

Discharge to Community-Post Acute Care (DTC-PAC) Skilled Nursing Facility (SNF) Measure

Technical Specification Report

Prepared for

**Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services**
7500 Security Boulevard
Baltimore, MD 21244-1850

Prepared by

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September 2026



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Introduction

This report presents the technical measure specifications for the refined Discharge to Community-Post Acute Care (DTC-PAC) Skilled Nursing Facility (SNF) measure.

Section 1 provides an overview of the measure including a measure description, a history of the original version of this measure and the rationale for and summary of the refinements in the current measure, and the purpose and rationale for the original and current versions of the measure.

Section 2 describes the measure specifications, including the construction of the denominator and numerator, data sources, measure observation window, the risk adjustment model, and steps for calculating the final measure result.

Section 3 discusses measure testing, including the measure's reportability, variability, reliability, and validity results.

1. Overview

This chapter provides an overview of the updated SNF DTC-PAC measure, including a general description of the measure, the history of the measure's development, refinements to the original measure (Section 1.1), and the purpose and rationale for the measure and refinements (Section 1.2). A more detailed explanation of the measure specifications is available in Chapter 2.

1.1 Measure Description

The SNF DTC-PAC measure assesses the rate at which beneficiaries are successfully discharged to the community from the SNF. Specifically, this measure reports a SNF's risk-standardized rate of Medicare beneficiaries who are discharged to the community after a SNF stay, do not have an unplanned readmission to an acute care hospital or Long-Term Care Hospital (LTCH), and remain alive during the 31 days following that discharge. Community, for this measure, is defined as home/self-care, with or without home health services.

This measure is conceptualized similarly across the multiple post-acute care settings, in terms of the definition of the discharge to community outcome, the approach to risk adjustment, and the measure calculation. Each measure is specific to the particular PAC setting (i.e., home health [HH], inpatient rehabilitation facilities [IRF], skilled nursing facilities [SNF], or long term care hospitals [LTCH]); we do not pool PAC patients/residents across settings in the measure development and calculation.

This measure calculates a risk-adjusted DTC rate for each SNF. This is derived by first calculating a standardized risk ratio – the predicted number of SNF stays with successful discharge to the community divided by the expected number of SNF stays with successful discharge to the community for the same patients if treated at the average SNF. The

standardized risk ratio is then multiplied by the mean rate of SNF stays with successful discharge to the community in the population (i.e., all SNF stays for Medicare fee-for-service (FFS) and Medicare Advantage patients eligible for the measure) to generate the SNF-level standardized rate of discharge to community.

1.1.1 Updates to the DTC-PAC Measure to Include Medicare Advantage Beneficiaries

This Technical Specifications Report describes updates to the DTC-PAC measure to add Medicare Advantage (MA) records as a data source in addition to Medicare FFS claims.

Updates related to the inclusion of MA records include:

1. Additional data sources Section 2.1
2. Updates to stay creation, Section 2.2.1
3. Modifications of the exclusion criteria to not exclude beneficiaries with MA (Part C) coverage, and to exclude stays with problematic data coming from MA records, Section 2.2.3
4. Addition of a risk adjustment covariate for Medicare Advantage (Part C) coverage at the start of the SNF stay, Section 2.5.1.

1.2 Purpose/Rationale for the Measure

Discharge to home or community is an important patient-centered outcome in post-acute care because it reflects higher functional abilities and effective care transitions, and is associated with lower mortality and costs.^{1,2} Across diverse patient populations, including patients with stroke, traumatic brain injury, hip fracture, cancer, and medically complex conditions, patients discharged to the community generally experience better outcomes than those discharged to institutional settings.^{3,4}

¹ Patel, S. V., Arcidiacono, A., Austin, C. P., Imburgio, S., Heaton, J., DiSandro, K., Mathur, D., Besa, R., Angelo, E., Walch, B., Bakr, M., Buccellato, V., Frank, E., Hossain, M. A., & Asif, A. (2024). Improving Patient Outcomes Using Measures to Increase Discharge Rates to Home. *Cureus*, 16(5), e59738. <https://doi.org/10.7759/cureus.59738>

² Bardenheier, B. H., Rahman, M., Kosar, C., Werner, R. M., & Mor, V. (2021). Successful Discharge to Community Gap of FFS Medicare Beneficiaries With and Without ADRD Narrowed. *Journal of the American Geriatrics Society*, 69(4), 972-978. <https://doi.org/10.1111/jgs.16965>

³ Singh, S., Eguchi, M., Min, S. J., & Fischer, S. (2020). Outcomes of Patients With Cancer Discharged to a Skilled Nursing Facility After Acute Care Hospitalization. *J Natl Compr Canc Netw*, 18(7), 856-865. <https://doi.org/10.6004/jnccn.2020.7534>

⁴ Augustine, M. R., Intrator, O., Li, J., Lubetsky, S., Ornstein, K. A., DeCherrie, L. V., Leff, B., & Siu, A. L. (2023). Effects of a Rehabilitation-at-Home Program Compared to Post-acute Skilled Nursing Facility Care on Safety, Readmission, and Community Dwelling Status: A Matched Cohort Analysis. *Med Care*, 61(11), 805-812. <https://doi.org/10.1097/mlr.0000000000001925>

There are clinical predictors of discharge to the community, including functional status at discharge, particularly mobility, transfers, and self-care ability.^{5,6,7} Greater functional improvement during post-acute care and higher rehabilitation intensity increase the likelihood of home discharge.^{8,9} Specific impairments, such as lower extremity impairments, cognitive deficits, dysphagia, and incontinence, reduce the likelihood of discharge home unless targeted during rehabilitation.^{10,11,12} Lower medical complexity, fewer comorbidities, and younger age are also consistently associated with better discharge outcomes.^{13,14}

Non-clinical factors are equally influential. For example, the presence of a caregiver is one of the strongest predictors of discharge home, often exceeding clinical factors.^{15,16} Social determinants, including housing stability, transportation access, and neighborhood vulnerability, significantly affect discharge outcomes.¹⁷ Care gaps remain, with differences in post-acute care

⁵ Andrews, A. W., & Bohannon, R. W. (2023). Functional Independence predicts patients with stroke more likely to be discharged to the community after inpatient rehabilitation. *Topics in Stroke Rehabilitation*, 30(4), 393-401. <https://doi.org/10.1080/10749357.2022.2038834>

⁶ Deutsch, A., Palmer, L., Vaughan, M., Schwartz, C., & McMullen, T. (2022). Inpatient Rehabilitation Facility Patients' Functional Abilities and Validity Testing of the Standardized Self-Care and Mobility Data Elements. *Arch Phys Med Rehabil*, 103(6), 1070-1084.e1073. <https://doi.org/10.1016/j.apmr.2022.01.147>

⁷ Toth, M., Palmer, L., Marino, M. E., Smith, A., Schwartz, C., Deutsch, A., & McMullen, T. (2023). Validation of the Standardized Function Data Elements among Medicare Skilled Nursing Facility Residents. *J Am Med Dir Assoc*, 24(3), 307-313.e301. <https://doi.org/10.1016/j.jamda.2022.12.014>

⁸ Kumar, A., Roy, I., Warren, M., Shaibi, S. D., Fabricant, M., Falvey, J. R., Vashist, A., & Karmarkar, A. M. (2022). Impact of Hospital-Based Rehabilitation Services on Discharge to the Community by Value-Based Payment Programs After Joint Replacement Surgery. *PTJ: Physical Therapy & Rehabilitation Journal*, 102(4), 1-8. <https://doi.org/10.1093/ptj/pzab313>

⁹ Kushner, D. S., Johnson-Greene, D., Felix, E. R., Miller, C., Cordero, M. K., & Thomashaw, S. A. (2023). Predictors of discharge to home/community following inpatient-rehabilitation in a US national sample of Guillain-Barre-Syndrome patients. *PLoS One*, 18(5), e0286296. <https://doi.org/10.1371/journal.pone.0286296>

¹⁰ Ginex, V., Viganò, M., Gilardone, G., Monti, A., Gilardone, M., & Corbo, M. (2023). Predicting home discharge after inpatient rehabilitation of stroke patients with aphasia. *Neuropsychol Rehabil*, 33(3), 393-408. <https://doi.org/10.1080/09602011.2021.2021951>

¹¹ Shogenji, M., Yoshida, M., Sumiya, K., Shimada, T., Ikenaga, Y., Ogawa, Y., Hirako, K., & Sai, Y. (2022). Relationship between Bowel/Bladder Function and Discharge in Older Stroke Patients in Convalescent Rehabilitation Wards: A Retrospective Cohort Study. *Prog Rehabil Med*, 7, 20220028. <https://doi.org/10.2490/prm.20220028>

¹² Lee, S. W., Elsagr, C., Joung, K. M., & Ayutyanont, N. (2025). Outcomes after inpatient rehabilitation for older adults with hip fractures: A cross-sectional study. *Clinical Rehabilitation*, 39(1), 35-46. <https://doi.org/10.1177/02692155241300647>

¹³ Dubin, A., Zarreii, P., Shariffar, S., Nixon, R. M., Conic, R. R. Z., Pendem, K., & Vincent, H. K. (2025). The impact of body mass index on rehabilitation outcomes after lower limb amputation. *Pm r*, 17(5), 539-547. <https://doi.org/10.1002/pmrj.13292>

¹⁴ Porto, C. M., Wolman, D. N., Feler, J. R., Chuck, C. C., Karayi, G., Torabi, R., Moldovan, K., Furie, K. L., & Mahta, A. (2025). Predictors of Skilled Nursing Facility Length of Stay and Discharge After Aneurysmal Subarachnoid Hemorrhage. *Neurohospitalist*, 15(3), 257-265. <https://doi.org/10.1177/19418744251323639>

¹⁵ Herbold, J., Elmohsen, E., Gutierrez, G., Helgesen, M., & Babyar, S. (2023). Prediction of Discharge Destination After Inpatient Rehabilitation for Stroke Using Mobility and Self-Care Assessment in Section GG of the Inpatient Rehabilitation Facility - Patient Assessment Instrument. *Arch Rehabil Res Clin Transl*, 5(4), 100292. <https://doi.org/10.1016/j.arrct.2023.100292>

¹⁶ Li, T. K.-T., Ng, B. H.-P., Chan, D. Y.-L., Chung, R. S.-F., & Yu, K.-K. (2020). Factors predicting clinically significant functional gain and discharge to home in stroke in-patients after rehabilitation – A retrospective cohort study. *Hong Kong Journal of Occupational Therapy*, 33(2), 63-72. <https://doi.org/10.1177/1569186120979428>

¹⁷ Bright, L., Baum, C. M., & Roberts, P. (2025). Impact of race on discharge location for stroke survivors: Associations with home discharge from a retrospective analysis. *Pm r*, 17(6), 638-645. <https://doi.org/10.1002/pmrj.13303>

access among Medicaid beneficiaries.¹⁸ Facility-level factors, including patient safety culture and care coordination, also influence successful community discharge.¹⁹

Interventions that increase the likelihood of community discharge to home include:

- Increase rehabilitation intensity and focus on mobility/transfer training^{8,9}
- Provide caregiver training and support, enabling safe home transitions²⁰
- Enhance discharge planning and care coordination, including multidisciplinary programs and post-acute management^{1,21}
- Ensure post-discharge support, such as home health care, which reduces readmissions²²

Emerging clinical programs, such as condition-specific rehabilitation programs, more frequent dialysis in SNFs, and targeted transitional care, show promise in accelerating return home.^{23,24}

Discharge to home/community is a meaningful and multifactorial outcome. The evidence shows that improving this outcome requires integrated strategies that combine intensive, function-focused rehabilitation with caregiver support, coordinated transitions, and attention to social and structural barriers. Approaches that address both clinical recovery and non-clinical determinants are most effective in increasing safe and equitable discharge to home.

1.2.1 Relevance of Cross-Setting Measure Development Work Under the IMPACT Act

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), enacted Oct. 6, 2014, directs the Secretary of Health and Human Services to “specify quality measures on which Post-Acute Care (PAC) providers are required under the applicable reporting provisions to submit standardized patient assessment data” in several domains, including

¹⁸ Strelko, O., Spiro, E., Lui, A., Tarapore, P. E., Huang, M. C., Manley, G. T., Yue, J. K., & DiGiorgio, A. M. (2026). Insurance-based disparities in traumatic brain injury length of stay and discharge dispositions: A retrospective cohort analysis of the national trauma data bank. *Injury*, 113358. <https://doi.org/10.1016/j.injury.2026.113358>

¹⁹ Guo, W., Li, Y., & Temkin-Greener, H. (2021). Community Discharge Among Post-Acute Nursing Home Residents: An Association With Patient Safety Culture? *J Am Med Dir Assoc*, 22(11), 2384-2388.e2381. <https://doi.org/10.1016/j.jamda.2021.04.022>

²⁰ Smith, S., Wilson, C. M., Lipple, C., Avromov, M., Maltese, J., Siwa, E., Jr., Colombo, R., & Seidell, J. W. (2020). Managing Palliative Patients in Inpatient Rehabilitation Through a Short Stay Family Training Program. *Am J Hosp Palliat Care*, 37(3), 172-178. <https://doi.org/10.1177/1049909119867293>

²¹ Armstrong, D., Agovi, A. M., Gehr, A. W., Cvitanovich, M., McNamara-Pittler, E., Goodier, N., Hasty, K., Govea, A., Woods, M., & Ojha, R. P. (2026). Effects of a post-acute care management program on subsequent acute care utilization for hospitalized patients discharged to skilled nursing facilities. *BMC Health Serv Res*, 26(1), 177. <https://doi.org/10.1186/s12913-025-13944-7>

²² Weerahandi, H., Bao, H., Herrin, J., Dharmarajan, K., Ross, J. S., Jones, S., & Horwitz, L. I. (2020). Home Health Care After Skilled Nursing Facility Discharge Following Heart Failure Hospitalization. *Journal of the American Geriatrics Society*, 68(1), 96-102. <https://doi.org/10.1111/jgs.16179>

²³ Bellin, E. Y., Hellebrand, A. M., Markis, W. T., Ledvina, J. G., Kaplan, S. M., Levin, N. W., & Kaufman, A. M. (2024). More Frequent On-Site Dialysis May Hasten Return to Home for Nursing Home Patients with End-Stage Kidney Disease. *Kidney360*, 5(8), 1126-1136. <https://doi.org/10.34067/kid.0000000000000487>

²⁴ Manes, M. R., Kendall, H. A., Bowden, M. G., Bailey, C. E., Paris, T., Hoertz, J. S., Shah, P., & Maher, K. (2025). Development and Evaluation of an Inpatient Rehabilitation Model of Care Tailored to Solid Organ Transplantation. *Clin Transplant*, 39(10), e70324. <https://doi.org/10.1111/ctr.70324>

medication reconciliation and resource use measures.²⁵ Measures developed to meet the requirements of the IMPACT Act include: Medicare spending per beneficiary, discharge to community and all-condition risk-adjusted potentially preventable readmission rates. The IMPACT Act requires the implementation of measures to address these measure domains in HHAs, SNFs, LTCHs, and IRFs.

The SNF DTC-PAC measure was originally finalized for adoption in the SNF Quality Reporting Program (QRP) through the FY 2017 SNF PPS Final Rule.²⁶ Documentation for this measure, SNF DTC-PAC, is available on the CMS Measures Inventory Tool website.²⁷

2. Measure Specifications

This section describes the methodology used to construct the updated SNF DTC-PAC measure. Section 2.1 describes the data sources used. Section 2.2 describes SNF stay construction and measure inclusion/exclusion criteria. Sections 2.3 and 2.4 describe the denominator and numerator, respectively. Section 2.5 describes the risk adjustment model and variables used for risk adjustment. Section 2.6 presents the steps involved in calculating the final measure result. Section 2.7 describes the measure results.

2.1 Data Sources

This measure relies on data from Medicare FFS Part A claims, MA Encounter Data Records, and Medicare's Enrollment Database, as well as the Medicare Minimum Data Set, accessed via the CMS Centralized Data Repository (CDR) and the Integrated Data Repository (IDR) environments. The enrollment files provide beneficiary-level information such as date of birth, date of death, sex, reasons for Medicare eligibility, and enrollment histories in Medicare Parts A and C. The FFS claims and Medicare Advantage encounter files provide information about each SNF and hospital stay, including dates of admission and discharge, diagnoses and procedures, and indicators for care received. Claims and encounter data are used to construct for each person a history of care before the SNF stay, which is used for constructing risk adjustment variables. This measure also uses publicly available data, such as the Clinical Classification Software (CCS), Planned Readmission Algorithm (PRA), and Hierarchical Condition Categories (HCC).

Documentation for the Medicare FFS claims data, Medicare Advantage encounter data, and Medicare enrollment data is provided online by the Chronic Conditions Data Warehouse (CCW). Data dictionaries for all standard analytical files are available at: <https://www2.ccwdata.org/web/guest/data-dictionaries>.

²⁵ More information on the IMPACT Act is available at <https://www.govtrack.us/congress/bills/113/hr4994>.

²⁶ <https://www.federalregister.gov/documents/2016/08/05/2016-18113/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities>

²⁷ Discharge to Community - Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP). Additional information available at: <https://cmits.cms.gov/cmits/#/MeasureView?variantId=1985§ionNumber=1>

2.2 SNF Stay Construction and Measure Inclusion/Exclusion Criteria

2.2.1 Construct SNF and Hospital Stays

Construct SNF and hospital stays for the measure period. SNF and hospital stays are constructed using final action Medicare FFS Part A claims and MA Encounter Data Records. Stays are constructed by linking claims that share the same beneficiary identifier, facility CCN, and admission date. Records with missing or invalid admission dates are first assigned an admission date by linkage to other claims with valid admission dates within the same stay, linked using beneficiary identifier, facility CCN, from date, through date, and patient status code. If no such linkage is identified, the admission date is imputed using the claim from date.

SNF stays considered for the denominator prior to exclusion criteria are those that end within the measure period, based on the discharge date. To implement exclusion criteria and apply risk adjustment, index SNF stays are linked to other stays, Medicare Minimum Data Set, and demographic and enrollment data using the beneficiary identifier.

2.2.2 Measure Time Window

The measure is calculated using two years of data. All SNF stays ending during the measure window, except those that meet the exclusion criteria, are included in the measure. For SNF patients/residents with multiple SNF stays during the two-year period, each stay is eligible for inclusion in the measure.

2.2.3 SNF Stay Exclusion Criteria

Index SNF stays are excluded from the measure calculation if any of the following exclusion criteria are met. All remaining index stays are eligible for measure calculation.

1. The beneficiary was under 18 years of age at the start of the stay.

Rationale: There is limited literature on discharge destination outcomes in this age group; patients/residents in this age group represent a different cohort, likely living with their parents, and may be expected to have higher discharge to community rates compared with the rest of the Medicare population; and patients/residents in this age group represent a small proportion of the post-acute Medicare population.

2. The beneficiary was not discharged from an acute care hospital or Inpatient (IP) psychiatric hospital within 30 days prior to SNF admission.

Rationale: Acute care claims from the 30 days prior to IRF, SNF, or LTCH admission provide the principal diagnosis and other important patient/resident data for risk adjustment. In IRF, SNF, and LTCH settings, patients/residents without a short-term acute care discharge within the 30 days prior to PAC admission will be excluded from the measure, because important risk adjustment data will be missing.

3. The beneficiary was discharged from the SNF against medical advice.

Rationale: Patients/residents who discharge themselves against medical advice are excluded because their care plan may not have been fully implemented, and the discharge destination may not reflect the facility's discharge recommendation. Additionally, patients/residents discharged against medical advice may potentially be at higher risk of post-discharge readmissions or death, depending on their medical condition, or due to potential non-adherence or non-compliance with care recommendations.

4. The beneficiary was discharged from the SNF to an IP psychiatric hospital .

Rationale: Patients/residents discharged to psychiatric hospital are excluded from the measure because community living at the time of discharge may be potentially inappropriate or unsafe for them due to their mental health or psychiatric condition.

5. The beneficiary was discharged from the SNF to the same level of care (i.e., another SNF).

Rationale: Post-acute stays that end in transfer to the same level of care (e.g., SNF to SNF transfer) are excluded from the measure because their post-acute episode has not ended. For a post-acute episode that involves transfer to the same level of care, only the final post-acute provider is included in the measure. (Note that this exclusion does not apply to transitions across different levels of post-acute care (e.g., SNF to LTCH)).

6. The beneficiary was discharged from the SNF to a federal hospital or disaster alternative care site.

Rationale: Patients/residents discharged to disaster alternative care sites are excluded because these discharges are likely influenced by external emergency conditions, and may not represent discretionary discharges by the PAC provider. Discharges to federal hospitals are excluded because we will not have inpatient claims to determine whether the hospitalization was planned or unplanned.

7. The beneficiary was discharged from the SNF to court/law enforcement.

Rationale: Patients/residents who are discharged to court or law enforcement are likely ineligible for discharge to the community due to legal restrictions.

8. The beneficiary was either discharged from the SNF to hospice or has a hospice benefit period that overlaps with the 31-day post-SNF discharge window (identified via the presence of a hospice benefit start or end date within 31 days of SNF discharge).

Rationale: Patients/residents discharged to hospice care and those with a hospice benefit in the post-discharge observation window are terminally ill, and have very different goals of care compared with non-hospice patients/residents. For non-hospice patients/residents, the primary goal of post-acute care is to return to baseline, independent living in the community; death is an undesirable outcome in the non-hospice population. For hospice patients/residents, the goal is to provide the opportunity to die comfortably, at home or in a facility. A large proportion of hospice

patients/residents die in the 31-day window following discharge from the post-acute setting. The hospice agency, not the post-acute care setting, makes the final decision of discharge to hospice-home or hospice-facility.

9. The beneficiary was not continuously enrolled in Medicare (Part A, Original Medicare, and/or Part C, Medicare Advantage) for at least 90 days prior to SNF admission and for at least 31 days after SNF discharge.

Rationale: Patients/residents not continuously enrolled in Medicare (Part A and/or Part C) for the 90 days prior to the PAC admission date are excluded because risk adjustment for certain comorbidities requires information on acute inpatient bills for 90 days prior to post-acute admission. Patients/residents not continuously enrolled in Medicare for at least 31 days after post-acute discharge are excluded because readmissions and death must be observable in the 31-day post-discharge period. Patients/residents without continuous Medicare coverage during the pre- and post-PAC periods will not have complete inpatient claims in the system.

10. The beneficiary was discharged from an acute care hospital or an IP psychiatric hospital within 30 days prior to SNF admission, but the stay was for non-surgical treatment of cancer.

Rationale: Patients/residents whose prior short-term acute care stay was for non-surgical treatment of cancer are excluded because they have a different trajectory for recovery after discharge, with a high mortality rate.

11. The SNF stay is associated with problematic or incomplete data. This includes anomalous records for stays that overlap wholly or in part, or are otherwise erroneous or contradictory; stays where the beneficiary cannot be matched with Medicare enrollment data; or if the beneficiary exhausted their Medicare Part A or Medicare Advantage benefits during the stay.

Rationale: This measure requires accurate information from the post-acute stay and prior short-term acute care stay in the elements used for risk adjustment. Patients/residents who have exhausted their Medicare Part A coverage during the PAC stay are excluded because the discharge destination decision may be related to exhaustion of benefits.

12. The SNF stay was outside the 50 states, District of Columbia, Puerto Rico, and U.S. Territories (determined via the CCN of the provider rendering care, using the SOM CCN-to-U.S. state mappings).

Rationale: Patients/residents who received care from foreign facilities may not have complete inpatient claims in the system, and these facilities may not be subject to policy decisions related to this quality measure.

13. The beneficiary had a long-term nursing home stay in the 180 days preceding their prior proximal hospitalization (identified via NH MDS Omnibus Budget Reconciliation Act

[OBRA] assessments) and was not discharged to community from that stay prior to the hospitalization.

Rationale: Baseline long-term NF residents did not live in the community before their SNF stay, and discharge to a community setting may not be a safe or expected outcome for these residents.

14. The SNF stay ended in planned discharged from the SNF to an acute care hospital, IP psychiatric hospital, or an LTCH, identified by the presence of a claim from that facility type with a “claim from” date within one day of SNF discharge that is flagged as a planned admission by the planned readmission algorithm (note that all IP psychiatric hospital stays are considered planned).

Rationale: For the IRF and SNF settings, planned discharges to an acute care hospital or LTCH will be excluded. For the LTCH setting, planned discharges to an acute care hospital will be excluded. (Note that, in the LTCH setting, transfer to another LTCH is excluded because it represents a transfer to the same level of care).

15. The index SNF stay occurred in a Critical Access Hospital (CAH) swing bed.

Rationale: Critical access hospital (CAH) swing bed stays are excluded from the SNF setting measure. This is because CAH swing bed facilities are not required to submit quality data under the SNF QRP, and are exempt from the SNF Prospective Payment System (PPS). Note that non-CAH swing bed stays are included in the measure, because non-CAH swing bed facilities are required to submit quality data under the SNF QRP and are subject to the SNF PPS.

2.3 Denominator

The measure denominator is the risk-adjusted expected number of SNF stays with a discharge to community. This estimate includes risk adjustment for stay-level characteristics, with the SNF-level random effect removed. The “expected” number of SNF stays with a discharge to community is projected as if the same patients had been treated at the average SNF.

The regression model used to calculate the denominator is developed using all non-excluded SNF stays in the national data. The denominator is computed in the same way as the numerator, but the SNF effect is set at the average. The descriptions of the discharge to community outcome, patient stays included in the measure, and numerator calculation are provided below.

2.4 Numerator

The measure numerator is the risk-adjusted predicted number of SNF stays where the patient/resident is discharged to the community, does not have an unplanned readmission to an acute care hospital or LTCH in the 31-day post-discharge observation window, and remains 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.

2.4.1. Identifying Numerator Events

Identify SNF stays ending in discharge to either home/self-care, home under care of an organized home health agency (HHA), home with a planned acute care hospital readmission, or discharged home under care of an HHA with a planned acute care hospital readmission, as indicated by the patient discharge status code on the last claim of the stay. Exhibit 1 below lists the Patient Discharge Status Codes used to define community.

Exhibit 1. Patient Discharge Status Codes Used to Determine Discharge to Community

Status Code	Description
01	Discharged to home or self-care (routine discharge)
06	Discharged/transferred to home under care of organized home health service organization
81	Discharged to home or self-care with a planned acute care hospital readmission
86	Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission

2.4.2. Numerator Exclusions: Death in the 31-Day Post-Discharge Observation Window

Remove numerator stays where the beneficiary died during the SNF stay or within 31 days of SNF discharge, identified by the patient status code or the beneficiary's date of death from the Medicare enrollment database.

2.4.3. Numerator Exclusions: Unplanned Readmissions in the 31-Day Post-Discharge Observation Window

Remove numerator stays where the beneficiary has an unplanned readmission to an acute care hospital or an LTCH within 31 days of SNF discharge, including the day of discharge, as determined using the planned readmission algorithm. IP Psychiatric hospital stays are considered always planned.

Exhibit 2. Prevalence of Events Included in the DTC-PAC Numerator Definition

Measure	FFS, n (%) N= 1,964,002	MA, n (%) N= 1,692,954	Total, n (%) N= 3,656,956
Numerator Events			
Successful discharge to community outcome per measure definition	970,838 (49.4%)	875,998 (51.7%)	1,846,836 (50.5%)
Discharge destination code is community (1, 6, 81, 86)	1,163,788 (59.3%)	1,084,847 (64.1%)	2,248,635 (61.5%)
Numerator Exclusions			
Unplanned readmissions at or following discharge (0-31 days)	564,050 (28.7%)	440,158 (26.0%)	1,004,208 (27.5%)
Death within stay	53,890 (2.7%)	21,024 (1.2%)	74,914 (2.0%)
Death at or following discharge (0-31 days)	157,645 (8.0%)	97,354 (5.8%)	254,999 (7.0%)

Note: Includes SNF stays eligible for the DTC-PAC measure from fiscal year (FY) 2023-2024. The FFS column represents statistics for stays that include only FFS claims. The MA column represents statistics for stays that include any Medicare Advantage encounter record.

2.5 Statistical Risk Model and Risk Adjustment Covariates

2.5.1. Risk Adjustment Covariates

To account for beneficiary characteristics that may affect the risk of potentially preventable hospitalizations and observation stays, the risk adjustment model uses potential risk factors associated with each SNF stay:

- Beneficiary age and sex categories.
- Original Reason for Entitlement Code (OREC) categories, defined as either (1) end-stage renal disease (ESRD), (2) disability, or (3) ESRD and disability. Age is the reference category.
- CCS category of principal diagnosis from the prior proximal acute care stay.
- Comorbidities based on the prior proximal acute care stay or a 90-day lookback.²⁸
- Surgical procedure categories (if present) for the procedure codes from the prior proximal acute care stay.
- Dialysis during the prior proximal acute care stay where ESRD is not indicated.
- Indicator for ESRD status.
- Length of prior proximal acute care stay (if stay was in non-psychiatric hospital), or indicator if prior proximal acute care stay was in an IP psychiatric hospital.
- Number of intensive/cardiac care days during the prior acute stay.

²⁸ Depending on the specific comorbidity, diagnoses are mapped to HCCs using principal or secondary ICD-10 diagnosis codes from IP claims; HCCs are constructed using either the secondary diagnoses from the prior proximal acute care stay or all diagnoses from IP stays, other than the prior proximal stay, in the 90-day lookback period.

- Ventilator use during the SNF stay.
- Number of acute hospital stays in the 90 days prior to SNF admission (excluding the prior proximal acute care admission).
- Medicare Advantage (Part C) coverage at the start of the SNF stay.

2.5.2. Statistical Risk Model

The following section summarizes the risk adjustment approach for the measure.

A hierarchical logistic regression to predict the probability of a countable discharge to community is used. The risk adjusters are predictor variables. The patient characteristics related to each discharge and a marker for the specific discharging SNF are included in the equation. The equation is hierarchical in that both individual stay-level characteristics are accounted for as well as the clustering of stays into SNFs. The statistical model estimates both the average predictive effect of the stay-level characteristics across all SNFs and the degree to which each provider has an effect on the rate of numerator events that differs from that of the average SNF. The SNF effects are assumed to be randomly distributed around the average (according to a normal distribution). When computing the SNF effect, hierarchical modeling accounts for predictors of numerator events, on average, such as demographic characteristics and other risk factors, the SNF-specific observed rate, and the SNF-specific number of stays eligible for the measure. The estimated SNF random effect is determined mostly by each SNF's own data if the number of stays is relatively large (as the estimate would be relatively precise) but is adjusted towards the national average if the number of SNF stays is small (as that would yield an estimate of lower precision).

Calculate coefficient estimates for use in risk adjustment using the following hierarchical model:

Let Y_{ij} denote the outcome (equal to 1 if beneficiary i is discharged to community, 0 otherwise) for a beneficiary i at facility j . Let $Z_{ij} = (Z_1, Z_2, \dots, Z_k)$ denote a set of k risk adjustment variables. Let α_j represent the facility-specific intercept, μ the adjusted average intercept across all facilities, and τ^2 the between-facility variance component.

The probability of the outcome occurring is assumed to relate to the covariates via a logit function:

$$\text{logit}(P(Y_{ij} = 1|Z_{ij}, \alpha_j)) = \log\left(\frac{P(Y_{ij} = 1|Z_{ij}, \alpha_j)}{1 - P(Y_{ij} = 1|Z_{ij}, \alpha_j)}\right) = \alpha_j + \beta * Z_{ij}$$

$$\alpha_j = \mu + \omega_j ; \omega_j \sim N(0, \tau^2)$$

2.6 Measure Calculation Algorithm

2.6.1 Determine the National Observed Rate.

Divide the number of eligible stays resulting in a successful DTC (Section 2.4) by the total number of all eligible stays (Section 2.2).

2.6.2 Calculate provider-level final scores.

Using the estimated coefficients β , μ , and $\alpha_j = \mu + \omega_j$ determined in Section 2.5, calculate the following values for each provider:

2.6.2.1 Facility-level expected DTC number:

The number of DTCs that would be expected if that facility's beneficiaries were treated at the average provider. This is defined as:

$$\text{Expected Value}_j = \sum \frac{\exp(\hat{\mu} + \hat{\beta} \cdot Z_{ij})}{\exp(\hat{\mu} + \hat{\beta} \cdot Z_{ij}) + 1}$$

2.6.2.2 Facility-level predicted DTC number:

The predicted number of DTCs that would occur from that facility assuming the estimated provider-specific effect in the model. This is defined as:

$$\text{Predicted Value}_j = \sum \frac{\exp(\hat{\alpha}_j + \hat{\beta} \cdot Z_{ij})}{\exp(\hat{\alpha}_j + \hat{\beta} \cdot Z_{ij}) + 1}$$

2.6.2.3 Risk-Standardized DTC Rate (RSDTCR):

The final risk-adjusted facility-level DTC rate, used as the final publicly reported score.

Let $\bar{Y}$ denote the national observed rate calculated in Section 2.6.1. The RSDTCR is then defined as:

$$\text{RSDTCR} = \frac{\text{Predicted Value}_j}{\text{Expected Value}_j} \times \bar{Y}$$

2.7 Measure Results

Exhibit 3 shows the stay-level observed DTC-PAC rate for all eligible SNF patients/residents. The proportion of SNF patients/residents successfully discharged to community was 49.22 for stays covered by FFS (Part A), 51.85 for stays covered by MA (Part C), and 50.44 across all stays.

Exhibit 3. Stay-level observed DTC-PAC Rate

Measure	FFS, n (%) N= 1,964,002	MA, n (%) N= 1,692,954	Total, n (%) N= 3,656,956
Stay-level Observed DTC-PAC rate	970,838 (49.43)	875,998 (51.74)	1,846,836 (50.50)

Note: Includes SNF stays eligible for the DTC-PAC measure from FY 2023-2024. The FFS column represents statistics for stays that include only FFS claims. The MA column represents statistics for stays that include any Medicare Advantage encounter record.

Exhibit 4 shows the SNF-level observed and risk standardized DTC-PAC rate for all SNFs and limited to SNFs with at least 25 eligible stays in the measure period. The risk standardized DTC-PAC rate across all SNFs was 50.13, and for SNFs with at least 25 stays was 50.61.

Exhibit 4. SNF-level observed and risk standardized DTC-PAC Rate

Measure	All SNFs N=14,923	SNFs with 25+ Stays N= 13,402
Observed DTC-PAC rate	43.53	44.90
Risk standardized DTC-PAC rate	50.13	50.61

Note: Calculated using SNF stays eligible for the DTC-PAC measure from FY 2023-2024.

3. Measure Testing

Below we provide testing results for the DTC measure including reportability, variability, reliability and validity.

3.1 Reportability

Reportability testing examines the total number and proportion of SNF providers that have at least 25 eligible SNF stays for the DTC-PAC measure in the reporting period. 13,402 SNFs out of 14,923 (89.8%) had at least 25 stays.

Exhibit 5. Publicly Reportable SNFs, FY 2023-2024

Total Number of SNFs	Total Number of SNFs with ≥ 25 Stays	Percentage of SNFs with ≥ 25 Stays
14,923	13,402	89.81%

Note: DTC-PAC measure results calculated using FY 2023-2024 data.

3.2 Variability

Variability testing summarizes the distribution of the provider-level final DTC-PAC results.

Exhibit 6. SNF-Level Distribution of DTC

N	Mean Score	Standard Deviation	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
13,402	50.61	10.14	3.81	43.75	50.94	57.76	85.52

Note: DTC results calculated using FY 2023-2024 data from providers with at least 25 stays.

3.3 Reliability

The split-half reliability test examined agreement between two DTC measure results for each SNF based on randomly split, independent subsets of observations for each SNF in the same measurement period. Good agreement between pairs of performance measure results calculated in this manner provides evidence that the measure is capturing an attribute of the SNF rather than the effect of random chance.

For SNFs with at least 25 eligible stays in FY 2023-2024, each SNF's residents were randomly divided into halves. We calculated a provider-level DTC result for each split-half sample. We used the Shrout-Fleiss intraclass correlation coefficient (ICC [2, 1]) with the Spearman-Brown correction to calculate agreement between the split-half results. The overall intraclass correlation coefficient for SNFs with more than 25 eligible residents was 0.881, which indicates excellent reliability.²⁹

The signal-to-noise ratio (SNR) assesses how well the DTC measure distinguishes true differences in performance across SNFs. The "signal" represents real variation in SNF performance, while the "noise" reflects random variation or measurement error. A higher SNR indicates that most of the observed variation is meaningful rather than due to chance. To ensure a stable estimate, the SNR calculation was limited to SNFs with at least 25 stays in the FY 2023-2024 measure window. The resulting SNR was 0.89, which corresponds to strong reliability.

3.4 Validity

To evaluate convergent validity, we examined the relationships between provider DTC results and related SNF measures. Using Spearman's rank correlation, we compared providers' DTC results to the claims-based measures Potentially Preventable 30-Day Post-Discharge Readmission (PPR-PD) and Medicare Spending per Beneficiary (MSPB). We hypothesized that the SNFs that have a lower (better) result on these measures are likely to have a higher (better) result on the DTC measure. Therefore, we are looking for a negative correlation between these measures and the DTC measure as support for these measures having convergent validity.

We found small, significant negative association between DTC-PAC results and PPR-PD and MSPB results. The analysis used DTC results calculated using FY 2023-2024 data from providers with at least 25 stays.

²⁹ Cicchetti, D. V. (1994). Guidelines, criteria, and rules of thumb for evaluating normed and standardized assessment instruments in psychology. *Psychological assessment*, 6(4), 284.

Exhibit 7. Correlations Between DTC and Other Publicly Reported Measures

Measure	N SNFs	Spearman's Correlation	p-value
Potentially Preventable 30-Day Post-Discharge Readmission (PPR-PD)	12,509	-0.055	< 0.001
Medicare Spending per Beneficiary (MSPB)	12,703	-0.291	< 0.001

Note: RTI analysis of Medicare FFS claims data and Medicare Advantage encounter data (DTC-PAC results calculated using FY 2023-2024 data from providers with at least 25 stays), and publicly reported SNF quality measures (available for download at <https://data.cms.gov/provider-data>). Data collection periods for publicly reported SNF claims-based measures used in this analysis are the most recent available.

Appendix A. SNF DTC Risk-Adjustment Covariates

Exhibit 8 shows the prevalence of each risk factor for SNF stays eligible for the DTC-PAC measure from FY 2023-2024, as well as risk adjustment coefficients and standard errors for the pooled (FFS and MA) population. The FFS column represents statistics for stays that include only FFS claims. The MA column represents statistics for stays that include any Medicare Advantage encounter record.

Exhibit 8. SNF DTC Risk-Adjustment Covariates Prevalence and Model Coefficients

Risk Factor	Prevalence			Risk Adjustment Model Coefficients	
	FFS (N=1,964,002)	MA (N=1,692,954)	Total (N=3,656,956)	Coefficient	P-value
MA coverage at start of stay	0 (0.0%)	1,686,106 (99.6%)	1,686,106 (46.1%)	0.1215	<0.001
Age 18-44 years, male	6,108 (0.3%)	3,458 (0.2%)	9,566 (0.3%)	-0.0178	0.4533
Age 45-54 years, male	13,673 (0.7%)	12,525 (0.7%)	26,198 (0.7%)	-0.0143	0.3161
Age 55-59 years, male	17,017 (0.9%)	19,020 (1.1%)	36,037 (1.0%)	-0.0088	0.4707
Age 60-64 years, male	30,639 (1.6%)	37,598 (2.2%)	68,237 (1.9%)	-0.0165	0.0740
Age 65-69 years, male	89,837 (4.6%)	101,098 (6.0%)	190,935 (5.2%)	-0.0410	<0.001
Age 70-74 years, male	119,330 (6.1%)	117,121 (6.9%)	236,451 (6.5%)	-0.0570	<0.001
Age 75-79 years, male	143,164 (7.3%)	123,172 (7.3%)	266,336 (7.3%)	-0.0959	<0.001
Age 80-84 years, male	150,016 (7.6%)	119,473 (7.1%)	269,489 (7.4%)	-0.1681	<0.001
Age 85-89 years, male	124,034 (6.3%)	87,395 (5.2%)	211,429 (5.8%)	-0.2687	<0.001
Age 90-94 years, male	68,793 (3.5%)	42,506 (2.5%)	111,299 (3.0%)	-0.4418	<0.001
Age 95+ years, male	21,594 (1.1%)	11,363 (0.7%)	32,957 (0.9%)	-0.6264	<0.001
Age 18-44 years, female	4,518 (0.2%)	3,339 (0.2%)	7,857 (0.2%)	-0.0949	<0.001
Age 45-54 years, female	11,282 (0.6%)	13,624 (0.8%)	24,906 (0.7%)	-0.0615	<0.001
Age 55-59 years, female	14,198 (0.7%)	20,426 (1.2%)	34,624 (0.9%)	-0.0111	0.3719
Age 60-64 years, female	27,382 (1.4%)	42,663 (2.5%)	70,045 (1.9%)	0.0182	0.0442
Age 65-69 years, female [REFERENCE GROUP]	92,979 (4.7%)	118,506 (7.0%)	211,485 (5.8%)	-	-
Age 70-74 years, female	153,064 (7.8%)	161,518 (9.5%)	314,582 (8.6%)	-0.0159	0.0021

Risk Factor	Prevalence			Risk Adjustment Model Coefficients	
	FFS (N=1,964,002)	MA (N=1,692,954)	Total (N=3,656,956)	Coefficient	P-value
Age 75-79 years, female	210,927 (10.7%)	195,599 (11.6%)	406,526 (11.1%)	-0.0499	<0.001
Age 80-84 years, female	234,363 (11.9%)	189,410 (11.2%)	423,773 (11.6%)	-0.1163	<0.001
Age 85-89 years, female	219,567 (11.2%)	153,949 (9.1%)	373,516 (10.2%)	-0.2271	<0.001
Age 90-94 years, female	147,960 (7.5%)	88,409 (5.2%)	236,369 (6.5%)	-0.3780	<0.001
Age 95+ years, female	63,557 (3.2%)	30,782 (1.8%)	94,339 (2.6%)	-0.5802	<0.001
Prox. Surgery: Vascular	24,479 (1.2%)	30,005 (1.8%)	54,484 (1.5%)	0.0010	0.9209
Prox. Surgery: Orthopedics	341,598 (17.4%)	351,235 (20.7%)	692,833 (18.9%)	0.1311	<0.001
Prox. Surgery: General	96,634 (4.9%)	106,905 (6.3%)	203,539 (5.6%)	0.1302	<0.001
Prox. Surgery: Cardiothoracic	26,078 (1.3%)	30,355 (1.8%)	56,433 (1.5%)	0.4408	<0.001
Prox. Surgery: Neurosurgery	26,777 (1.4%)	29,911 (1.8%)	56,688 (1.6%)	0.0785	<0.001
Prox. Surgery: Plastic	55,698 (2.8%)	58,346 (3.4%)	114,044 (3.1%)	0.0210	0.0034
Prox. Surgery: Otolaryngology	3,620 (0.2%)	3,669 (0.2%)	7,289 (0.2%)	0.1730	<0.001
Prox. Surgery: Obstetrics/gynecology	3,080 (0.2%)	3,007 (0.2%)	6,087 (0.2%)	0.1102	<0.001
Prox. Surgery: Urologic	14,889 (0.8%)	12,844 (0.8%)	27,733 (0.8%)	0.0431	0.0028
Dialysis in hospital where HCC 136/ESRD not indicated	16,706 (0.9%)	19,175 (1.1%)	35,881 (1.0%)	-0.0762	<0.001
ESRD	74,522 (3.8%)	66,547 (3.9%)	141,069 (3.9%)	-0.2254	<0.001
Original reason for entitlement is age [REFERENCE GROUP]	1,543,503 (78.6%)	1,189,734 (70.3%)	2,733,237 (74.7%)	-	-
Original reason for entitlement is ESRD	14,388 (0.7%)	9,817 (0.6%)	24,205 (0.7%)	-0.2158	<0.001
Original reason for entitlement is disability	399,758 (20.4%)	488,240 (28.8%)	887,998 (24.3%)	-0.1103	<0.001
Original reason for entitlement is disability and current ESRD	6,353 (0.3%)	5,163 (0.3%)	11,516 (0.3%)	-0.1872	<0.001
ICU/CCU days associated with prior acute stay: 0 [REFERENCE GROUP]	1,223,602 (62.3%)	984,887 (58.2%)	2,208,489 (60.4%)	-	-
ICU/CCU days associated with prior acute stay: 1-3	272,168 (13.9%)	97,939 (5.8%)	370,107 (10.1%)	0.0122	0.0016
ICU/CCU days associated with prior acute stay: 4-9	336,453 (17.1%)	346,543 (20.5%)	682,996 (18.7%)	-0.0048	0.1178

Risk Factor	Prevalence			Risk Adjustment Model Coefficients	
	FFS (N=1,964,002)	MA (N=1,692,954)	Total (N=3,656,956)	Coefficient	P-value
ICU/CCU days associated with prior acute stay: 10-19	105,398 (5.4%)	198,535 (11.7%)	303,933 (8.3%)	-0.0371	<0.001
ICU/CCU days associated with prior acute stay: 20+	26,381 (1.3%)	65,050 (3.8%)	91,431 (2.5%)	-0.1938	<0.001
Prior stay: LOS 1-6 days [REFERENCE GROUP]	973,415 (49.6%)	600,181 (35.5%)	1,573,596 (43.0%)	-	-
Prior stay: LOS 7-14 days	762,171 (38.8%)	802,963 (47.4%)	1,565,134 (42.8%)	-0.1510	<0.001
Prior stay: LOS 15+ days	216,635 (11.0%)	286,183 (16.9%)	502,818 (13.7%)	-0.4362	<0.001
Prior stay: psychiatric hospital	11,781 (0.6%)	3,627 (0.2%)	15,408 (0.4%)	-0.6954	<0.001
Prior ACH stays: 0 stays in past 90 days (excluding prior proximal) [REFERENCE GROUP]	1,278,734 (65.1%)	1,194,886 (70.6%)	2,473,620 (67.6%)	-	-
Prior ACH stays: 1 stay in past 90 days (excluding prior proximal)	463,078 (23.6%)	343,455 (20.3%)	806,533 (22.1%)	-0.2999	<0.001
Prior ACH stays: 2 stays in past 90 days (excluding prior proximal)	154,754 (7.9%)	108,375 (6.4%)	263,129 (7.2%)	-0.5627	<0.001
Prior ACH stays: 3 stays in past 90 days (excluding prior proximal)	47,819 (2.4%)	31,632 (1.9%)	79,451 (2.2%)	-0.8025	<0.001
Prior ACH stays: 4 stays in past 90 days (excluding prior proximal)	13,832 (0.7%)	9,840 (0.6%)	23,672 (0.6%)	-0.9917	<0.001
Prior ACH stays: 5 stays or more in past 90 days (excluding prior proximal)	5,785 (0.3%)	4,766 (0.3%)	10,551 (0.3%)	-1.3753	<0.001
Prolonged ventilation during current PAC stay	3,708 (0.2%)	2,141 (0.1%)	5,849 (0.2%)	-1.1807	<0.001
HCC 1: HIV/AIDS	5,532 (0.3%)	6,703 (0.4%)	12,235 (0.3%)	-0.0270	0.1767
HCC 2: Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	206,188 (10.5%)	207,019 (12.2%)	413,207 (11.3%)	-0.0509	<0.001
HCC 6: Opportunistic Infections	7,872 (0.4%)	7,121 (0.4%)	14,993 (0.4%)	-0.0666	<0.001
HCC 8: Metastatic Cancer and Acute Leukemia	51,252 (2.6%)	39,832 (2.4%)	91,084 (2.5%)	-0.4165	<0.001
HCC 9: Lung and Other Severe Cancers	35,746 (1.8%)	29,885 (1.8%)	65,631 (1.8%)	-0.1851	<0.001
HCC 10: Lymphoma and Other Cancers	29,838 (1.5%)	21,748 (1.3%)	51,586 (1.4%)	-0.0880	<0.001
HCC 17, 18, 19: Diabetes with Acute Complications; Diabetes with Chronic Complications; Diabetes without Complication	727,160 (37.0%)	735,374 (43.4%)	1,462,534 (40.0%)	-0.0731	<0.001

Risk Factor	Prevalence			Risk Adjustment Model Coefficients	
	FFS (N=1,964,002)	MA (N=1,692,954)	Total (N=3,656,956)	Coefficient	P-value
HCC 21: Protein-Calorie Malnutrition	280,880 (14.3%)	238,852 (14.1%)	519,732 (14.2%)	-0.2583	<0.001
HCC 27, 28: End-Stage Liver Disease; Cirrhosis of Liver	69,882 (3.6%)	68,204 (4.0%)	138,086 (3.8%)	-0.2505	<0.001
HCC 29: Chronic Hepatitis	7,530 (0.4%)	9,117 (0.5%)	16,647 (0.5%)	-0.0724	<0.001
HCC 46: Severe Hematological Disorders	11,618 (0.6%)	8,283 (0.5%)	19,901 (0.5%)	-0.1773	<0.001
HCC 47: Disorders of Immunity	91,499 (4.7%)	73,522 (4.3%)	165,021 (4.5%)	-0.0407	<0.001
HCC 51, 52: Dementia With Complications; Dementia Without Complication	471,222 (24.0%)	334,686 (19.8%)	805,908 (22.0%)	-0.4087	<0.001
HCC 57: Schizophrenia	41,723 (2.1%)	25,960 (1.5%)	67,683 (1.9%)	-0.3744	<0.001
HCC 58: Reactive and Unspecified Psychosis	8,526 (0.4%)	5,944 (0.4%)	14,470 (0.4%)	-0.1455	<0.001
HCC 59: Major Depressive, Bipolar, and Paranoid Disorders	124,747 (6.4%)	128,686 (7.6%)	253,433 (6.9%)	-0.0531	<0.001
HCC 60: Personality Disorders	1,994 (0.1%)	1,707 (0.1%)	3,701 (0.1%)	-0.4143	<0.001
HCC 70: Quadriplegia	16,351 (0.8%)	9,909 (0.6%)	26,260 (0.7%)	-0.5172	<0.001
HCC 71: Paraplegia	10,896 (0.6%)	8,843 (0.5%)	19,739 (0.5%)	-0.2683	<0.001
HCC 72: Spinal Cord Disorders/Injuries	24,524 (1.2%)	24,399 (1.4%)	48,923 (1.3%)	-0.1070	<0.001
HCC 73: Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	1,597 (0.1%)	1,079 (0.1%)	2,676 (0.1%)	-0.3574	<0.001
HCC 74: Cerebral Palsy	7,080 (0.4%)	3,489 (0.2%)	10,569 (0.3%)	-0.3414	<0.001
HCC 76: Muscular Dystrophy	1,516 (0.1%)	1,202 (0.1%)	2,718 (0.1%)	-0.2344	<0.001
HCC 77: Multiple Sclerosis	16,063 (0.8%)	14,899 (0.9%)	30,962 (0.8%)	-0.0845	<0.001
HCC 78: Parkinson's and Huntington's Diseases	91,990 (4.7%)	64,101 (3.8%)	156,091 (4.3%)	-0.1097	<0.001
HCC 79: Seizure Disorders and Convulsions	101,254 (5.2%)	91,266 (5.4%)	192,520 (5.3%)	-0.0646	<0.001
HCC 80: Coma, Brain Compression/Anoxic Damage	32,757 (1.7%)	28,548 (1.7%)	61,305 (1.7%)	-0.2219	<0.001
HCC 82: Respirator Dependence/Tracheostomy Status	10,758 (0.5%)	8,436 (0.5%)	19,194 (0.5%)	-0.3956	<0.001
HCC 84: Cardio-Respiratory Failure and Shock	433,808 (22.1%)	407,073 (24.0%)	840,881 (23.0%)	-0.0865	<0.001
HCC 85: Congestive Heart Failure	711,651 (36.2%)	626,800 (37.0%)	1,338,451 (36.6%)	-0.1533	<0.001
HCC 86: Acute Myocardial Infarction	90,309 (4.6%)	88,875 (5.2%)	179,184 (4.9%)	-0.0427	<0.001

Risk Factor	Prevalence			Risk Adjustment Model Coefficients	
	FFS (N=1,964,002)	MA (N=1,692,954)	Total (N=3,656,956)	Coefficient	P-value
HCC 96: Specified Heart Arrhythmias	721,717 (36.7%)	584,809 (34.5%)	1,306,526 (35.7%)	-0.0978	<0.001
HCC 99: Intracranial Hemorrhage	15,834 (0.8%)	19,217 (1.1%)	35,051 (1.0%)	-0.1418	<0.001
HCC 100: Ischemic or Unspecified Stroke	22,644 (1.2%)	37,352 (2.2%)	59,996 (1.6%)	-0.1927	<0.001
HCC 103: Hemiplegia/Hemiparesis	129,079 (6.6%)	127,124 (7.5%)	256,203 (7.0%)	-0.2043	<0.001
HCC 104: Monoplegia, Other Paralytic Syndromes	10,248 (0.5%)	9,722 (0.6%)	19,970 (0.5%)	-0.0096	0.5253
HCC 106: Atherosclerosis of the Extremities with Ulceration or Gangrene	33,879 (1.7%)	41,074 (2.4%)	74,953 (2.0%)	-0.3716	<0.001
HCC 107, 108: Vascular Disease with Complications; Vascular Disease	303,845 (15.5%)	309,870 (18.3%)	613,715 (16.8%)	-0.0357	<0.001
HCC 110, 111: Cystic Fibrosis; Chronic Obstructive Pulmonary Disease	453,218 (23.1%)	443,047 (26.2%)	896,265 (24.5%)	-0.0738	<0.001
HCC 114: Aspiration and Specified Bacterial Pneumonias	88,364 (4.5%)	78,458 (4.6%)	166,822 (4.6%)	-0.1032	<0.001
HCC 134: Dialysis Status	65,135 (3.3%)	59,865 (3.5%)	125,000 (3.4%)	-0.3000	<0.001
HCC 135: Acute Renal Failure	512,103 (26.1%)	497,776 (29.4%)	1,009,879 (27.6%)	-0.1752	<0.001
HCC 136: Chronic Kidney Disease, Stage 5	16,247 (0.8%)	13,677 (0.8%)	29,924 (0.8%)	-0.3630	<0.001
HCC 137: Chronic Kidney Disease, Severe (Stage 4)	32,932 (1.7%)	26,308 (1.6%)	59,240 (1.6%)	-0.2253	<0.001
HCC 138, 139: Chronic Kidney Disease, Moderate (Stage 3); Chronic Kidney Disease, Mild or Unspecified (Stage 1-2 or Unspecified)	186,534 (9.5%)	159,756 (9.4%)	346,290 (9.5%)	-0.0365	<0.001
HCC 157: Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone	15,140 (0.8%)	9,447 (0.6%)	24,587 (0.7%)	-0.7901	<0.001
HCC 158: Pressure Ulcer of Skin with Full Thickness Skin Loss	39,760 (2.0%)	31,388 (1.9%)	71,148 (1.9%)	-0.5772	<0.001
HCC 159: Pressure Ulcer of Skin with Partial Thickness Skin Loss	33,801 (1.7%)	27,735 (1.6%)	61,536 (1.7%)	-0.4111	<0.001
HCC 161: Chronic Ulcer of Skin, Except Pressure	58,954 (3.0%)	60,536 (3.6%)	119,490 (3.3%)	-0.1743	<0.001
HCC 176: Complications of Specified Implanted Device or Graft	43,223 (2.2%)	40,077 (2.4%)	83,300 (2.3%)	-0.1241	<0.001

Risk Factor	Prevalence			Risk Adjustment Model Coefficients	
	FFS (N=1,964,002)	MA (N=1,692,954)	Total (N=3,656,956)	Coefficient	P-value
HCC 188: Artificial Openings for Feeding or Elimination	46,060 (2.3%)	31,083 (1.8%)	77,143 (2.1%)	-0.2529	<0.001
HCC 189: Amputation Status, Lower Limb/Amputation Complications	30,765 (1.6%)	32,477 (1.9%)	63,242 (1.7%)	-0.1001	<0.001
CCS 1, 3, 4, 5, 7, 8, 9: Tuberculosis; Bacterial infection, unspecified site; Mycoses; HIV infection; Viral Infection; Other infections, including parasitic; Sexually transmitted infections (not HIV or hepatitis);	5,861 (0.3%)	4,894 (0.3%)	10,755 (0.3%)	-0.4462	<0.001
CCS 2: Septicemia (except in labor)	237,299 (12.1%)	209,044 (12.3%)	446,343 (12.2%)	-0.5296	<0.001
CCS 6, 150, 151: Hepatitis; Liver disease, alcohol-related; Other liver diseases	8,098 (0.4%)	6,881 (0.4%)	14,979 (0.4%)	-0.8815	<0.001
CCS 11: Cancer of head and neck	706 (<0.1%)	805 (<0.1%)	1,511 (<0.1%)	-0.5041	<0.001
CCS 12, 13, 14: Cancer of esophagus; Cancer of stomach; Cancer of colon	4,674 (0.2%)	4,264 (0.3%)	8,938 (0.2%)	-0.2151	<0.001
CCS 15: Cancer of rectum and anus	973 (<0.1%)	931 (0.1%)	1,904 (0.1%)	-0.6879	<0.001
CCS 16, 17, 18: Cancer of liver and intrahepatic bile duct; Cancer of pancreas; Cancer of other GI organs, peritoneum	1,199 (0.1%)	1,138 (0.1%)	2,337 (0.1%)	-0.2971	<0.001
CCS 19, 20: Cancer of bronchus, lung; Cancer, other respiratory and intrathoracic	886 (<0.1%)	935 (0.1%)	1,821 (<0.1%)	-0.4085	<0.001
CCS 21, 22, 23, 26, 28, 29, 30, 31, 36: Cancer of bone and connective tissue; Melanomas of skin; other non-epithelial cancer of skin; Cancer of cervix; Cancer of other female genital organs; Cancer of prostate; Cancer of testis; Cancer of other male genital organs; Cancer of thyroid	1,309 (0.1%)	1,164 (0.1%)	2,473 (0.1%)	-0.5375	<0.001
CCS 24, 25, 27: Cancer of breast; Cancer of uterus; Cancer of ovary	1,055 (0.1%)	937 (0.1%)	1,992 (0.1%)	-0.3515	<0.001
CCS 32, 33, 34: Cancer of bladder; Cancer of kidney and renal pelvis; Cancer of other urinary organs	2,105 (0.1%)	1,838 (0.1%)	3,943 (0.1%)	-0.5553	<0.001
CCS 35: Cancer of brain and nervous system	544 (<0.1%)	493 (<0.1%)	1,037 (<0.1%)	-0.6800	<0.001

Risk Factor	Prevalence			Risk Adjustment Model Coefficients	
	FFS (N=1,964,002)	MA (N=1,692,954)	Total (N=3,656,956)	Coefficient	P-value
CCS 37, 38, 39, 40, 41, 43, 45: Hodgkin's disease; Non-Hodgkin's lymphoma; Leukemias; Multiple myeloma; Cancer, other and unspecified primary; Malignant neoplasm without specification of site; Maintenance chemotherapy, radiotherapy	816 (<0.1%)	780 (<0.1%)	1,596 (<0.1%)	-0.4994	<0.001
CCS 42: Secondary malignancies	1,962 (0.1%)	1,948 (0.1%)	3,910 (0.1%)	-0.4748	<0.001
CCS 44, 46, 47, 167: Neoplasms of unspecified nature or uncertain behavior; Benign neoplasm of uterus; Other and unspecified benign neoplasm; Nonmalignant breast conditions	3,430 (0.2%)	3,312 (0.2%)	6,742 (0.2%)	-0.4507	<0.001
CCS 48: Thyroid disorders	1,601 (0.1%)	1,659 (0.1%)	3,260 (0.1%)	-0.6978	<0.001
CCS 49, 50: Diabetes mellitus without complication; Diabetes mellitus with complications	43,352 (2.2%)	52,976 (3.1%)	96,328 (2.6%)	-0.5558	<0.001
CCS 51, 53: Other endocrine disorders; Disorders of lipid metabolism	9,359 (0.5%)	7,665 (0.5%)	17,024 (0.5%)	-0.4639	<0.001
CCS 52: Nutritional deficiencies	2,361 (0.1%)	1,899 (0.1%)	4,260 (0.1%)	-0.8262	<0.001
CCS 54: Gout and other crystal arthropathies	2,142 (0.1%)	1,973 (0.1%)	4,115 (0.1%)	-0.1966	<0.001
CCS 55: Fluid and electrolyte disorders	34,107 (1.7%)	24,792 (1.5%)	58,899 (1.6%)	-0.6243	<0.001
CCS 56, 127, 128: Cystic fibrosis; Chronic obstructive pulmonary disease and bronchiectasis; Asthma	16,344 (0.8%)	15,006 (0.9%)	31,350 (0.9%)	-0.6366	<0.001
CCS 57, 61, 62, 63, 64: Immunity disorders; Sickle cell anemia; Coagulation and hemorrhagic disorders; Diseases of white blood cells; Other hematologic conditions	5,217 (0.3%)	3,667 (0.2%)	8,884 (0.2%)	-0.5712	<0.001
CCS 58: Other nutritional, endocrine, and metabolic disorders	9,779 (0.5%)	7,217 (0.4%)	16,996 (0.5%)	-0.7985	<0.001
CCS 59: Deficiency and other anemia	7,853 (0.4%)	5,422 (0.3%)	13,275 (0.4%)	-0.7458	<0.001
CCS 60: Acute posthemorrhagic anemia	4,852 (0.2%)	3,334 (0.2%)	8,186 (0.2%)	-0.6334	<0.001
CCS 76, 77, 78: Meningitis (except that caused by tuberculosis or sexually transmitted disease);	2,735 (0.1%)	2,551 (0.2%)	5,286 (0.1%)	-0.5080	<0.001

Risk Factor	Prevalence			Risk Adjustment Model Coefficients	
	FFS (N=1,964,002)	MA (N=1,692,954)	Total (N=3,656,956)	Coefficient	P-value
Encephalitis (except that caused by tuberculosis or sexually transmitted disease); Other CNS infection and poliomyelitis					
CCS 79: Parkinson's disease	7,035 (0.4%)	4,476 (0.3%)	11,511 (0.3%)	-0.5696	<0.001
CCS 80: Multiple sclerosis	1,067 (0.1%)	1,279 (0.1%)	2,346 (0.1%)	-0.5570	<0.001
CCS 81, 82: Other hereditary and degenerative nervous system conditions; Paralysis	3,640 (0.2%)	2,851 (0.2%)	6,491 (0.2%)	-0.5012	<0.001
CCS 83: Epilepsy, convulsions	12,142 (0.6%)	11,241 (0.7%)	23,383 (0.6%)	-0.4895	<0.001
CCS 84, 86, 87, 88, 89, 90, 91, 92, 93, 94: Headache, including migraine; Cataract; Retinal detachments, defects, vascular occlusion, and retinopathy; Glaucoma; Blindness and vision defects; Inflammation, infection of eye (except that caused by tuberculosis or sexually transmitted disease); Other eye disorders; Otitis media and related conditions; Conditions associated with dizziness or vertigo; Other ear and sense organ disorders	5,607 (0.3%)	4,226 (0.2%)	9,833 (0.3%)	-0.1847	<0.001
CCS 85: Coma, stupor, and brain damage	149 (<0.1%)	114 (<0.1%)	263 (<0.1%)	-0.6673	<0.001
CCS 95: Other nervous system disorders	41,112 (2.1%)	31,245 (1.8%)	72,357 (2.0%)	-0.5160	<0.001
CCS 96: Heart valve disorders	7,745 (0.4%)	7,023 (0.4%)	14,768 (0.4%)	-0.4935	<0.001
CCS 97, 101: Peri-, endo-, and myocarditis, cardiomyopathy (except that caused by tuberculosis or sexually transmitted disease); Coronary atherosclerosis and other heart disease	11,564 (0.6%)	13,308 (0.8%)	24,872 (0.7%)	-0.3828	<0.001
CCS 98, 99: Essential hypertension; Hypertension with complications and secondary hypertension	109,356 (5.6%)	95,128 (5.6%)	204,484 (5.6%)	-0.5611	<0.001
CCS 100, 107: Acute myocardial infarction; Cardiac arrest and ventricular fibrillation	20,693 (1.1%)	21,539 (1.3%)	42,232 (1.2%)	-0.5152	<0.001
CCS 102, 104: Nonspecific chest pain; Other and ill-defined heart disease	3,338 (0.2%)	2,551 (0.2%)	5,889 (0.2%)	-0.5056	<0.001

Risk Factor	Prevalence			Risk Adjustment Model Coefficients	
	FFS (N=1,964,002)	MA (N=1,692,954)	Total (N=3,656,956)	Coefficient	P-value
CCS 103: Pulmonary heart disease	13,689 (0.7%)	12,124 (0.7%)	25,813 (0.7%)	-0.4114	<0.001
CCS 105, 106: Conduction disorders; Cardiac dysrhythmias	38,179 (1.9%)	32,399 (1.9%)	70,578 (1.9%)	-0.4459	<0.001
CCS 108: Congestive heart failure, nonhypertensive	6,286 (0.3%)	4,876 (0.3%)	11,162 (0.3%)	-0.7358	<0.001
CCS 109: Acute cerebrovascular disease	69,791 (3.6%)	72,453 (4.3%)	142,244 (3.9%)	-0.7016	<0.001
CCS 110: Occlusion or stenosis of precerebral arteries	2,001 (0.1%)	1,998 (0.1%)	3,999 (0.1%)	-0.2332	<0.001
CCS 111: Other and ill-defined cerebrovascular disease	1,161 (0.1%)	1,086 (0.1%)	2,247 (0.1%)	-0.3901	<0.001
CCS 112: Transient cerebral ischemia	5,384 (0.3%)	3,971 (0.2%)	9,355 (0.3%)	-0.3475	<0.001
CCS 113: Late effects of cerebrovascular disease	4,154 (0.2%)	3,936 (0.2%)	8,090 (0.2%)	-0.4866	<0.001
CCS 114: Peripheral and visceral atherosclerosis	5,842 (0.3%)	6,344 (0.4%)	12,186 (0.3%)	-0.5272	<0.001
CCS 115: Aortic, peripheral, and visceral artery aneurysms	3,606 (0.2%)	4,308 (0.3%)	7,914 (0.2%)	-0.3814	<0.001
CCS 116: Aortic and peripheral arterial embolism or thrombosis	1,016 (0.1%)	1,178 (0.1%)	2,194 (0.1%)	-0.6217	<0.001
CCS 117: Other circulatory disease	14,345 (0.7%)	11,308 (0.7%)	25,653 (0.7%)	-0.3727	<0.001
CCS 118: Phlebitis, thrombophlebitis and thromboembolism	6,956 (0.4%)	5,820 (0.3%)	12,776 (0.3%)	-0.5570	<0.001
CCS 119, 120, 121, 247: Varicose veins of lower extremity; Hemorrhoids; Other diseases of veins and lymphatics; Lymphadenitis	3,880 (0.2%)	3,145 (0.2%)	7,025 (0.2%)	-0.5832	<0.001
CCS 122: Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	100,091 (5.1%)	72,897 (4.3%)	172,988 (4.7%)	-0.4570	<0.001
CCS 123: Influenza	7,518 (0.4%)	5,909 (0.3%)	13,427 (0.4%)	-0.1836	<0.001
CCS 124, 136, 137: Acute and chronic tonsillitis; Disorders of teeth and jaw; Diseases of mouth, excluding dental	870 (<0.1%)	656 (<0.1%)	1,526 (<0.1%)	-0.4950	<0.001
CCS 125, 126: Acute bronchitis; Other upper respiratory infections	2,703 (0.1%)	1,636 (0.1%)	4,339 (0.1%)	-0.2973	<0.001
CCS 129: Aspiration pneumonitis, food/vomitus	17,164 (0.9%)	10,959 (0.6%)	28,123 (0.8%)	-0.7153	<0.001

Risk Factor	Prevalence			Risk Adjustment Model Coefficients	
	FFS (N=1,964,002)	MA (N=1,692,954)	Total (N=3,656,956)	Coefficient	P-value
CCS 130: Pleurisy, pneumothorax, pulmonary collapse	4,715 (0.2%)	3,570 (0.2%)	8,285 (0.2%)	-0.5259	<0.001
CCS 131: Respiratory failure, insufficiency, arrest (adult)	25,371 (1.3%)	23,700 (1.4%)	49,071 (1.3%)	-0.6334	<0.001
CCS 132, 133, 134: Lung disease due to external agents; Other lower respiratory disease; Other upper respiratory disease	4,721 (0.2%)	3,552 (0.2%)	8,273 (0.2%)	-0.6720	<0.001
CCS 135: Intestinal infection	9,758 (0.5%)	7,194 (0.4%)	16,952 (0.5%)	-0.5595	<0.001
CCS 138: Esophageal disorders	2,564 (0.1%)	1,989 (0.1%)	4,553 (0.1%)	-0.5912	<0.001
CCS 139: Gastroduodenal ulcer (except hemorrhage)	1,438 (0.1%)	1,477 (0.1%)	2,915 (0.1%)	-0.4884	<0.001
CCS 140, 141: Gastritis and duodenitis; Other disorders of stomach and duodenum	4,771 (0.2%)	3,600 (0.2%)	8,371 (0.2%)	-0.5966	<0.001
CCS 142: Appendicitis and other appendiceal conditions	1,018 (0.1%)	823 (<0.1%)	1,841 (0.1%)	-0.1484	0.0038
CCS 143: Abdominal hernia	7,099 (0.4%)	6,295 (0.4%)	13,394 (0.4%)	-0.3230	<0.001
CCS 144, 146, 148: Regional enteritis and ulcerative colitis; Diverticulosis and diverticulitis; Peritonitis and intestinal abscess	12,764 (0.6%)	10,038 (0.6%)	22,802 (0.6%)	-0.5142	<0.001
CCS 145: Intestinal obstruction without hernia	14,128 (0.7%)	11,082 (0.7%)	25,210 (0.7%)	-0.3649	<0.001
CCS 147: Anal and rectal conditions	2,372 (0.1%)	1,543 (0.1%)	3,915 (0.1%)	-0.5621	<0.001
CCS 149: Biliary tract disease	9,608 (0.5%)	7,818 (0.5%)	17,426 (0.5%)	-0.4316	<0.001
CCS 152: Pancreatic disorders (not diabetes)	3,369 (0.2%)	3,039 (0.2%)	6,408 (0.2%)	-0.4033	<0.001
CCS 153: Gastrointestinal hemorrhage	24,244 (1.2%)	17,373 (1.0%)	41,617 (1.1%)	-0.5941	<0.001
CCS 154, 155: Noninfectious gastroenteritis; Other gastrointestinal disorders	14,744 (0.8%)	10,751 (0.6%)	25,495 (0.7%)	-0.5776	<0.001
CCS 156, 157: Nephritis, nephrosis, renal sclerosis; Acute and unspecified renal failure	59,084 (3.0%)	52,086 (3.1%)	111,170 (3.0%)	-0.7140	<0.001
CCS 158: Chronic kidney disease	227 (<0.1%)	454 (<0.1%)	681 (<0.1%)	-0.4218	<0.001
CCS 159: Urinary tract infections	78,021 (4.0%)	54,007 (3.2%)	132,028 (3.6%)	-0.7162	<0.001
CCS 160: Calculus of urinary tract	793 (<0.1%)	529 (<0.1%)	1,322 (<0.1%)	-0.6986	<0.001

Risk Factor	Prevalence			Risk Adjustment Model Coefficients	
	FFS (N=1,964,002)	MA (N=1,692,954)	Total (N=3,656,956)	Coefficient	P-value
CCS 161, 162: Other diseases of kidney and ureters; Other diseases of bladder and urethra	3,199 (0.2%)	2,508 (0.1%)	5,707 (0.2%)	-0.6890	<0.001
CCS 163: Genitourinary symptoms and ill-defined conditions	1,688 (0.1%)	1,031 (0.1%)	2,719 (0.1%)	-0.6423	<0.001
CCS 164, 165, 166: Hyperplasia of prostate; Inflammatory conditions of male genital organs; Other male genital disorders	2,561 (0.1%)	2,071 (0.1%)	4,632 (0.1%)	-0.5133	<0.001
Female Reproductive (CCS 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196)	972 (<0.1%)	881 (0.1%)	1,853 (0.1%)	-0.6406	<0.001
CCS 197, 198, 200: Skin and subcutaneous tissue infections; Other inflammatory condition of skin; Other skin disorders	28,188 (1.4%)	24,156 (1.4%)	52,344 (1.4%)	-0.5455	<0.001
CCS 199: Chronic ulcer of skin	5,838 (0.3%)	4,460 (0.3%)	10,298 (0.3%)	-0.8667	<0.001
CCS 202, 210, 211: Rheumatoid arthritis and related disease; Systemic lupus erythematosus and connective tissue disorders; Other connective tissue disease	19,138 (1.0%)	16,433 (1.0%)	35,571 (1.0%)	-0.4969	<0.001
CCS 205: Spondylosis, intervertebral disc disorders, other back problems	38,790 (2.0%)	39,116 (2.3%)	77,906 (2.1%)	-0.3192	<0.001
CCS 207: Pathological fracture	36,091 (1.8%)	31,080 (1.8%)	67,171 (1.8%)	-0.4665	<0.001
CCS 208, 209, 212, 213, 214, 215, 216, 217: Acquired foot deformities; Other acquired deformities; Other bone disease and musculoskeletal deformities; Cardiac and circulatory congenital anomalies; Digestive congenital anomalies; Genitourinary congenital anomalies; Nervous system congenital anomalies; Other congenital anomalies	6,173 (0.3%)	5,866 (0.3%)	12,039 (0.3%)	-0.2620	<0.001
CCS 225, 228, 229, 230, 231: Joint disorders and dislocations, trauma-related; Skull and face fractures; Fracture of upper limb; Fracture of lower limb; Other fractures	157,272 (8.0%)	138,271 (8.2%)	295,543 (8.1%)	-0.4804	<0.001

Risk Factor	Prevalence			Risk Adjustment Model Coefficients	
	FFS (N=1,964,002)	MA (N=1,692,954)	Total (N=3,656,956)	Coefficient	P-value
CCS 226: Fracture of neck of femur (hip)	139,583 (7.1%)	146,884 (8.7%)	286,467 (7.8%)	-0.4786	<0.001
CCS 227: Spinal cord injury	1,273 (0.1%)	1,591 (0.1%)	2,864 (0.1%)	-0.8509	<0.001
CCS 232: Sprains and strains	3,560 (0.2%)	2,564 (0.2%)	6,124 (0.2%)	-0.2383	<0.001
CCS 233: Intracranial injury	26,363 (1.3%)	23,401 (1.4%)	49,764 (1.4%)	-0.6532	<0.001
CCS 234: Crushing injury or internal injury	6,730 (0.3%)	6,217 (0.4%)	12,947 (0.4%)	-0.3006	<0.001
CCS 235, 236, 240: Open wounds of head, neck, and trunk; Open wounds of extremities; Burns	4,546 (0.2%)	3,783 (0.2%)	8,329 (0.2%)	-0.4744	<0.001
CCS 237, 238: Complication of device, implant or graft; Complications of surgical procedures or medical care	103,547 (5.3%)	85,555 (5.1%)	189,102 (5.2%)	-0.5418	<0.001
CCS 239: Superficial injury, contusion	7,918 (0.4%)	5,271 (0.3%)	13,189 (0.4%)	-0.3912	<0.001
CCS 241, 242, 243, 260: Poisoning by psychotropic agents; Poisoning by other medications and drugs; Poisoning by nonmedicinal substances; E Codes: All (external causes of injury and poisoning)	4,285 (0.2%)	4,244 (0.3%)	8,529 (0.2%)	-0.3165	<0.001
CCS 244: Other injuries and conditions due to external causes	11,847 (0.6%)	10,827 (0.6%)	22,674 (0.6%)	-0.5944	<0.001
CCS 245: Syncope	6,608 (0.3%)	4,793 (0.3%)	11,401 (0.3%)	-0.3744	<0.001
CCS 246: Fever of unknown origin	563 (<0.1%)	359 (<0.1%)	922 (<0.1%)	-0.3469	<0.001
CCS 248: Gangrene	3,328 (0.2%)	3,523 (0.2%)	6,851 (0.2%)	-0.7564	<0.001
CCS 249: Shock	625 (<0.1%)	645 (<0.1%)	1,270 (<0.1%)	-0.5109	<0.001
CCS 250: Nausea and vomiting	685 (<0.1%)	509 (<0.1%)	1,194 (<0.1%)	-0.5450	<0.001
CCS 251: Abdominal pain	724 (<0.1%)	503 (<0.1%)	1,227 (<0.1%)	-0.6406	<0.001
CCS 252: Malaise and fatigue	9,474 (0.5%)	6,861 (0.4%)	16,335 (0.4%)	-0.6312	<0.001
CCS 253: Allergic reactions	489 (<0.1%)	321 (<0.1%)	810 (<0.1%)	-0.5048	<0.001
CCS 257: Other aftercare	1,649 (0.1%)	915 (0.1%)	2,564 (0.1%)	-0.3260	<0.001
CCS 259: Residual codes, unclassified	3,186 (0.2%)	1,792 (0.1%)	4,978 (0.1%)	-0.7030	<0.001
CCS 650, 651, 652, 654, 655, 656: Adjustment disorders; anxiety disorders; attention-deficit,	885 (<0.1%)	491 (<0.1%)	1,376 (<0.1%)	-0.6474	<0.001

Risk Factor	Prevalence			Risk Adjustment Model Coefficients	
	FFS (N=1,964,002)	MA (N=1,692,954)	Total (N=3,656,956)	Coefficient	P-value
conduct, and disruptive behavior disorders; Developmental disorders; Disorders usually diagnosed in infancy, childhood, or adolescence; Impulse control disorders, NEC					
CCS 653: Delirium, dementia, and amnestic and other cognitive disorders	24,821 (1.3%)	13,267 (0.8%)	38,088 (1.0%)	-0.9425	<0.001
CCS 657, 658, 662: Mood disorders; Personality disorders; Suicide and intentional self-inflicted injury	6,040 (0.3%)	2,940 (0.2%)	8,980 (0.2%)	-0.5248	<0.001
CCS 659: Schizophrenia and other psychotic disorders	5,549 (0.3%)	1,300 (0.1%)	6,849 (0.2%)	-0.7685	<0.001
CCS 660, 661, 663: Alcohol-related disorders; Substance-related disorders; Screening and history of mental health and substance abuse codes	11,066 (0.6%)	10,704 (0.6%)	21,770 (0.6%)	-0.3831	<0.001
CCS 670: Miscellaneous mental health disorders	507(<0.1%)	536 (<0.1%)	1,043 (<0.1%)	-0.1535	0.0205

Note: Includes SNF stays eligible for the DTC-PAC measure from FY 2023-2024. The FFS column represents statistics for stays that include only FFS claims. The MA column represents statistics for stays that include any Medicare Advantage encounter record.