Long-Term Care Hospital (LTCH) QRP Listening Session Summary: Administrative Burden of the LTCH QRP

October 17, 2023

Summary Report

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Contents

1. Introduction

The Centers for Medicare & Medicaid Services (CMS) has contracted with Acumen, LLC (hereafter referred to as Acumen) to develop and maintain assessment items and instruments for the Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP). Acumen operates under the *Quality Measure & Assessment Instrument Development & Maintenance & QRP Support for the Long-Term Care Hospital, Inpatient Rehabilitation Facility, Skilled Nursing Facility, Quality Reporting Programs, & Nursing Home Compare* contract (75FCMC18D0015/Task Order 75FCMC19F0003).

On October 17, 2023, Acumen hosted an LTCH Listening Session: Administrative Burden of the LTCH QRP, which was held to seek LTCHs' input on potential improvements to the LTCH QRP, the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS), advancements to interoperability, and opportunities to enhance provider education. Registration was open to the LTCH community through CMS's LTCH QRP webpage, and over 200 participants registered. This report provides a summary of the participants' feedback during the Listening Session. Sections 2 through 4 present a summary of the presentation for each discussion topic as well as stakeholder input for each discussion question. Specifically, Section 2 reviews the background of the LTCH QRP and the maturation of the LCDS. Section 3 summarizes the current state of interoperability in LTCHs. Finally, Section 4 covers existing and potential future methods of provider education provided by CMS.

In the 30 days following the listening session, CMS also invited additional feedback from participants on these topics via email using a dedicated email inbox, LTCH-Listening-Session-2023@acumenllc.com. However, no additional feedback was received. Finally, CMS received a number of comments during the listening session that were unrelated to the questions asked at the session, and therefore, they are not included in this report.

2. Background and Maturation of the LTCH QRP and LCDS

2.1 Summary of Presentation

The LTCH QRP was mandated by the Patient Protection and Affordable Care Act (ACA) in order to begin linking payment to quality outcomes under the Medicare program. The first LCDS was necessitated by the adoption of the Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury measure in the fiscal year (FY) 2012 Inpatient Prospective Payment System (IPPS)/LTCH Final Rule (77 FR 53258), which required a standardized item set for data collection. The rule finalized an item set using a subset of items from the CARE item set[1] for the collection and submission of information.

Since 2012, the LCDS has evolved in response to both quality initiatives and statutory requirements to support data collection for evaluation of health outcomes in LTCHs. The FY

[1] As a part of the Medicare Post-Acute Care Payment Reform Demonstration (PAC-PRD), a standardized patient assessment tool was developed for use at acute hospital discharge and at post-acute care admission and discharge. This tool was named the Continuity Assessment Record and Evaluation (CARE) Item Set. More information can be found at: https://www.cms.gov/medicare/quality/initiatives/pac-quality-initiatives/care-item-set-and-b-care.

2014 IPPS/LTCH Prospective Payment System (PPS) Final Rule[2] finalized the LTCH QRP compliance requirements. As a result, any LTCH that does not meet the minimum reporting requirements for collecting and submitting LCDS information may be subject to a two-percentage-point (2%) reduction in its Annual Payment Update (the Annual LTCH Payment Update for the LTCH prospective payment system). That same year, the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act of 2014) added section 1899B to the Social Security Act requiring the reporting of standardized patient assessment data with regard to quality measures. Most recently, the LCDS 5.0 was implemented beginning October 1, 2022 and represents a significant milestone for CMS with the collection of items on social determinants of health (SDOH).

The LTCH QRP is one way CMS implements quality initiatives to ensure quality health care for Medicare beneficiaries through accountability and public disclosure. The quality measures are tools that measure or quantify healthcare processes, healthcare outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care.

The LTCH QRP currently consists of 18 measures. Thirteen of these measures are stewarded by CMS; 10 are collected via the LCDS and three via LTCH PPS claims. The remaining five measures are stewarded by the Centers for Disease Control and Prevention (CDC) and collected via the National Healthcare Safety Network (NHSN).

CMS uses a consistent approach when deciding whether to add or remove measures from the LTCH QRP. It consists of four key considerations: (i) the measure removal factors listed in statute, (ii) legislative considerations, (iii) a set of guiding principles, and (iv) the Measure Set Review (MSR) process, which is another process enabled by statute. These are discussed in turn below.

CMS has adopted eight measure removal factors for the LTCH QRP, established by the FY 2013 IPPS/LTCH PPS final rule (77 FR 53614 through 53615) and FY 2019 IPPS/LTCH final rule (83 FR 41625 through 41627):

1. Measure performance is so high and unvarying that meaningful distinctions in improvements can no longer be made.
2. Performance or improvement on a measure does not result in better patient outcomes.
3. A measure does not align with current clinical guidelines or practice.
4. Availability of a more broadly applicable measure for the particular topic.
5. Availability of a measure more proximal in time to the desired patient outcomes.
6. Availability of a measure more strongly associated with desired patient outcomes.
7. Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.

[2] https://www.federalregister.gov/documents/2013/08/19/2013-18956/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the.

8. Costs associated with a measure outweigh the benefits of its continued use in the program.

Additionally, several measures in the LTCH QRP are required by law. The first pertinent law is the Pathway for SGR Reform Act of 2013, which required a measure of the change in mobility among LTCH patients requiring ventilator support. Secondly, the IMPACT Act of 2014 required the reporting of standardized patient assessment data across the PAC settings, including LTCHs, in several measure domains, including falls, function, skin integrity, transfer of health information, and resource use. A number of items on the LCDS are used in the calculation of measures to meet the IMPACT Act of 2014 requirements.

CMS also uses a set of guiding principles for selecting and prioritizing LTCH QRP quality measures and concepts. The first principle is actionability, which addresses whether LTCH QRP measures provide information to LTCHs to act upon using clinical evidence or other best practices. The second principle is comprehensiveness and conciseness. CMS wants the LTCH QRP measures to represent all LTCH core services using the smallest number of measures that comprehensively assess the value of care provided in LTCH settings. The third principle focuses on provider responses to payment, and refers to how CMS takes into consideration whether the LTCH performance measures might exacerbate or induce unwanted responses to the payment systems. The fourth and final principle is to ensure the LTCH QRP maintains compliance with CMS statutory requirements, other CMS policies, and key program goals.

Finally, the MSR process is a relatively new aspect of measure development and maintenance required by the Consolidated Appropriations of Act of 2021, and is conducted by an independent organization called a consensus-based entity (CBE). The goal of the MSR process is to build consensus around measure removals in order to optimize the CMS measure portfolio using specific criteria to assess the impact of a measure, the redundancy of the measure, and the measure's ability to address important aspects of care as a patient moves through the continuum of care.

2.2 Discussion Questions

- *Keeping in mind the requirements we just discussed, are there items on the LCDS or LTCH QRP measures you believe could be retired?*

One participant noted that measures related to the COVID-19 public health emergency (PHE) may no longer be relevant to include in the LTCH QRP, especially as new patients and staff are no longer required to provide proof of vaccination. However, another participant acknowledged that statutory requirements make it difficult to remove measures from the program.

Two participants also spoke to LCDS items they considered to be unsuitable for the LTCH setting. One stated the way some items are collected is not aligned with industry standards, and gave the example of Section GG and the Brief Interview for Mental Status (BIMS). Additionally, this participant explained that it is common, especially in the LTCH environment, that patients are unable to respond, and so providers often mark "unable to respond" at admission. The other participant stated that the Section GG functional assessment items may not be appropriate for all

LTCH patients, especially for the high-complexity patients who are on ventilator support. This participant noted it is not reasonable to expect functional improvement by the time of discharge for complex patients.

- *Are there items on the LCDS and/or LTCH QRP measures that attendees think could be improved or refined, either through guidance or alternative language or responses?*

One participant asked if it would be possible to leverage other patient data or patient records to collect information on the new SDOH items. Two other participants also noted that LTCH patients often have difficulties responding to interview questions due to their cognitive status or the complexity of their medical condition(s), and can become frustrated both at the length of the assessment and not being able to provide answers.

- *Would having a 4-day assessment period, rather than 3-day, mitigate burden of completing the LCDS?*

Generally, participants supported adopting a 4-day assessment period. A total of six participants agreed that having a 4-day assessment period would help alleviate clinician burden. Two of those participants flagged that the current 3-day assessment period limits the number of weekend admissions they are able to accommodate due to staffing constraints and the limited time period in which to collect the information for the LCDS. They noted that more patients could be admitted prior to and on weekends with a 4-day assessment period. However, two participants did not think a 4-day assessment period would improve clinician burden. Instead, they emphasized the need to limit the number of items included in the assessment.

3. Current State: Interoperability in LTCHs

3.1 Summary of Presentation

In 2022, CMS launched its National Quality Strategy (NQS). The NQS focuses on a person-centric approach from birth to death as individuals journey across the continuum of care, from home or community-based settings to hospital to post-acute care, and across payer types, including Traditional Medicare, Medicare Advantage, Medicaid and Children's Health Insurance Program (CHIP) coverage, and Marketplace plans. The NQS has four priority areas:

1. Outcomes and Alignment
2. Equity and Engagement
3. Safety and Resiliency
4. Interoperability and Scientific Advancement

CMS wants to support data standardization and interoperability by developing and expanding requirements for sharing, receipt, and use of digital data. One of the first areas CMS identified to improve digital strategy is using Fast Healthcare Interoperability Resource (FHIR)-based standards to exchange clinical information through application programming interfaces (APIs), aligning with other programs where possible, to allow LTCHs to digitally submit quality information one time that can then be used in many ways. Using FHIR interfaces would allow

the exchange of data for purposes beyond just reporting to CMS, and could facilitate coordination of care across multiple providers.

Table 1 displays the poll questions attendees were asked, their answers, and the percentage breakdowns for each question.

Table 1: Poll Questions and Answers

Do you currently use an electronic health record (EHR)?	
Yes	50/126 (39.7%)
No	9/126 (7.1%)
No Response	67/126 (53.2%)
Of those using EHR, do you currently share information electronically with other providers using Fast Healthcare Interoperability Resource (FHIR)-based application programming interfaces (APIs)?	
Yes	20/126 (15.9%)
No	32/126 (25.4%)
No Response	74/126 (58.7%)
What kind of information do LTCHs think is feasible for CMS to digitally collect from your EHR?	
Lab Results	26/126 (20.6%)
Physician Orders	20/126 (15.9%)
LCDS Items	33/126 (26.2%)
No Response	47/126 (37.3%)

3.2 Discussion Questions

- *What are your current experiences with exchanging data? Is anyone using FHIR-based APIs to exchange data?*

One participant noted that specifically in the LTCH setting, implementation of electronic health records (EHRs) was not incentivized in the same way it was for short-term Acute Care Hospitals (ACHs). This participant noted that even in larger systems, LTCHs struggle with recording lab results and similar services in a systematic way because they may not have the capacity to conduct these activities in-house and have to rely on integration with other hospitals. As such, they have to coordinate with other facilities to obtain this information even when their EHR systems are more developed. Therefore, it may be more challenging to have a generalized approach for LTCHs regarding EHR implementation.

- *Could you facilitate and/or conduct a pilot demonstrating the flow of PAC data using FHIR-based APIs?*

Participants did not specifically address this question.

- *What specific barriers do you experience during care transitions with exchanging data?*

Participants did not specifically address this question.

- *What should CMS do to facilitate the process of interoperable data exchange?*

One participant recommended CMS work with EHR vendors to facilitate their participation. LTCHs currently have the burden of development costs and integration, and if CMS were to work with EHR vendors to facilitate integration across LTCHs, it would reduce burden on providers. This participant stated that LTCHs struggle with both upstream and downstream systems for collecting basic clinical info because they don't have robust information technology (IT) support systems. Finally, this participant noted that while some states have mandated information-sharing, it has been extremely difficult to actually implement due to the resources, time, and money required, despite being a great idea in theory.

4. Provider Education Needs

4.1 Summary of Presentation

CMS provides numerous provider education tools and materials free of charge to all LTCHs. These materials mitigate LTCH burden by reducing the need for LTCHs to create their own training materials for new data collection requirements. CMS provides recordings, such as the *Achieving a Full APU* webinar training and the *Section GG 3-Course Training Series.* Additionally, CMS holds live trainings for providers, such as the June 2022 LTCH QRP Training. CMS provides job aides to assist providers in the assessment and coding of targeted assessment items and also publishes quarterly Q&As so that all LTCH providers have the clarifications to existing guidance. Lastly, the QRP Helpdesk is available seven days a week for providers to submit questions.

4.2 Discussion Questions

- *Are there other methods of provider education CMS should consider (e.g., onsite or live)?*

One participant commented that managing trainings across staff is very time-consuming, especially given high job turnover and contract labor in the industry. Managing staff struggle to keep up with materials shared by CMS and get these materials to the necessary end users. This participant also noted that many of the trainings that CMS has provided thus far are too lengthy to be completed by the staff who are actually providing care to patients. The participant noted that the ideal training should occur prior to the start of staff employment, be comprehensive, and no more than one hour in total length. Additionally, this participant suggested that training should be provided in a format that could be uploaded directly to a LTCH's computer-based learning platform so it can be completed and tracked digitally.

- *Are there particular educational videos that have been most helpful or you find yourself using frequently? Are there any CMS should expand?*

Participants did not specifically address this question.

- *What additional subject areas or topics should CMS develop educational resources for to ease the transition to new data collection?*

One participant commented that since CMS no longer has in-person educational sessions, the opportunity to connect with other LTCH facilities across the country is missing. LTCHs would previously use these sessions to share best practices and discuss areas of data collection that CMS does not address. However, LTCHs have had to find other ways to connect with peers such as through their national associations. This participant acknowledged that virtual sessions are more convenient, but also suggested periodic live sessions would still be beneficial for the purpose of helping LTCHs connect.