Discharge from Inpatient Facilities to Home-Based Settings for Medicaid Participants

Public Comment Framing Document

The Lewin team, on behalf of the Centers for Medicare & Medicaid Services (CMS), seeks stakeholder comments on the following concept under development:

TITLE:

Discharge from Inpatient Facilities to Home for Medicaid Participants

DESCRIPTION:

This concept assesses the percentage of discharges of Medicaid participants 18 years and older from an inpatient facility (e.g., acute care hospital, long-term acute care hospital [LTAC], skilled nursing facility [SNF], inpatient rehabilitation facility [IRF]) to their home (e.g., assisted living, adult family home, group home).

NOTE: This document provides a draft description of the measure. We seek comments from the public about the draft measure concept and specific questions outlined in the *Feedback* section of this document. See the draft narrative for the concept below for more details.

MEASURE RATIONALE:

Findings from an environmental scan/literature review suggest there is a measurement gap for assessing discharges to non-institutional settings for high-risk and high-need populations across Medicaid. The environmental scan results also emphasized the value of rebalancing efforts, which focus on ensuring that individuals and families avoid institutional settings and live out their lives at home. Additional findings suggested that discharges to home from inpatient/facility settings are associated with reduced inpatient facility readmissions, improved quality of life, and decreased health care expenditures. The proposed *Discharge to Home* concept is distinct from existing rebalancing measures, as its sole focus is on home discharge as a signal of quality.

MEASURE INTENT:

The measure concept intends to assess rates of discharges for Medicaid participants from inpatient facilities to home-based settings. The concept is intended for use at the state level, with the goal of providing data to facilitate quality improvement and planning on HCBS

placement of inpatient facility discharges. Implementation of the measure will facilitate monitoring of discharge trends, with the goal of increasing the rates of discharges to home, which increases the likelihood of improved quality of services provided and participant quality of life.

DRAFT MEASURE CONCEPT NARRATIVE:

- **Measure Concept:** The measure assesses the proportion of discharges from inpatient facilities (e.g., acute care hospital, long-term acute care hospital (LTAC), skilled nursing facility (SNF), inpatient rehabilitation facility (IRT)) to home settings (e.g., assisted living, adult family home, group home) for Medicaid participants 18 years or older, including dual eligible participants, by state, that are not followed by a readmission to a facility or death within a certain number of days (e.g., 30 days) post discharge.
- **Measure Interpretation:** Higher values (those toward the high end of the percentile distribution) indicate a greater proportion of Medicaid participants discharged to the home. Evidence from the literature suggests that discharges to home from inpatient/facility settings are associated with reduced inpatient facility readmissions, improved quality of life, and decreased health care expenditures. The recent experience with the COVID-19 pandemic has further showcased the association of institutional care settings with higher risks of mortality, morbidity, and attendant strain. Higher values (more discharges to home) may therefore also signal increased likelihood of improvement in participant quality of life.
- **Initial Population:** Discharge (from inpatient facilities) for Medicaid participants aged 18 years and older with at least 10 months of enrollment within a one-year window of claims data.
- **Numerator:**[1] The number of discharges to participant's home setting (e.g., private residence, assisted living, adult family home, group home).

  ***Note**: The numerator intends to capture "successful" discharges. "Successful" is defined as discharges to home not followed by readmission to an inpatient facility or death within a certain number of days[2] (e.g., 30 days) post discharge.*
- **Denominator:** All discharges of Medicaid participants 18 years and older from an inpatient facility (e.g., acute care hospital, LTAC, SNF, IRF).
- **Denominator Exclusions:**[3] Planned admissions to the inpatient facility (i.e., acute or nonacute) associated with the discharge (e.g., deliveries; organ transplant; maintenance chemotherapy; planned procedures such as coronary, brain and spinal cord procedures;

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1 A measurement of the process or outcome expected for each patient, procedure, or other unit of measurement defined in the denominator.

2 This public comment solicitation requests comments on the length of post-discharge observation window. Related additional analysis will be done during beta testing.

3 Denominator exclusions are used to identify participants who should be removed from the initial population before determining if the numerator criteria are met because the measured process or outcome should not apply to them.

infusion or monitoring device procedures), hospice and palliative care, death, and length of stay in institution post discharge (i.e., 1–20 days, 21–100 days, 101+ days in SNF post-discharge).

NEXT STEPS FOR MEASURE CONCEPT:

Following the close of the public comment period, the Lewin team will review stakeholders' comments and determine if revisions to the measure concept are needed. The Lewin team will then begin testing draft technical specifications for the concept, results of which will be published on CMS's *Blueprint for the Measures Management System (MMS)* website at a future date.

FEEDBACK REQUESTED:

The Lewin team, on behalf of CMS, is seeking feedback on all components of the measure, including the following topics:

- The potential importance, validity, feasibility, and usability of the *Discharge to Home* measure, which aims to assess and improve the quality of care for Medicaid participants.
- The potential measure exclusions.
- Options for the timeframe, post-discharge, to observe a discharge to home (i.e., a qualifying numerator event). For example, a discharge to home without readmission to an acute or post-acute care facility within 30, 60, 90, or another number of days of the discharge event.
- The availability of discharge data , particularly for dual eligible participants, and whether collection of these data will present undue burden on states being measured.
- The potential unintended consequences of the measure's focus and/or implementation.