## CBE ID

3480

## Title

Discharge to Community-Post Acute Care Measure for Long-Term Care Hospitals (LTCH)

## Endorsement Status

Endorsed

## Is Under Review

No

## Next Maintenance Cycle

Fall 2026

## Previous Endorsement Cycle

Fall 2018

## Initial Endorsement

Mon, 06/10/2019 - 09:03

## Steward

Centers for Medicare & Medicaid Services

## 1.0 New or Maintenance

Maintenance

## 1.1 Measure Structure

Single Measure

## 1.3 Electronic Clinical Quality Measure (eCQM)

No

## 1.6 Measure Description

The Discharge to Community-Post Acute Care Measure for Long-Term Care Hospitals (DTC-PAC LTCH) was developed to address the resource use and other measures domain of Discharge to the Community mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). This outcome measure assesses successful discharge to community from an LTCH, with successful discharge to community including no unplanned rehospitalizations and no death in the 31 days following LTCH discharge. The measure reports an LTCH's risk-standardized rate of Medicare fee-for-service (FFS) patients who are discharged to the community following an LTCH stay, and do not have an unplanned readmission to an acute care hospital or long-term care hospital (LTCH) in the 31 days following discharge to community, and who remain alive during the 31 days following discharge to community. The measure is calculated using two consecutive years of Medicare FFS claims data and was developed using calendar year (CY) 2012-2013 data. This submission is based on fiscal year (FY) 2016-2017 data; i.e., LTCH discharges from October 1,

2015 through September 30, 2017.

The measure was adopted by the Centers for Medicare & Medicaid Services (CMS) for the LTCH Quality Reporting Program (QRP) finalized in the FY 2017 Inpatient Prospective Payment System (IPPS)/LTCH PPS Final Rule and implementation began October 1, 2016 [1]. Confidential feedback reports on measure performance were distributed to LTCH providers in Fall 2017. The measure will be publicly reported on the LTCH Compare website (https://www.medicare.gov/longtermcarehospitalcompare/) in Fall 2018 using FY 2016-2017 data. Four claims-based discharge to community measures were developed for LTCH, inpatient rehabilitation facility, skilled nursing facility, and home health agency settings to meet the mandate of the IMPACT Act. These measures were conceptualized uniformly across the four settings, in terms of the definition of the discharge to community outcome, the approach to risk-adjustment, and the measure calculation.

References
[1] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; Technical Changes Relating to Costs to Organizations and Medicare Cost Reports; Finalization of Interim Final Rules With Comment Period on LTCH PPS Payments for Severe Wounds, Modifications of Limitations on Redesignation by the Medicare Geographic Classification Review Board, and Extensions of Payments to MDHs and Low-Volume Hospitals, Vol. 81, No. 162. https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf

## 1.7 Measure Type

Outcome

## 1.8 Level of Analysis

Facility

## 1.14 Numerator

The measure numerator is the risk-adjusted predicted estimate of the number of patients who are discharged to the community, and do not have an unplanned readmission to an acute care hospital or LTCH in the 31-day post-discharge observation window, and who remain alive during the post-discharge observation window. This estimate starts with the observed number of discharges to community, defined as: (i) discharges to home or self care with or without home health services, based on Patient Discharge Status Codes 01, 06, 81, or 86 on the Medicare FFS claim [2]; and (ii) no unplanned acute or LTCH hospitalizations in the 31-day post-discharge window; and (iii) no death in the 31-day post-discharge window. The discharge to community outcome is risk-adjusted for patient characteristics and a statistical estimate of the facility effect beyond case-mix (described below).References [2] National Uniform Billing Committee Official UB-04 Data Specifications Manual 2018, Version 12, July 2017, Copyright 2017, American Hospital Association.

## 1.15 Denominator

The target population for the measure is the group of Medicare FFS beneficiaries who are discharged from an LTCH during the measurement period and are not excluded based on the measure exclusion criteria (see S.8. and S.9.). The measure denominator is the risk-adjusted expected number of discharges to community. This estimate includes risk-adjustment for patient characteristics with the facility effect removed. The “expected” number of discharges to community is the predicted number of risk-adjusted discharges to community if the same patients were treated at the average facility. The logistic regression model used to calculate the denominator is developed using all non-excluded facility stays in the national data. The denominator is computed in the same way as the numerator, but the facility effect is set at the average.

### 1.20 Types of Data Sources

Claims Data

### 6.1.2 Current or Planned Use(s)

Public Reporting, Quality Improvement (Internal to the specific organization)

### 6.1.3 Current Use(s)

Public Reporting, Quality Improvement (Internal to the specific organization)

### Exclusions

Measure exclusion criteria are based on administrative data from Medicare claims and eligibility files. Exclusion criteria were selected to maintain clinical validity of the measure by excluding stays for which discharge to community would not be appropriate, to ensure data availability and completeness, to exclude stays with problematic claims data, and to maintain relevance to the LTCH QRP (e.g., excluding LTCHs not included in the LTCH QRP based on regional location). Only LTCH stays that are preceded by a short-term acute care stay in the 30 days prior to the LTCH admission date are included in the measure; this is because risk-adjustment variables come from the short-term acute care stay in the 30 days prior to LTCH admission. Stays ending in transfers to the same level of care (i.e., LTCH-to-LTCH discharge) are excluded, because the LTCH episode of care had not ended. We also excluded certain discharge status codes on the LTCH FFS claim that indicated that the patient was not appropriate for community discharge (e.g., discharges against medical advice). See section S.9 for detailed rationale and data sources for each exclusion.

Measure exclusion criteria are as follows:

• Age under 18 years;
• No short-term acute care hospital discharge within the thirty days preceding an LTCH admission;
• Discharges to a psychiatric hospital;
• Discharges against medical advice;
• Discharges to disaster alternative care site or a federal hospital;
• Discharges to court/law enforcement;
• Discharges to hospice or patient stays with a hospice benefit in the 31-day post-discharge window;
• Planned discharges to an acute or LTCH setting;

• Stays for patients without continuous Part A FFS Medicare enrollment during the 12 months prior to the LTCH admission date and the 31 days after the LTCH discharge;
• LTCH stays preceded by a short-term acute care stay for non-surgical treatment of cancer;
• Stays ending in transfer to an LTCH;
• Stays with problematic claims data (e.g. anomalous records for stays that overlap wholly or in part or are otherwise erroneous or contradictory, claims not paid);
• Exhaustion of Medicare Part A benefit during the LTCH stay; and
• LTCH stays in facilities outside of the United States, Puerto Rico, or another U.S. territory.

## Planned Use

Quality Improvement (Internal to the specific organization)

## Risk Adjustment

Statistical risk model

## The measure developer is different from the measure steward

No

## Steward Organization

Centers for Medicare & Medicaid Services

## Steward POC email

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