the index discharge from an acute care hospital, regardless of the length of stay, which is consistent with other CMS readmission measures implemented in various quality programs and is intended to improve care coordination. The SNFRM readmission definition also excludes planned readmissions, a feature that cannot be included in the OnPoint-30 measure given its reliance on MDS data[1]. SNFRM does not include observation stays since they are captured in a different claims data set, while the OnPoint-30 measure captures observation stays[2].

Exclusion Criteria: The OnPoint-30 measure does not exclude any patients who are discharged from an acute care facility to a SNF. The SNFRM provides for multiple exclusion criteria consistent with the All-Cause Hospital-Wide Readmission measure (NQF#1789). However, both the OnPoint-30 and SNFRM restrict the measure to admissions from acute hospitals with no gaps in stay or other post-acute care use between hospital discharge and SNF admission.

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[1] RTI analysis of 2011 Medicare claims data identified 27,956 stays (1.3% of total stays or 5.6% of readmissions) as having planned readmissions.

[2] RTI analysis of 2011 Medicare claims data found 10,172 of the patients included the SNFRM denominator would have been added to the measure numerator if observations stays been included as readmissions in the numerator definition. This would have been an addition of 0.5 percentage points to the national rate (21.1%) or 2.1 percent of readmissions.

Risk Adjustment: The Onpoint-30 measure uses a logistic regression model accounting for function, prognosis, skin integrity, selected diagnoses and utilization variables obtainable via the MDS. The SNFRM uses a hierarchical logistic regression model (consistent with other CMS readmission measures) using Medicare FFS claims data to identify patient primary diagnoses, surgical procedures, and comorbidities in addition to prior hospitalizations, ICU use and length of the prior hospital stay. Both measures use similar demographic adjusters (age, gender).

II. Do the differences justify having 2 measures?

We believe that the unique strengths of each measure allow them to complement one another. Broadly, CMS and AHCA submit that one of the strengths of the OnPoint-30 is its relatively small data lag and range of clinical status indicators (cognition, pain, and functional dependencies). Benefits of the SNFRM include its ability to exclude planned readmissions, and the incorporation of a broad range of comorbidities available in claims data. The lag in claims processing for the SNFRM was selected to ensure the most accurate claims data, which is especially critical when a measure may be used to assess facility performance and apply payment penalties. The SNFRM provides no data on non-Medicare FFS patients, and cannot take into account selected patient characteristics, such as functional status, that are not available through claims data. However, prior analyses conducted by AHCA and CMS did not demonstrate either risk adjustment methodology to be more or less robust than the other.

We envision the measures being implemented simultaneously, with the OnPoint-30 measure providing near-immediate feedback to facilities on patient outcomes, while the SNFRM ensures that accountability is maintained among SNFs, and sustains alignment across CMS programs. We do not believe that either measure is capable of matching the strengths of the other measure while retaining its own strengths.

III. Can the measure specifications be harmonized?

Due to differences in data sources, harmonization is difficult to impossible without using both data sources in a harmonized measure. It has been suggested that a hybrid measure incorporating both data sources could be used, but we note that incorporating claims data with MDS data into a single measure will largely negate several key strengths of the MDS data based measure, which are its rapid availability and inclusion of all patients regardless of payor status. Similarly, it would negate some of the strengths of the SNFRM measure by rendering impossible harmonization of this measure with other CMS rehospitalization measures in other health care settings. Because the measure strengths and weaknesses are essentially inherent to the data source, it is not feasible to align these measures in most respects.

We did identify a single area for potential harmonization. At present, the OnPoint-30 measure does not report rates for any facility with fewer than 30 qualifying discharges. In contrast, the SNFRM does not report rates for any facility with fewer than 25 qualifying discharges. We note that these cut points are essentially arbitrary, chosen by balancing concerns for patient privacy, assessment reliability, and the capacity to include as many facilities as was feasible. Both developers are open to harmonization on this point, and welcome the steering committee's input.

Conclusion

Because these measures use distinct data sources with their different inherent strengths and weaknesses, we believe that harmonization is not meaningfully possible. However, these same strengths and weaknesses render the two measures capable of supporting multiple quality needs when operating in tandem. As neither measure can truly replicate the strengths of the other, they serve complementary purposes and SNF quality will benefit more from the endorsement and implementation of both measures as appropriate to their individual advantages, than if either measure were endorsed in place of the other.