Publication of the Discharge to Community—Post Acute Care Measures for the Inpatient Rehabilitation Facility, Long-Term Care Hospital, and Skilled Nursing Facility Quality Reporting Programs

External Questions and Answers

Q: What is being announced with regards to the Discharge to Community—Post Acute Care (DTC-PAC) measures in the IRF, LTCH, and SNF Quality Reporting Programs (QRPs)?

A: The Centers for Medicare & Medicaid Services (CMS) is announcing a change in statistical methodology for assigning providers to performance categories for public display of the DTC-PAC measures beginning in fall 2019.

Q: Why were the Discharge to Community—Post Acute Care (DTC-PAC) measures developed?

A: The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) directed the Secretary to specify and publicly report measures reflecting successful discharge to community for use in the IRF, LTCH, SNF, and home health (HH) QRPs. CMS developed the DTC-PAC measures to meet the IMPACT Act mandate and finalized them through rulemaking in Fiscal Year 2017 (IRF, LTCH, SNF) and Calendar Year 2017 (HH).

Q: What do the DTC-PAC measures assess?

A: The DTC-PAC measures assess 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, these measures report a provider's risk-standardized rate of Medicare fee-for-service (FFS) patients/residents who are discharged to the community following a PAC stay, and do not have an unplanned readmission to an acute care hospital or 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. A statistical approach is used to calculate confidence intervals for the provider's DTC rate. These confidence intervals are then compared to the national observed DTC rate to assign providers to performance categories for public reporting. The performance categories are (i) better than the national rate, (ii) no different from the national rate, and (iii) worse than the national rate.

Q: What change has CMS made for public display of the DTC-PAC measures?

A: CMS has refined the statistical methodology for assigning providers to performance categories for public display to align with the claims-based Potentially Preventable Readmissions measures in the PAC QRPs and the Hospital-Wide Readmission measure in the Inpatient QRP. Our refined methodology results in greater variation in provider performance categories, allowing better

discernment of providers that underperform or overperform considerably compared with the national rate. This refinement will be reflected in the fall 2019 Quarterly Refresh for the IRF, LTCH, and Nursing Home Compare websites and the June/July 2019 Provider Preview Reports and future years. The DTC-PAC HH measure was displayed for the first time on HH Compare in May 2019 using the updated methodology.

For more information, please visit:

- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Spotlights-Announcements.html for the IRF QRP;
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Spotlight-Announcements.html for the LTCH QRP; and
- 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.

Q: Why was this change necessary?

A: We implemented this change to align our methodology for provider assignment to performance categories with that of CMS' Potentially Preventable Readmissions measures in the PAC QRPs and the Hospital-Wide Readmission measures in the Inpatient QRP.

Q: What is the impact of this change?

A: This change results in greater variability in provider distribution across the three performance categories, allowing better discernment of providers that underperform or overperform considerably compared with the national rate.