



MLN Connects®

National Provider Call Transcript



**Centers for Medicare & Medicaid Services
IRF and LTCH Quality Measure Report Call
MLN Connects National Provider Call
Moderator: Leah Nguyen
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Operator: At this time, I would like to welcome everyone to today's MLN Connects® National Provider Call.

All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now the call over to Leah Nguyen. Thank you. You may begin.

Announcements and Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I would like to welcome you to this MLN Connects National Provider Call on Quality Measure Reports. MLN Connects Calls are part of the Medicare Learning Network®.

During this call, CMS experts present on the CASPER Quality Measure Reports for the Inpatient Rehabilitation Facility and Long-Term Care Hospital Quality Reporting Program, find out how to get aggregate performance for the current quarter or past three quarters, find reporting errors that may affect your performance, and interpret the information. A question-and-answer session will follow the presentation.

Before we begin, I have a few announcements.

You should have received a link to the presentation for today's call in previous registration emails. If you have not already done so, please view or download the presentation from the following URL -- go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

Finally, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website.

At this time, I would like to turn the call over to Charles Padgett from the Centers for Clinical Standards and Quality at CMS.

Presentation

Charles Padgett: Thank you, Leah.

Good afternoon. My name is Charles Padgett, and I work here at CMS. I lead the public reporting aspect of the IRF and LTCH quality reporting programs. And, today, I'm going to be presenting, as Leah said, on public reporting and the CASPER Quality Measure Reports that are available to providers that will assist you in understanding sort of where your facility or hospital stands with respect to your performance on specific

quality measures and other useful information. And, so, I'll be reviewing the reports and how to access the reports as we move through this presentation.

I'm going to move on to page -- or to slide 3 right now. This slide -- there are a number of acronym that we'll use during the presentation. And this slide just is a reference of all of these acronyms. Hopefully, most of them are written out in long hand prior to being used throughout the rest of the presentation. But just in case you need to refer back, you can refer back to this slide.

Moving on to slide 4. Those acronyms continue on that slide. And, so, you can refer to that slide as well.

Slide 5 goes over the background of public reporting. The IRF and LTCH quality reporting programs were sort of birthed, if you will, through the Affordable Care Act, more specifically, Section 3004 of the Affordable Care Act, which mandated the Secretary to establish procedures for making quality data submitted by LTCHs and IRFs available to the public under their respective quality reporting programs.

The actual framework for the LTCH and IRF public reporting was first established in the fiscal year 2012 Inpatient Prospective Payment System or IPPS/LTCH PPS final rule and the fiscal year 2012 IRF PPS final rule, respectively. And public reporting of the first set of quality measures will begin in the fall of 2016, which we are currently in and sort of coming to the end of the year.

So, moving on to slide 6, which is the agenda.

So the purpose of this presentation -- we will identify the quality measures for public reporting in 2016. We will name and describe reports associated with public reporting. We'll explain the content of the Certification and Survey Provider Enhanced Reports—or CASPER Reports, Quality Measure Reports -- or CASPER Quality Measure Reports by data source. We'll review how to interpret facility- and patient-level results. And we'll describe how to access the reports in CASPER. Lastly, we'll identify some helpful resources for providers.

Quality Measures

Slide 7. There are essentially three types of quality measures in our quality reporting programs, and this pertains to both IRFs and LTCHs. We have -- the categories are really based on the data source of the measures. We have assessment-based measures. And for LTCHs, those measures are informed by data collected via the Long-Term Care Hospital Continuity Assessment Record and Evaluation, or LTCH-CARE, data set. And for IRFs, that would -- the data source would be the Inpatient Rehab Facility-Patient Assessment Instrument, or IRF-PAI, as it's commonly known. And the second category is Centers for Disease Control and Prevention National Healthcare Safety Network

Measures of the health -- and these are health care acquired infection measures. And, lastly, claims-based measures that are based on either LTCH PPS or IRF PPS claims.

Moving on to slide 8. Our focus during this presentation is the quality measure reports, really, not the quality measures themselves. So, I'm not going to go into a lot of specifics about the quality measures themselves. If you have questions on those, I would ask that you submit question to our respective IRF and LTCH help desks. We will field questions at the end of this presentation as well, and we can certainly try to get to your questions. If we don't get to your questions or any questions we don't get to, I would ask that you submit to their respective help desks and we'll lift them also.

But, the quality measures that are listed on the next several slides represent the quality measures that are actually included on the current versions of the IRF and LTCH QM reports, which will be discussed throughout this presentation. And that's not to say that is the whole of the measures for each of the programs.

And, so, for an exhaustive list of the quality measures for each program, on slide 8 we list our websites -- our quality reporting websites that you can go to in order to see all of the finalized measures for each of the quality reporting programs.

Moving on to slide 9. We're going to go over the assessment-based measures here that are included in this report or in these reports. And, again, the assessment-based measures are for LTCHs. that would be measures informed to the -- data collected through the LTCH-CARE data set, and for IRFs, collected using the IRF-PAI. And those are the Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine short stay measure. And that's NQF number 0680. And data collection for this measure for both settings began on October 1st of 2014. And the second assessment measure is Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened short stay measure. And that's NQF number 0678. And data collection for this measure for both settings began on October 1st of 2012.

Moving on to slide 10. This slide lists the CDC NHSN measures that are included in these reports currently. The NHSN Catheter-Associated Urinary Tract Infection (or CAUTI) Outcome Measure. And data collection for that measure began on October 1st of 2012. And, also, the Central Line-Associated Bloodstream Infection Outcome Measure -- and that is only collected for the LTCH setting. So that only pertains to the LTCH setting. And data collection for that measure also began on October 1st of 2012.

Moving on to slide 11. This slide lists the claims-based measures that are included in these reports. It is a very similar measure for each program. All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from IRFs or All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from LTCHs. And data collection -- it states here data collection began on October 1st of 2012. These are claims-based

measures. So, we do not require LTCHs or IRFs to submit any additional data beyond that of data we receive when you submit your PPS claims.

The reason for the date, this measure requires 2 years of data. Providers do not, like I said, submit data for this quality measure since it is claims-based. And this measure reports if a patient is discharged from an IRF or LTCH and readmitted to an acute care hospital or an LTCH for IRFs only. So, that is to say for IRFs, it reports whether a patient was readmitted to a higher level of care—and an LTCH would be considered a higher level of care—within 30 days of discharge from the IRF or LTCH. And that patient may have been discharged home or to a lower level of care from the respective setting.

Okay, moving on to slide 12. This slide is a visual. And it is -- represents sort of the ideal state of reports and reporting for the quality reporting programs. We will not be describing all the aspects of reporting during this presentation. This graphic displays the CASPER reporting and it includes confidential reports for providers, compliance reports, and then public reporting.

So, it essentially represents sort of the order in which reports are applicable as we move through a quarter. You will see the Review and Correct Reports, which I will talk about a little later, the Quality Measure, or QM, Reports, which I will be discussing during this presentation, and Provider Preview Reports, which have been discussed previously during a former training that we've given. And, then, you see Compare listed there, which is the public reporting of the quality data. So, each of these reports give you somewhat different information and are for different purposes.

Moving on to slide 13. The CASPER Reports, of which there are three. The Provider Preview Reports—those were launched on September 1st of 2016. I see the slide says September 2nd. That is actually September 1st. The Review and Correct Reports were launched -- will be launching in spring of 2017, so, coming up here in a few months. And, then, the QM Reports, which are facility-level and patient-level—two different types of reports—and those are now available to both LTCHs and IRFs via the CASPER system.

Lastly, public reporting, which refers to the IRF Compare website and the LTCH Compare website, which will be launching here shortly. And, then, there will also be downloadable data from data.medicare.gov, which will contain the raw data that will be available to researchers and the public.

And as I said, we've already presented on the Provider Preview Reports. And I just want to let you know that that presentation, the slides that were -- was -- the slides that were used for the presentation are available on both the IRF Quality Reporting Program and LTCH Quality Reporting Program websites. And, so, you do have access to those if you wish to review those.

CASPER

Moving on to slide 14. This is sort of an overview of the Quality Measure Reports. As I said, there's a facility-level report and a patient-level report. CMS and other contractors may also refer to these reports as CASPER User-Requested Reports or Confidential Feedback Reports, they can also be known as the IMPACT Act requires us to -- IMPACT Act of 2014 requires us to provide confidential feedback to providers regarding their quality data, and these reports satisfy that requirement. They will be available to providers prior to public reporting for internal purposes only and not for public display. And providers can use it for feedback to help providers identify data errors and improve quality for care -- so, for internal benchmarking purposes. And, then, they contain quality measure information at the facility and at the patient level for a single reporting period.

Moving to slide 15. Again, this refers to these same QM Reports, the CASPER Reports. They are available on demand. So, a provider can go in and run these reports whenever you wish. You're able to select the data collection end date and obtain aggregate performance data. And it's important to note that the claims-based measures and the CDC NHSN quality measures are not included in the patient-level reports because we don't have patient-level data available for those reports. So, only assessment data, the LTCH-CARE data set data and the IRF-PAI data, will be available on the patient-level report.

The next few slides are going to provide details of the reports. We're first going to go over the facility-level reports, and then the patient-level reports. And as I go through this, you'll see -- either a snapshot of the IRF or LTCH version of the report will be displayed. So, for the purposes of this presentation, it was just too cumbersome to show both. But, what I'm presenting here is relevant to both settings.

As you go in and access your reports, everything will look exactly the same. The only real difference is that, you know, the LTCH setting has a measure that's not available for IRFs because IRFs don't report that measure. And then, in the future, as we move forward and subsequent versions of these reports are available to you, you know, the LTCH and IRF settings will have different measures on their reports. But, they will also share some measures. So, some measures will be on both reports. But, for the purposes of this presentation, what I'm going to show you -- whether it says IRF or LTCH at the top of the report, it is definitely applicable to both settings.

Moving on to slide 16. This slide is a -- shows you the information that's available or contained within the header of the reports -- facility ID, CMS certification number, your facility or provider name, location, the report period, and the comparison group period. So -- and national rates are calculated based on stays within the State range.

The comparison group period is the same as the report period to allow for a consistent comparison. And the report run date that's listed here and that's listed at the top of the report refers to when the report was created, as well as the version number.

Moving on to slide 17. The report header allows for the user to clearly identify the type of report and the provider type. So, as you see at the top, it says CASPER Report and IRF Facility-Level Quality Measure Report. This is what the header looks like. And the information listed on the report regardless -- is listed on the report regardless of the specific quality measure that's displayed in the report.

Moving on to slide 18. Again, talking about the facility-level reports that are available to you, some important notes. We ask that you review the data about that -- about your facility -- so, your facility's demographic data, including facility name, your CMS certification number or CCN number, primary contact information, and the date of certification.

And you'll see in parenthesis here it says "exception IRF T-units." The reason for that is for IRF T-units in some States, the certification number that is fed into this report, which comes from the ASPEN system, is that of your parent hospital. So, for those units, those IRF units that are within a hospital, for some States, that certification date that displays is the certification date for your parent hospital that is updated on a yearly basis when your hospital is surveyed. So this -- we just want to draw attention to that because it's not always -- you're not always able to update that information within the ASPEN system.

The major source of public reporting help desk questions, all of these demographic information concerning the Provider Preview Reports that I talked about previously and that were released in September. We received many questions stating that addresses were wrong and certification dates were incorrect -- that sort of thing.

So, I can't stress enough. It's really important you review this information on your reports. And to the best of your ability, make sure the Medicare certification date for your facility is correct within the ASPEN system.

And -- because CMS has really no ability to monitor the validity of the Medicare certification dates within ASPEN and nor do we have the authority to issue a correction within the system, so we cannot update that system for you. Believe me, if we could, we would. We realized that would be a much easier way to go about this. But, unfortunately, we're just not able to do that. So, we have to depend on you to ensure that this information is correct. And if you're seeing inaccurate information on one of your reports, we're going to ask that you do your best to get that information corrected.

Moving to slide 19. This -- how to correct your information? We're going to ask that you contact your Medicare Administrative Contractor by visiting the website that's listed

right below there. You'll click on your State map or select from a drop-down list below the map. Contact information for your State will then be displayed below the map and you can find your regional office at the following link that's here. PDFs of contact information for each regional office are available at the bottom of the page. So, that'll make more sense when you go to the link listed on this page. I know it sounds a little strange. But, it's -- it'll be much more clear when you actually go and use the link. But, as I said, you need to contact your Medicare Administrative Contractor and make sure that the information -- your demographic information is correct.

Assessment-Based QMs

All right. Moving on to slide 20. A little bit -- I'm going to talk about assessment-based quality measures contained within the reports themselves. The source is listed -- so, where the data comes from, which as I stated before, is either the IRF-PAI or the LTCH-CARE data set for assessment-base quality measures.

The measure -- the measure name and the NQF number, when appropriate, if the measure's endorsed, will be listed. Then you'll see a CMS measure ID, which is an internal ID that CMS assigns to quality measure. We update it to reflect changes in quality measure development, for example, if underlying items on the assessment form change.

The numerator, which is the number of stays in the facility that trigger the indicated quality measure during the reporting period -- and we ask that you see the Quality Measure User's Manual for details on how to determine this value for applicable quality measures. Denominator or total number of qualified stays in the facility which did not meet the exclusion criteria during the report period. Facility observed percent, which is an unadjusted or crude rate, which is based on the numerator and denominator. And comparison group U.S. national average, which shows the average of the measure within the comparison group time period for comparison purposes.

So moving on to slide 21. You'll -- you see a snapshot of the Results section of the report. And what is displayed for the measure -- this is an LTCH version of a report. And what you see in this section of the report differs by quality measure. So, as you see, the first measure that we see on the report here is percent of residents or patients with new or worsened pressure ulcers.

Also listed for this QM is facility-adjusted percent, which is computed using a mathematical model that accounts for patient or resident characteristics and the national rate. And we also ask that you see the QM User's Manual for details on how to determine this value for any applicable quality measure. So, those are all listed for the pressure ulcer measure on the report.

Moving on to slide 22. This page of the report -- and this, again, is the facility-level report. We're showing an IRF snapshot right now on slide 22. The measure is Percent of

Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine Short Stay Measure. And for this measure, you'll see the fields that are available. We have the numerator listed, the denominator, the facility observed percent, and the comparison group U.S. national average.

This particular quality measure is further listed as submeasures A, B, and C to provide the breakdown by category. So, the influenza measure also lists residents or patients who received the seasonal influenza vaccine, residents or patients who were offered and declined the seasonal influenza vaccine, and residents or patients who did not receive due to medical contraindications the seasonal influenza vaccine.

The numerator for this measure is the number of stays in the facility that triggered the indicated quality measure during the reporting period. The denominator is the total number of qualified stays in the facility which did not meet the exclusion criteria for this measure. And, again, the facility-observed percent is the unadjusted or crude rate based on the numerator and denominator. Lastly, the comparison group U.S. national average shows nationwide average of the measure within the comparison group time period for comparison purposes.

NHSN Measures

Moving on to slide 23. The next two measures are the NHSN CDC measures, which are CAUTI and CLABSI. Again, I would just want to note that CLABSI is only reported for LTCHs. IRFs do not report on CLABSI.

(Background conversation.)

Charles Padgett: Moving on to slide 24.

The LTCH mockup is currently displayed for the CDC measures. And for these measures, it's easier to sort of -- to first display the report and then to review the information that's contained in the report. So, slide 24 shows a snapshot of the report with both the CAUTI and CLABSI measures.

As you'll notice at the top, it's an LTCH snapshot because it contains the CAUTI -- or, I'm sorry -- it contains CLABSI. So, it'd definitely be LTCH. And it shows all of the various fields in the report -- CMS measure ID, reported number of infections, device days, predicted number of infections, SIR, 95-percent confidence interval, comparison group U.S. national SIR, and comparative performance category.

Slide 25 sort of reviews the different fields for that measure -- for the NHSN measures that I just went over.

So, we can move on to slide 26. You'll notice also at the top of the report before we report performance data, there will be a table legend which provides further

information. A, for instance, standardized infection ratio -- so, the SIR as the ratio of reported to predicted infections and explains that a lower SIR is better as you're viewing this report. B displays the lower and upper limits of confidence interval. C, standardize infection ratio, U.S. national benchmark equals one. And then, D, CDC measures are not included in CMS patient-level quality measure reports. So, the legends just give you additional information about the reports.

Moving on to slide 27. We're going to go ahead and review the fields that are listed for the CAUTI and CLABSI measures. The reported number of infections -- that is the numerator. The device days -- the total -- which are the total number of days in the facility associated with the device. So, for CAUTI, it would be the catheter or catheter days, and for CLABSI, it would be the central line days. And predicted number of infections is device days multiplied by the national rates, which is based on aggregated national data of reported infections during a CDC-designated time period. And that is used to calculate the SIR or standardized infection ratio. And the standardized infection ratio is the reported number of infections in the facility divided by the predicted number of infections in the facility. It includes a lower and upper limit of the 95-percent confidence interval for the SIR. So, all of that information is contained within this report for the CAUTI and CLABSI measures.

Moving on to slide 28. This slide talks about the confidence interval, which indicates ranges of values that are likely to encompass the true value. And in statistics, we cannot be certain really of the ratio of reported to predicted infections. We can't be certain that it's exact. And your IRF or LTCH's ratio of reported to predicted infections -- for instance, if the SIR was 0.923, then the confidence interval says that we are 95-percent confident that the true population result is between 0.075 and 0.797. And you can see that the SIR of 0.293 does fall within the boundary of those two numbers. The confidence interval gives you sort of a safety net or boundaries for the upper and lower limits.

Excuse me.

All right. Moving on to slide 29. Again, just continuing on with the NHSN measures. The comparison group U.S. national SIR that's on the report is the reported number of infections in the nation divided by the predicted number of infections in the nation. So just as -- very similar to the SIR for your facility, but it's at a national level. The comparative performance category that we use on these reports compares the performance of the facility to the U.S. national benchmark.

So, the national benchmark is always set at one regardless of what the U.S. national standardized infection ratio is. So, if your facility performed worse than the U.S. national benchmark and you exceed that category, that means that the SIR lower limit is greater than one. If your facility received a category of no different than the U.S. national benchmark, that means that the SIR confidence interval includes one. And if you receive

the category better than U.S. national benchmark, that means that the SIR's lower limit is less than one.

Claims-Based Measures

All right. Moving on to slide 30.

This slide displays the claims-based measures that are included on these facility-level reports. Again, it's the All-Cause Unplanned Readmission measure for 30 Days post Discharge from IRFs or LTCH, depending upon your setting.

The claims-based measure -- the report contains the following information for claims-based measures: the number of unplanned readmissions following discharge—and that is the number of patients who have the event of an unplanned or potentially preventable readmission in the 30-day post discharge window; the number of eligible stays—and that's the number of eligible stays for the reporting time period; the crude readmission rate, which is the number of unplanned or potentially preventable readmissions following discharge—and that's divided by the number of eligible stays and then multiplied time 100; the risk standardized readmission rate—and the results are risk-adjusted for this rate to account for the patient characteristics and facility effect.

And we ask you to, or I would refer you to the Quality Measure Specifications and QM User's Manual for further details about that. But we -- it's showing you the risk-adjusted rate for your facility. The U.S. national crude rate, which is the number of unplanned or potentially preventable readmissions following discharge in the nation divided by the number of eligible stays in a nation and then multiplied time 100.

And then, lastly, on the report you'll see the comparative performance category, just as I spoke about before, which is either -- it compares the performance of your facility or hospital to the national benchmark. Worse than the U.S. national rate means that the entire confidence interval is above that national crude rate. No different from the U.S. national rate means that the 95-percent confidence interval contains the national crude rate -- so it falls between them. And better than U.S. national rate -- if that's your rating, it means that the entire 95-percent confidence interval is below the national crude rate.

Okay. Moving on to slide 32. On this slide, it shows a mockup of the LTCH report with the readmissions measure displayed. You'll see all of the categories I -- or all of the different fields that I just went over are listed on this report. As we said, this changes depending upon the measure. So, each measure is on a different page of your report. And then, you know, what's displayed is dependent upon the particular measure that is being displayed.

CASPER QM Patient-Level Reports

Slide 33. We're going to begin talking about the patient-level reports. These reports contain quality measure information at the patient level for a single reporting period. Providers are able to specify the reporting end date and obtain aggregate performance for the current quarter. And it may be partial and past three quarters. So, if you're running this and you're using the current quarter that you're in, the result may be partial for that quarter because all of the data has not been reported to CMS and will include the past three quarters. And the patient-level reports, as I noted earlier—and it's important to remember—only contain the assessment-based measures.

The patient-level reports -- the header contains the following information. You'll see the facility ID; the CCN number; the city and the State of your facility or hospital; the report period; the report run date, which is the date the report was created; the report version number; and, then, the status legend. And, again, the status legend provides the key for each patient status with regard to the quality measure.

So, X -- the use of an X in the report means that the quality measure was triggered by that patient. The use of NT indicates that the quality measure was not triggered by that patient. And the use of an E indicates that an exclusion outlined by the quality measure exclusion criteria occurred or that patient was excluded as outlined by the exclusion criteria of that quality measure.

And whether the QM is triggered can be positive or negative, depending upon the quality measure, as we review the reports. So, the pressure ulcer quality measure is shown on the first report or the first mockup that you see on slide 35. And the pressure ulcer quality measure represents what we call an undesirable outcome or process. So, an X representing triggered is not positive. It's not a good result, while the NT or not triggered is a good outcome for this measure. The patient name and ID are listed, as well as the admission and discharge date for that particular patient.

So, just for example, the first line you see "Doe, Charles"; their patient ID; their admission date, which was 11/01/2014; their discharge date, which was 12/01/2014. And then you'll see the quality measures listed at the top. Percent of Residents with Pressure Ulcers That Are New or Worsened -- and you'll see and X for Charles Doe. So, that means that he triggered the measure. And, then, the other columns you see here are for future measures that will be added to these reports.

All right. Moving on to slide 36. The patient-level reports only include the assessment-based measures. And there are only two assessment-based measures that are on these reports at this time. And that is the pressure ulcer measure, which we just showed you, and the influenza measure, Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine Short Stay Measure.

And for this measure, we need to look at how to interpret the yes or no for the overall measure and submeasures. Yes for the overall measure equals Y in one submeasure. And an N for overall measure equals N in all submeasures. So, that will make sense as we move forward here. But, again, I'm just going to repeat that. A yes for the overall measure means that there's a yes in one of the submeasures, and an N for the overall measures means that there's an N in all of the submeasures.

All right. Moving on to slide 37. So, this is a mockup of an IRF Patient-Level Quality Measure Report. The report – you'll see the status legend, which lists Yes, No, or Excluded from Analysis based on exclusions criteria, the quality measure Patient Seasonal Influenza Vaccine Measure. And you also see the source that's listed, which is the IRF-PAI. On the right, you'll see a list of patient names, then their IDs, admission date, discharge date. And, then, you'll see the quality measure listed first followed by the three submeasures. And I covered these before.

So, just for example, if we look at the first row, which is a Charles Doe, he -- this has an N listed for the measure, Percent of Residents or Patients Who Were Assessed and Appropriately Given a Seasonal Influenza Vaccine (Short Stay). And having an N for the -- for the main measure -- that patient should have an N for all submeasures. So, they did not trigger this measure.

And, then, for instance, Fred Doe, which is below Charles Doe in the second row, you'll see that for the main measure that this patient did trigger the measure. And that means that they also had to trigger one of the three submeasures. And they did trigger one of the three, Residents or Patients Who Received the Seasonal Influenza Vaccine. So that patient actually did receive the vaccine.

All right. At this time, we're going to pause for just a minute. I'm going to hand it back over to Leah for some audience polling.

Keypad Polling

Leah Nguyen: Thank you, Charles.

At this time, we will pause for a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note, there will be a few moments of silence while we tabulate the results.

Holley, we are ready to start polling.

Operator: At this time, I would like to welcome everyone to today's MLN -- CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are

the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter nine.

Again, if you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter nine.

Please hold while we complete the polling.

Again, please continue to hold while we complete the polling.

Again, please continue to hold while we complete the polling.

Thank you. I will turn the call back over to Leah Nguyen.

Leah Nguyen: Thank you, Holley.

I will now turn the call back over to Charles to continue the presentation.

Presentation Continued

Charles Padgett: Thank you, Leah. All right. We are going to pick back up on slide 38.

How To Obtain Reports

And, now, I'm – we're going to talk about how you access these reports within the CASPER system. The example that we use within this presentation displays the IRF version. The LTCH process is exactly the same, and the system looks the same for both settings. So, please don't worry if you're an LTCH that what you're seeing here is different for you. It's not.

So, you access the reports from the QIES system, and you access them beginning with the Welcome to the QIES System for Providers page. When you're on that page, you will see—and it's circles in red here—CASPER Reporting, which is on sort of the lower left-hand side of the page. And you're going to click on that.

And once you click on that, we're going to move to slide 39. And this will -- this is the page that you will see. This will pop up. And you're going to need to choose Reports. You'll see the Welcome -- once you log in, you'll see the Welcome to CASPER page. And at the top, just above Welcome to CASPER, you'll see one of the tabs -- I believe it's the fourth one in when you are moving from left to right. It says Reports. You're going to click on that.

And, then, once you click on Reports, you're going to see a page that looks like what's on slide 40. And you're going to see -- as you see here on the left-hand side of the page, it says Report Categories, IRF Quality Reporting Program. And below that, it says IRF-PAI Provider. It'll be the same for LTCH. You're going to want to choose the folder under Report Categories that says IRF Quality Reporting Program or LTCH Quality Reporting Program.

And once you choose that, you'll see right next to that the yellow folder, which says, IRF Quality Reporting Program. So, once you choose that, you will see your quality reporting program. And then right under that, you're going to see the -- a list of the on-demand reports that are available to you. In this example, there are two. As time goes by and we add more reports and you go into the system, any report associated with quality reporting that's available to you to run on demand when you wish will be listed here in the system. So, you'll either choose the facility-level or the patient-level report and you'll click on that.

And once you click on that, in the example we use, you'll see below IRF Facility-Level Quality Measure Report. And, then, you'll see that it allows you to enter the parameters of the report that you want—so, the begin date, the end date and the influenza season dates, which you'll choose. So, you'll enter all of that information and you'll submit.

Again -- moving to slide 41, you'll see at the top IRF Patient-Level Quality Measure Report. The same thing -- it allows you to enter the parameters for that report—begin date, end date, influenza season dates. And, then, once you hit Submit, it will run the report. And once the report is run, it's going to show up in your inbox. So, as you can see on slide 41 in the inbox, there's two reports there, and the date the reports were requested is listed there. So, you'd be able to choose the report that you've run. And you'll click on that, and it will open your report. So, when you select a report to run, you'll see the next screen. Or when you select -- yes.

Okay. Moving on to slide 42. A few final screenshots here of the reports and notes. When you open the report, again, there's a table legend there that gives you extra information about the page of the report that you're looking at. For example, that N/A means not available and dashes represent a value that could not be computed. So, it gives you extra information about what you're looking at so you don't have to interpret it on your own.

And moving on to slide 43. If you look at the blue arrow sort of toward the bottom right-hand corner of the side, it's pointing toward our sort of statement here that says "This report may contain privacy protected data and should not be released to the public. Any alteration to this report is strictly prohibited." This is a disclaimer that is -- that shows up on every report. I just wanted to point it out here.

Remember -- I mean, the examples I've shown you throughout this presentation, especially the patient-level reports, include fake patient information. However, when a report for your facility -- they will -- it will show patient information. It will show all your patient names and their admission date and discharge date, as well as the patient ID. So, you know, just remember that's protected health information, and that's one of the reasons that this is stated here that it should not be released to the public.

Moving on to slide 44. Just, again, I want to note the table legend here as an example. It helps to interpret the report for the page of the report that you're looking at. Here, for instance, it is -- on slide 44, when you're looking at one of the NHSN measures, the CAUTI measure for IRFs -- and at the top, it gives more information about what you're looking at.

Slide 45. Same thing. This one just is showing the claims-based measure, the readmission measure for IRFs, and the legend for that.

And moving on to slide 46. Again, I just want to stress that in an actual patient-level report, patient names are listed with patient ID and admission and discharge date, which should be protected.

Slide 47 is just an additional shot of the reports.

And, then, moving on to slide 48. Again, this is a summary. Although we focused on quality measure reports, this sort of helps you visualize all aspects of the sort of big picture of reporting. Review and Correct Reports, which will be coming out this spring 2017, will sort of be released to providers following the end of each quarter and will allow you to review and make corrections to any data that you find to be inaccurate prior to the data submission deadline, so they will help you in identifying any errors that you've made in data submission and, then, getting those errors corrected so that that is all complete before any data submission deadline rolls around. So, that will be another sort of helpful report for you coming up here.

The Quality Measure Reports -- there's both the patient level and facility level that we covered here. And those can be used for internal quality controls, also for looking at your performance data for your facility or hospital. And, then, the Provider Preview Reports. And those preview reports are released prior to us publicly reporting any data. You will see or have a preview of the data that is to be publicly reported.

And in doing so, you'll have a chance to verify that what's on that report and what's going to eventually make it to the compare site is actually accurate and that you agree with it. And if you don't agree with it, there are steps you can take to contact CMS and request review of the data contained within your report.

And, again, the preview report presentation that we did last month -- those slides are available on both the LTCH and IRF Quality Reporting websites under Training, I believe. So, go there and, by all means, review them again. You should be having another Preview Report coming out here very soon, which will relate to the spring 2017 release of publicly reported data for IRFs and LTCH.

Resources

Moving on to slide 49. This slide lists IRF resources and links for you -- helpful links -- Assessment Submission: User Guides & Training page on the QIES Technical Support Office website. The link is listed there. There's a link for CASPER Reports: IRF User Guides and Training page on the QIES Technical Support Office webpage listed there for you. IRF Public Reporting Help Desk email address is listed there, and our IRF Quality Reporting webpage address is listed there as well.

Slide 50 lists similar resources for LTCHs -- User Guides & Training page for the QTSO, QIES Technical Support Office are listed there, the Public Reporting help desk email address and, then, also the LTCH Quality Reporting webpage. That has all sorts of helpful information for providers. You know, those Quality Reporting websites have links to our manuals and our data collection instruments, our rules, information about public reporting, processes you would follow to apply for an extension or an exception, and directions for appealing a decision that CMS has made with respect to your annual payment updates and so forth.

So, lots of good information on there. And there's also a help link on each of those webpages that lists all of the help desks related to a particular quality reporting program.

All right. We are going to move in and take a few minutes of questions here.

Question and Answer Session

Leah Nguyen: Yes. Thank you, Charles.

We will now take your questions. But, before we begin, I would like to remind everyone this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization.

In an effort to get to as many of your questions as possible, we ask that you limit your question to just one. If you would like to ask a followup question or have more than one question, you may press star, one to get back into the queue, and we'll address additional questions as time permits.

All right. Holley, we're ready to take our first question.

Operator: To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note, your line will remain open during the time you are asking you question, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

Okay. Stand by for your first question.

Our first question comes from Andrew Baird.

Andrew, go ahead.

Andrew Baird: Thank you. Can you hear me?

Charles Padgett: Yes.

Leah Nguyen: Yes.

Andrew Baird: Great. Thank you. My name is Andrew Baird. I am with HealthSouth. We're a large provider of IRF services. My question is just about the breakdown between the claims-based measures and the assessment-based measures with regards to patient-level data. I guess, as I'm -- as we understand the feedback structure, we'll have Preview Reports to look at for both of those types of measures, both the claims-based and the assessment-based. And I'm wondering how you all are envisioning our ability to accurately verify the claims-based data, which is only at a facility level -- an aggregate facility-level number -- if we don't also have the patient-level data available for those measures, for example, the readmissions measures or the discharge to community measures or the other claims-based measures that are in the QRP now.

Oftentimes, we don't, you know, have a way of knowing that some patient was either readmitted or was, you know, discharged to home correctly or not if that happens a significant amount of time after they leave our facility. So, I'm just wondering if there's a mechanism to be able to verify what those rates actually will be if we don't have the patient-level data to double back and check.

Charles Padgett: Okay. Thanks, Andrew. This is Charles Padgett. And I understand sort of, you know, the frustration here with that. And at this time, I mean, as far as -- especially for measures such as -- or readmissions or discharges to community, CMS is just not able at this time to provide patient-level data because the data that, you know, would be valuable to you at that point is data that pertains to a different provider and to who they were admitted to and so forth. So, I mean, I will let you know that CMS is trying to work toward a solution and this is something that we're aware of and delving into all of the time. I mean, we have continuously sort of, you know, been searching for

the right answer here. I will tell you that we haven't gotten there yet. But, we are aware that this sort of thing would be very helpful. I know that, you know, we have received similar comments on our rules and that there's, you know, similar data that is available to hospitals. But, there's, you know, different sort of implications for our settings and so forth. So, I will let you know that we are working towards that. We don't have that at this time. But, it's something that we're aware of and that we're moving toward.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Lisa Ingriff.

Lisa Ainsworth: How about Lisa Ainsworth? This is Lisa Ainsworth.

Operator: Yes. Go ahead.

Lisa Ainsworth: Well, good. We were wondering how many people -- forgive me. It's Lisa Ainsworth from Cedar Rapids, Iowa. St. Luke's Hospital. We are wondering how many people gets access -- can have access to a username and password to access these reports per facility.

Debra Weiland: Hi. This is Deb Weiland with the QTSO help desk. Each facility or LTCH provider is allowed to have two QIES user IDs and passwords per facility. If you have a --

Lisa Ainsworth: Thank you.

Debra Weiland: So, yes. Just two.

Lisa Ainsworth: Thank you very much.

Debra Weiland: Yes.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Karen Nelson.

Karen Nelson: Hi. Good afternoon. Thank you so much. I had a question about a slide -- either on slide 12 or 48. I might have missed it during the conversation. But, could you refer me again to what is the Provider Threshold Report, the PTR?

Charles Padgett: Oh, sure. So, the two reports that are listed at the bottom of slide 48 have to do with compliance and, one of which is the Provider Threshold Report. And that's a report that will be available -- I believe it is already available for the IRF setting -- and lets you know sort of where you stand with respect to compliance for any given time period.

So, for instance, data submitted during calendar year 2016 is related to the fiscal year 2018 APU payment determination. And, so, you can look and see the required measures and where you stand with respect to meeting compliance for each of those quality measures. I will tell you that the report at this time may not be comprehensive and that we are working to get a comprehensive version of the report out there. It does already exist for IRFs -- this report -- and will be available in the near future for LTCHs.

Leah Nguyen: Thank you.

Operator: If you would like to ask a question, press star, one on your telephone keypad. To withdraw a question or if your question has been answered, you may remove yourself from the queue by pressing the pound key. Our next question will come from the line of Renee Cutway.

Renee Cutway: Hi. This is Renee from Catholic Health in Buffalo, New York. I'm fairly new to IRF reporting and I wanted to just confirm that the patient influenza data is coming from the IRF-PAI and not NHSN.

Charles Padgett: Correct.

Renee Cutway: Okay. Thank you.

Charles Padgett: Yes.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Erica Hill.

Erica Hill: Hi. This is Erica Hill from Select Medical in Mechanicsburg, Pennsylvania. We're very anxious and excited to have the LTCH Compare website come out. We've kind of been waiting to get some more guidance on when it will go live as well as the format in which the data will be displayed. Could you tell us anything about that?

Leah Nguyen: Hold on a moment.

Charles Padgett: Hi. This is Charles Padgett. Thanks for your question. I can't give specific information at this time. I will tell you to check our website very closely over the next 2 weeks. But, it will be very soon, and we will have a public announcement regarding the launch of both the IRF and LTCH Compare websites.

Erica Hill: Great. Thank you.

Charles Padgett: You're welcome.

Operator: And our next question will come from the line of Steve Forer.

Steve Forer: Hi. This is Steve Forer. I'm a rehab consultant representing a number of inpatient rehab facility providers. My question is, how long after the request for the report is generated by the provider will it appear in the queue or in the folder for viewing?

Debra Weiland: That's a...

Charles Padgett: Go ahead, Deb. Thank you.

Debra Weiland: Sorry, Charles. That's a very good question. This is Deb from the QTSO help desk. The report processing time is generally very quick. Of course, that depends upon the system activity and the number of other reports that have been requested of the system at the same time. So, I would say that you could check back with 15 minutes.

Most of the time, it is going to be processed and available for you to review in a much shorter time period than that. But, if it is not, understand that it may be a time of high system activity, and you'll just log back in at another time and access your report later.

Steve Forer: Thank you.

Debra Weiland: Yes.

Operator: Our next question will come from the line of Jim Palucci.

Jim Palucci: Hi. I'm Jim Palucci from Beaumont Hospital in Troy, Michigan, inpatient rehab. Just a quick question about what future quality measures may you -- may you expect to be reported in the near future? In other words, maybe FIM scores, CARE tool, self-evaluation, and mobility scores. Do you see those in the near future?

Charles Padgett: I would refer you -- thanks for your question. I would refer you to the IRF PPS final rule -- the fiscal year 2017 final rule that we published back in August of 2016. We have a list of future quality measures that we list within our rule. And I would also refer you to the National Quality Forum's Measures Application Partnership, which is a public meeting that takes place every year in December during which we submit measures under consideration for use in our programs. And those measures are reviewed by the Measures Application Partnership panel. And that is a public discussion.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Pamela Madison.

Pamela Madison: Hello.

Hello. This is Pam Madison. I am from Parkview Hospital, Fort Wayne, Indiana. And if we have a problem with our facility information -- and I've already gone through -- I've already contacted our RO. I've been working on this for the past 3 months and I haven't gone anywhere to get it changed. Is there another step that I can take to get that changed in that ASPEN system?

Charles Padgett: Have you contacted our help desk or ...

Pamela Madison: I have—several times.

Charles Padgett: You have. Okay. Can I ask that you contact us again and refer to this call?

Pamela Madison: Okay.

Charles Padgett: And what's your last name again?

Pamela Madison: Madison. M-A-D-I-S-O-N.

Charles Padgett: All right. And we'll see what we can do to get you straightened out there.

Pamela Madison: Okay. Wonderful. Thank you.

Charles Padgett: You're welcome.

Operator: And our next question will come from the line of Patricia Warnick.

Patricia Warnick: My question is the CAUTI information as well as the readmission rate, since those items are not included on the IRF-PAI submission. How are you getting that information?

Leah Nguyen: Hold on a moment.

Charles Padgett: So, you're asking where do we get the rate for the readmission measure?

Patricia Warnick: Right.

Charles Padgett: And that's -- I mean, the rate is a calculated number.

Patricia Warnick: Right. How do you know who's readmitted?

Laurie Coots: This is Laurie Coots from RTI. I'm happy to weigh in a bit here on the readmission measure in particular. That information comes from the Medicare Fee-for-Service claims data that your facility and hospitals already submit to the Medicare program. So, essentially, it's your claims or your bills. And that's where the data is extracted from.

Patricia Warnick: And is that the CAUTI data as well?

Charles Padgett: So, you're asking where the rate comes for -- comes from for the CAUTI measure?

Patricia Warnick: Just how you get that information because as an IRF, we don't submit that on our IRF-PAI.

Charles Padgett: Yes, you don't. It's calculated from the information that you do submit, though.

Patricia Warnick: Right. Just from our coding?

Charles Padgett: From the data that you submit via NHSN, the National Healthcare Safety Network.

Patricia Warnick: Okay.

Leah Nguyen: Thank you.

Operator: All right. And our next question will come from Troy Hillman.

Troy Hillman: Hi, Charles. This is Troy Hillman from UDSMR. Just a general question regarding the Provider Threshold Report that was previously mentioned. The training information only indicates some of the measures that are currently collected as part of the public reporting process.

However, for the fiscal year 2018 annual payment update, additional measures such as the functional outcomes measures, the process measure as well as the self-care mobility measures are indicated to be used for that payment update. Does the Provider Threshold Report include those measures as part of that report? And then, secondly, are individual reports available -- facility-level reports available for those additional functional outcomes measures on the CASPER system?

Charles Padgett: Great question. And my answer is not at this time. The reports, as I stated earlier, are not comprehensive yet. But, we are -- we do have versions in development that will bring everything up to speed and will be comprehensive. And, so,

you will be able to use them in real time to determine compliance status and so forth. So -- and those will be released in the near future.

Leah Nguyen: Thank you.

Operator: Thank you. And that was our last question. I'll turn the call over to you, Leah.

Additional Information

Leah Nguyen: Thank you.

An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release an announcement in the MLN Connects Provider eNews when these are available.

On slide 52 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your MLN Connects Call experience.

Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's MLN Connects Call on Inpatient Rehabilitation Facility and Long-Term Care Hospital Quality Measure Reports.

Have a great day, everyone.

Operator: This concludes today's call. Presenters, please hold.

-END-

