RELEASE: May 30, 2019

Publication of Potentially Preventable Readmission Measures for the Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Long-Term Care Hospital (LTCH), and Home Health (HH) Quality Reporting Programs (QRPs)

External Questions and Answers

Q: What is being announced with regards to the SNF, IRF, LTCH, and HH QRPs?

A: The Centers for Medicare & Medicaid Services (CMS) is announcing the upcoming public reporting of a potentially preventable readmission (PPR) measure for the SNF, IRF, LTCH, and HH QRPs. The PPR measures for the SNF, IRF, LTCH, and HH QRPs will be published beginning Fall 2019.

Q: What are the PPR measures and why were they developed?

A: The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 directs the Secretary to specify a measure that reflects all-condition risk-adjusted potentially preventable hospital readmission rates for use in the SNF, IRF, LTCH, and HH QRPs. The IMPACT Act also requires the Secretary to publicly report provider performance on resource use and other measures, including measures to reflect all-condition risk-adjusted potentially preventable hospital readmission measures. In addition to the potentially preventable 30-day post-discharge readmission measures for the SNF, IRF, LTCH, and HH QRPs, CMS developed a potentially preventable within-stay measure for the IRF QRP.

These PPR measures are outcome measures that reflect readmission rates for patients who are readmitted to a hospital for a reason that is considered unplanned and potentially preventable. These measures are calculated using Medicare Fee-For-Service claims and do not require any data collection on the part of providers.

PPRs are a subset of all-cause, unplanned readmissions. CMS had previously publicly reported all-cause unplanned readmission measures for IRFs and LTCHs (NQF #2502 and #2512) and is currently using the SNF all-cause readmission measure (NQF #2510) for the SNF Value-Based Purchasing Program. Because all-cause, unplanned readmissions among the Medicare population are common and costly occurrences, focusing readmission measures on those readmissions that are more likely to be preventable with high-quality care may allow providers to focus on conditions considered more actionable.

Q: What is a PPR?

A: CMS defines a PPR to be a readmission in which the principal diagnosis coded on the claim is included on CMS's list of PPR diagnoses. CMS has grouped these PPR diagnoses based on clinical rationale, as follows:

1. Inadequate management of chronic conditions
2. Inadequate management of infections
3. Inadequate management of other unplanned events
4. Inadequate injury prevention

CMS developed this list of PPR diagnoses based on a comprehensive environmental scan to identify studies and previously published methodologies related to potentially preventable hospitalizations and hospital readmissions, empirical analyses to identify the most-frequent diagnoses associated with hospital readmissions among those who received post-acute care, and feedback from technical experts and clinicians.

For more information about the PPR definition, please visit

- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Measure-Specifications-for-FY17-SNF-QRP-Final-Rule.pdf on the PPR measure for the SNF QRP;
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/Measure-Specifications-for-FY17-IRF-QRP-Final-Rule.pdf on the PPR measures for the IRF QRP;
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/Measure-Specifications-for-FY17-LTCH-QRP-Final-Rule.pdf on the PPR measure for the LTCH QRP; and
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/MeasureSpecificationsForCY17-HH-QRP-FR_updated_8_2018.pdf on the PPR measure for the HH QRP.

Q: What will CMS post regarding these PPR measures?

A: CMS will post the provider's PPR performance rate and its performance category—whether the provider's rate is "better than the national rate," "worse than the national rate," or "no different than the national rate." CMS will also publish the provider's confidence interval, a measure of the uncertainty surrounding the provider's rate, which is used as the basis for the performance categories. This approach aligns with the discharge to community measures for post-acute care and the CMS hospital readmission measures used in other programs.

Q: Why is CMS announcing the publication of these PPR measures now?

A: CMS postponed publishing these measures late last year to allow for more testing to ensure that the measures provide an accurate picture of a provider's performance on quality. We have since completed this additional testing and are ready to begin public reporting.

Q: Did CMS make any modifications to the PPR measures as a result of additional testing?

A: Yes. CMS refined the method for assigning providers to performance categories. This refinement will be reflected in both the Fall 2019 Quarterly Refresh for the Nursing Home, IRF, LTCH, HH Compare websites and the Summer 2019 Provider Preview Reports. This refinement will better align the PPR measures with CMS hospital readmission measures used in other programs.

For more information, please visit

- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-

Program/SNF-Quality-Reporting-Program-Spotlights-and-Announcements.html for the SNF QRP;

- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/ for the IRF QRP;
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html for the LTCH QRP; and
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html for the HH QRP.