



Post-Acute Care QRPs: Reporting Requirements and Resources Call

Moderated by: Aryeh Langer
June 5, 2019 1:30 PM

Table of Contents

Announcements & Introduction.....	2
Presentation	2
Data Submission Requirements.....	3
The Quality Reporting Program Annual Payment Update Process.....	4
Overview of Reports.....	6
Review and Correct Report.....	6
Quality Measure (QM) Reports	9
Provider Preview Report	11
Obtaining Reports.....	13
Question & Answer Session	15
Additional Information.....	21

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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. 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 an objection, you may disconnect at this time. I will now turn the call over to Aryeh Langer. Thank you, you may begin.

Announcements & Introduction

Aryeh Langer: And thank you very much. As you just heard my name is Aryeh Langer from the Provider Communications Group here at CMS and I'm your moderator for today's call. I would like to welcome you to this Medicare Learning Network call on Post-Acute Care QRPs: Reporting Requirements and Resources.

During today's call, learn about Reporting Requirements and Resources for the Inpatient Rehabilitation Facility, Long-Term Care Hospital, and Skilled Nursing Facility Quality Reporting Programs. Before we get started, you received a link to the presentation in your confirmation email. The presentation is available at the following URL: go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

Today's event is not intended for the press, and the remarks are not considered on the record. If you are a member of the press, you may listen in, but please refrain from asking questions during the Q&A session. If you have any inquiries, please contact press@cms.hhs.gov. At this time, I would like to turn the call over to Lorraine Wickiser from CMS.

Presentation

Lorraine Wickiser: Thank you. Good afternoon, everyone, and welcome to our overview of the Quality Reporting Program. For the first couple slides, I'm just going to give you an introduction of what the Quality Reporting Programs are and some of the background on how they came into date.

The first two slides are just the acronyms that are used in this presentation, that would be slides 2 and 3, and we can skip down to slide 4. So, the specific Post-Acute Care Quality Reporting Program settings that we're going to talk about today involve Inpatient Rehabilitation Facilities or IRFs, Long-Term Care Hospitals or LTCHs, and the Skilled Nursing Facilities which are known as SNFs.

They came into being back in 2014 when Congress passed the IMPACT Act after the Improving Medicare Post-Acute Transformation Act. The Act requires that these PAC settings submit standardized data across each of these settings. Although we're talking about the 3 settings I just mentioned, also in the IMPACT Act includes the Home Health Agencies.

Next slide. So, each Quality Reporting Program has specific Quality Reporting Requirements and Deadlines. For the SNF and the LTCH, they have an Annual Payment Update. And then for the LTCHs, they use an Annual Increase Factor.

Submission deadlines are required by 11:59 PM Pacific Standard Time on the 15th of the following months that are listed here on the slide; February, May, August, and November. The quarters that are associated with those deadlines are listed in the following slide, which we'll go over.



Also, note that there is a delay between the collected data and the affected Fiscal Year. So, example, the calendar year for 2018 would affect the Fiscal Year APU or AIF for 2020.

Next slide, slide 7. So, for the APU compliance date, which I just spoke about, their data is collecting on two different kinds of assessments for IRF and LTCH. The first one is an assessment instrument, and it's called the IRF-PAI or the IRF Patient Assessment Instrument. It also collects data on CDC data using the National Healthcare Safety Network.

For LTCH, we use the Long-Term Care Continuity Assessment Record and Evaluation CARE Data Set to collect the assessment data, and we also collect data on CDC measures using the National Healthcare Safety Network. For SNF, they use the assessment instrument for the Minimum Data Set, and they do not collect any measures at this time for CDC measures.

Data Submission Requirements

Next slide. The Data Submission Requirements that's slide 8, we're going to go to slide 9. There're different requirements for each program, which I spoke a little bit about before. But for the IRF-PAI they need 95% data submitted must contain a 100% of the required data elements for the 10 assessment measures—10 based assessment measures.

And then a 100% of the data needs to be submitted for the 4 CDC measures using the National Healthcare Safety Network. The CDC determines that completeness of that data for CMS. If the facilities fail to submit the data required, they will be subjected to that 2% of their Annual Increase Factor. So, in other words, they're saying out of a 100% of the data that's submitted 95% have to have that 100% completed.

Next slide. So, for LTCHs, we have an 80% data submission accuracy, and that must contain a 100% of the required data using the 9 assessment-based measures. Again, they also have to have a 100% of the necessary CDC measures for 6 of their measures that are now reported, and they use the National Healthcare Safety Network. Again, CDC determines that completeness of that data for CMS. If facilities fail to submit that required data, they're subject to the 2%-point reduction in our Annual Payment Update.

Next slide. And for SNFs, they also hold that 80% compliance rate and that must contain a 100% of the required data for their 9 assessment-based measures. If SNFs failed to submit that data requirement, they also will be held for the 2-percentage-point reduction in their Annual Payment Update. That data is collected on a calendar year, like I said before. So, for the calendar year 2018, it would affect their payment update for the Fiscal Year 2020.

Next slide. So, before, we mentioned the months of the year of the final submission deadline and they are February, August, May, August, February--I missed one, November, and February. So, the collection time for the 1st quarter, which includes January through March, that submission deadline is August 15th. Quarter 2 is April through June, and that submission deadline is through November 15th. Quarter 3, which affects July through September that's a February 15th deadline. And Quarter 4 is October through December of a calendar year, which affects May 15th submission deadline.



On the next slide, you'll see the webpage links that you can go to for all the deadlines that I just talked about and the measures that are associated with that. And now I will turn it over to my colleague Chris Grose, so she can go over the Annual Payment Update process.

The Quality Reporting Program Annual Payment Update Process

Christine Grose: Good afternoon, everyone. I'll be providing an overview of the compliance termination process and describe the steps for submitting a reconsideration request in the event if a provider feels they have received a notice of non-compliance in error.

Next slide, please. This slide displays a high-level overview of the data submission and compliance timeline in effect for a given Fiscal Year for the Quality Reporting Programs. For the most part, as Lorraine mentioned, data submission and collection periods are for a calendar year.

In this diagram, we're showing the data submission period for Fiscal Year 2020 to demonstrate how the time periods inform the APU process. Data submitted for calendar year 2018 is utilized to determine reporting compliance for Fiscal Year 2020 APU, which begins on October 1, 2019.

So, the 2% penalty would be implemented for discharges on or after October 1 for those providers determined to be non-compliant. To further explain or reiterate on what Lorraine had presented, the reporting deadline for submitting data corrections for Quarter 1 of 2018 was August 15th, 2018, for Quarter 2 the submission deadline was November 15th, 2018.

Providers have until February 15th, 2019, to submit their data for Quarter 3, and May 15th, 2019 was the submission deadline for submitting the final quarter of data required for Fiscal Year 2020 APU.

Following the May 15th deadline, final analysis is done to determine whether or not providers met the compliance threshold for the Quality Reporting Program. CMS then sends initial notices of non-compliance to those providers who did not meet the compliance thresholds for data submission and reporting. CMS will post messaging on our QRP webpages and our Post-Acute Care listserv to inform providers of the methods that will be used to send the notification letters.

Our goal is to use at least two methods, and this could be the MACs, it could be CASPER folders in iQIES for IRFs and SNFs, or the reports folder in iQIES for LTCH, or US mail. Only those providers who did not submit the required data will receive these notifications of non-compliance.

Providers then have 30 days to submit a reconsideration request if they feel they were notified in error. After the end of the 30-day reconsideration period, CMS will send final decision letters to those providers who submitted reconsideration requests. And this will be prior to October 1, 2019.

We encourage providers to go to the QRP webpages to become familiar with the data submission timelines for each of the Quality Reporting Programs to ensure that all data gets submitted timely and accurately, as there are a few exceptions to the calendar year examples that Lorraine presented and that I mentioned, such as the patient influenza measures.



Next slide, please. To reiterate, CMS intends to use multiple methods for notifying providers, such as letters from your MAC, letters distributed in the CASPER or iQIES reports folders. The method of communication will be announced on our QRP webpages and via our Post-Acute Care listserv. It is extremely important for the providers to confirm their contact information is up to date so that the right people get these notifications.

Next slide. This slide gives a little bit more detail regarding the timelines for the activities associated with compliance termination and notification, as well as reconsideration. Providers can expect to receive their initial notices of non-compliance typically in late June or early July each year.

Announcements will be posted our spotlight webpage and sent by the listserv, as we've mentioned, to alert those providers who may suspect that they will receive these notices. Providers who receive this notice of non-compliance may submit a reconsideration request if they feel they were notified in error. The 30-day reconsideration period typically ends in mid-August.

Next slide, please. Providers have 30 days to submit a reconsideration request if they feel they were notified in error. The deadline date for submitting reconsideration requests will be included in the provider's notice of non-compliance and will be posted on each of the QRP websites.

Next slide. Complete instructions for submitting a reconsideration request, including the email address for the reconsideration mailboxes, are posted on the IRF, LTCH, and SNF reconsideration webpages. Reconsideration requests will only be accepted via email.

In addition to provider information, the reconsideration request should include supporting documentation demonstrating compliance. Again, the information required to be submitted with each request is identified and listed on our QRP reconsideration webpages.

Do not include patient or resident information in your reconsideration request or supporting documentation. This is a HIPAA violation. Therefore, CMS cannot review requests that contain any Protected Health Information. This may also put you at risk for not meeting the reconsideration request deadline. The reconsideration request submission deadline cannot be extended to accommodate resubmission of requests due to PHI.

Next slide, please. Some additional dos and don'ts for submitting a reconsideration request. Each year we receive hundreds of pages of reports and documentation that does not prove compliance, and it increases your risk of sending PHI. Please only include the specific information that supports your reconsideration request; and ensure that all Protected Health Information is redacted from all pages.

For example, if you send 600 pages of documentation and on one of the pages you missed removing the PHI, we have to stop our review, and the request can no longer be reviewed. If you can still see the information on the submitted attachments, then it has not been fully redacted.

Some options for ensuring that PHI is fully redacted could be to print off the documentation that supports your request, cut out those sections that contain PHI, then scan so they can be attached. Using a black marker sometimes works; do not use dry erase markers, that sometimes doesn't work. Striking through the patient information with the pen may not be sufficient. Again, if we can see the information, then it has not been fully redacted, and it is a HIPAA violation.



Submit your reconsideration request prior to the deadline to ensure that CMS received in time; we cannot review requests submitted after the deadline. Also, be sure that you receive an email confirmation of receipt of your reconsideration request in addition to the automated response from the mailbox. If you do not receive confirmation of receipt, please resubmit or contact the reconsideration helpdesk for assistance.

And we cannot emphasize this enough, do not send us Protected Health Information for patients or residents, we are not able to review these requests. Make sure your submissions are less than 20 megabytes in size. And we cannot accept final validation reports or reports from third-party vendors as supporting documentation.

Next slide, please.

Aryeh Langer: Slide 21.

Christine Grose: Oh, sorry, thank you. Providers submitting a reconsideration request should receive a notice of the final determination prior to the October 1 implementation date.

Next slide, please. The 2% penalty for non-compliance for meeting the reporting requirements for the IRF, LTCH, and SNF quality reporting programs goes into effect for discharges on or after October 1 for each Fiscal Year. This penalty is applicable only for that Fiscal Year.

If you have any questions regarding the plan's threshold, data reporting requirements, or the reconsideration process, you can always contact reconsideration mailbox for the quality reporting programs. And that concludes my piece. And now I'll turn it over to Deb Weiland.

Overview of Reports

Debra Weiland: Thanks very much, Chris, and good afternoon, everyone. I'm going to spend the remainder of this training session reviewing the QRP reports.

Next slide, please. This graphic may look familiar to those who have participated in the QRP training in the past. The graphic shows two types of reporting; confidential reporting and public reporting.

Confidential reports include the review and correct reports, the facility- and patient-level Quality Measure Reports, and the Provider Preview Report. These reports are only available for viewing by the providers. The green shading at the right of the graphic depicts how the data on the Provider Preview Reports are eventually posted publicly on the Compare website.

Next slide. Let's now take a bit of time and review the three types of Quality Measure Reports that are available to you. As this slide shows, the three types of reports are the Review and Correct Reports, The Quality Measure Reports, and the Provider Preview Reports.

Review and Correct Report



The first type of report we'll review is the Review and Correct Reports. These are user-requested, on-demand reports, meaning that the user must request these reports at their desired frequency. These reports are not automatically generated for the user.

The IRF and SNF Review and Correct Reports are available in the certification and survey provider enhanced reporting or CASPER reporting application. The LTCH Review and Correct Report is available in the internet Quality Improvement and Evaluation System or iQIES.

These reports are confidential to providers, and they provide quarterly and cumulative performance rates for the assessment-based publicly reported quality measures. The report displays data for the 4 most recent quarters. The report contains rolling quarter functionality, which means as a new reporting quarter is added to the report, the oldest quarter is removed from the report.

This report displays observed or raw measured results only. Risk adjusted measure results are not displayed on this report. However, risk adjusted rates are needed in order to calculate the discharge self-care and discharge mobility measures that display on the review and correct report.

The data on this report are updated weekly until the data correction deadline for the reporting quarter is reached. When the reporting quarter ends data for that reporting quarter are available on the Review and Correct Report the next calendar day.

For example, Quarter 2, 2019 will end on June 30th, and the data for that reporting quarter will be made available on the report on July 1st. This report displays the data correction deadline date for each reporting quarter and identifies whether the correction period is open for closed as of the date the report is run.

Next slide, thank you. Here's a table of the data submission deadlines. Remember that the final submission deadlines for the QRP are based on the quarterly data collection timeframes. All assessment data must be accepted into the CMS's national database prior to the final submission deadline for that reporting quarter.

The submission deadline is four and a half months after the data collection end date. Correction periods for each quarter are as follows: the submission deadline for the Quarter 1 data collection time frame, which is January 1st through March 31st, is August 15th. The data for Quarter 1 will be available on the Review and Correct Report on April 1st. So, providers will have between April 1st and August 15th to report or correct their data.

The submission deadline for Quarter 2 data collection time frame, which is April 1st through June 30th, is November 15th. Data for Quarter 2 are added to the Review and Correct Report on July 1st, which means providers will have between July 1st and November 15th to correct their data.

The submission deadline for Quarter 3 data collection time frame, which is July 1st through September 30th, is February 15th. The data for Quarter 3 are added to the Review and Correct Report on October 1st. So, this means providers will have between October 1st and February 15th of the subsequent year to correct their data.

Finally, the data submission deadline for Quarter 4 data collection time frame, which is October 1st through December 31st, is May 15th. Quarter 4 data are added to the Review and Correct Reports on January 1st, allowing providers to correct their data between January 1st and May 15th. Data correction deadlines are for



data that are used to calculate the publicly reported measures and are not applied to the confidential QM or Quality Measure Report.

Aryeh Langer: We are on slide 30 now.

Debra Weiland: Thank you. Effective April 1st, 2019, there were several enhancements to the review and correct report. Patient- and resident-level data are now available on the report and display a list of patients, or residents, associated to each measure. Patients and resident data are also available in a comma-separated values or CSV file. The CSV file will allow you the ability to sort or manipulate the data to meet your needs.

When requesting this report you are able to identify how you would like the data on the report to be sorted, including by patient's last name, patient's first name, patient's status indicating whether or not this day was included in the measure or was triggered, whether this day was not triggered, or whether this day was excluded from the calculation, as well as the ability to sort by discharge or admission dates.

You are also able to filter the reports by individual QMs. Here's a graphic of the enhanced review and correct report. While the IRF review and correct report is shown in this graphic, the same display applies to the LTCH and SNF review and correct reports.

You'll notice the facility-level results that you're accustomed to seeing are displayed at the top of the report. The corresponding patient-level results are displayed at the bottom of the report. When looking at the report, you'll see that the measure name is displayed above the tabled facility of facility results, and in this example, this measure of application of functional assessment measure is being displayed. And beneath this is the table legend.

The information in the table legend helps you understand the data that's displayed on the report. The table of facility level data results includes the reporting quarter, the start and end data collection dates, which are identified by the start and end date columns on the report and the corresponding data correction deadline date for that reporting quarter.

Finally, the data correction period, as of the report run date, identifies whether the data correction period is open or closed as of the date the report was run. On the right side of the facility level results table, you'll notice the results that are specific to the measure being displayed. In this example, you can see that the number of stays that triggered the QM displays first, this is the numerator, followed by the number of stays included in the denominator, and finally the facility percent.

Beneath the facility-level data table is the patient-level data tables. And here's a closer look at the new patient resident-level data table. You'll notice that the reporting quarter displays first on the left side of the table, followed by the patient name, and the unique patient ID assigned to the patient's record in the national database by this system at the time of the assessment processing.

The next columns, you'll notice, are the admission and discharge dates, and these are the dates from the assessments that were included in the reporting period. Following the admission and discharge dates is a column containing the data correction deadline date, followed by the data correction period as a report run date, which indicates whether the data correction period is open or closed.



Finally, a column containing the status of the measure results for that patient displays. In this example, you will see that the NT displays in the status column, which indicates that the measure was not triggered.

So, let's review the data in the first row. You'll notice in the first row the reporting quarter is Quarter 4 2018, which is the data collection period of October 1st, 2018 through December 31st, 2018.

The next two columns provide the patient name and patient ID, followed by the admission and discharge dates from the assessment that was included in the calculation. In this example, you'll notice the admission date is December 5th, 2018, and the discharge date is December 24th, 2018.

The data correction deadline date for Quarter 4 2018 is May 15th, 2018. As of the time this report was run, the data correction period was still open, indicating corrected assessments could still be submitted to the CMS national database and included in the next weekly calculation. Finally, the status shows that, based upon the data in this patient's assessment, the measure was not triggered for this patient.

Next slide, please.

Aryeh Langer: Slide 33.

Debra Weiland: Thank you.

Quality Measure (QM) Reports

The next reports that we are going to review are the quality measure or QM reports. Like the Review and Correct Reports, these are also user-requested, on-demand reports. These reports contain data that includes data prior to public reporting of the measures. These reports are also known as the confidential feedback report.

Like the Review and Correct Reports, the QM reports are user-requested and on-demand reports. Providers can specify the reporting period of their choice and obtain aggregate performance data for the current and past three quarters. Keep in mind that, depending on when you run the report, the current quarter may only include partial data.

There are two types of Quality Measure or QM reports; the Patients or Resident Level QM report and the Facility Level QM report. The Patient/Resident Level to report only contains assessment-based quality measure data. The IRF and LTCH Facility Level QM report includes assessment-based, CDC NHSN, and claims-based quality measure data whereas the SNF Facility Level QM report contains assessment-based and claims-based measure data only.

The QM reports provide a snapshot of performance for quality improvement purposes based on the data submitted and the results on this report, or risk-adjusted if applicable. The data on these reports are available to providers prior to public reporting and are for internal purposes only. Data on these reports are not for public display.



While the CDC and claims-based measure results are displayed on the facility-level report, there are no patient-level results for these data. One important note to remember is that the Review and Correct Report and Quality Measure Reports are not static, and they do not match. The Review and Correct Reports are updated weekly, whereas the QM reports are updated monthly. Additionally, the Review and Correct Reports do not contain risk-adjusted data, but the Quality Measure Reports will contain risk-adjusted data for the applicable measures.

Aryeh Langer: Slide 35

Debra Weiland: Here's a sample of the IRF Facility-Level QM report. Beneath the header information, you'll see that the report displays the name of the Quality Measure, the unique CMS measure ID associated to that quality measure, the numerator, denominator, facility percent, and national average for the measure. If the quality measure is risk-adjusted, you would also see a column for the risk-adjusted measure results. Of note, the display of the LTCH and SNF facility-level QM report is the same as the IRF Facility-Level QM report that is shown in the slide.

And here is a sample of the IRF Patient-Level QM report. This report displays the patients whose records were included in the reporting period, record specific information such as the admission and discharge date of the record or records, and indicators identifying the status of the measure. Such as, an X will display if the measure is triggered or it meaning that the stay met the criteria for that particular stay to be included in the measure numerator, NT would display if the measure is not triggered, and E would display is to stay was excluded from the calculations based on the data submitted in the record.

The picture on this slide shows 3 of the desirable outcome measures. Of interest, one would be the patient residents with an admission and discharge functional assessment and a care plan that addresses functions. When an X displays in a patient row for a desirable outcome measure, this indicates that the patient's assessment met the desirable outcome and/or in other words, the measure for which this stay was triggered.

For the desirable outcome processes perform measures, the triggered measure is a positive event. If an NT value displays for a desirable outcome or processes measure performed, this is a negative or unfavorable event indicating that the desirable outcome was not met.

Conversely, for the undesirable outcome measures, such as the Falls with Major Injury measure, an X indicates that the measure was triggered because the patient or resident's assessments indicates that a fall with major injury event occurred during this patient or resident's stay in your facility. This is a negative or unfavorable event. If an NT displays for an undesirable outcome measure, such as the falls measure, this is a positive result, as the goal is for the patient and resident not to experience any undesirable outcomes.

Aryeh Langer: Slide 37

Debra Weiland: There will be enhancements applied to the IRF, LTCH, and SNF patient- and resident-level reports in the fall of 2019. Let's take a closer look at the Falls with Major Injury measure data on the enhanced patient-level report that will be available in the fall.



Next slide. So, referencing the above screenshot, you'll see that the application of percent of residents experiencing one or more Falls with Major Injury measure is being featured. The quality measure legend presents each measure included in the report and the following information about each.

You'll notice that there is a column of measure interpretation. This information identifies the type of measure that is being reported, such as an undesirable outcome; desirable outcomes are processes performed and change in function scores.

Adjacent to the measure interpretation column is the report period column. This identifies the reporting time period for which the quality measures are calculated. The next column is the CMS ID column. This displays the unique ID that is assigned to the particular quality measure.

The CMS ID Discharge Date column identifies the range of discharge dates that are included in the reporting period for the measure.

Beneath the quality measure legends table is a section that contains a table legend. The table legend provides additional definition about the measure results displayed in the patient level results table.

The final table contains the patient- and resident-level result. In this example, you'll see that QM number two displays in the quality measures legend, but there's also a column for QM number two in the patient-level results table.

Referencing QM number two column in the patient-level results table will help you identify whether the patient in residence triggered the Falls with Major Injury measure for all assessments included in the reporting period.

How can the QM reports be helpful to you?

Data in these reports are refreshed monthly on the first day of the month. The reports will provide updates about facility- and patient-level results for a single reporting period. These reports provide a snapshot of performance for quality improvement purposes based on the data submitted and risk adjustment of measures as applicable.

To reiterate this important note, the data on the Review and Correct Reports and the Quality Measure Reports are not static, and they will not match.

Now we'll move along to the last report, and that is the Provider Preview Report.

Aryeh Langer: Slide 41.

Provider Preview Report

Debra Weiland: This report is automatically created for you and saved in your provider shared folder. The report displays the facility-level aggregated results that will display on the compare website with the next refresh. This report is available approximately 5 months after the end of the data collection quarter.



Providers are given a 30-day preview period prior to the data being publicly reported. The 30-day review period begins the date the reports are saved into your facility shared folder.

Next slide. Thank you.

The preview reports, pardon me, providers are not allowed to correct the underlying data in these reports, once the data collection period has ended. All corrections must be made prior to the applicable quarterly data submission deadline, which is also referred to as the quarterly freeze date. If the data correction deadline has passed, providers will not have the opportunity to request correction of the underlying publicly reported data.

Aryeh Langer: Slide 43.

Debra Weiland: CMS strongly encourages you to review the data about your facility. If you have questions related to this report, please contact the appropriate CMS public reporting help desk.

Listed on this slide are the email addresses for questions about the IRF Provider Preview Report, the LTCH Provider Preview Report, and the SNF Provider Preview Report should be submitted.

If you compare the Provider Preview Report to the Compare website, you may notice a couple of differences. First, you may notice that the order of the measures on the Provider Preview Reports may vary from the order of the measures that are displayed on the Compare website.

Secondly, you will notice that the title of the measures on the preview report are not the consumer language titles that appear on the Compare website. For your convenience, there is a file that contains a crosswalk between the two titles, and this file is located on the Compare website.

Here's a snapshot of the IRF Provider Preview Reports. You'll notice that the report run date displays in the top left corner. This is the date that the report was generated. The report period four section contains a list of the publicly reported QRP measures and the reporting periods for which the data are displayed for these measures.

Note that SNP QRPs does not have CDC measures. Therefore, reporting periods for the CDC measures will not display on this report.

Beneath the reporting periods are the or is the facility demographic information, which includes your facility CCN, your facility's name, and other demographic information.

And the body of the report contains the actual measure results. Data are displayed by measure type, first by assessment-based measures, then by CDC NHSN measures, and finally by claims-based measures.

In this example, you'll see the measure results for the percent of residents or patients with pressure ulcers that are new or worsening measures is displaying. The LTCH and SNF Provider Preview Reports look like this as well, but they are customized to report the measures specific to the provider setting.

Aryeh Langer: Slide 45.



Debra Weiland: The Provider Preview Reports are automatically refreshed or generated quarterly. These are not reports that you must request on your own. Your facility is allowed a 30-day review period, prior to the posting of the measure results on the Compare website.

These reports provide results of your facility's performance, which maybe used for quality improvement purposes.

As I mentioned earlier, CMS strongly encourages you to review the measure results on this report. If you disagree with the accuracy of the performance data, for example, the numerator, denominator, or other QM specific results, you can request a review of the data by CMS.

If you wish to have CMS review the data on your Provider Preview Report, the request for review must be submitted within the 30-day review period that begins on the date that the reports were made available to you in your shared folders.

As a reminder, you will not have the opportunity to request the correction of underlying data if the data correction deadline has passed.

There are specific procedures that must be followed when requesting a review of your data. All requests must be emailed to the appropriate public reporting email address, and you can see that we've included those email addresses on the slide.

The title or subject of the email must contain the following text: your facility's name, followed by the words - public reporting request for review of data, and your facility CCN or CMS Certification Number. You can see an example of a subject line has been included in the slide for your convenience.

The body of the email must include the information identified in this slide, which includes: your facility CCN, your business name, business address, CEO or Chief Executive Officer and including the contact information for this individual, and finally, information supporting why you believe the data contained in your facility's Provider Preview Reports are erroneous.

We encourage you to include specific information such as the QMs that are affected, and the aspect of the QM that is affected, for example, the numerator, denominator, or other QM results.

CMS will review all requests and provide a response by email. Data that CMS agrees to correct will be reflected in the subsequent quarterly release of the quality data on the Compare website.

It's very important to note that CMS will not review any email requests that contain Protected Health Information or PHI.

Aryeh Langer: Slide 52.

Obtaining Reports

Debra Weiland: Let's spend a few moments and review how to obtain these various reports.



Providers will obtain their QPR reports from the CASPER Reporting Application. As you can see here, this is the welcome to the CMS key systems for providers webpage, where you will access the link to the CASPER Reporting Application.

To access CASPER, enter your key user ID and password credentials. and select the login button. The welcome to the CASPER home page will display once you have successfully logged into the CASPER Reporting Application.

To request the Review and Correct or Quality Measures Reports, you would select the reports button from the menu bar, and the CASPER reports page will display.

While the IRF QRP report webpages are shown here, the same type of webpages and functionality exists for the LTCH, and SNF QRP reports.

To request the IRF QRP QM reports, you would select the IRF Quality Reporting Program link in the left frame, and a list of the IRF QM and Review and Correct Reports will display in the right frame.

If you wish to request the IRF Review and Correct Report, you would simply select the IRF Review and Correct Report Link.

Aryeh Langer: Slide 56.

Debra Weiland: ...and the CASPER Report Submit Page, where you can specify the criteria for this report, will display.

The Review and Correct Report is selected based upon a selected end date. Once the end date is selected, the corresponding begin date for the 12 months reporting period will automatically display.

This screen shot shows you the new functionality that was made available on April 1st. The new functionality allows you to select one or more measures from the Quality Measures section to be included in the report.

If you wish to include patient-level data in the report or have a patient-level data CSV file created, you may select the appropriate check boxes. You may select which patient-level data should be included in your report by status to include those stays that were triggered, those measures that were not triggered, and those measures that or stays that were excluded.

You may select one or more reporting quarters for the reporting year for which the data will display. You may select whether to include data for the reporting quarters that are opened, closed or both. And you may define the data sort that will be applied to report, such as this sort by discharge date, admission date, and so on.

Aryeh Langer: Slide 57.

Debra Weiland: The completed report will display in my inbox folder. To view the reports, select a report name link, in the right frame, and the report will display.



The automatically created Provider Preview Reports are saved in your facility's non-VR or Non-Validation Report Shared Folder, as highlighted here. The Provider Preview Reports will be listed on the right side of the webpage. To view the Provider Preview Report, simply select the report link, and the report will display.

Debra Weiland: CMS...

Aryeh Langer: Slide 59. I'm sorry.

Debra Weiland: No, my apologies. CMS encourages you to refer to the CASPER Reporting User's Guide should you have questions regarding the user requested QPR Reports. This guide is available on the Welcome to the CMS QIES Systems for Providers webpage and on the QIES Technical Support Office, or QTSO website. A link to the provider-specific QTSO webpages has been included in this slide.

Please note that the LTCH CARE Data Sets submissions in reporting is currently in the process of migrating to the new Internet Quality Improvement and Evaluation System or iQIES, but the reports are still available in CASPER.

The LTCH version of the CASPER Reporting User Guide continues to provide detailed information about the LTCH QRP Report.

This concludes the overview of the QRP Reports.

Question & Answer Session

Aryeh Langer: Thank you very much for that very comprehensive presentation.

At this time, we will take your questions. As a reminder, this event is being recorded and transcribed. In an effort to get to as many questions as possible, each caller is limited to one question to allow more participants the opportunity to ask questions. Please send question, specific to your organization to the resource mailbox Listed on slide 43, so our staff can do more research. Preference will be given to general questions applicable to a larger audience and we'll be mindful of time spent on each question.

Lorraine, do you have a comment to make.

Lorraine Wickiser: Yes. For the question today, we would like to limit it to the presentation. If you have any further questions that you would like to address to CMS, you can write into our help desk questions or to the reconsideration mailbox. But today, we'd like to answer any questions that are referenced on this presentation today.

Aryeh Langer: Thank you very much. At this time, we are ready for 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. Once your line is opened, state your name and organization. Please note your line will remain open during the time you're asking your question, so anything you say, or any background noise will be heard in the conference.

If you have more than one question, press star one to get back into the queue, we will address additional questions as time permits. Please hold while we compile the Q&A roster. Please hold while we compile the Q&A roster.

Your first question comes from the line of Donna Williams.

Aryeh Langer: Hello, your line is open.

Donna Williams: Yes. Hello. In the beginning, you had gave us a website to go to, and I got as far as the G.O.V. forward slash, what was after that?

Aryeh Langer: You talking about for the presentation for today?

Donna Williams: Correct.

Aryeh Langer: Okay. It's go dot C. M. S. dot G. O. V. forward slash N. P. C. Nancy Peter Charlie.

Donna Williams: And that was go.cms.gov G. O. V.

Aryeh Langer: Yes, one-time G. O. V. forward slash NPC.

Donna Williams: NPC. Oh! Okay. That's where I went wrong. Thank you so much

Aryeh Langer: Sure.

Operator: Your next question comes from the line of Mary Madison.

Mary Madison: Good afternoon, and thanks for the presentation. My question is about a number that's on slide 11; it references 9 assessment-based measures. I attended the SNF QRP training last month in Kansas City, and I'm looking at, also, page 11 of that material, and I can only see 8 assessment-based measures. Am I missing one of them?

Aryeh Langer: Can you give us one moment, please?

Lorraine Wickiser: Hi Mary. Thank you for pointing it out work. We're checking that right now. That could just have been a typo. So, just thank you so much.

Mary Madison, Thank you.

Aryeh Langer: Let's go ahead and take the next question while we're doing some research here, please.



Operator: Your next question comes from the line of Nancy Shires.

Nancy Shires: Hello. I have a question related to if inadvertently my MDS Coordinator submitted assessment for those manage cares that we complete for our payment but do not submit, but let's say that she batched them and inadvertently sent them. Is inactivation enough to take them out so that they don't affect my QRP?

Debra Weiland: Thank you for your question. This is Deb. No, that would be not an adequate step to take that. Those assessments should never been submitted and accepted by the CMS national database. Therefore, you would need to contact your state RAI coordinator to identify the next steps to remove those assessments permanently from the database.

If you access the CMS website, you will go to be the MDS 3.0 Ethical Information Page. When you arrive at that page, there is a list of links on the left side. Select the RAI manual link. And at the bottom of that webpage in the download box, you will find a file titled Appendix B.

The RAI coordinators information is contained in that file. So, if you're uncertain who to contact in your state, please reference Appendix B, and you can contact that appropriate person and explain the situation. And she can -- he or she can help you with next steps.

Aryeh Langer: Thank you very much.

Nancy Shires: Thank you.

Debra Weiland: Yes.

Operator: If you'd 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.

Your next question comes from a line of Joan Kowalski.

Joan Kowalski: Hi, Good afternoon. I hope you can hear me. I had to use my cell phone.

Aryeh Langer: Yes, go ahead.

Joan Kowalski: Okay thank you. Can you please clarify or perhaps simplify the triggered versus not triggered and when it's desirable regarding those measures with the goals and the care plans versus the falls with major injury for example?

Debra Weiland: Absolutely, this is Deb. That's an excellent question. That's those are kind of tricky references we use. So, when we talk in general about the words triggered or not triggered, we're indicating whether or not that patient stay or patient record was included in the numerator count for the measure. When we talk about desirable versus undesirable measures, we think of those measures that we want to have positive outcomes as desirable measures.



For example, your measure for those patients that had a functional assessment, admission and discharge assessment, and a care plan that addresses function would be a positive measure, right because, we want -- CMS wants all patients to be adequately assessed and ensure that they have a care plan. So, the higher the number in your numerator and your facility percent in this particular type of a measure, the better it is. So, that's what we would term as a desirable outcome measure.

An undesirable outcome measure would be the example of the falls with major injuries measure. We don't want patients and residents to fall and have major injuries, but we do measure for that. CMS does measure for that.

So, any patients or residents that had an indication of a fall with major injury on the assessment that was included in the reporting period would trigger that measure, and so, that's a negative outcome. So, in that case, in the undesirable measures, you want your numerator count to be as low as possible, zero if possible because those are unfavorable events. Did that help explain the difference?

Joan Kowalski: You know it did, but I guess it's the legend that's confusing me, so the X versus the NT.

Debra Weiland: Okay. That's -- thank you for the follow-up question.

So, for the legend, the X indicates that the measure was triggered. So, in the desirable outcome measures, for example, our function measure, if the person had an admission and discharge functional assessment and a care plan that addressed their goals, and they were appropriately included in the numerator, then the X would display at a patient level.

That means that when you look at the patient level results for the desirable outcome measures if there is an X for that patient's record or stay, that's a desirable outcome. That patient was included in the numerator, and that's a good thing.

If for the function measure the patient was not included in the numerator because their assessment data did not support that, an NT, meaning not triggered would display in the patient level reports, and that says to us that, based on the assessment data that was included in the reporting period, that measure was not met. And therefore, the NT indicating not triggered displays.

And the opposite is true for the undesirable outcome measures. So, with our Falls with Major Injury measure, if the person's records indicated that there was a fall with major injury during the reporting period, an X would display for that measure. So, you look at it in a little different way for the undesirable outcome measures. The X in this case for those measures indicate that that stay was included in the numerator, which is not a positive event.

For the undesirable outcome measures, such as the falls measure, if NT displays on the patient level report, that means there was no indication that, that person had a fall with major injury, and therefore, that stay was not included in the numerator count for your facility.

Joan Kowalski: You've made it very clear, and now I understand thank you so much.

Debra Weiland: Good, I'm so glad, thank you.



Operator: The next question comes from the line of Tasha Crum.

Tasha Crum: Hi, I have a question in regards to the reference that you made to -- you stated to remove or inactivate MDS's submitted erroneously. I got to the point MDS 3.0. What was after that to get to the RAI manual?

Debra Weiland: Sure, that's a good question, you can go to the CMS website and do a search by the page MDS 3.0 -- actually you can search by MDS 3.0 RAI manual. And then you should arrive at the page where the manual is posted, and it is from there that you'll locate Appendix B.

Tasha Crum: Okay. Thanks.

Debra Weiland: Thank you for your follow-up.

Aryeh Langer: Before we take our next question, we want to circle back to the first question received, I believe from Mary.

Christine Grose: Right, this is Chris. So, we wanted to follow up. We believe the confusion is related to the pressure ulcer measure that will be removed. The training is focused on the upcoming release, the MDS. And I think the difference will be the removal of -- we have a new pressure -- skin integrity measure.

So, we believe that's probably where you're getting a little bit of confusion because that measure will be going away, but the training was focused on how things will be beginning October 1. So, hopefully, that helps, and if you have any additional questions or follow up to that, please submit it to the helpdesk, the QRP helpdesk.

Aryeh Langer: Thank you.

Operator: Your next question comes from a line of Tom Popwar.

Tom Popwar: Hello. Can you hear me?

Aryeh Langer: Yes, go ahead.

Tom Popwar: Okay, my question is in regards to the corrections for the Provider Preview Reports. I just want to clarify I think I know this answer, but I want to know if those corrections are to the data, the overall percentages on the reports, not the individual MDS questions. And if we need to make changes to the MDS questions that affect those reports, how long do we have to do that, and is it similar to what you said about the inactivation thing? Do we have to contact the state RAI coordinator on it?

Debra Weiland: So, this is Deb. You've asked some very nice questions. To ensure that I'm able to answer them entirely, would you mind submitting your questions to the Quality Reporting Program helpdesk? You had several questions imbedded, and I want to be sure not to miss any of those?

Tom Popwar: Okay, sure.

Debra Weiland: Thank you very kindly.



Tom Popwar: Yes.

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. The next question comes from the line at Deborah Dijack.

Deborah Dijack: Yes, thanks for your presentation. I have a question. Can you explain exactly what happens when you risk-adjust the report that you mentioned? I think it was the second one. What does that mean exactly?

Debra Weiland: Hi, this is Deb. That's a fine question as well. So, risk-adjustment simply is -- it doesn't apply to all measures. For example, a measure that risk-adjustment would apply to would be the residents or patient pressure ulcer new or worsened measure.

So, the measure specifications take into account any extenuating circumstances that the resident might have. For example, perhaps they have a low BMI, or they're incontinent, some sort of other additional event that would put that resident at higher risk for the pressure ulcer measure.

So, if the person with one of these events triggers the pressure ulcer measure, the quality measure calculations will take into account any of those extra conditions for that patient and risk-adjust your facilities accordingly. So, in other words, it makes your score less...

Christine Grose: Levels the playing field.

Debra Weiland: Levels the playing field, yes so, it's not as -- it adjusts the percentage to a different level so it's not as bad acknowledging that there are patients with risk factors that could put them at a higher risk for these particular types of measures. So, as Chris said, it levels the playing field.

Deborah Dijack: And which of the quality measures are risk-adjusted?

Christine Grose: This is Chris. I would refer you to the specifications for all of the measures that are on the QRP website. We do have that information for each of the measures available there. Is there anything you wanted to add to that?

Debra Weiland: No, that's exactly what I was going to say. So, I'm not sure which provider type you're addressing, but for example, if you were talking about the SNF QRP, measures you could go to SNF QRP webpages, and there would be a link that would allow you to access the quality measures specifications or the quality measure user manual. And within that manual, you can identify which of those measures are risk-adjusted.

Deborah Dijack: Okay, thanks.

Debra Weiland: And if you do need additional assistance, please send an email to the Quality Reporting helpdesk, and we can provide you that specific link.

Operator: Your next question comes from the line of Beth Villena.



Beth Villena: Hello, can you hear me?

Aryeh Langer: Yes, go ahead, please.

Beth Villena: I have had difficulty with the Provider Preview Report giving us real data or real information about our data. It comes up as us not having data available every single time, and I believe it is linked to the certification date for my organization.

We were originally certified October 1st, 1989, but every year, we have to submit a report to the state of North Carolina. And it means that our certification date is basically updated October 1st of that current year, making many of the quality measures not available because it doesn't look like we were in existence before that time.

Each time I get a Provider Preview Report, I send this information along to the email address that you listed, but I have struggled to get any sort of correction to this in an ongoing way, and are, therefore, our Medicare compare does not show the data that we need. Is there any advice that you have about this?

Debra Weiland: This is Deb. Thank you, that's a very good question, and we're sorry that you've been struggling with this occurrence. This is a rare occurrence that happens in the national database. We are aware of it. We're in the process of addressing the issue. In the short term, we are —we have taken steps to, for those providers, those IRF providers who are experiencing this issue, we are updating your original participation date or your CMS certification date in the database to reflect the original date in your example 1989 I believe you said.

So, we are taking steps to update that in the database prior to the time the next preview reports are generated, so that your data will -- so it won't appear that you're a new facility, and your data measure results will be available. But CMS continues to work ongoing to make a more permanent correction for this rare occurrence.

Beth Villena: Okay. So, we should just expect that that will be resolved manually until something automatically get fixed? Do I need to continue to email you if it's not accurate?

Christine Grose: We, I think -- this is Chris. So, I want to tell you we appreciate your patience. We have been struggling to find a solution for this, and we come up with solutions. We think that this one will work. It's a temporary fix. I mean, we're well aware of it. I mean, you can still certainly send your emails, but believe me, we hear you, and we appreciate your patience as we work this out.

Beth Villena: Okay, thank you so much.

Debra Weiland: Thank you for your question.

Operator: I show no further audio questions at this time.

Additional Information



Aryeh Langer: Okay, thank you very much. Looks like everybody's going to get an extra 20 minutes to their day. If we did not get to your question because you weren't able to get in or you're thinking of it after the fact, please email it to the email address that was mentioned a few times on slide 43.

We hope you'll take a few moments to evaluate your experience with today's call. See slide 60 for more information regarding the evaluation. An audio recording and transcript will be available in about two weeks at the web address I mentioned at the beginning of the call and to the first question it was at go.cms.gov/npc.

Again, my name is Aryeh Langer. I'd like to thank our presenters here at CMS, and also thank you all for participating in today's Medicare Learning Network event on Post-Acute Care QRPs: Reporting Requirements and Resources. Have a great day, everyone.

Operator: Thank you for participating in today's conference call may now disconnect. Presenters, please hold.