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LTCH
LONG-TERM CARE HOSPITAL
QUALITY REPORTING PROGRAM

Today's Agenda

- Welcome and Introductions.
- What is the Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)?
- LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS) and Submission and Reporting Requirements.
- Internet Quality Improvement and Evaluation System (iQIES).
- Determining Compliance With the LTCH QRP.
- Resources.
- Q&A Session.

May 27

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Objectives

- Recall the basics of the LTCH QRP.
- Identify the LCDS submission requirements and data submission threshold.
- Describe the steps related to LCDS data submission and acceptance.
- Discuss the application of various iQIES reports.
- Describe the impact of LTCH QRP data submission on the Annual Payment Update (APU).
- Identify one resource for providers related to each of the topics presented.

Today's Presenters

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Associate Scientist/Nurse Researcher

Abt Associates

Acronyms in This Presentation

- APU – Annual Payment Update
- ARD – Assessment Reference Date
- CARE – Continuity Assessment Record and Evaluation
- CAUTI – Catheter-Associated Urinary Tract Infection
- CCN – CMS Certification Number
- CDC – Centers for Disease Control and Prevention
- CDI – *Clostridium difficile* Infection
- CLABSI – Central Line-Associated Bloodstream Infection
- CMS – Centers for Medicare & Medicaid Services

Acronyms in This Presentation (cont. 1)

- CY – Calendar Year
- FVR – Final Validation Report
- FY – Fiscal Year
- HAI – Healthcare-Associated Infections
- IMPACT Act – Improving Medicare Post-Acute Care Transformation Act
- iQIES – Internet Quality Improvement and Evaluation System
- LCDS – LTCH CARE Data Set
- LTCH – Long-Term Care Hospital
- MAC – Medicare Administrative Contractor

Acronyms in This Presentation (cont. 2)

- NHSN – National Healthcare Safety Network
- PAC – Post-Acute Care
- PHE – Public Health Emergency
- PHI – Protected Health Information
- PTR – Provider Threshold Report
- QM – Quality Measure
- QRP – Quality Reporting Program
- QTSO – iQIES Technical Support Office
- SBT – Spontaneous Breathing Trial
- SPADES – Standardized Patient Assessment Data Elements

Help During the Presentation

- If you need any technical assistance during this webinar, please let us know using the Q&A panel to the right of the presentation.
  - You may also submit any content-related questions during this presentation via the Q&A panel.
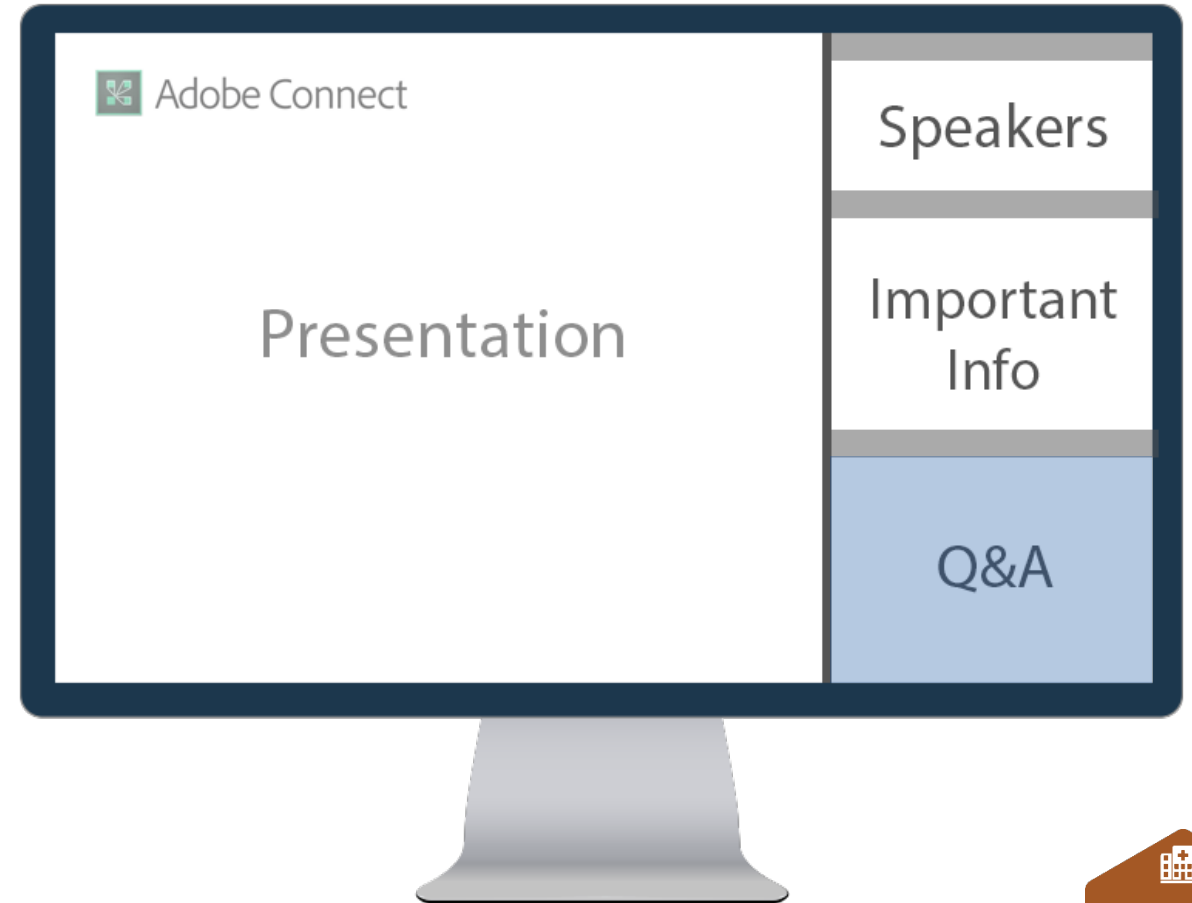
Dial-In, Closed Captioning, and Files

- The Important Information Panel to the right of your screen has valuable information. If you are having trouble connecting to the audio, the dial-in information is provided.

- There are also links for downloading the presentation slides and for viewing live closed captioning in a browser.
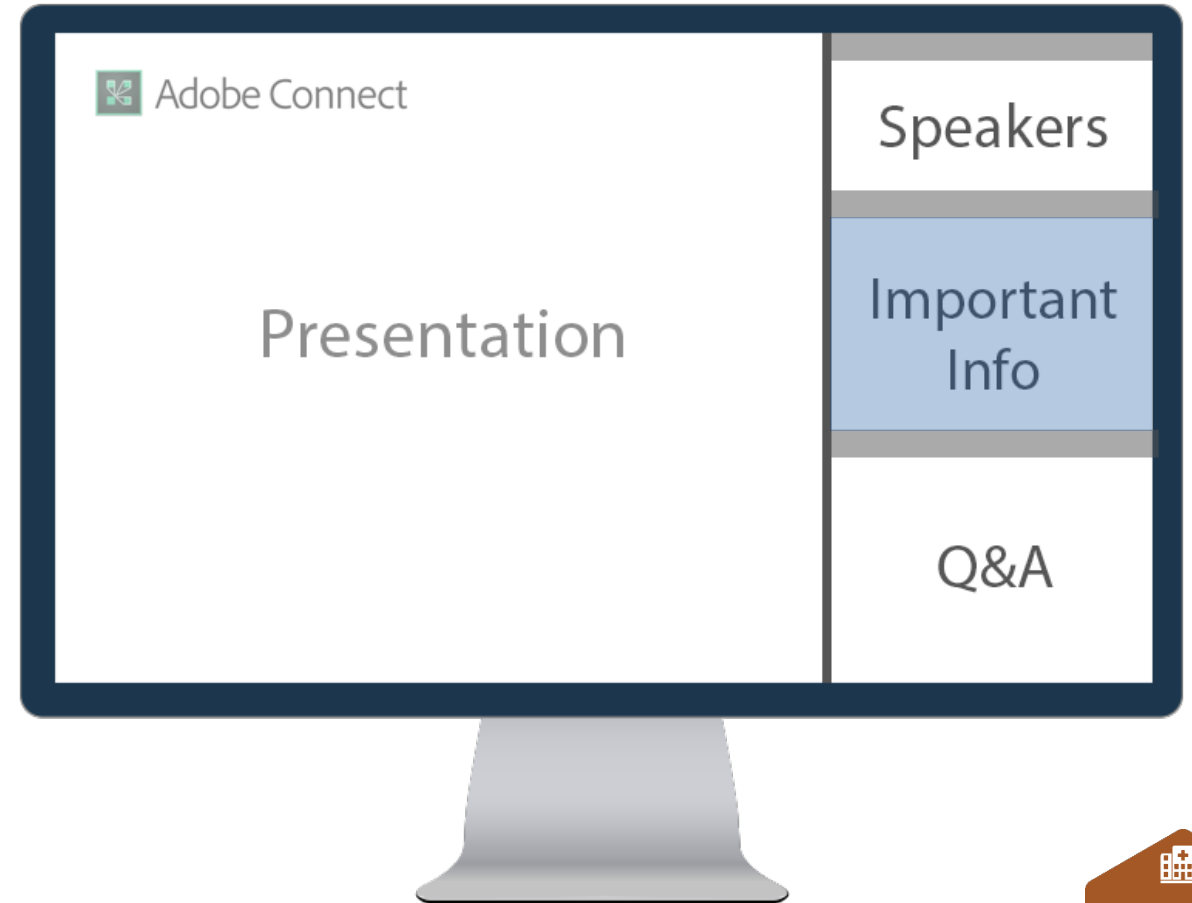
Interactive Polling

- During this presentation, we will occasionally poll the audience. When polls are activated, they will temporarily appear in the panel to the right of the presentation.
  - To participate, simply select your desired response.
  - You will have some time to respond to each question.
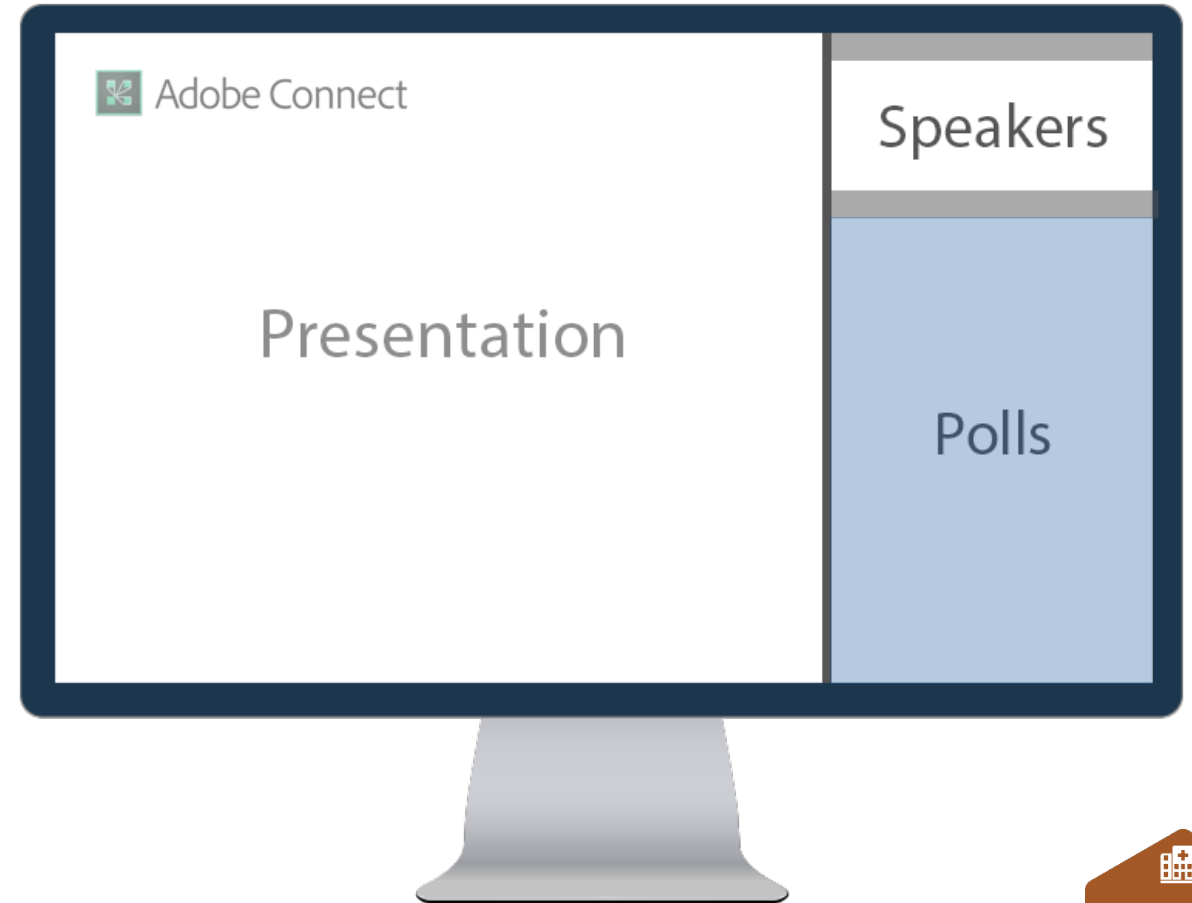
How many people (including you) are joining this webinar together in the same room?

A. Just me – I am the only one participating.

B. Two people.

C. Three or four people.

D. Five or more people.

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Which President signed Medicare into law?

A. Richard M. Nixon.

B. Lyndon B. Johnson.

C. Dwight D. Eisenhower

D. Gerald Ford.

Which President signed Medicare into law? (cont.)

The correct answer will be reviewed during the webinar.

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Q3 Who was enrolled as the very first Medicare beneficiary by President Johnson?

A. Harry S. Truman.

B. Claudia Alta "Lady Bird" Johnson.

C. Richard Nixon.

D. Betty Ford.

Q3 Who was enrolled as the very first Medicare beneficiary by President Johnson? (cont.)

The correct answer will be reviewed during the webinar.

LTCH LONG-TERM CARE HOSPITAL QUALITY REPORTING PROGRAM

What Is the LTCH QRP?

What Is the LTCH QRP?

- Section 3004(a) of the Patient Protection and Affordable Care Act of 2010 amended section 1886(m)(5) of the Social Security Act requiring the Secretary to establish quality reporting requirements for LTCHs beginning in fiscal year (FY) 2012.

- In response to reporting requirements identified in the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, the Centers for Medicare & Medicaid Services (CMS) required the reporting of standardized patient assessment data elements (SPADEs) by LTCHs.

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CMS Quality Goals

- Quality healthcare for people with Medicare is a high priority for CMS.
- CMS defines quality as having the following properties or domains:

Effectiveness
- Providing care processes and achieving outcomes as supported by scientific evidence.

Efficiency
- Maximizing the quality of a comparable unit of health care delivered or unit of health benefit achieved for a given unit of health care resources used.

Equity
- Providing health care of equal quality to those who may differ in personal characteristics other than their clinical condition or preferences for care.

Patient Centeredness
- Meeting patients' needs and preferences and providing education and support.

Safety
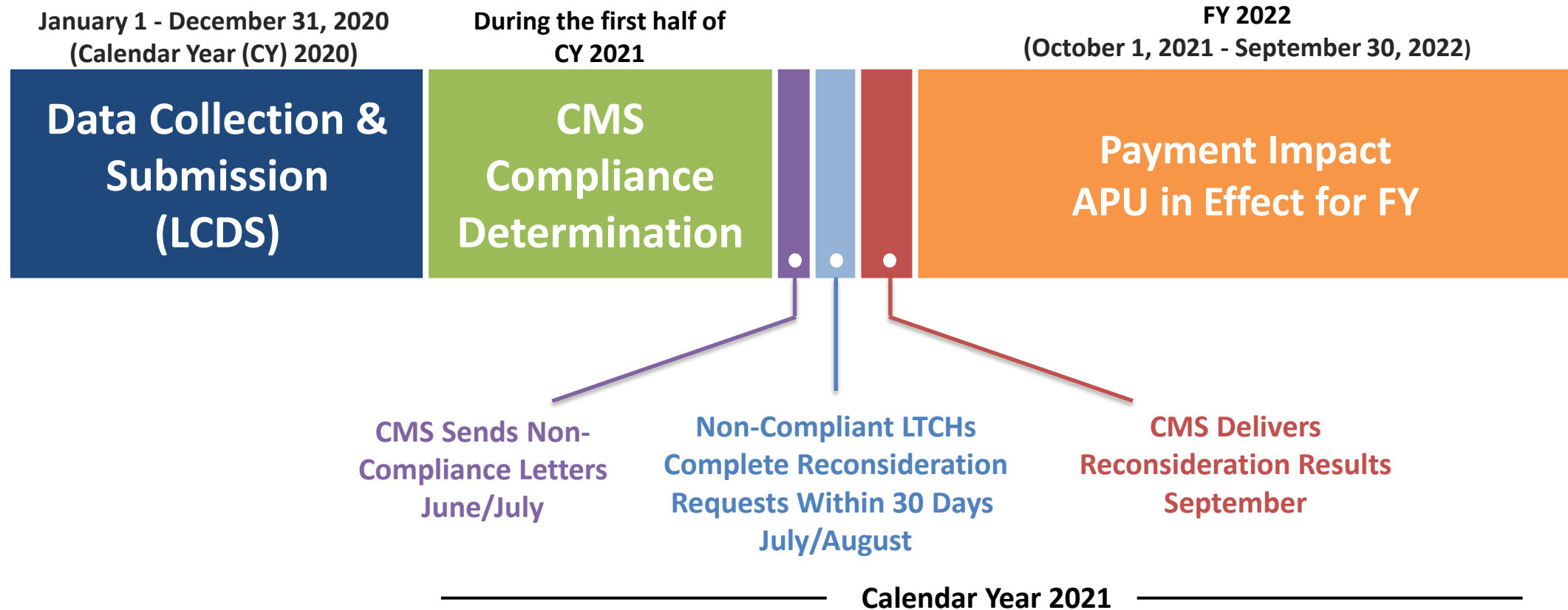- Preventing or reducing risk for actual or potential bodily harm.

Timeliness
- Obtaining needed care while minimizing delays.

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LTCH QRP Requirements

- The LTCH CARE Data Set (LCDS) is applicable to all patients receiving inpatient services in a facility certified as a hospital and designated as an LTCH under Medicare.

- The LCDS should be completed for individual LTCH patients who are admitted to, discharged from, or die in the LTCH, regardless of length of stay.

- LCDS data are required to be submitted and accepted within the threshold and according to the established submission timelines.

LTCH QRP Life Cycle

January 1 - December 31, 2020 (Calendar Year (CY) 2020)

During the first half of CY 2021

FY 2022 (October 1, 2021 - September 30, 2022)

Data Collection & Submission (LCDS)	CMS Compliance Determination				Payment Impact APU in Effect for FY

CMS Sends Non-Compliance Letters June/July

Non-Compliant LTCHs Complete Reconsideration Requests Within 30 Days July/August

CMS Delivers Reconsideration Results September

Calendar Year 2021

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LCDS Submission and Reporting Requirements

The LTCH CARE Data Set (LCDS)

- The LCDS is the assessment instrument LTCH providers use to collect patient assessment data in accordance with the LTCH Quality Reporting Program (QRP).

- Collection and submission of data elements on the LCDS is necessary to calculate the quality measures (QMs) as mandated by the LTCH QRP and the SPADEs and QMs specified in the IMPACT Act.

- Per the IMPACT Act, the data elements in the LCDS are to be standardized and interoperable to allow for:

  – Exchange of information among PAC providers and other providers.

  – Access to longitudinal patient information.

  – Coordination of care.

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LCDS Submission Requirements for the LTCH QRP

- LCDS Assessments must be completed and submitted for any patient admitted to a facility certified as a hospital and designated as an LTCH under the Medicare program **regardless of payment/payer source, age, or diagnosis (e.g., including pediatric patients and patients with psychiatric diagnoses)**.

- LCDS Assessments include:
  - Admission Assessment.
  - Planned Discharge Assessment.
  - Unplanned Discharge Assessment.
  - Expired Assessment.

LCDS Submission Requirements for the LTCH QRP (cont.)

- The data for the LTCH QRP are collected and submitted through three methods:

LCDS	Centers for Disease Control and Prevention (CDC) Healthcare Safety Network (NHSN)	Medicare Fee-for-Service Claims
Used to capture data elements used in the calculation of 10 assessment-based QMs.	Data are submitted through CDC and used in the calculation of four QMs.	Provide information for three claims-based QMs. There is no additional data collection or submission required by LTCHs.

NHSN Submission Requirements

- For NHSN data, providers are required to report Patient Safety and Healthcare Personnel Safety data for each calendar month, with three months of data due by each submission deadline.

- Submitting data within 30 days of the end of the month in which it is collected has the greatest impact on infection prevention activities.

NHSN Submission Requirements (cont.)

- For the purpose of fulfilling CMS quality reporting requirements, each LTCH's data must be entered into NHSN no later than 4½ months after the end of the reporting quarter.

- For summary reporting of the *Influenza Vaccination Coverage Among Healthcare Personnel* measure, only data from Quarter 4 of the prior year and Quarter 1 of the current year data must be entered by May 15th following each influenza season.

- For all other NHSN measures, providers that submit complete data for all 12 months will be found compliant.

LTCH QRP Assessment-Based QMs

- Changes in Skin Integrity Post-Acute Care (PAC): Pressure Ulcer/Injury.
  - *Lower* percentages are better.
- Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay).
  - *Lower* percentages are better.
- Functional Outcome Measure: Change in Mobility LTCH Patients Requiring Ventilator Support.
  - *Displayed as change score*.

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LTCH QRP Assessment-Based QMs (cont. 1)

- Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function.
  - *Higher* percentages are better.
- Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function.
  - *Higher* percentages are better.
- Drug Regimen Review Conducted with Follow-Up for Identified Issues – PAC LTCH QRP.
  - *Higher* percentages are better.

LTCH QRP Assessment-Based QMs (cont. 2)

- Compliance with Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay.
    - *Higher* percentages are better.
- Ventilator Liberation Rate.
    - *Higher* ratios are better.

LTCH QRP Assessment-Based QMs (cont. 3)

- Transfer of Health Information to the Provider – PAC.
  - *Higher* percentages are better.
- Transfer of Health Information to the Patient – PAC.
  - *Higher* percentages are better.

LTCH QRP Claims-Based QMs

- Rate of Potentially Preventable Hospital Readmissions 30 Days After Discharge From an LTCH.
  - *Lower* rates are better.
- Rate of Successful Return to Home and Community From an LTCH.
  - *Higher* rates are better.
- Medicare Spending Per Beneficiary for Patients in LTCHs.
  - *Displayed as a ratio.*

LTCH QRP NHSN QMs

- Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure.
  - *Lower* rates are better.
- Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure.
  - *Lower* rates are better.
- Facility-Wide Inpatient Hospital-Onset *Clostridium difficile* Infection (CDI) Outcome.
  - *Lower* rates are better.
- Influenza Vaccination Coverage Among Healthcare Personnel (HCP).
  - *Higher* rates are better.

LCDS Data Submission Deadlines

- There are individual LCDS data submission deadlines that must be met to be in compliance with the LTCH QRP.

- The data collection year runs from January to December, and submission deadline quarters are as follows:

Calendar Year Data Collection Quarter	Data Collection Submission QRP	Submission Deadline*
Quarter 1	January 1 - March 31	August 15
Quarter 2	April 1 - June 30	November 15
Quarter 3	July 1 - September 30	February 15
Quarter 4	October 1 - December 31	May 15

*This data must be reported by 11:59 p.m. local time zone on the 15th of the month or on dates specified by CMS each year.

Temporary LTCH QRP Exceptions Due to COVID-19

Exceptions <u>ended</u> on June 30, 2020.

- CMS granted an exception to the LTCH QRP reporting requirements for the quarters below.
  - These requirements were temporarily changed to assist LTCHs as they directed resources toward caring for patients and ensuring the health and safety of patients and staff during then COVID-19 public health emergency (PHE).

Quarter	LCDS Data Submission Reporting
Quarter 4 (October 1 - December 31, 2019)	Optional
Quarter 1 (January 1 - March 31, 2020)	Excepted
Quarter 2 (April 1 - June 30, 2020)	Excepted

Impact of LTCH QRP Exceptions Due to COVID-19 on Public Reporting

- The LTCH QRP is a pay-for-reporting program; as such, CMS is statutorily required to publicly report the data.

- Even though the data submission for Q4 2019 was optional, data submission was strong, so these data were included in the measure calculations for public reporting.

- Data for Q1 and Q2 2020 will impact what is displayed on Care Compare for LTCHs; therefore, CMS developed a strategy to accommodate the excepted quarters of data.

LTCH QRP Data Submission Thresholds

- LTCHs must meet or exceed **two** separate data completeness thresholds in order to comply with the LTCH QRP.
- LTCHs are required to submit LCDS data to the Internet Quality Improvement and Evaluation System (iQIES) and measures data to the CDC via NHSN.

80 Percent

Threshold for LCDS assessment data submitted that must contain 100% f the required quality data elements for the 10 assessment-based QMs.

100 Percent

Threshold for measures data collected and submitted using CDC's NHSN.

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LTCH QRP Data Submission Thresholds (cont.)

- LTCHs that fail to submit the required data by the data submission deadlines will be subject to a 2-percentage-point reduction in their APU for the affected FY.

LCDS Records From	LCDS Submission Threshold	NHSN Submission Threshold	Reporting Year
CY 2021	80%	100%	FY 2023
CY 2022	80%	100%	FY 2024
CY 2023	80%	100%	FY 2025

Impact of LTCH QRP Exceptions Due to COVID-19 on Public Reporting (cont. 1)

Quarter Refresh	LTCH Compare (LTCH QRP) Assessment-Based Measures Claims-Based Measures NHSN-Based Measures
September 2020	Continued to display June 2020 refresh data.
December 2020	Normal refresh – included Q4 2019 data (inaugural posting of three new QMs).
March 2021	Freeze
June 2021	Freeze
September 2021	Freeze
December 2021	Public reporting resumes*
March 2022	Normal Refresh

IMPORTANT NOTICE

All NHSN (e.g., CAUTI, CLABSI, CDI, and HCP influenza) QMs will be frozen beginning with the December 2020 refresh through the December 2021 refresh. CMS will continue to report NHSN infection data to PAC providers via their confidential provider feedback reports throughout this time.

*To account for missing PHE-excepted data (Q1 2020 and Q2 2020) when public reporting resumes, any potential change in measure calculation methodology will be subject to notice-and-comment rulemaking.

Impact of LTCH QRP Exceptions Due to COVID-19 on Public Reporting (cont. 2)

- CMS is aware that some of the Discharge Assessments submitted on or after July 1, 2020, may not have a matching LCDS Admission record if the admission occurred in Q1 or Q2 2020.

- This may cause an "out of sequence" warning error (909) during the submission process. Please note that despite this warning, data will still be accepted into iQIES.

- CMS will make adjustments to accommodate any records with missing Admission Assessments.

- These mismatched sets of records will not be counted or included in your LTCH data calculations for Care Compare.

Error Number	Error Type	Error Description
909	Out of Sequence	**Inconsistent Record Sequence:** Under CMS sequencing guidelines, this type of record does not logically follow the type of record received prior to this one.

Despite this warning, data will still be accepted into the system. *(no action is needed)*

LCDS Reporting Requirements

- To meet LTCH QRP requirements, LTCHs must:
  - Meet the LCDS data collection requirements.
  - Submit LCDS data on time per submission deadlines.
  - Ensure LCDS data are accepted.

The act of submitting data does not equal acceptance.

LCDS Admission Assessment

- The LCDS Admission Assessment is completed for each new patient admitted to the LTCH.

- There is a maximum of a 3-day assessment period in which the patient's assessment must be conducted to obtain information for the LCDS Admission Assessment items.

- The Assessment Reference Date (ARD) (A0210) must be no later than the 3rd calendar day of the patient's admission (Admission Date (A0220) + 2 calendar days).

LCDS Admission Assessment (cont.)

- The Completion Date (Z0500B) should be no later than the 8th calendar day of the patient's admission (ARD + 5 calendar days) but also may occur on, but not before, the ARD.

- Submission should be no later than the 15th calendar day of the patient's admission (Completion Date + 7 calendar days) but also may occur on, but not before, the ARD.

LCDS Planned Discharge Assessment

- The LCDS Planned Discharge Assessment must be completed when a patient is non-emergently, medically released from care at the LTCH, for longer than 3 days, for some reason that was arranged for in advance.

- The assessment period begins 2 days prior to the date of discharge, with the actual date of discharge being the end of the assessment period. However, some items (e.g., M0800) refer back to the Admission Assessment).

- The ARD (A0210) must be equal to the Date of Discharge (A0270).

LCDS Planned Discharge Assessment (cont.)

- The Completion Date (Z0500B) should be no later than Discharge Date (A0270) + 5 calendar days, and also may occur on, but not before, the ARD.

- Submission must be completed no later than the Completion Date + 7 calendar days, and also may occur on, but not before, the ARD.

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LCDS Unplanned Discharge Assessment

- The LCDS Unplanned Discharge Assessment must be completed if a patient has a transfer or unplanned transfer to another hospital/facility and does not return to the LTCH within 3 calendar days. Other examples include:
  - Leaving the LTCH against medical advice.
  - Decision to go home or to another hospital or facility.
- The assessment period begins 2 days prior to the date of discharge, with the actual date of discharge being the end of the assessment period. However, some items (e.g., M0800) refer back to the Admission Assessment).

LCDS Unplanned Discharge Assessment (cont.)

- Due to the nature of unplanned discharges, the LTCH should complete an LCDS Discharge Assessment to the best of its ability.

- ARD (A0210) must be equal to the Date of Discharge (A0270).

- The Completion Date (Z0500B) should be no later than Discharge Date (A0270) + 5 calendar days, and also may occur on, but not before, the ARD.

- Submission must be completed no later than the Completion Date + 7 calendar days, and also may occur on, but not before, the ARD.

LCDS Expired Assessment

- The LCDS Expired Assessment must be completed when the patient dies in the LTCH.

- If the patient dies during the Admission assessment period, both an LCDS Admission and LCDS Expired Assessment must be completed.

- The ARD (A0210) must be equal to the Discharge Date (A0270), which is patient's date of death.

- The Completion Date (Z0500B) should be no later than the Discharge Date (A0270 + 5 calendar days), and also may occur on, but not before, the ARD.

- Submission must be completed no later than the Completion Date + 7 calendar days, and also may occur on, but not before, the ARD.

Patient _____ Identifier _____ Date _____

LONG-TERM CARE HOSPITAL (LTCH) CONTINUITY ASSESSMENT RECORD & EVALUATION (CARE) DATA SET - Version 4.00
PATIENT ASSESSMENT FORM - EXPIRED

Section A	Administrative Information

A0050. Type of Record
Enter Code
1. Add new assessment/record
2. Modify existing record
3. Inactivate existing record

A0100. Facility Provider Numbers. Enter Code in boxes provided.
A. National Provider Identifier (NPI):
B. CMS Certification Number (CCN):
C. State Medicaid Provider Number:

A0200. Type of Provider
Enter Code
3. Long-Term Care Hospital

A0210. Assessment Reference Date
Observation end date:
Month Day Year

A0220. Admission Date
Month Day Year

A0250. Reason for Assessment
Enter Code
01. Admission
10. Planned discharge
11. Unplanned discharge
12. Expired

A0270. Discharge Date. This is the date of death.
Month Day Year

Interrupted Stay and LCDS Assessment Completion

- Program Interruption refers to an interruption in a patient's care given by an LTCH because of the transfer of that patient to another hospital/facility per agreement for medical services (e.g., need for acute-care services). Such an interruption must not exceed 3 calendar days.
  - If a patient is returning to the LTCH after more than 3 calendar days (day of transfer + 2 calendar days) at another hospital or facility, then an LCDS Discharge Assessment related to the transfer should be competed and a new LCDS Admission Assessment should be completed.
  - If a patient is returning to the LTCH after a stay at another hospital lasting less than 3 calendar days, then an LCDS Discharge Assessment related to the transfer should **not** be completed and a new LCDS Admission Assessment should **not** be completed.
  - If the patient did not return to the LTCH by day 3 of the transfer, it is no longer considered an "interrupted stay," and the LTCH should complete an LTCH CARE Data Set Planned or Unplanned Discharge Assessment, as appropriate.

Where to Submit Data

- LCDS records are submitted to CMS iQIES.

- Ensure that your submissions are in the correct format, contain the correct information, and will be accepted by iQIES.

- The *iQIES Reports Training Guide* is an important resource for providers.

Log In

Enter your user ID and password to log in.

All required fields are marked with an asterisk (*)

User ID *

Password *

Forgot User ID or Password? ⬀

Create an Account ⬀

Log In

HCQIS Access Roles and Profile (HARP) is a secure identity management portal provided by the Centers for Medicare & Medicaid Services (CMS).

For security, account registration and credential management are processed through HARP.

⬇ Video: How to Create an Account

Welcome to iQIES

Accessibility and connectivity are essential for health care professionals.

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How to Ensure That Data Submitted Are Accepted

- The iQIES:
  - Confirms that the submission was received.
  - Includes the name of the file you submitted.
- **The submission of data does not mean the data were accepted.**
- The *LTCH Provider Final Validation Report* (FVR) will verify acceptance or rejection of LCDS records.

The FVR is the only way to verify that submitted files were also accepted.

Where do you submit LCDS for the LTCH QRP?

A. The Nursing Home Survey Data Center.

B. Centers for Disease Control and Prevention.

C. The Quality Manager at your agency.

D. The iQIES.

Where do you submit LCDS for the LTCH QRP? (cont.)

The correct answer will be reviewed during the webinar.

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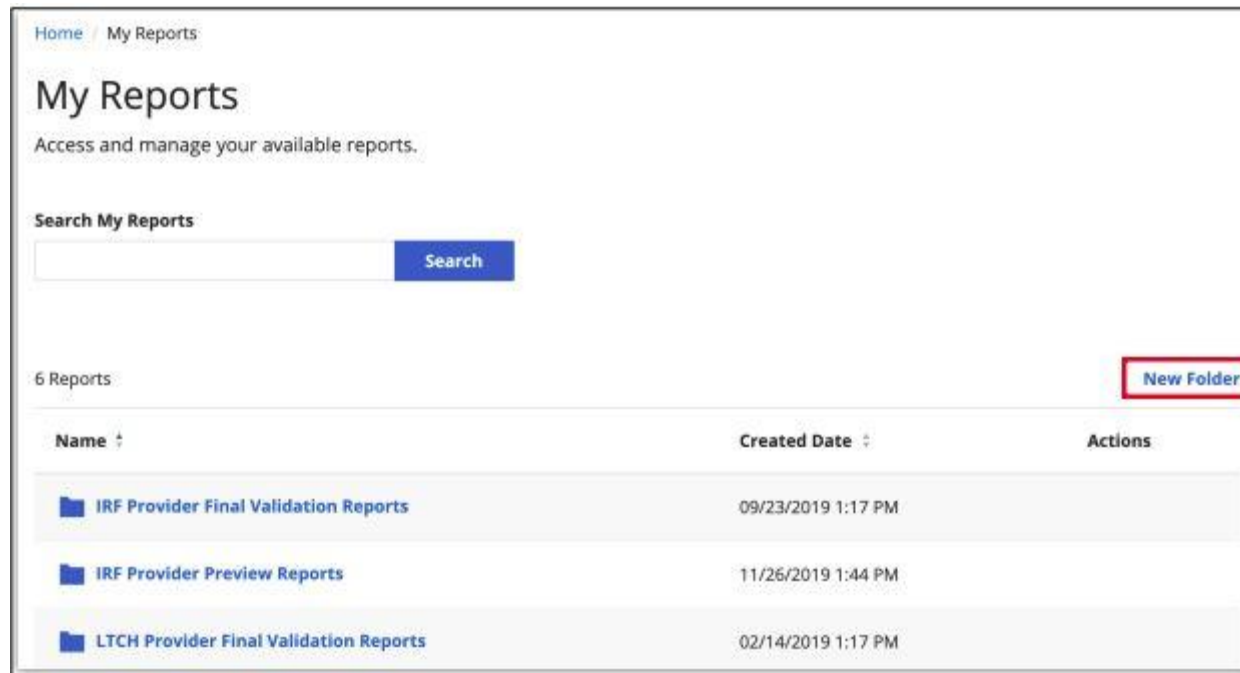
iQIES Reports

How to Access iQIES Reports

- To find a report, select *Find a Report Type* from the *Reports* dropdown menu.
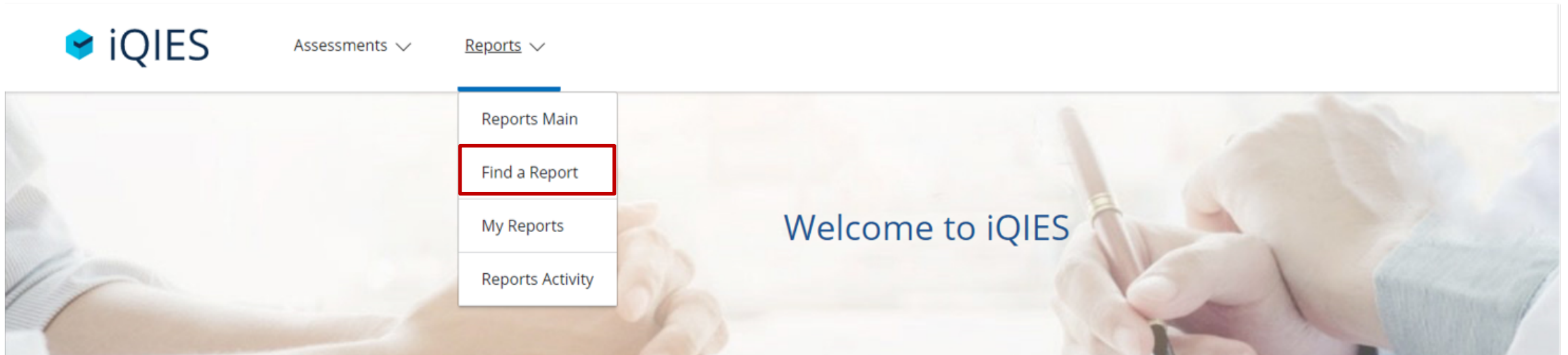
How to Access iQIES Reports (cont.)

- There are many valuable reports in iQIES.
  - Select *My Reports* from the *Reports* menu dropdown to view all your saved reports, which can be organized into folders.

Public Reporting

Reporting — iQIES Reporting

Confidential Reporting
- Review & Correct Report
- Provider Threshold Report
- QM Reports
- Provider Preview Report

Public Reporting
- Care Compare

Final Validation, Review and Correct, and Provider Threshold Reports

Final Validation Report

Review and Correct Report

Provider Threshold Report
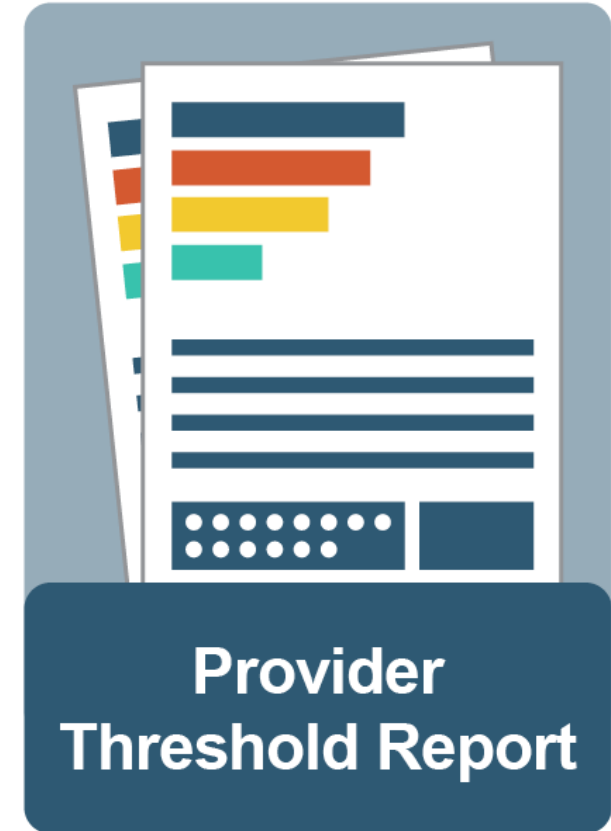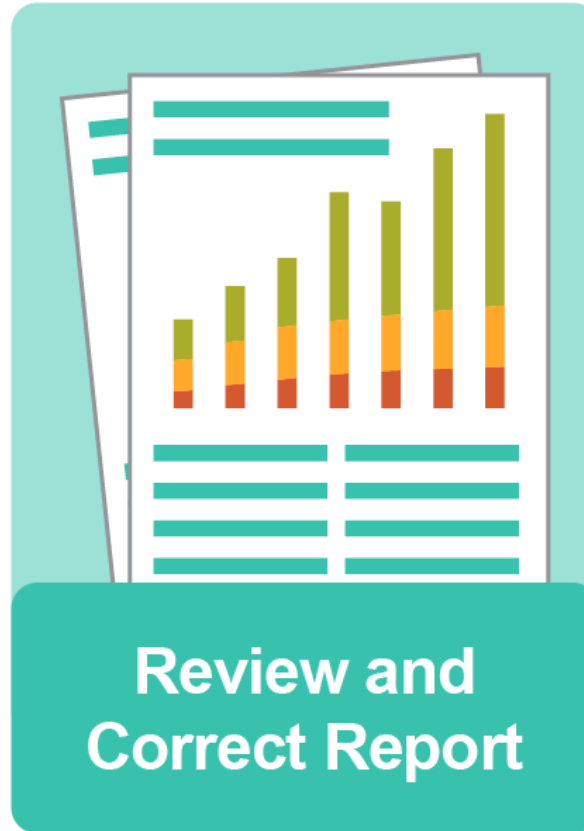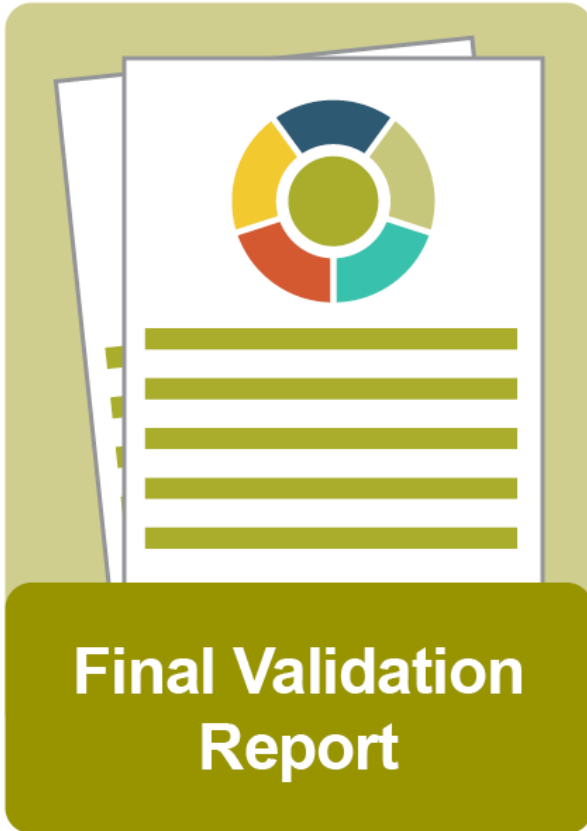
LTCH Final Validation Report (FVR)

- The FVR is automatically generated in iQIES within 24 hours of the submission of a file and placed in the provider's *My Reports* folder.
- Provides detailed information about the status of select submission files.
  - Indicates if the records submitted were accepted or rejected.
  - Details the warning and fatal errors encountered, which can include:
    - Fatal File Errors.
    - Fatal Records Errors.
    - Warnings.
- The FVR can also be user-requested.

Final Validation Report

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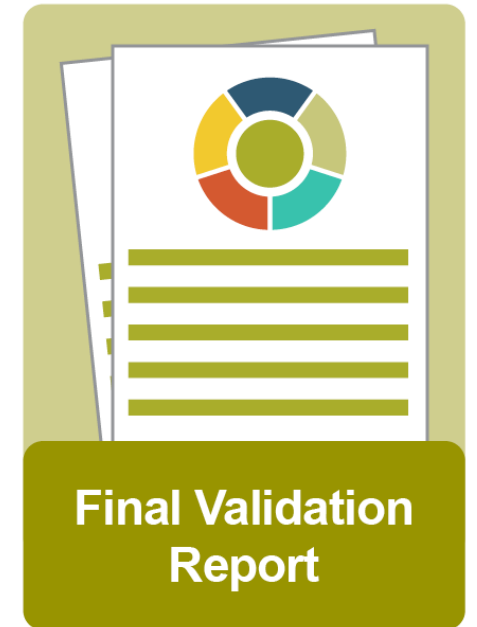
How to Access the LTCH FVR

Home / Find a Report

Find a Report

Search by report keyword, category, or type.

Report Keyword

[   ]

Report Category

[Provider Reports   ▼]

Report Type

[Select one   ▼]

[**Find Report**]   **Reset**

Report Type

✓ Select one
Activity Report
Administration Reports
Admissions/Discharges Report
Discharge Report
Error Detail Report
Error Summary Report
Exception Report
Final Validation Report
Late Submission
Provider History Report
Quality Reporting Program Report
Roster Report
Submission Report
Vendor List

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Example: LTCH Provider FVR

Errors and Warnings on the LTCH FVR

- There are many conditions that may prevent a file or record from being successfully submitted.

- The FVR outlines these errors, whether fatal or simply a warning, encountered in submitted records.

- Each error or warning is noted on the report by its identifier. Section 5 of the *LTCH Submission User's Guide* provides a list of all errors/warnings and includes guidance for correcting errors, if necessary: https://qtso.cms.gov/system/files/qtso/Users_Sec5_6.pdf

All fatal errors in a file or record MUST be corrected and the file or record resubmitted.

Fatal File Errors

- Fatal File Errors: The submission file structure is checked against LCDS data submission specifications; if the file does not meet requirements, it is rejected.
  - Examples of fatal file errors include:
    - File is not a **ZIP** file.
    - File cannot be read.
- **Files that are rejected must be corrected and resubmitted.**

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Fatal Record Errors

- Each LCDS record within the file is checked for fatal record errors.

- Fatal record errors include, but are not limited to, the two following types:

    - Duplicate assessment.

        - For example, if the submitted record is a duplicate of a previously submitted record.

    - Inconsistent relationships between items.

        - For example, an inconsistent date pattern, such as the Patient's Birth Date (A0900) being in the same year as the Admission Date (A0220).

Fatal Record Errors (cont.)

- Records with fatal errors are rejected by iQIES, and the record is not accepted.
- Rejected records are not saved in iQIES.
- **Fatal record errors must be corrected and resubmitted** to ensure that data are accepted.

Nonfatal Errors or Warnings

- Late submission of LCDS records will result in a nonfatal (warning) error.

- Records containing warnings, or nonfatal errors, can still be accepted by iQIES.

- Any combination of fatal errors and nonfatal errors will be rejected and must be corrected.

- Warning messages alone do not cause an LCDS record to be rejected by iQIES.

Warning messages should be reviewed to see whether the information needs to be corrected and resubmitted.

Example: Error/Warning

Error ID	Sev	Error Message	Error Description
-3863	Warn	Inconsistent A1400 Values: If A1400K is equal to 1, then A1400A through A1400J and A1400X and A1400Y must equal 0.	**Cause**: The value submitted in this item is not consistent with one or more values submitted in related items A1400A – A1400J, A1400X, and A1400Y (Payer Information). • IF A1400K is a 1, THEN all items A1400A through A1400J, A1400X, and A1400Y must be 0. **Tip:** A checked response displays as a "1" on the validation report. An unchecked response displays as a "0" on the validation report. **Action**: Make appropriate corrections to the record and resubmit. Refer to the current data specifications to identify the acceptable values for this item.
-3900	Warn	Payment Reduction Warning: A dash (-) submitted in this quality measure item may result in a payment reduction for your facility of two percentage points for the affected payment determination.	**Cause:** The value submitted in this quality measure item is a dash (-) indicating that the item was not assessed or information was not available. Not assessing a quality measure item may result in a payment reduction for your facility of 2% for the affected fiscal year payment determination. **Action**: Make appropriate corrections to the record and resubmit. Refer to the current data specifications to identify the acceptable values for this item.

Review and Correct Report

Review and Correct Report
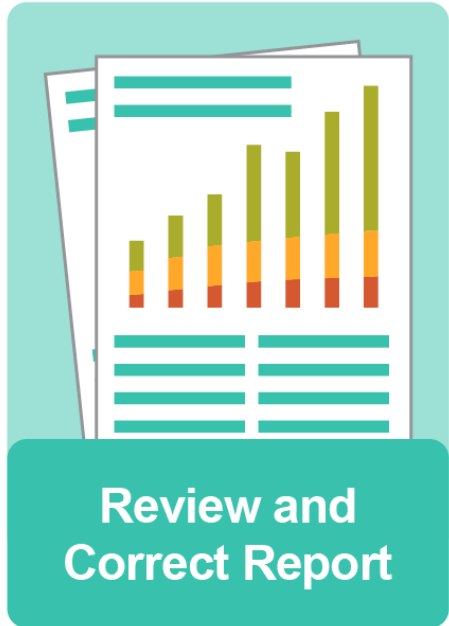
- User-requested, on-demand report.

- Confidential to providers.

- Provides quarterly and cumulative performance rates for assessment-based publicly reported QM data at both the patient and facility level.
  - Providers are able to request by individual quality measure.
  - Patient-level data is available as a comma-separated value (CSV) flat file.

- Displays four most recent quarters.
  - Rolling quarters: Once a new quarter is added, the oldest quarter is dropped.

Review and Correct Report (cont. 1)

- Only observed (raw) data are provided: risk-adjusted rates are not shown.
- Available for providers to run with updated data weekly (until the data correction deadline).
- When reporting quarter ends, data for that reporting quarter is available the next calendar day.
- Displays data correction deadlines and whether the data correction period is open or closed.

Due to the COVID-19 PHE exceptions, there will be no data available (open) to correct for Q1 2020 and Q2 2020.

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Review and Correct Report (cont. 2)

- Ability to sort patient-level data by fields such as:
  - Patient last name.
  - Patient first name.
  - Patient status.
  - Discharge date.
  - Admission date.
- Ability to request report by individual QM.

Data Collection/Correction Periods

Calendar Year Data Collection Quarter	Data Collection Submission QRP	Quarterly Review and Correction Periods*
Quarter 1	January 1 – March 31	April 1 – August 15
Quarter 2	April 1 – June 30	July 1 – November 15
Quarter 3	July 1 – September 30	October 1 – February 15
Quarter 4	October 1 – December 31	January 1 – May 15

* Data correction deadlines are for data that are used to calculate the publicly reported measures and are **not** applied to the confidential QM reports.

Due to the COVID-19 PHE exceptions, there will be no data available (open) to correct for Q1 2020 and Q2 2020.

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Example: Review and Correct Facility-Level Data

Example: Review and Correct Patient-Level Data

LTCH Provider Threshold Report (PTR)

- The LTCH Provider Threshold Report (PTR) allows providers to monitor their compliance status of the required data submission for the LTCH QRP measures for the current APU by FY.

- It is user-requested, on-demand.

- The LTCH PTR will display an asterisk (*) for future dates (monthly and quarterly) when a measure is active but data are not available yet.

Provider Threshold Report

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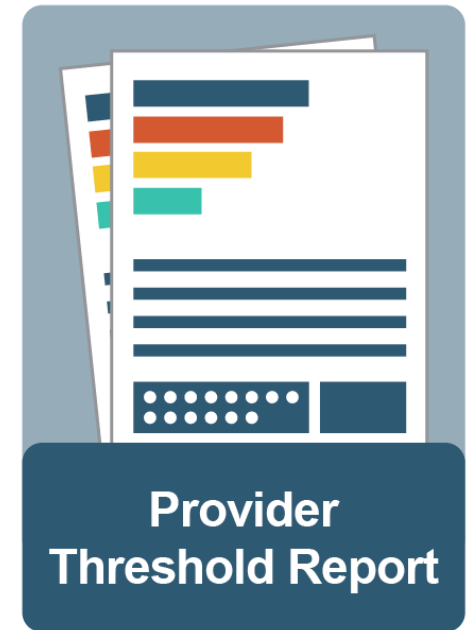
Example: LTCH PTR

iQIES Reports Training

- To learn more about these reports and other iQIES functionalities, refer to the *iQIES Training* YouTube playlist.

https://www.youtube.com/playlist

Which report provides detailed information about the status of select submission files?

A. LTCH Final Validation Report.

B. LTCH Error Summary by Provider Report.

C. Review and Correct Report.

D. Provider Threshold Report.

Which report provides detailed information about the status of select submission files? (cont.)

The correct answer will be reviewed during the webinar.

Q6 Which of the following statements regarding the Review and Correct Report is **false**?

A. Can be requested on-demand.

B. Is confidential to providers.

C. Provides only facility-level QM data.

D. Displays four most recent quarters of data.

Q6

Which of the following statements regarding the Review and Correct Report is **false**? (cont.)

The correct answer will be reviewed during the webinar.

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Determining Compliance With the LTCH QRP

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LTCH QRP LCDS Compliance

- For the purposes of calculating compliance with the LTCH QRP, LCDS submissions for the calendar year are reviewed against the requirements of the LTCH QRP.

- LTCH QRP requirements include:
  - **Submission and acceptance** of an LCDS Admission Assessment followed by either a Planned Discharge Assessment, an Unplanned Discharge Assessment, or an Expired Assessment.
  - LCDS are required to be submitted by established quarterly deadlines.
  - 80% of the assessments received must contain 100 percent of the data required to calculate the LTCH QRP QMs.

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LCDS Threshold Calculation

$$\frac{\text{Numerator}}{\text{Denominator}} = \frac{\text{Assessments with 100\% of the required LCDS data elements}}{\text{Assessments submitted successfully before the submission deadlines*}} \times 100 = \text{LCDS Threshold Percentage}$$
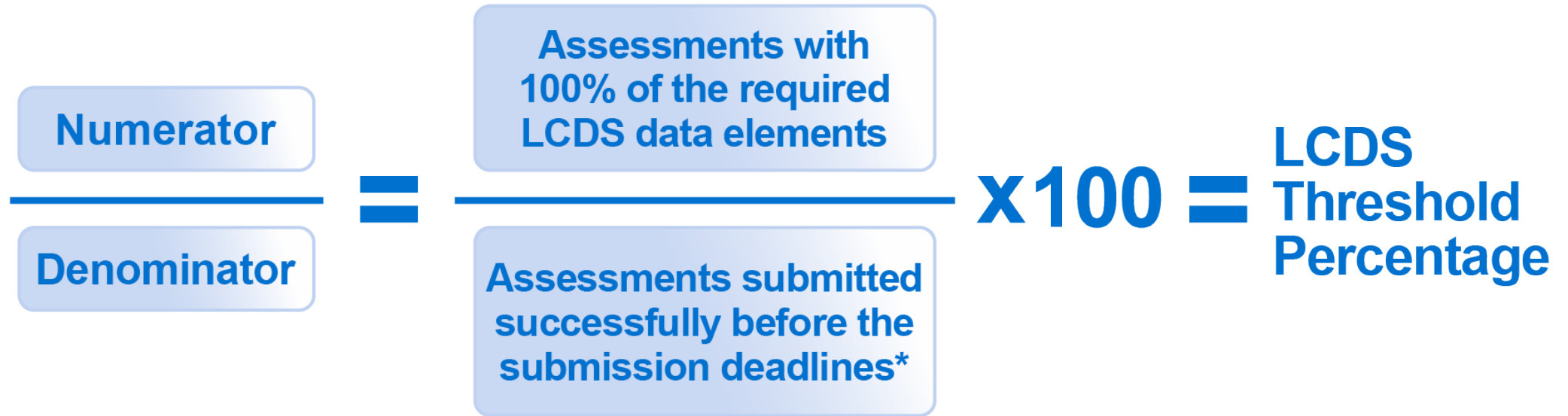
*Note: The calculation algorithm will be adjusted in the event that an LTCH was granted an extension or exemption by CMS.

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LCDS Threshold Calculation Example

$$\frac{\text{Numerator}}{\text{Denominator}} = \frac{95}{100} \times 100 = 95\% \checkmark$$

Compliant with LTCH QRP LCDS Data Reporting Requirements

LTCH QRP NHSN Compliance

- For NHSN data, providers are required to report data for each calendar month, with three months of data due by each quarterly submission deadline.

- Providers must report any instances of healthcare-associated infections (HAIs) for the required measures (including reporting a zero (0) if no infections occurred), summary data, and reporting plan(s).

- Providers that submit complete data for all 12 months will be found compliant for the NHSN measures*

* For submission of the *Influenza Vaccination Coverage Among Healthcare Personnel* measure, only data from Q4 of the prior year and Q1 of the current year must be entered by May 15th following each influenza season.

NHSN LTCH QRP data submission deadlines occur quarterly.

LTCH QRP Non-Compliance

- Any LTCH that does not meet the requirements of the LTCH QRP will be considered non-compliant and subject to a 2-percentage point reduction in their APU for the applicable FY.
- In June–July, CMS issues notices of non-compliance in at least one of two ways:
  - Letter from their Medicare Administrative Contractor (MAC) via the U.S. Postal Service or email.
  - Non-Compliance Notification folders in iQIES.
- This notice will include the reason(s) for non-compliance and instructions for requesting reconsideration of CMS' decision.

What is Reconsideration?

- Reconsideration is a request for review of the initial CMS compliance determination for a given LTCH for a given FY.
- If a LTCH has been identified for the 2-percentage point payment reduction in APU, they have the right to request a reconsideration of the non-compliance decision.

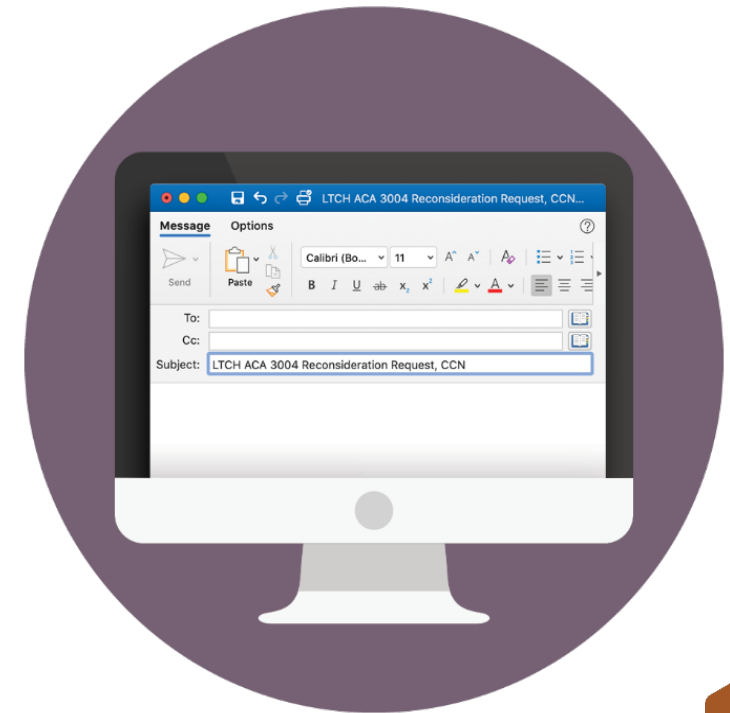# Why Would a LTCH Submit a Reconsideration Request?

- LTCHs may file for reconsideration if:
  - They believe CMS finding of non-compliance is in error.
  - They have evidence of the impact of extraordinary circumstances that prevented timely submission of data.
- Requests must be submitted within 30 days of the date documented on the non-compliance notification letter.
- No requests will be accepted after the 30-day deadline.

Creating a Reconsideration Request

- The only method for submitting a reconsideration request is via email to CMS.

- The subject line of the email should include "LTCH ACA 3004 Reconsideration Request" and the LTCH's CMS Certification Number (CCN).

- The Reconsideration Request must be sent to the following email address:

    - LTCHQRPReconsiderations@cms.hhs.gov

LTCH ACA 3004
Reconsideration Request, CCN

Creating a Reconsideration Request (cont. 1)

- The following must be included in the request:
    - The CCN, business name, and address.
    - The CEO or designated contact information.
    - The CMS-identified reasons(s) for non-compliance (from the notification letter).
    - The reason(s) for requesting reconsideration.
    - Information supporting the LTCH's belief that either the finding of non-compliance is in error or they have evidence of the impact of extraordinary circumstances which prevented the timely submission of data.

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Creating a Reconsideration Request (cont. 2)

- Include supporting documentation demonstrating compliance, such as:
    - Proof of submission.
    - Email communications.
    - Data submission reports from iQIES.
    - Proof of previous waiver approvals for exception or extension for the reporting timeframe.
    - Copy of the CCN activation letter.
    - Other documentation supporting the rationale for seeking reconsideration.

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Creating a Reconsideration Request (cont. 3)

- Determination will be made based solely on the documentation provided.

- CMS **will not** contact the LTCH to request additional information or to clarify incomplete or inconclusive information.

- Reconsideration requests that contain protected health information (PHI) will **not** be processed.

IMPORTANT NOTICE

Do not submit protected PHI to CMS for review.

Reconsideration Response

- CMS should acknowledge receipt of the reconsideration request within 5 business days through an email.

- Following its review of the request and supporting documentation, reconsideration request decisions are distributed by the MAC and the reconsideration contractor.

- If the decision upholds the finding of non-compliance, a provider may file an appeal with the Provider Reimbursement Review Board.

Reconsideration Process: Do's and Don'ts

- Do:
  - Send reports demonstrating compliance with all PHI redacted.
  - Submit your reconsideration request prior to the deadline.
  - Ensure that you receive an email confirmation of receipt in addition to the automated response from the mailbox.
- Don't:
  - **SUBMIT PHI.**
  - Submit an email that is larger than 20 MB.
  - Submit reports from third-party vendors.

Reconsideration Process: Estimated Timeline

- **June–July:** Non-compliant LTCHs that failed to meet QRP requirements are notified.
- **July–August:** Reconsideration requests are due to CMS no later than 30 days from the date on the notification of non-compliance.
  - CMS provides an email acknowledgement within 5 business days upon receipt of reconsideration request.
- **September:** CMS notifies LTCHs of the decision on reconsideration requests.
- **October:** APU penalty imposed on LTCHs found to be non-compliant with QRP requirements.

Estimated Timelines

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Annual Payment Update (APU)

- CMS annually updates the Medicare fee-for-service prospective payment rates provided to LTCHs that are billing MACs for services provided to Medicare beneficiaries. This is called the LTCH APU.

- This APU occurs on a FY basis, on October 1.

- LTCHs that do not meet the reporting requirements of the LTCH QRP are subject to a 2-percentage point reduction in their APU.

Which of the following statements regarding the reconsideration process is **false**?

A. LTCHs have 30 days to submit a reconsideration request.

B. CMS will contact the LTCH if it has further questions.

C. Requests can only be sent by email.

D. CMS issues a decision via the MAC and reconsideration contractor.

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Which of the following statements regarding the reconsideration process is **false**? (cont.)

The correct answer will be reviewed during the webinar.

Relationship Between Quality Reporting and APU: LTCH QRP Life Cycle

January 1 - December 31, 2020 (CY 2020)

During the first half of CY 2021

FY 2022 (October 1, 2021 - September 30, 2022)

Data Collection & Submission (LCDS)

CMS Compliance Determination

Payment Impact APU in Effect for FY

CMS Sends Non-Compliance Letters June/July

Non-Compliant LTCHs Complete Reconsideration Requests Within 30 Days July/August

CMS Delivers Reconsideration Results September

Calendar Year 2021

LTCH LONG-TERM CARE HOSPITAL QUALITY REPORTING PROGRAM

Resources

Resources

- The LTCH QRP webpage:
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index
- LTCH CARE Data Set 4.0 webpage:
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-CARE-Data-Set-and-LTCH-QRP-Manual
- LTCH Reconsideration and Exception & Extension webpage:
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Reconsideration-and-Exception-and-Extension
- CMS Resources for NHSN Users: CMS Requirements | NHSN | CDC

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Resources (cont.)

- The *LTCH Submission User's Guide* provides detailed information about submission of the LCDS to iQIES.
  - Available at the *LTCH Providers Reference & Manuals* page on the iQIES Technical Support Office (QTSO) website: https://qtso.cms.gov/providers/long-term-care-hospital-ltch-providers/reference-manuals
- The *iQIES Reports Training Guide* provides information on reports available.
  - Available at the *iQIES Software Reference & Manuals* webpage: https://qtso.cms.gov/software/iqies/reference-manuals

Help Desk Assistance

- LTCH QRP Help Desk: LTCHQualityQuestions@cms.hhs.gov

- LTCH QRP Public Reporting Help Desk: LTCHPRquestions@cms.hhs.gov

- iQIES Help Desk: iqies@cms.hhs.gov

- QTSO Help Desk: Help@QTSO.com

- LTCH Reconsiderations Help Desk: LTCHQRPReconsiderations@cms.hhs.gov

- APU Compliance Outreach: QRPHelp@swingtech.com

Previous Trainings

- LTCH QRP Training webpage:
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index

Thank You.