Background Information on Long-Term and Post-Acute Care (LTPAC) Assessments and Reporting to CMS

Provided by CMS Center for Clinical Standards and Quality

CMS collects specified, statutorily required, standardized assessment data at the patient level for all Medicare beneficiaries cared for in inpatient rehabilitation facilities that receive the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) payment and on all patients, regardless of payer, receiving care from certified home health agencies, long-term acute care hospitals, skilled nursing facilities, and nursing facilities. These assessments are the Minimum Data Set (MDS), Outcome and Assessment Information Set (OASIS), Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF PAI), and the LTCH Continuity Assessment Record & Evaluation (CARE) Tool. Except for long-term care hospitals (LTCH) the assessments are legally part of the medical record for the settings.

These setting-specific assessments serve many purposes such as provider quality improvement, care planning, survey and certification, quality measurement, and payment. In addition, the long-term care assessment data elements are used for purposes outside of CMS (e.g., care planning, state payment purposes). The assessment data is submitted to CMS via the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. CMS receives over three million records a month via the QIES ASAP system. The data is stored in the QIES National Data Base.

The CMS assessment tools are standardized to the setting and submitted electronically to CMS. To submit the assessment information to CMS, providers must follow CMS submission specifications which are posted on CMS’ website, or they can download CMS’ free software. CMS also provides a free user validation utility tool (VUT) for vendors and software developers to test their software to ensure data validity and successful submission. If entities test their software using the VUT, and the records pass the edit programming, their data will most likely be successfully submitted and accepted into the QIES data base.  There are some edits the VUT cannot test for and thus a record could still be rejected (e.g., if a duplicate record is submitted, QIES will reject).  When a record is rejected, CMS provides a report that informs the provider of the reasons for rejection (e.g., “fatal” edits) as long as the system is able to read the file.  For records that are accepted, CMS provides “non-fatal” (warnings) edits when appropriate to improve reliability of data.   CMS does not require the use of certified vendors or IT systems.

Once the assessment data has been submitted into the QIES system, CMS is then able to use the data for quality measurement calculation, payment purposes or research. In addition, providers can also receive reports in near-real-time for quality improvement purposes; view their quality measurement results, and preview their feedback reports, as well as receive real-time submission reports. Provider reports are available in a CMS central system, Certification and Survey Provider Enhanced Reporting (CASPER). CASPER reports are custom reports that are provided to not only the providers but also serve other needs, such as those related to the survey and certification process for nursing facilities.

CMS providesfree, national, train-the-trainer assessment tool trainings for providers. CMS also hosts software developer (e.g., vendors, provider IT support) national calls for information on the technical data specifications.  CMS hosts training materials and videos related to training on its website, and provide helpdesk support for providers.

The majority of the MDS, OASIS, and the CARE Tool’s data elements have been assigned LOINC[[1]](#footnote-1) and SNOMED CT[[2]](#footnote-2) vocabulary standards.  The submission specifications that are required of providers to submit their assessment data is separate from EHR-related requirements. CMS’ submission requirements are impartial to a provider’s use of an EHR, although post-acute providers use EHRs, and we would expect that there is likely a growing use of EHRs in post-acute care.

There are important differences between the EHR related requirements and the CMS assessment submission-related requirements of the post-acute settings. For example, for submission of the post-acute assessments the majority of data elements and language standards are tested and evaluated for their psychometrics, and for their inter-rater reliability, validity, and Kappa scoring, prior to their integration into an assessment. CMS specifies the assessment information required. Therefore, the only testing recommended is via the VUT to ensure successful submission. Another difference is that the quality measures are calculated after receipt of the data; the data is not submitted in an aggregated manner from the facility nor calculated by the facility and submitted.

The lifecycle of the CMS assessments has a predictable design, development, and testing timeframe. Major updates to the tools vary depending on provider setting, legislation, regulations, CMS initiatives and stakeholder feedback and needs. CMS updates all required guides and manuals as indicated with each release.

1. Logical Observation Identifiers Names and Codes [↑](#footnote-ref-1)
2. Systemized Nomenclature of Medicine – Clinical Terms [↑](#footnote-ref-2)