Quality Reporting In CMS’ Post-Acute Care Quality Reporting Programs

Presenter:
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Post-Acute Care (PAC) Quality Reporting

• DCPAC is the “Business Owner” with oversight responsibilities of 5 Quality Reporting Programs (QRP).

1. Home Health Agency QRP (HHA QRP)
2. Hospice QRP
3. Long-term Acute Care Hospital QRP (LTCH QRP)
4. Inpatient Rehabilitation Facility QRP (IRF QRP)
5. Skilled Nursing Facility QRP (SNF QRP)

• Each of the 5 quality reporting programs are penalty based programs

• Failure to submit the required data, results in a 2% reduction to the PAC provider’s CY/FY annual payment update (APU)
## POST-ACUTE CARE (PAC)

Section 3004 of the Affordable Care Act mandates the establishment of PAC quality reporting programs (QRP) for long-term care hospitals (LTCH), inpatient rehabilitation facilities (IRF), and hospices.

The Improving Medicare Post-Acute Care Transformation Act of 2014 mandates the establishment of QRP for skilled nursing facilities (SNF).

Section 1995 of the Social Security Act mandates the establishment of home health agencies (HHA) QRP.

### PAC Providers: General Overview

<table>
<thead>
<tr>
<th>PAC Setting</th>
<th>Facilities</th>
<th>Providers Assessment</th>
<th>Medicare Beneficiaries</th>
<th>PAC Medicare Spending (in Billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTCH</td>
<td>411</td>
<td>408 k</td>
<td>118 k</td>
<td>$8.4</td>
</tr>
<tr>
<td>SNF</td>
<td>15,031</td>
<td>20.2 million</td>
<td>1.7 million</td>
<td>$28.6</td>
</tr>
<tr>
<td>IRF</td>
<td>1,177</td>
<td>469 k</td>
<td>339 k</td>
<td>$7</td>
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<tr>
<td>HHA</td>
<td>12,461</td>
<td>17.3 million</td>
<td>3.4 million</td>
<td>$17.7</td>
</tr>
<tr>
<td>Hospices</td>
<td>4,092</td>
<td>441 k</td>
<td>1.3 million</td>
<td>$15.1</td>
</tr>
<tr>
<td>All PAC Facilities</td>
<td>33,172</td>
<td>38.9 million</td>
<td>6.9 million</td>
<td>$73.8</td>
</tr>
</tbody>
</table>

**Quality reporting in PAC settings aligns with the CMS National Quality Strategy Goals:**

- Mixing Care Sater
- Effective Prevention & Treatment of Chronic Diseases
- Patient and Family Engagement
- Communication & Care Coordination
- Best Practice of Healthy Living
- Making Care Affordable

• DCPAC leads the development and maintenance of measures for both setting-specific, as well as the cross-setting IMPACT Act measures.
  – Currently maintaining over 100 measures across its QRPs.
• 50 measure concepts are either being considered for development or are under development
• All patient assessment measures are collected by our assessment instruments.
Home Health Agency (HHA) Quality Reporting Program

HHA Goal: Furnishing skilled nursing or therapy services to homebound individuals with care needs for up to 60 days per episode of care.

Services Provided:
Skilled nursing or therapy services provided to people who are homebound.

- Number of facilities: **12,461**
- Medicare spending: **$17.7 billion**
- Average length of episode of care: **59 days**
- No. of beneficiaries: **3.4 million**

**Quality Reporting Measures**
- OASIS - Outcome and Assessment Information Set submissions: **17.3 million**

**PROGRAM VARIABLES**
- Consumer Assessment of Healthcare Providers and Systems Survey
- Deficit Reduction Act & IMPACT Act
- CMS Quality Strategy

Better outcomes for health and health care
Hospice Quality Reporting Program

People who have a terminal condition and a life expectancy of six months or less, may decide to receive services that provide pain relief, comfort, and other support. The Hospice Quality Reporting Program (HQRP) establishes quality reporting requirements for hospices and makes quality data available to the public with a focus on measuring the quality of care for the “whole person”, including physical, emotional, social, and spiritual needs.

**SERVICES PROVIDED:**
Palliative and support services, including pain management and spiritual counseling, provided to people who have terminal conditions

- Number of facilities: 4,092
- Average length of stay: 88.2 days
- No. of beneficiaries: 1.3 million

Medicare spending: $15.1 billion
HIS – Hospice Item Set submissions: 441 k

**PROGRAM VARIABLES**
- Consumer Assessment of Healthcare Providers and Systems Survey
- Affordable Care Act
- CMS Quality Strategy

Medicare.gov Compare (Fall 2017)

Better Outcomes for health and health care
Long-Term Care Hospital (LTCH) Quality Reporting Program

Establishes reporting requirements for Medicare-certified Long-Term Care Hospitals and makes information available to the public with a goal to improve health and health care outcomes by promoting provider accountability for quality of care and better health care decision-making. To qualify as an LTCH for Medicare payment, a facility must meet Medicare’s conditions of participation for acute care hospitals and its Medicare patients must have an average length of stay greater than 25 days.

SERVICES PROVIDED: Hospital level of care such as prolonged ventilator support and ventilator weaning, wound care management, pain management, treatment for sepsis, and post-traumatic and postoperative infections provided for extended periods to patients with chronic critical illness—those who exhibit metabolic, endocrine, physiologic, and immunologic abnormalities that result in profound debilitation and often requiring respiratory failure.

Number of facilities: 411
Average length of stay: 26.3 days
No. of beneficiaries: 118
Medicare spending: $5.4 billion

LTCH CARE Data Set - LTCH Continuity Assessment Record and Evaluation (CARE) Data Set submissions: 408

Data Sources:
1. Report to Congress: Medicare Hospital Outliers, Medicare Payment Advisory Commission (MedPAC), Washington, D.C., March 2018
2. CMS, Division of Quality Improvement Assessment and Standards (DIVA)

Better outcomes for health and health care

Medicare.gov Compare
(Fall 2016)
Inpatient Rehabilitation Facility (IRF) Quality Reporting Program

IRF QRP Objective: 1. Measure the quality, resource use, efficiency, and other dimensions of care with a goal to improve the delivery of patient-centered, cost-effective care; improve the efficiency of the healthcare services; and reduce unnecessary variation in care.

SERVICES PROVIDED:
Intensive rehabilitation services such as physical and occupational therapy, rehabilitation nursing, speech-language pathology, prosthetic and orthotic devices provided to patients after an illness, injury, or surgery.

Number of facilities: 1,177
Average length of stay: 12.8 days
No. of beneficiaries: 339,300
Medicare spending: $7 billion
IRF-PAI - IRF-Patient Assessment Instrument (PAI) submissions: 469

Data Sources:
2. CMS, Division of Quality Systems (Underserved Areas and Rural Medicare_DRG):

PROGRAM VARIABLES
- IMPACT Act
- Affordable Care Act
- CMS Quality Strategy

Quality Reporting Measures

Medicare.gov Compare (Fall 2016)

Better outcomes For health and health care

Skilled Nursing Facilities (SNF) Quality Reporting Program

SNF Goal: Furnishing extended skilled nursing and rehabilitative care to individuals with daily care needs for up to 100 days.

Services provided:
Short-term skilled nursing and rehabilitation services to individuals whose health problems are too severe or complicated for home care or assisted living

Number of facilities: 15,166
Average length of stay: N/A
No. of beneficiaries: 1.7 million
Medicare spending: $28.6 billion
MDS - Minimum Data Set submissions: 20.2 million

Data sources:
2. CMS, Center for Medicare & Medicaid Services.
3. CMS, Division of Quality Systems for Reimbursement and Services (QIE).

Better outcomes for health and health care
PAC QM vs. Hospital/EP eCQM Processes

• Data Collection:
  – Hospitals and EPs: Clinical data entry in CEHRT (certified EHR technology) software which produces QRDA files
    • Source data must be EHR-generated
  – PAC Settings: Setting-specific assessment instrument completion via vendor software/free CMS software which produces XML submission files
    • Source data can come from a variety of sources including an EHR, but is then abstracted into the vendor or CMS free software

• Data Submission:
  – Hospitals and EPs: CMS reporting portals
  – PAC Settings: ASAP System

• Quality Measure Reporting:
  – Hospitals and EPs: Submission and measure reports via CMS portal
  – PAC Settings: Submission and measure reports via CASPER Reporting System
Assessment Data

• Patient level on all patients in LTCHs & Hospices; Medicare in SNFs, Medicare/Medicaid in HHAs, and Medicare and MA in IRFs

• Discrete information, e.g., health assessment such as pressure ulcers, function, vaccination, mental status, etc.

• Specifies timepoints of when/what assessment information can be submitted

• Data is to be verified and attestations to accuracy is required
Assessment Instrument Collection: One Data Element: Many Uses

GG0160. Functional Mobility
(Complete during the 3-day assessment period.)

Code the patient’s usual performance using the 6-point scale below.

CODING:
- Safety and Quality of Performance: If helper assistance is required because patient’s performance is unsafe or of poor quality, score according to amount of assistance provided.
- Activities may be completed with or without assistive devices.

06. Independent - Patient completes the activity by him/herself with no assistance from a helper.
05. Setup or clean-up assistance - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
04. Supervision or touching assistance - Helper provides VERBAL CLUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. Dependent - Helper does ALL of the effort. Patient does none of the effort to complete the task.

07. Patient refused
09. Not applicable
If activity was not attempted, code:
88. Not attempted due to medical condition or safety concerns

Enter Codes in Boxes
A. Roll left and right: The ability to roll from lying on back to left and right side, and roll back to back.
B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
C. Lying to Sitting on Side of Bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support.

Data Element & Response Code

Care Planning/Decision Support
Quality Reporting
Payment
Care Transitions
Components of the Assessment Instruments

<table>
<thead>
<tr>
<th>Section</th>
<th>Cognitive Patterns</th>
</tr>
</thead>
<tbody>
<tr>
<td>C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?</td>
<td></td>
</tr>
<tr>
<td>Attempt to conduct interview with all residents</td>
<td></td>
</tr>
<tr>
<td>Enter Code:</td>
<td></td>
</tr>
<tr>
<td>0. <strong>No</strong> (resident is rarely/never understood) → skip to and complete C0700-C1000, Staff Assessment for Mental Status</td>
<td></td>
</tr>
<tr>
<td>1. <strong>Yes</strong> → continue to C0200, Repetition of Three Words</td>
<td></td>
</tr>
</tbody>
</table>

**Brief Interview for Mental Status (BIMS)**

<table>
<thead>
<tr>
<th>C0200. Repetition of Three Words</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question:</strong> Ask resident: &quot;I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words.&quot;</td>
</tr>
<tr>
<td><strong>Enter Code:</strong></td>
</tr>
<tr>
<td>0. <strong>None</strong></td>
</tr>
<tr>
<td>1. <strong>One</strong></td>
</tr>
<tr>
<td>2. <strong>Two</strong></td>
</tr>
<tr>
<td>3. <strong>Three</strong></td>
</tr>
<tr>
<td><strong>Number of words repeated after first attempt</strong></td>
</tr>
<tr>
<td>After the resident's first attempt, repeat the words using cues (&quot;sock, something to wear; blue, a color; bed, a piece of furniture&quot;). You may repeat the words up to two more times.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C0300. Temporal Orientation (orientation to year, month, and day)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question:</strong> Ask resident: &quot;Please tell me what year it is right now.&quot;</td>
</tr>
<tr>
<td><strong>Enter Code:</strong></td>
</tr>
<tr>
<td>A. Able to report correct year</td>
</tr>
<tr>
<td>0. Missed by &gt; 5 years or no answer</td>
</tr>
<tr>
<td>1. Missed by 2-5 years</td>
</tr>
<tr>
<td>2. Missed by 1 year</td>
</tr>
<tr>
<td>3. Correct</td>
</tr>
</tbody>
</table>

**Definitions**

**Section C**

**Cognitive Patterns**

**Parent**

**Question**

**Response Option**

**Definitions**

**Instructions**
# Data Element Collection for Quality Measures

## Section J - Health Conditions

### J1800. Any Falls Since Admission

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Has the patient had any falls since admission?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
<td>Skip to M0210. Unhealed Pressure Ulcer(s)</td>
</tr>
<tr>
<td>1. Yes</td>
<td>Continue to J1900. Number of Falls Since Admission</td>
</tr>
</tbody>
</table>

### J1900. Number of Falls Since Admission

#### CODING:

- 0. None
- 1. One
- 2. Two or more

#### Enter Codes in Boxes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td><strong>No injury</strong>: No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall</td>
</tr>
<tr>
<td>B.</td>
<td><strong>Injury (except major)</strong>: Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain</td>
</tr>
<tr>
<td>C.</td>
<td><strong>Major injury</strong>: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma</td>
</tr>
</tbody>
</table>
Complete only at the time of discharge.

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Has the patient had any falls since admission?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
<td>Skip to M0210. Unhealed Pressure Ulcer(s)</td>
</tr>
<tr>
<td>1. Yes</td>
<td>Continue to J1900. Number of Falls Since Admission</td>
</tr>
</tbody>
</table>
J1900 Coding Instructions

- Complete at the time of discharge.
- Determine the number of falls that occurred since admission.
- Code the level of fall-related injury for each.
- Code each fall only once. If the patient has multiple injuries in a single fall, code the fall for the highest level of injury.
Using Data Elements to Calculate Quality Measures

The number of patient episodes where falls with major injury occurred

Everyone in facility who is assessed

Observed Score

Numerator

Denominator

Measure Rate

The number of patient episodes that are eligible for the desired process

J1900C
PAC Data Submission and Reporting

• PAC setting collects assessment data and uses ASAP system to submit data to QIES National database
• Quality measure data is calculated and stored in the QIES National database
• User-requested and auto-generated Quality Measure reports available to providers via the CASPER Reporting system
  – Provider-Level QM Reports
  – Patient-Level QM Reports
  – Preview Reports (providers preview data prior to public reporting)
# Assessment Data Submission, Flow, and Sharing

## Data Submission
- **Provider**
  - Logs into CMSNet
  - User id and password
  - Submits file containing patient level assessments (submission file) to CMS systems via the Assessment Submission and Processing (ASAP) system
    - MDS 3.0, OASIS-C2, IRF-PAI, LTCH, and Hospice

## Data Flow
- **CMS systems**
  - Send data to QIES national database
  - Verify submission file is accepted -> Submission validation report
  - Edit each record – passes edits -> final validation report (FVR)
    - Fatal record
    - Error messages

## Data Sharing
- Files can be placed on mainframe
- Files can be sent to a requestor
- Users access
  - QIES Extracts for Medicare Administrative Contractors
  - QIES Workbench
## Assessment Data Uses and Users

<table>
<thead>
<tr>
<th>Care Planning</th>
<th>Quality Measures</th>
<th>Survey</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Providers</td>
<td>• CCSQ, S&amp;C</td>
<td>• CMS CO S&amp;C</td>
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<td>• State &amp; RO S&amp;C</td>
<td>• QIOs</td>
<td>• State and RO S&amp;C</td>
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<td>• OIG</td>
<td>• State Agencies</td>
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<td>• Ombudsmen</td>
<td>• Providers</td>
<td>• Public reporting</td>
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<td>- Nursing Home</td>
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<td>- Compare, Home</td>
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<td>- Health Compare</td>
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<td>- IRF Compare,</td>
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<td>- and Hospice</td>
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<td>• CMS website</td>
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<td>• ORDI - research (CCW)</td>
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<td>• State Agencies (Title II)</td>
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<td>• CDC</td>
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<td></td>
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<td>• Researchers</td>
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</tbody>
</table>
The CMS Data Element Library (DEL)
Thank You!

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Tara McMullen: tara.mcmullen@cms.hhs.gov