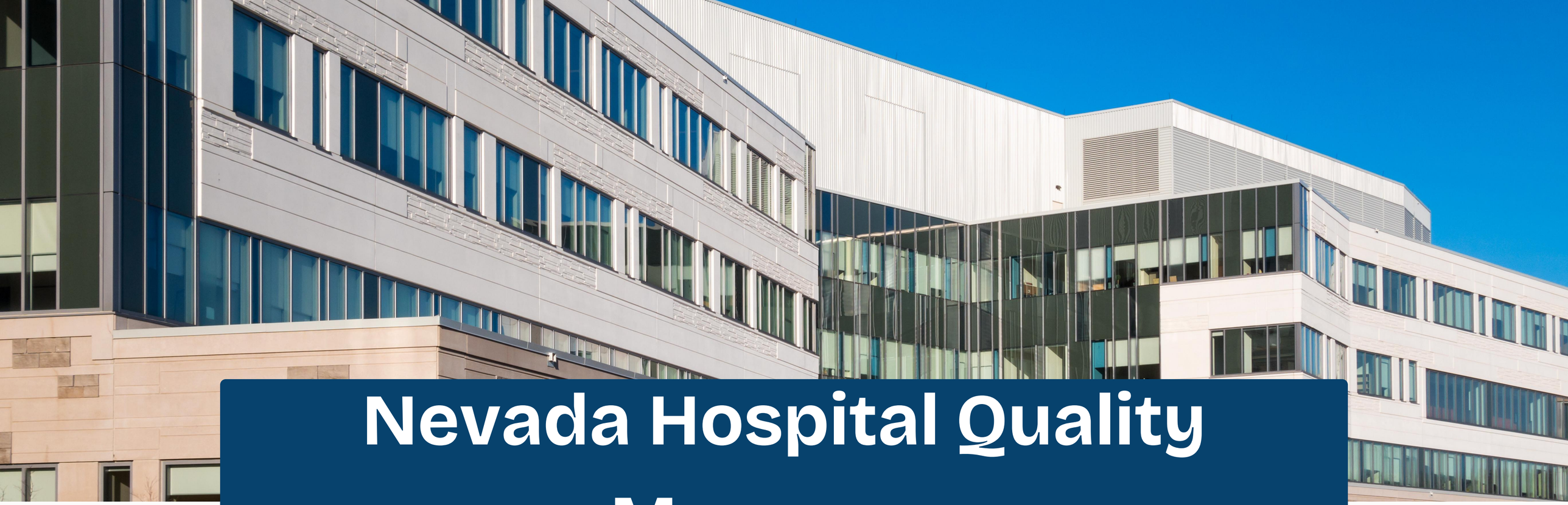

Nevada Hospital Quality Measures

DTC - PAC: Discharge to the Community

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Measure Overview

The Discharge to Community (DTC) measure was mandated by the IMPACT Act of 2014 to standardize outcome reporting across various Post-Acute Care (PAC) settings. It is a claims-based measure used in the Quality Reporting Programs (QRP) for Long-Term Care Hospitals (LTCH) and Inpatient Rehabilitation Facilities (IRF). DTC-PAC assesses the rate at which Medicare Fee-For-Service (FFS) beneficiaries are successfully discharged from a PAC setting, achieve functional gains, and sustain their recovery in a non-institutional setting.

This measure emphasizes the **LTCH** or **IRF's** ability to provide effective discharge planning and clinical preparation that enables patients to manage their care successfully at home.

*Centers for Medicaid & Medicare Services/ Partnership for Quality Measurement

Strategic Goals & Impact

Public Reporting & Reputation

Performance is publicly reported on CMS Compare websites, influencing patient choice and referral patterns.

Quality Reporting Program (QRP)

Non-compliance with overall QRP reporting requirements results in a 2.0 percentage point reduction in the Annual Payment Update.

Value-Based Payment Alignment

It aligns care efforts with the goal of Medicaid to reduce total spending and improve functional outcomes across the post-acute care continuum.

Reducing Costly Utilization

Success means the patient avoided an unplanned acute hospital or LTCH readmission within 31 days, saving significant financial resources.

The DTC-PAC is a foundational cross-setting outcome metric, demonstrating a facility's ability to maximize patient recovery and minimize costly, preventable re-institutionalization. Nationally, successful IRF discharge rates often exceed 80%, but failure to meet or exceed the national average directly impacts public perception and reimbursement.

Defining the Population

Denominator *(Who's included)*

- **Payer**: Medicaid beneficiaries.
- **Age**: 18yrs or older
- **Discharge Status**: Patient discharged from the LTCH or IRF to a community setting.
- **Enrollment**: Must have continuous Medicaid enrollment for 12 months prior to admission and 31 days after discharge.

Numerator *(CMS "Success" Definition)*

- **Discharged to Community:** Medical record indicates discharge to home/self-care (with or without home health).
- **Alive:** Patient remains alive for 31 days post-discharge.
- **No Readmissions:** Patient is not readmitted to an acute care hospital or LTCH within the 31-day window.

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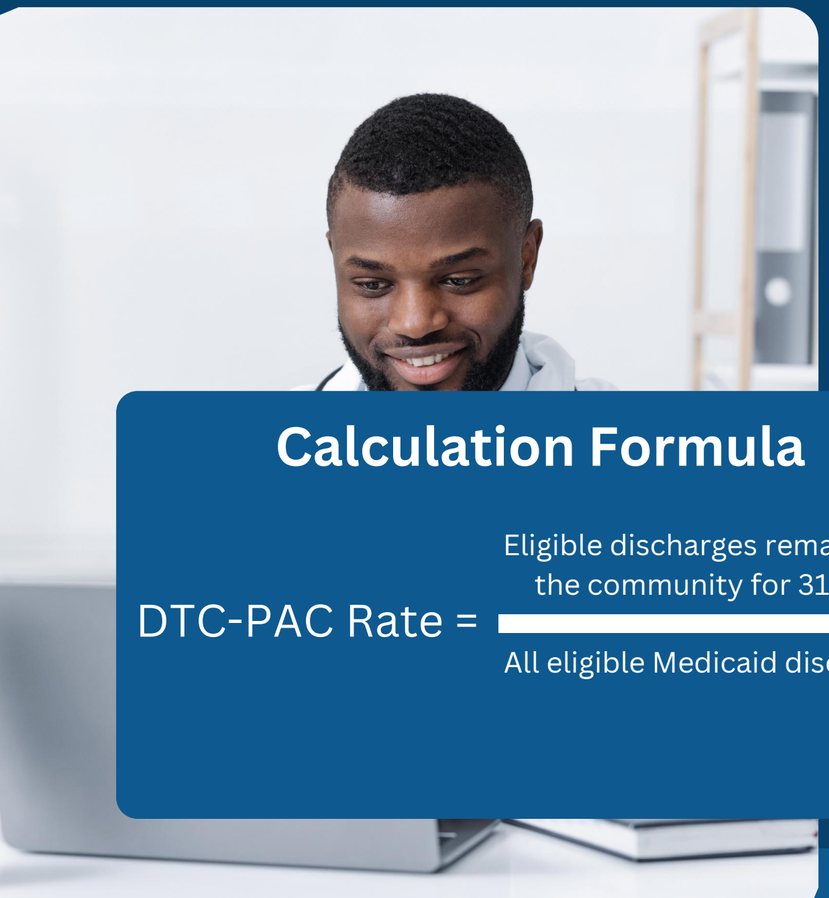
Understanding Exclusions

Exclusions are a vital part of the DTC-PAC measure calculation, ensuring that facilities are only held accountable for outcomes they can influence. Patients are removed from the denominator if their stay was fundamentally interrupted (e.g. unplanned transfer to an acute hospital) or if their care goals changed to end-of-life status (Hospice). By filtering out these cases, CMS allows for a more accurate comparison of successful community reintegration between LTCHs and IRFs.

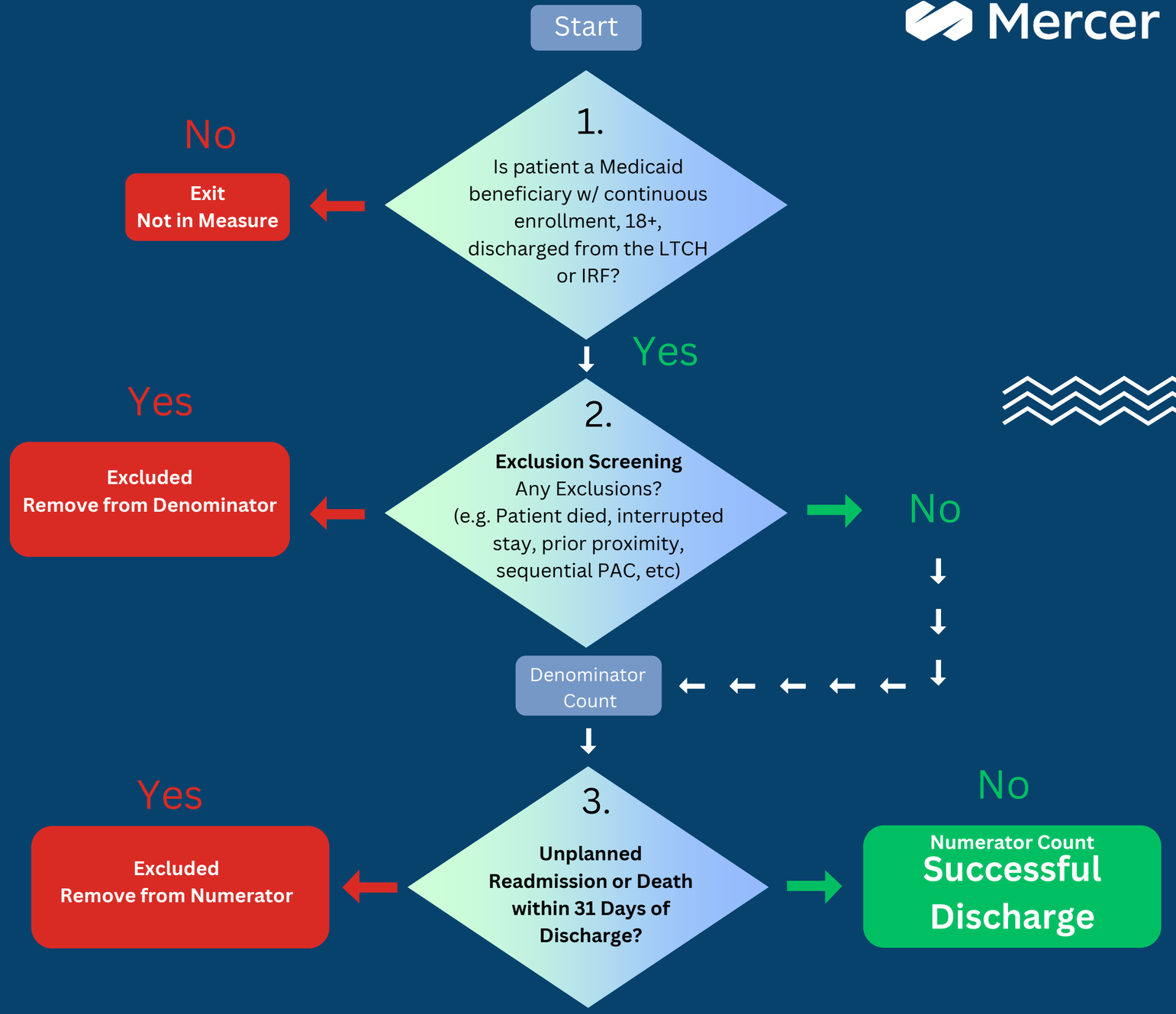
Exclusion Category	Description	Rationale for Exclusion
Patient Status	Patient died during the LTCH/IRF stay	Patient's outcome is not attributable to the facility's discharge planning effectiveness.
Non-Compliance	Patient discharges against medical advice (AMA).	Patient leaves prematurely, preventing the completion of care and discharge planning.
End-of-Life Focus	Patient discharged directly to a Hospice program or facility.	Patient's goal of care is comfort, not community integration/rehabilitation.
Interrupted Stay	Patient transferred to an Acute Care Hospital (ACH) before the planned discharge.	Stay was interrupted due to an acute issue, breaking the continuity of the PAC treatment course.
Sequential PAC	Patient transferred to another LTCH or IRF.	Patient is continuing their post-acute care journey, and the outcome will be measured at a later point by the receiving facility.
Federal/External	Patient transferred to a Federal Hospital, or court/law enforcement.	Outcome is tracked by a non-Medicaid reporting entity.
Prior Proximity	Patient was not discharged from an ACH within 30 days prior to the LTCH/IRF admission.	This ensures the measure focuses only on PAC stays related to recent acute illness or injury.
Planned Treatment	Patients stay preceded by a short-term acute care stay for a non-surgical treatment of cancer.	The PAC stay is a continuation of planned care, not a rehabilitation phase following an acute event, which is the focus of the measure.

Measure Logic Flowchart



Calculation Formula

$$\text{DTC-PAC Rate} = \frac{\text{Eligible discharges remaining in the community for 31 days}}{\text{All eligible Medicaid discharges}}$$



Best Practices for Data Extraction

Since the DTC-PAC measure is calculated solely by CMS using your billing claims, the primary best practice is ensuring the accuracy and consistency of all codes submitted. Close coordination between clinical staff, coders, and the billing department is required to accurately capture the patient's full journey and discharge disposition. Mismatches in documentation or incorrect discharge codes are the primary cause of missed success points.

Focus Area	Key Action
Discharge Status Codes	Verify the patient's final destination against the official Medicaid Discharge Status Codes to ensure the claim matches the actual discharge plan.
Prior Stay Linkage	Check the admission source to confirm the patient was discharged from an Acute Care Hospital within the last 30 days (validating they belong in the denominator).
Post-Discharge Surveillance	Implement a 31-day follow-up check (via phone calls, HIE alerts, or primary care coordination) to confirm the patient is still alive and has not been readmitted to a hospital.
Hospice & AMA Documentation	Clinically document all reasons for exclusion and ensure the specific exclusion discharge code is used on the claim.

Common Data Capture Pitfalls

Accurate DTC-PAC reporting requires bridging the gap between clinical discharge events and the final billing claims processed by CMS. The most frequent errors stem from the "invisible" 31-day post-discharge period and misaligned exclusion coding, which creates significant variance between internal dashboards and public reports. Avoiding these traps is essential for a reliable self-reporting strategy.

The “Happy Goodbye” Fallacy

Counting a patient as a "Success" immediately upon discharge without verifying they remained alive and out of the hospital for the full 31-day window.

Hidden Hospice Designations

Failing to use specific discharge status codes for Hospice, prevents the removal of terminally ill patients from your denominator, negatively skewing results.

Vague Discharge Dispositions

Using generic discharge codes that do not explicitly map to CMS "Community" definitions causes valid successful discharges to be processed as failures in the numerator.

Miscounting Planned Readmissions

Incorrectly penalizing your internal score for planned hospital returns, which CMS specifications actually allow without counting as a failure.

Frequently Asked Questions

1. What is a freestanding rehabilitation hospital?

For Nevada's private hospital assessment, related UPL payments, and the SDP tied to these performance measures, rehab hospitals are classified as such in the initial NHA model and in all subsequent state-generated models shared with the NHA.

2. What is the definition of "community discharge"?

CMS defines a successful community discharge as a patient being discharged to the community and not experiencing an unplanned rehospitalization or death within 31 days of discharge. The community is defined as home or self-care, with or without home health services.

3. Should patients who exhausted their Medicaid benefit be included?

Patients who exhausted their Medicaid benefit during the LTCH stay should not be added to the numerator or denominator, based on the CMS Partnership for Quality Measurement exclusion criteria.

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How Can We Help?

For additional questions, personalized 1:1 coaching, or to schedule a meeting to review your facility's data, please reach out to our support team members below:

State Directed Payments- Ann Jensen
ajensen@nvha.nv.gov

Reporting Template- Liza Auterino
Liza.Auterino@govmercer.com

Clinical Support- Sherrian Thompson
Sherrian.Thompson@govmercer.com

Success is a 31-Day Commitment

A "successful" outcome is not achieved until the patient remains alive and free of acute care readmissions for a full 31 days post-discharge.

Coding Equals Performance

Since this is strictly a claims-based measure, using the precise discharge status codes are the only way to accurately capture your success.

Exclusions Protect Your Score

Properly identifying and coding exclusions, ensures your denominator is clean and you are not penalized for non-rehabilitation outcomes.

Bridge the “Blind Spot”

Internal self-reporting templates will artificially inflate your success rate unless you implement a post-discharge follow-up process to catch readmissions that occur after the patient leaves your facility.

Key Takeaways

The Discharge to Community measure acts as a barometer for the durability of patient recovery, assessing not just the immediate discharge destination but the patient's stability for a full month afterward. As a strictly claims-based metric, accurate performance relies entirely on precise billing codes rather than manual clinical assessments. Success requires facility teams to look beyond their doors, ensuring that care transitions are robust enough to prevent readmission during the critical 31-day window.

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Thank you!

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