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National Provider Call Transcript

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Improving Medicare Post-Acute Care Transformation Act
MLN Connects National Provider Call
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Operator: At this time I would like to welcome everyone to today's MLN Connects® National Provider Call. 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 any objections, you may disconnect at this time.

I will now turn the call over to Amanda Barnes. Thank you, you may begin.

Announcements and Introduction

Amanda Barnes: Thank you Kalia, I am Amanda Barnes from the Provider Communications Group here at CMS, and I am your moderator today. I would like to welcome you to this MLN Connects National Provider Call on the Improving Medicare Post-Acute Care Transformation Act. MLN Connects Calls are part of the Medicare Learning Network®.

The Improving Medicare Post-Acute Transformation, or IMPACT, Act of 2014. Transformation and the use of standardized data will improve the long-term outcomes of beneficiaries receiving post-acute services across the nation. This call includes information on opportunities for provider participation and stakeholder engagement.

Before we begin, I have a couple of announcements. You should have received a link to today's slide presentation email. If you have not already done so, you may view or download the presentation from the following URL, www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the web page, select National Provider Calls and Events, then select the date of today's call from the list.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. Registrants will receive an email when these materials become available. Lastly, registrants were given the opportunity to submit questions. We will answer a few after the presentation.

At this time I would like to turn the call over to Stace.

Presentation

Stace Mandl: Hi, I am Stace Mandl from the Division of Chronic and Post-Acute Care here at CMS. And first of all, I want to thank everyone from across the nation who has taken —who has taken the time out of their incredibly busy day to join this call. It's truly an honor to be here presenting to all of you information pertaining to the IMPACT Act of 2014.

The IMPACT Act was a bipartisan bill that was passed in September of 2014 and signed into law in October by President Obama. It requires many things, and — but today we're going to really focus on the information specific to LTCHs, long-term care hospitals,

inpatient rehab facilities or hospitals, skilled nursing facilities and home health agencies, and standardized data, and obviously, opportunities for engagement.

So some information pertaining to the IMPACT Act that many of you may already know or don't already know, but that it requires standardized patient assessment data that will enable a data element uniformity — obviously, help promote quality care and improved outcomes, comparability of data across post-acute care, improve discharge planning, enable the exchangeability or interoperability of information and data, and facilitate coordinated care.

Driving Forces behind the IMPACT Act

Some of the driving forces behind that of the IMPACT Act included purposes such as improving Medicare beneficiary outcomes, provider access to longitudinal information to facilitate coordinated care, the ability to have comparable data and quality across post-acute care settings, to improve hospital discharge planning and post-acute care discharge planning, and to facilitate research using comparable data.

And why the attention on post-acute care? Well, there are escalating costs within post-acute care, and, actually, as many of you may know, there is a lack of standardized data across the – for – these four particular post-acute care provider types, which really does not enable the exchange of information at critical points in time in transitions of care. And also, for the goals of establishing payment rates according to individual characteristics of the — of the person, and not the care setting itself.

If you're following the slides, I'm on slide 6. And I just want to highlight here, this information. I am not going to read all of this out loud. These sort of four cards that appear on this particular slide give a little bit of background information on these four particular post-acute care provider types. But noteworthy is that the annual estimated cost to Medicare is about $60 billion.

Some of the legislative background on data standardization is — I think it's very important to kind of walk through the history prior to this very historical law that was passed, and that is BIPA of the year 2000 required the Secretary to report to Congress on standardized assessment items across the post-acute settings. And then that was followed in 2005 by the Deficit Reduction Act, which required the standardization of assessment items used at discharge from an acute care hospital and an admission to a post-acute care setting.

That brought to light what was the Post-Acute Care Payment Reform Demonstration, or referred to as PAC-PRD, to harmonize payments for similar settings in post-acute care settings. And that led to the development of the Continuity Assessment Record and Evaluation tool, or the CARE tool or item set, which was component to — which was a component for testing the reliability of the standardized items when used in each Medicare setting.

What happened was, during that time, was there was testing that went on to inform CMS about the ability to collect the same information in a variety of provider-type settings and collect that information that — to see if it would be reliable and valid, regardless of a setting or provider type. And within the Post-Acute Payment Reform Demonstration, in 2006, the data was needing to meet the Federal HIT, or Health Information Technology, interoperability standards, and these were all incredibly important milestones that, I think, help shape the IMPACT Act itself.

In slide 8, the PAC-PRD and the development and the testing of the CARE item set and the HIT work that went with it helped to develop some important guiding principles. And those guiding principles are uniform data or information that is standardized, enables reusable data that's informative. It increases the likelihood of reliable and valid information. And such valid information that can be reused can help facilitate patient care coordination. And that uniform data that is also made interoperable, or able to be exchanged across provider types, allows communication to occur across provider types. And, obviously, the ultimate goal of that is to enable care coordination with information that follows the person.

And then, at the end, in following these sort of principles, are the goals of fostering seamless care transitions, enabling measures that can follow the individual, the ability to evaluate longitudinal outcomes for persons at trigger settings, the assessment of quality across settings, obviously, improving outcome and efficiency in an efficient manner, and ultimately, reducing provider burden with the idea of collect once, use multiple times.

And when we talk about these data elements and standardization, in those four post-acute provider types that I went over — the LTCHs and the IRFs, the SNFs, and the home health agencies — they all collect standardized assessment data, standardized to those individual settings. And we have begun, even prior to the IMPACT Act, to introduce uniform items in those assessment instruments that would be uniform, regardless of the provider type or setting.

And on slide 9 are the various different assessment instruments. I won't read them all out loud. But looking sort of at the center of that colorful diagram is where we find uniformity. And, really, the goal behind standardizing categories within the assessment instruments is to take that sort of sweet spot of uniformity and make it larger, so that there's more uniformity across the provider types.

And we're also working within CMS, looking at the home- and community- based services space and long-term services and support, for where could standardized data be useful in informing that sort of long-term care sort of services area, and also when that individual, perhaps, transfers to services within institutions, where information could be used in a sort of in a backwards and forwards kind of manner. So really, the

goal of this slide is to just to sort of depict where that sweet spot is in uniformity, and knowing that over time that area where it converges and sort of the Venn diagram becomes larger.

And now I'm going to turn the presentation on to my colleague, Dr. Tara McMullen, who will begin her part of the presentation.

Data Elements and Standardization

Dr. Tara McMullen: Well, hi. Yes, thanks Stace. This is Tara McMullen from the Division of Chronic and Post-Acute Care. I'm the measure lead under the IMPACT Act, and I'll be picking up on slide 10, the slide that is titled, What is Standardization? And many times when we're speaking to quality measures and standardizing data elements, we have a lot of folks ask us what is standardization. So we developed this slide to help illuminate CMS's interpretation of how standardization can occur within the quality realm.

So, picking up from Stace's last slide, to get to the sweet spot of uniformity that you saw in the middle of the Venn diagram, CMS understands that, really, standardization begins at the atomic data — atomic level, the core clinical data element that we have, that really drives a lot of our quality measure development.

And so what you see in this slide is that we demonstrate how standardization occurs at that data element level, that one element is standardized, collected, and coded the same way across all post-acute care settings through our assessment instruments in order to create standardized data outputs.

However, in our current state — and if you slip back to slide 9, you'll see our assessment instruments — the MDS, the OASIS, the LTCH CARE data set, and with the IRF-PAI. In the current state, we collect on many items that at the surface level are standardized, such as eating. You'll see that on the side. However, when you assess how the item is collected, how it's coded, what are the response and question options, the items themselves are not standardized to one another. They cannot talk to one another across the assessment instruments. There's no one common language and, therefore, data is not interoperable.

So currently, with the mandate of the IMPACT Act, CMS is taking steps to move to this ideal state of standardization and interoperability, starting at the data element level with our functional — for example, with our functional process quality measures that have been finalized in the IRF, LTCH, and SNF FY 16 PPS rules.

And just as an example here, the process measure, which is titled – and this is on the CMS site — but it's titled, The Percent of Patients, Residents, Persons with an Admission and Discharge Functional Assessment and a CARE Plan that addresses function, uses a source of CARE data from the CARE items or the CARE tool. This quality measure,

finalized for the IRF, LTCH, and SNF settings, is comprised of data elements, such as eating, that are nested within each quality measure.

That is, eating is in the IRF, LTCH, and SNF quality measure and is collected in a standardized way through the new section, Section GG, Functional Abilities and Goals, which will be added to the IRF-PAI, MDS, and LTCH CARE data sets. Those are assessment instruments. In this way, we are collecting analogous information across the PAC settings in a manner that is consistent in order to standardize data and to allow for data comparisons. From these items, collected in a standardized manner, we will be able to move forward with the development of outcome-based measures.

Moving into slide 11, you have a graphic here that talks about the standardized assessment data elements, and you'll see here that this is also a graphic of our assessment instrument and of the new Section GG, Functional Abilities and Goals. This slide presents a graphic that shows us the main point here is that the assessment instrument, as a vehicle for the collection of data by means of the standardized items, has many uses — care planning, quality improvement, payment, discharge planning, and decision support, and so on.

A lot of time, testing, stakeholder input, and vetting go into the development of the questions, responses, and, really, the overall assessment instrument in order to reach this ideal state of standardization. And the one thing that we always like to highlight from this slide is the fact that the IMPACT Act allows us to collect data, so data follows the person. Really information is following the person as they traverse the care continuum, or the multiple PAC settings.

And you'll see this highlighted in this salmon-colored box here that says Care Transitions. So really, CMS is following input to meet the mandate of the IMPACT Act, and we're really focusing on creating this longitudinal source of information so that we can better compare and understand what is going on with all individuals as they traverse the PAC settings — SNF, IRF, LTCH, and home health.

So moving into slide 12. We have this graphic — this is one of our newer slides, but we like to say that standardization, however, is not limited to just the item-to-item alignment. It's not just the data alignment at the core atomic level. The more that we move through the process of item and quality measure and domain development, the more apparent it is that standardization really has this like ripple effect. And with this said, we see standardization through many lenses.

Again, it begins at the core element, but it really moves out into the scales, the measures, the instrument — really into beyond what we have here delineated, but into the reporting and the comparison of data, and to the collection of data. So standardization is not just an easy item-to-item, OK, we're done. There's a lot of science that goes into this and, thus, the technical aspect is very real.

Going into slide 13 and 14, you'll see here is just this infographic representing basically what we're describing with our functional process measure that was finalized in the IRF, LTCH, and SNF settings. The yellow highlighted rows represent the items that are in the standardized functional process measure for the IRF-PAI, the MDS, and the long-term care — LTCH CARE data set. The other items are additional items that are used for various other functional outcome measures in each setting, but the yellow lines are — delineate specifically how we standardize.

And at this point on slide 15, I'll turn it back to Stace.

Quality Measures and Implementation Phases

Stace Mandl: Thank you Tara. So on slide 15 and slide 16, there is information that pertains to the measure domain and the timelines associated with what's required for implementation. This is all outlined within the act itself, and we always encourage folks to read the act to really get the information firsthand, but this is a summary.

And so, I won't read all of the dates out loud, but I'll just read the measure categories. So the first set of five, the statute requires that the Secretary develop measures and implement measures using the standardized data by certain periods of time for home health agencies, long-term acute care hospitals, inpatient rehab facilities, and skilled nursing facilities with at least these five domains. And the domains are — domain one is functional status, cognitive function and changes in function and cognitive function. The second domain is skin integrity and changes in skin integrity. The third is medication reconciliation. The fourth is the incidence of major falls. And the fifth is communicating the existence of and providing for the transfer of health information and care preferences.

And when you look at these five domains, it's very apparent that these five domains are obviously incredibly important critical areas of quality, and where gaps currently exist. Some of them pertain to health-care acquired conditions, some we just know that are very vulnerable times for our beneficiaries and persons as a whole as they traverse the system.

And then at the bottom of slide 16 are the resource use and other measures that are to be specified for reporting. Those — the act does not specify — must come from standardized data from the assessment instruments, and those three domains that we must have at least — measures for at least those three domains pertain to total estimated Medicare spending per beneficiary, discharge to community, and measures to reflect all condition, risk-adjusted, potentially preventable hospital readmission rates. And the dates associated with their specifications are — and implementation — are to the right.

On slide 17, we think it's always very, very important that we help communicate to the public and our stakeholders where do our marching orders come from. We work to develop measures for implementation into our quality reporting programs. And, hopefully, the genesis of our measures and, sort of, our footprint, is analogous to the provider industry, and that is to follow the National Quality Strategy of better health, health care, and lower cost and the priorities that fall within those three domains — better care, healthy people, and affordable care.

And slide 18 reviews the six priorities that dial up to those three aims. And the six priorities — I won't read this particular slide out loud, but they're all found within the Nationals Quality Strategy. And CMS has developed its own quality strategy, which aligns with the National Quality Strategy. And the six priorities are our six goals:

- Making care safer,
- Strengthening person and family engagement,
- Promoting effective communication and coordination of care,
- Promoting effective prevention and treatment,
- Work with communities to promote best practices of healthy living, and
- Making care affordable.

And on slide 20, with the function measures that Tara had just described, the standardized data elements for, we believe that function is a very unique area of focus for quality because functional attainment — functional goals and preservation touches on all six priorities and, ultimately, rolls up to all three goals and aims. That function is really central to long-term outcome and success for individuals in their lives.

But on slide 21 — or I should say and not but — and on slide 21, what's very unique about the IMPACT Act, and this really is a historic — historic legislation. It really provides for the capability to harness three areas of quality gaps that are very difficult.

Strengthening person and family engagement as partners in their care, the IMPACT Act requires not only quality measures where information can actually follow the person, but it also calls for discharge planning within all of the provider types that is based on an individual's goals, preferences, and, of course, comparable quality data to help them make their discharge planning decisions. It also — the act also promotes effective communication and coordination of care for all the reasons already described, and how the standardized data can be leveraged in an interoperable way to inform settings as that person traverses the system, and then, of course, promoting effective prevention and treatment of chronic disease.

For those most vulnerable, having that information in real time available to —whether it's the home setting or the next provider setting — is critical. And we're very aware of

how this information can be, again, harnessed to really allow for improved outcomes for those most vulnerable.

On slide 22, I just want to go over some of the requirements within the IMPACT Act, there's three. And then the first is measure implementation phases, and there's three phases. The initial implementation phase is where we specify the measures through rule-making, and then implement for data collection. And then the second phase is to provide for a post-acute care providers confidential feedback reports on their data. And then the third is the actual implementation phase, and that's the public reporting of the post-acute care provider's performance.

We are also required, although there are exceptions provided, that we seek consensus-based entity endorsement for the measures, and, also, that the third requirement is that we include the treatment of the application of the pre-rulemaking process, and that is referred to you as the Measures Application Partnership, the MAP, and the contract for both numbers 2 and 3 are currently held with the National Quality Forum.

At this point, I'm going to take a quick commercial break and hand the microphone over to Amanda.

Keypad Polling

Amanda Barnes: Thank you. At this time, we're going to pause for a few moments to complete keypad polling. Kalia, we're ready to start.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling.

Please continue to hold while we complete the polling. Please continue to hold while we complete the polling. Thank you for your participation. I'd now like to turn the call back over to Amanda Barnes.

Presentation Continued

Amanda Barnes: Thank you so much Kalia. Tara, we're ready to resume the presentation.

Quality Measure Details

Dr. Tara McMullen: OK, so picking up on slide 23, Tara McMullen again. We're going to move in to some of the more granular details and map out some of — timelines, I guess,

at this point. So, the — slide 23 talks to the MUC list, and the MUC list is a part of the MAP. The MUC is a Measures under Consideration list, which is utilized by CMS and HHS for the Measures Application Partnership. The Measures Application Partnership is a multistakeholder group convened, which is required under 1890 of the Social Security Act, and this partnership really guides HHS, as well as CMS, on the selection of performance measures for Federal health programs.

The MAP provides a coordinated look across Federal programs at performance measures being considered within the use of each program. In this case, these are the post-acute care programs. CMS issues the MUC list, Measures under Consideration list, to comply with multiple mandates, and in this case, the mandate of the IMPACT Act. And on slide 23, you see here the anticipated placing of a few measure concepts or constructs for the 2015 MUC list to satisfy the IMPACT Act measure domains of medicine reconciliation. Resource use measures include a total estimated Medicare spending per beneficiary, discharge to community, and the all-condition, risk-adjusted potentially preventable hospital readmission rates. So CMS anticipates placing these measures on the 2015 MUC list.

Moving into slide 24, you will see the measures that were placed on the ad hoc MUC list, I believe, at the turn of the year, so 2015 — January — December 2014, I believe. So CMS issued an ad hoc MUC list in order to comply with the IMPACT Act within the timelines delineated by the IMPACT Act itself. And to comply with rule-making, CMS utilized this ad hoc MUC list for the off-cycle MAP to make public the measures being considered or being considered at that time under the provisions of the IMPACT Act so the Measures Application Partnership could provide their input.

And you will see here the measures that were added were the percent of residents, patients, and persons with pressure ulcers that are new and worsened. This measure was finalized in the IRF, LTCH, SNF FY 16 rule. This measure is also currently proposed in the Home Health CY 16 rule.

The second measure here is the percent of patients, residents, and persons with an admission and discharge functional assessment and a care plan that addresses function. Again, this measure was finalized in the IRF, LTCH, and SNF FY 16 rule.

Finally, you have the percent of persons, residents, and patients experiencing one or more falls with major injury. And once again, this measure was finalized in the IRF, LTCH, SNF FY 16 rule.

Moving into slide 25. So there are many measure activities occurring in order to meet the mandate of the IMPACT Act, and many of the domains specified. First and foremost, it should be stated that the measure domains provided in the act are not exhaustive. Therefore, quality measure concepts, or even constructs to be standardized, could be added as deemed appropriate by the Secretary. So, the IMPACT Act requires, again, the

Secretary to specify quality measures and resource use measures or other measures in post-acute care settings. She — the act specifically defines five domains and resource use in other domains, and three domains that are required by specific dates.

So here in this slide, basically, we are just delineating new measure development, which includes functional outcome, cognition outcome, communicating the existence of and providing for the transfer of health information and care preferences, and other measures to address cross-setting gaps in quality. The highlight here is this third bullet — the communicating the existence of and providing for the transfer of health information and care preferences. This measure is special in the way that it's not only to be standardized across post- acute cares setting but into the acute care setting.

Moving on into slide 26, actually 26, 27, 28, and 29, you'll see a lot of the slides that are — measures that have been finalized for use in the IRF, LTCH, SNF, and home health quality reporting programs.

The home health measure actually is currently proposed in the NPRM. So on slide 26, you'll see the three measures, their NQF IDs, and the reporting and payment timeline for the LTCH quality reporting program.

**** See updated slide presentation for further clarification****

These are the following measures that were just read — the new and worsened pressure ulcer measure, the experience — the falls with one or more —one or more falls with major injury measure, and the function measure. These meet the domains of skin integrity, incidence of major falls, and function.

Moving into slide 27, you'll currently see that we have proposed to meet the domain of skin integrity, the percent of residents or patients with pressure ulcers that are new and worsened quality measure.

Slide 28, for the SNF quality reporting program. Again, you see the pressure ulcer, the falls, and the function measure that were finalized in the SNF FY 16 rule to meet the domain of skin integrity, incidence and major falls, and function.

And finally on slide 29, for the IRF quality reporting program, you see the three measures again for pressure ulcers, falls, and function, but you see additional rows here that delineate four additional function quality measures. These are outcome measures that were in development prior — really, prior — before the IMPACT Act was even passed and signed into law. These are outcome measures that utilize care items from the CARE item set, and, we believe that these measures would be a good source to help develop further outcome-based measures.

Moving in slide 30. So, in the development of the new quality measures to meet the multiple domains of the IMPACT Act, you'll see four measure domains here listed, and you'll see the Technical Expert Panel through the public comment processes that CMS utilizes in order to receive stakeholder engagement. These processes are currently utilized by CMS through what we call a measures maintenance blueprint. And in the slide, you have delineated the time — the key time points of when these activities have occurred or will be occurring.

I'm moving into slide 31. You have the pre-rulemaking public comment on the quality measures for the Measures Application Partnership timeline. So you'll see some key dates here. Some of the dates have already occurred. There are some activities coming up. The key date for public engagement that, I think, is really important to highlight is that the actual Measures Application Partnership for the post-acute care, long-term care workgroup. The in-person workgroup for NQF is December 14th and 15th. This meeting is open to the general public, and at this time, this is when PAC LTC panel will review all the measures that were added for post-acute care on the Measures under Consideration list, the MUC list.

So now I will turn it back over to Stace.

Resources

Stace Mandl: Thank you Tara. Slide 32 is some very helpful and informative websites that we think that the public and provider industry would be very interested in having, sort of, readily on hand to see what's going on and where they can get engaged and find information. And those four links are provided on slide 32:

- The NQF calendar of activities,
- The MAP coordinating committee project page,
- The MAP post-acute care and long-term care workgroup project page, and
- CMS's pre-rulemaking page.

And then, on slide 32 is where we begin to talk a little bit more about the standardizing of data elements and the modification of — excuse me, on page — slide 33 — for the post-acute care standardized items that would be — that are required — that are requiring a modification of the assessment instruments. The requirements for reporting a standardized assessment data in the IMPACT Act is that providers must submit standardized assessment data through their PAC assessment instruments under their current applicable reporting provisions.

And the timelines for that are in sort of the center of this slide. But for skilled nursing facilities, inpatient rehab facilities, and long-term acute care hospitals, that is October 1, 2018, and for home health agencies, they follow by a quarter, and that's January 1, 2019. It — the act specifies that the data must be standardized and

submitted with respect to both the admission and the discharge for each patient or resident, or more frequently, as required.

The standardized assessment data is to be developed for the following data categories: functional status, cognitive function and mental status, special services, treatment and interventions, medical conditions and comorbidities, impairment, and other categories, as required by the Secretary.

Stakeholder Engagement

On slide 34, 35, 36, and 37 are four extremely valuable timelines that really spell out the activities that are going on at a high level for the public to be able to see what this all looks like over time between now and 2021 at least. And what I want to draw your attention to is a couple of areas where stakeholder engagement and input, you know, are — they just sort of go part and parcel with those activities.

At the top is a blue area with an arrow, and that's titled Measure Development — and that is exactly during that time that Tara spelled out in her discussion, where both public and stakeholder feedback is opened up to the nation, both through the public comment process as well as in — with the stakeholders and experts who join in the Technical Expert Panel, as well as in the Measures Application Partnership process.

Also, the next area to kind of call out is the Measures Application Partnership, which provides a very rich opportunity for the public to comment on Measures under Consideration. Of course, that's not only for the post-acute care programs, but all of the programs that CMS oversees. And then, below those sort of green boxes that march across the timeline, is in a yellow — excuse me, bluish box, is the item development for standardized assessment domain.

We have just awarded the contract to the RAND Corporation, who will be leading the work involved with developing the standardized assessment domain. And, historically, through the Post-Acute Care Payment Reform Demonstration, a very successful approach was laid out, and that is the important application of stakeholder engagement, consensus building, focus groups, and activities like that in this journey as we work towards the use of standardized data in all of these assessment instruments. And with that — with the standardized assessment development, will be all kinds of opportunities for engagement, and we'll describe some of those upcoming activities sort of towards the end of this presentation.

So the first slide is slide 34, and those are sort of the timelines as a whole, and then — I won't read all of these out loud, but the first one is the IRF timeline. Slide 35 is the LTCH timeline, 36 is the SNF timeline, and 37 is the home health timeline. And if you have the time to be able to sit down and look at it, we provide not only the measures as well as the patient assessment instrument domains, but also some of the other key

milestones, such as the public reporting, the provider feedback reports, and things of that nature.

**** See updated slide presentation for further clarification****

And I will jump to slide 38 to describe some of those key activities. As I had mentioned, the RAND Corporation will be reaching out to providers for the consensus development work to — I should say providers and stakeholders and experts and family and individuals and caregivers, and so forth. And we expect these activities to begin sort of in a flurry this fall and following into the wintertime.

Following that, because of the type of work that they'll be conducting, there'll be recruitment activities sometime in the winter, and alpha/beta testing of items we anticipate in the spring/fall of 2016. And then, because of the nature of the data elements requirements in statute, we do anticipate that there will be rulemaking coming up as well related to this work. Obviously, input is always valuable.

We do want to highlight some other opportunities. We are working to integrate into our sort of steady diet here at CMS utilizing Open Door Forums and Special Open Door Forums to be pushing out information to the public. We have an upcoming Open Door Forum October 29th where we're hoping to be able to push out information and details about some of the activities that Tara had described, and in November, the home health, hospice, DME Open Door Forum calls, and we're working to find space on those agendas.

We also have a very important upcoming Special Open Door Forum, Understanding the IMPACT Act, a patient and family focused meeting that's for informed decisionmaking, and we're really looking forward to this opportunity because, ultimately, you know, our beneficiaries and the public, they're our ultimate stakeholder.

On this slide, it does say the 28th of October. Actually, that date got pushed back to Tuesday, October 27th, and that Open Door Forum call will be from 2 to 3:30 eastern time. And then we're looking forward to, hopefully, having space at the upcoming CMS Quality Conference in December, and then the CMS National Training Program Partner Update Webinar, we're hoping to have that in January of 2016.

I also do want to provide sort of a commercial break to announce for folks that may not be aware that there's a 2-day training in November, on November 19th and 20th, 2015, from 8:45 to 5 p.m., for the long-term acute care hospital providers, their associations, and organizations. And this is a train-the-trainer event. With the assessment instruments, we believe that train-the- trainer types of — type of approach is the most effective because these assessment instruments are just that, they're

assessment-based. So part of ensuring that integrated reliability is to have such types of trainings.

The focus of this train-the-trainer program is to provide the LTCHs with assessment-based data collection instructions and updates associated with the changes in the April 1, 2016, release of the LTCH CARE data set version 3.0 and other reporting requirements of the LTCH quality reporting program. And that's on day 1.

Day 2, the CDC will be presenting on current and new quality measures, as well as use of the National Healthcare Safety Network, the NHSN, for submitting data associated with those measures.

Those who register by October 27th, 2015, will receive a special discounted rate on room reservations. And for more information on this, I highly encourage folks to go to the LTCH quality reporting program Spotlight and Announcement page for details and registration information.

And then on slide 40, just other opportunities we'll, as I said, continue on with the ODF, the Special Open Door Forums. We always ask folks to pay close attention to eNews updates, listening sessions, Medicare Learning Network activities, YouTube videos, and conference outreach and speaking engagements. And all of these sorts of opportunities as a whole is where we will be pushing out information.

And then on slide 41, just to sort of help illustrate the reach that we have with our listserv announcements, they go out to somewhere between 250,000 providers, 500,000-plus subscribers and Medicare Administrative Contractors, the MACs. And we have a website dedicated on medicare.gov to the IMPACT Act. We are currently upgrading that page, and we're anticipating updates to it in the next week or two, but to really make it a little bit user — more user friendly with its navigation. But on that page will be highlights and special announcements, upcoming events and educational sections, and stakeholder input opportunities, and then information specific to these four post-acute care programs and any other sort of measure specification types of information we historically have put there, as well as other resources. If you haven't accessed that website, I would encourage you to. We have already begun our journey into upgrading that page for folks based on feedback, and we look forward to continuing our outreach.

On slide 42, I won't read this out loud, but the IMPACT Act web page is provided there, and then we always encourage stakeholder input and questions to be submitted to the PAC quality initiatives mailbox at PACQualityInitiative@cms.hhs.gov.

On slide 43 are a whole lot of acronyms, because that's what we do. We speak in a lot acronyms, but it's always good to have that sort of list handy. And that concludes my — our presentation.

Questions Submitted in Advance

Amanda Barnes: OK, great. Thank you so much. And now we're going to start with some of the questions that were received from registration.

I'll hand that back over to you, Stace.

Stace Mandl: Yes, thanks. So we received some questions. We're going to go ahead and go over those — some very important questions and answers. We thank everyone for submitting their questions to us. We're still working through all of them, but we are hitting the highlights today. These questions and the answers to them will be provided by my colleague, Dr. Tara McMullen, as well as Jennie Harvell.

So, the first one — the first question was, Will assessments be standardized or the same for all post-acute venues of care?

And the response to that is, the IMPACT Act requires that post-acute care assessment data elements needed for at least these quality measure domains — function, cognitive status, changes in status, skin integrity and changes in skin integrity, medication reconciliation, major falls, and the transfer of health information — be standardized and be made interoperable. In addition, the IMPACT Act requires that the PAC assessment data elements in several assessment categories also be standardized and made interoperable.

These assessment categories include functional status, such as mobility and self-care; cognitive function, such as the ability to express ideas and to understand; mental status, such as depression and dementia; special services; treatments; interventions, such as the need for ventilator use, dialysis, chemotherapy, central line placement; and total parenteral nutrition; medical conditions and comorbidities, such as diabetes, congestive heart failure, and pressure ulcers; impairments, such as incontinence and an impaired ability to hear or see or swallow; and other categories as deemed necessary and appropriate by the Secretary.

But it's also important to point out that provider types — provider types have special needs and requirements related to data submission outside of the core items necessary to satisfy the intent and the requirements under the IMPACT Act. We also want to point out that we welcome public feedback on this topic, and we ask that you send any questions or comments to that web — to that web email address that I gave, and I'll give it again, and it's PACQualityInitiave@cms.hhs.gov.

And then the second question is, Please discuss how and when PAC assessment tools, MDS, OASIS, IRF PAI, will be revised in near term as referenced in MedPAC reports, and confirm when the CARE tool is expected to be implemented – 2023?

So we want to convey that the IMPACT Act does not require the implementation of the CARE tool item set. The CARE item set was an item set design for item-level testing in the acute care plus acute care providers as part of the PAC-PRD or the Post-Acute Care Payment Reform Demonstration research. We want to point out that there are timeframes provided within the IMPACT Act that are associated with the quality measures or assessment categories that require standardized data elements.

Those timeframes, which we went over, illuminate an incremental approach to the modification of the four assessment instruments. The timelines vary according to measure, assessment category, and provider type.

The next question is, Will IMPACT change OASIS?

The IMPACT Act requires a modification of all four post-acute care assessment instruments to enable the submission of the required standardized data in the timeframe specified. Our assessment development contractor, RAND, will be beginning the work shortly that pertains to the categories included within the act. It is too early to determine what the potential changes could be. That being said, as previously stated, we appreciate that there are assessment items necessary to a specific — and specific, excuse me — to a particular provider type, such as with home health.

We want to note that in addition to the timeframes required for the quality measures derived from standardized data, the modifications to the OASIS instrument that pertain to the categories provided under the IMPACT Act are to be implemented by January 1, 2019. While we are still in the initial planning phases, we welcome public feedback on this topic, and, please, again, send any questions or comments to that same email address.

And then the next question is, OASIS and IMPACT Act, how is that going to work?

The IMPACT Act requires that CMS standardize post-acute care assessment data elements and make these data elements interoperable to allow for the data to be comparable and to enable the exchange of such data between PAC providers and other providers in order to provide access to longitudinal information and for such providers to facilitate coordinated care and improve beneficiary outcomes.

As stated already, we anticipate that each assessment instrument will continue to use items unique to that setting, in addition to the core items that will satisfy the requirements under the IMPACT Act pertaining to standardized data. And again, we encourage folks to submit feedback on this topic to that same email address.

I will now turn the next question over to Tara.

Dr. Tara McMullen: All right, thank you. So the next question, we're moving into quality measures. Next question asks, Please discuss implementation of efficiency measure or the efficiency measure Medicare spending per beneficiary and how such a measure will be tailored for PAC providers.

The MSPB—it's acronym for Medicare spending per beneficiary, measure for post-acute care providers, including those such as skilled nursing facilities, inpatient rehab facilities, long-term care hospitals, and home health agencies — this measure is currently under development for these settings. As per the IMPACT Act requirements, the MSPB PAC measure, that's what we're calling it, MSPB PAC, reporting period will begin October 1st, 2016, for SNFs, IRF, LTCHs, and January 1st, 2017, for home health agencies.

We anticipate that this measure will be posted for comment on the CMS Quality Measures Public Comment page, that's on cms.gov. That will be posted in December. Further, we anticipate that it will be included on the 2015 Measures under Consideration list. Finally, we'll have a Technical Expert Panel for this quality measure on October 29th and 30th and a report of that Technical Expert Panel — those proceedings will be posted on the Post-Acute Care Quality Initiatives web page.

We welcome any feedback on this topic and this quality measure. Please send any questions and comments to, once again, to the PAC QualityInitiative email box.

The next question asks, Tara McMullen and Stella Mandl on a recent webinar stated that the MSPB and other IMPACT Act measures will be provider-specific, that is, one of Medicare Spending per Beneficiary measure for IRFs, one for LTCHs, one for SNFs, and one for home health agencies. Please confirm.

The measures developed to meet the domain of resource use measures included total estimated Medicare spending per beneficiary, as well as other stated domains within the act, that's the IMPACT Act, are currently in development. However, CMS is able to confirm that one measure per each PAC setting is being developed for the total estimated Medicare Spending per Beneficiary measure construct. CMS will seek public comment for this construct, and we'll be holding a Technical Expert Panel to receive subject matter expertise on the development of these measures.

The measure under development, in order to meet the mandate of the IMPACT Act, will also be discussed at the Measures Application Partnership that will be held December 14th and 15th at the National Quality Forum.

The next question asks, Why are Hospice Benefit Services not one of the targeted interests?

As defined in the legislation, the IMPACT Act requirements pertain to home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care

hospitals. Hospice quality continues to be a priority under the Hospice Quality Reporting Program mandated by the Affordable Care Act of 2010. However, CMS appreciates the importance of standardized data and cross-setting quality measures, and we anticipate such alignment efforts to develop or to be developed with the Hospice Quality Reporting Program.

And now, I'm going to turn it over to Jennie Harvell.

Jennie Harvell: Thank you Tara. The next question was, Reviewing the act, there's no apparent reference to leveraging telehealth to improve care and support the post-acute care clinician. I see this as an oversight given the longitudinal nature of capitated beneficiary management. How do you see telehealth playing a role in this act?

The response to that question is that the IMPACT Act does not reference telehealth. That said, we agree that there is benefit to the use of telehealth.

The next question was, How can hospitals better assist post-acute care providers and provide better data and information upon transfer?

The response to that question is that, in the recently published final rule for the 2015 Edition of Health IT Certification Criteria. The Office of the National Coordinator established new Health IT Certification Criteria that supports health information exchange with long-term, post-acute care, and other settings. The Office of the National Coordinator rule encourages providers to use certified technology that supports the ability to 1) create, and 2) receive interoperable Consolidated Clinical Document Architecture, CCDA, documents according to the CCDA released 2.1 standard.

Hospitals, physicians, and long-term post-acute care providers could use technology that is certified to these criteria to create and receive summary records at times when transfer of information is needed. In addition, the Office of the National Coordinator's final rule adopted a new care plan certification criterion that would require health IT modules to enable a user to record, change, access, create, and receive care plan information in accordance with the HL7 standard for care plans, that is, the care plan documents template in the HL7 Implementation Guide for CDA release 2.1 consolidated CDA templates for clinical notes.

The data that can be included in the care plan document template can help improve coordination of care by providing a structured format for documenting information, such as goals, health concerns, health status evaluations, and interventions. Hospitals, physicians, and long-term post-acute care providers could use technology that is certified to this criterion to create and exchange care plans. In addition, some of the care plan content could be derived from post-acute care assessments. Thank you.

Question-and-Answer Session

Amanda Barnes: Thank you so much Jennie. At this time, our subject matter experts will now take your questions about the 2014 IMPACT Act. But before we begin, I would like to remind everyone that this call is being recorded and transcribed. Please state your name and the name of your organization once your line is open. In an effort to get to as many participants as possible, we ask that you limit your question to just one.

All right, Kalia, we're ready to take our first question.
Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

Your first question comes from the line of Debra Schultz.

Debra Schultz: Hi, I work in a rehabilitation facility, and my question has to do with, although we're looking at standardizing all these data elements, what consideration has been given to standardizing the ICD-10 coding so that like diagnoses, when you start looking at comparative data, can be linked to the diagnosis that's affecting all of these patients in the different care settings?

Stace Mandl: So, this is Stace here at CMS. I think that's a fantastic question. And actually, I'm going to ask that, if you wouldn't mind, if you would be so kind as to submit that particular question to the mailbox that I provided. Do you need me to repeat that mailbox?

Debra Schultz: If you wouldn't mind, please?

Stace Mandl: Sure, it's PAC Quality Initiative, and it's on slide 42, so PACQualityInitiative@cms.hhs.gov. But it is on slide 42.

Debra Schultz: OK, thank you.

Stace Mandl: And you're so welcome, and we actually thank you.

Debra Schultz: Um-hum.

Operator: Your next question comes from the line of Cathy Borough.

Cathy Borough: Yes, I have a question regarding slide 36, regarding the timeline with SNF data. What is the difference between reporting the quality measure data from October 2016 to October 1, 2018? It seems to me like it reads the same.

Stace Mandl: This is Stace here at CMS. I'm sorry, could you just repeat that question? I had a little bit of a hard time hearing you.

Cathy Borough: OK, regarding slide 36, the timeline for SNF quality measure data, what's the difference between the timeline from October 1st, 2016, and then that of 2018? 'Cause it's like you're reporting both. Is one just data collection and one is — I mean, what's the difference? It seems to me it's the same.
Stace Mandl: Sure, no problem. I think those are — that's a fantastic question, and it helps actually others probably orient to these. So these are milestones as spelled out in the IMPACT Act. In 2016 is what was statutory required and actually proposed and finalized. The measures that must be implemented by that date, so that's the 10/1/16 date. And then the act specifies that in October 1, 2018, that additional measures, as well as the standardized assessment domains, be implemented.

So if you're involved in the SNF PPS system, we know that you already submit the MDS 3.0. These sort of hallmark timelines are when we must, you know, either propose measures, some of those measures that will use the MDS as its data source, or in 2018, specifically there, in addition to some of the measures within the act, is required for the standardized assessment data for those categories. And that's why those dates are sort of called out. Thank you.

Amanda Barnes: Next question please.

Operator: Your next question comes from the line of Michelle Wallace.

Michelle Wallace: Hi, I was wondering — you don't — there's no mention of swing bed in the IMPACT Act, and I wondered if this also applies to swing bed as well as SNF?

Stace Mandl: Yes, there's actually a requirement, you'd have to circle back all the way to the Social Security Act for the submission of the data for swing beds. The exception to that, I believe, is with critical access hospital swing beds.

Dr. Tara McMullen: Yes.

Stace Mandl: Thank you.

Michelle Wallace: Thank you.

Amanda Barnes: Thank you.

Operator: Your next question comes from the line of Melissa Smith.

Melissa Smith: We're curious as to why outpatient therapy or rehab hasn't been included as part of the post-acute care continuum, or will it be at some point?

Stace Mandl: Hi, this is Stace at CMS. I think it's an excellent question, would you mind submitting that particular question to the email address?

Melissa Smith: All right, thank you.

Amanda Barnes: Thank you.
Operator: Your next question comes from the line of Jerven. Jerven Dijon, your line is open. And that question has been withdrawn.

Your next question comes from the line of Troy Hillman.

Troy Hillman: Hi, this it Troy Hillman from UDSMR. My question is related to the functional outcome measures. It appears as though inpatient rehab facilities will be subjected to five functional outcome measures in October 2016, while the other post-acute care providers will only be subject to one.

In the fiscal year 2016 final rule, CMS noted that the addition of these five functional measures is adding roughly 42 minutes of data collection for every single inpatient rehab patient, while a similar burden is not being placed upon other post-acute care providers. In an effort, according to the IMPACT Act, to provide standardized and comparable data, will CMS be implementing these four additional inpatient rehab functional outcome measures to the other post-acute care providers, and if this isn't planned, would CMS consider delaying the implementation of these four additional measures until such a time as the implementation burden is placed upon all post-acute care providers?

Dr. Tara McMullen: Yes, that's a great question. Thank you. I would draw your attention to the 2015 MUC list. It becomes public December 1st, 2015. I'll draw your attention to the SNF Quality Reporting Program. We will be developing in the future measures that will be analogous to the measures for the IRF Quality Reporting Program that use the CARE data source, that are functional outcome measures that assess mobility and self-care.

Amanda Barnes: Thank you. Kalia, next question please.

Operator: Your next question comes from the line of Carrie Condon.

Carrie Condon: Hi, this is Carrie with Consulate. Thank you so much for your time.
I apologize if I'm being dense. I'm just trying to follow a little bit of the timelines as well

as the implementation phases. So if I look at slide 15 and I see that the SNF timeline for functional status, for example, is October 1st, 2016, does that correlate to on slide 22 the initial implementation phase of data collection?

Stace Mandl: Hi, we're thumbing through to the pages.

Carrie Condon: Thank you.

Stace Mandl: OK, so you're — to the timelines on slide 15, and 16, right?

Carrie Condon: Yes.
Stace Mandl: Slides 15 and 16, OK, those timelines, those are the statutory timelines, and they're sort of grouped together there by domain, and then if you go to slides 34, '5, '6, and '7, each one of them as a header is which program is involved in the timelines for those measures specific to that program, if that makes any sense. I hope that makes sense. Is that what you're — and if you look at what's also on slides 34, 35, 36, and 37 are the required timelines pertaining to the MAP, as well as the implementation phases.

Stace Mandl: Does that help?

Carrie Condon: Yes, I think so. I was trying to put the phases on 22 on to 36, and maybe I'm just over-complicating it. But, yes, the timeline on 36 is…

Stace Mandl: Yes.

Carrie Condon: … is clear. OK, all right. Thank you so much.

Stace Mandl: You're welcome. So if you look at 30 — on slide 36 and at sort of the bottom, the information from slide — what we tried to do was sort of for each program kind of march out what those timeframes would be. So on slide 36, the implementation of the measures, the confidential feedback reports that tie those measures, and the public reporting, that's sort of at the — on the red bar at the bottom kind of gives those in …

Carrie Condon: OK.

Stace Mandl: … where they're happening, those milestones. And these are all, obviously, the estimated timelines, you know, are built from the statute. Hopefully, that helps some more.

Carrie Condon: OK, it does, and then one just teeny quick question, I'm sorry.

Stace Mandl: That's OK.

Carrie Condon: On slide 36, where we have, "October 1st, 2016, begin 2 percent reduction for failure to report." Just so I understand …

Stace Mandl: Um-hum.

Carrie Condon: … the market basket will start to be reduced in 2016 if you fail to report? For some reason I was thinking we wouldn't see payment adjustments until 2018.

Stace Mandl: Right, actually — you actually bring up a really good point, and we probably should fix that slide. So what that really means is beginning that date, October 1, 2016, that's when if you fail to submit the data, starting then for the applicable APU year. So the reporting timeframe for 2018, as finalized in the rule, in the SNF PPS rule, is — the first quarter of data reporting is October 1 through December 31st of 2016.

That sort of begins the quality reporting program. If you fail to submit the data, as laid out in that final rule, the payment reduction would occur on 10/1/2017, and that's fiscal year 18. So thank you for bringing that up. We'll actually fix that 'cause it is — it is …

Carrie Condon: OK.

Stace Mandl: … no worries. Don't panic. It doesn't start October — from now …

Carrie Condon: We just need to know when we might get dinged, and I got to report the right date out.

Stace Mandl: Yes, you did. I hope I answered that.

Carrie Condon: Thank you very much.

Stace Mandl: Thank you.

****Post-Call Clarification- On Slide 36, the milestone marker depicted for October 1, 2016 data is in reference to the data reporting for the SNF QRP that begins October 1, 2016 for FY 18 payment determination as provided under the IMPACT Act and as finalized in the FY 16 SNF PPS Final Rule.****

Operator: If you would like to ask a question, press star 1 on your telephone keypad. To withdraw a question or if your question has been answered, you may remove yourself from queue by pressing the pound key.

Your next question comes from the line of Doug Josephson.

Doug Josephson: Hi, yes. Thank you for a great presentation. I've got a question about medication reconciliation and also discharge assessments. I don't see many — or much information as far as measures — assessment instruments, quality measures, or anything else really for medication reconciliation. Especially, I'm kind of curious about when that's all going to be coming out.

Dr. Tara McMullen: Hi, yes, this is Tara. That's a great question, so the drug — medication reconciliation domain, CMS is developing four quality measures that are under the title Drug Regimen Review, and that's a claims-based measure, so it won't be — have any — it won't affect the assessment instruments. The discharge to community measure also — for the domain discharge to community is also a claims-based measure.

If you scroll back to the CMS Public Comment page, as well as CMS Technical Expert page, you'll see that we just — for the Drug Regimen Review measure — we just finalized the public comment period as well as the Technical Expert Panel period for that quality measure to …

Doug Josephson: I can see that.

Dr. Tara McMullen: … to meet the mandates development, and we exercised that blueprint. For the discharge to community measure, we actually just completed the Technical Expert Panel phase of the blueprint for that quality measure, and we will be moving into public comment shortly. So please keep your eyes peeled, or I think you could sign up for email announcements through the CMS web page when there's new public comments for post-acute care, when those periods open. That should be in the next couple of weeks.

It should also be noted that the Medicare spending per beneficiary measure is also a claims-based, so the assessment instruments will not be affected by that.

Doug Josephson: OK, great. Thank you so much.

Amanda Barnes: Thank you.

Operator: Your next question comes from the line of Justin Hunter.

Justin Hunter: Hi, this is Justin Hunter from HealthSouth. Stace, Tara, thanks for the very helpful presentation. I have a follow-up from a comment or couple of comments that I think I heard from Stace referencing RAND or the RAND Corporation. Real quick, if you could just provide some additional detail on the interaction that RAND is going to be having with the post-acute care provider community going forward, how we can get in touch with them to ensure that we're doing our part to interact with them and

participate in whatever processes they are leading or involved with on the agency's behalf, that'd be great.

My second question is this. I'm on slide number, let's see, it's 34 here, for the PAC, QRP, IRF estimated timelines and milestones, and I'm down at the bottom of this slide, in the red line there for the IMPACT Act milestones, and looking — going right to, or, excuse me, left to right. That first gold little inverted triangle there for October 1st of next year, quite a few new additional items that are going to be reported there, what can you all tell us here in what's now becoming late October 2015 in the way of — or tell us about in the way of the training and, I guess, part of that pertains to the IRF-PAI Training Manual that is going to be released in anticipation of that first big milestone there? That may be more of a Chronic Care Policy Group–oriented question, but there's clearly a lot of training that's going to have to be done to get up and running as far as the IRF-PAI is concerned in meeting this first milestone, and just a sense of timing as to when we could anticipate some feedback on the training, including the IRF-PAI Training Manual, would be helpful if you can speak to that. Thank you.

Stace Mandl: Thank you Justin. This is Stace, and I'm going to do my best to answer all your questions. So if I missed them, please let me know.

First of all, thank you for asking about the efforts related to the standardization of the — of the data and the work that RAND will be doing. If you could actually submit that to me via the email address, and the reason why I'm saying that is so I don't forget. We'll convey that information over to the folks who are carrying out this work. So thank you very much, we very much appreciate the opportunity and, really, your requesting the opportunity to work together with this, so thank you for that.

And the second is an excellent question, which is one reason why I had sort of that commercial break about the upcoming LTCH training. So we've been very busy awarding contracts over the last few weeks, and a company by the name of Econometrica is the contractor who will be supporting the training. So way back when, with the Affordable Care Act Section 3004, when we had major updates for the 2012 implementation, we had an in-person train-the-trainer that was very well attended that was hosted here in Baltimore by the training contractor. And we clearly know and appreciate the need for assessment-based instruments to have train-the-trainers.

So Econometrica and their subcontractors and CMS will be working together to host in near future train-the-trainer opportunities, as well as sort of a nice portfolio of training materials, including webinars and slides posted. But we know that really the hallmark for these assessments is that train-the-trainer venue. So we don't have firm dates yet, but we, obviously, will be working very soon to start putting those sort of training milestones together and pushing that information out to the provider industry so that they can obviously get things going on on their end to identify the trainers that would join us. I hope that helps.

Did I answer all your questions?

Justin Hunter: It is helpful I know a lot of clinicians, including those on the lines, are looking forward to those opportunities. I know from the standpoint of IRFs, they are also awaiting, you know, what the IRF-PAI Manual or Training Manual is going to say about this, and, like I say, that may be more of a Chronic Care Policy Group–oriented question when we talk about the IRF-PAI Training Manual, but in any case, it is very helpful. Thank you.

Amanda Barnes: Thank you so much. Kalia, next question, please.

Operator: Your next question comes from the line of Jeff Reid.

Jeff Reid: Ah, yes, my question is along the same lines. I'm wondering if the training in November for LTCHs should be attended by the home health and SNF providers to get a preview, or is that contrary to the goal of that meeting?
Stace Mandl: This is Stace. We would encourage anyone who would desire the opportunity to glean information from the training. So if you're a provider type that's not LTCH, but you think that this training would be useful, which we think it would be, we would highly encourage folks. It's free, open to the public, and so forth. So, yes, absolutely. It's in Baltimore.

Jeff Reid: Thank you.

Stace Mandl: You're welcome.

Operator: Your next question comes from the line of Theresa.

Theresa: Yes, hello, this is Theresa, health care consultant working across the continuum of care. I'm showing here the slide 36, and the question came earlier on the 2-percent reduction for failure to report for SNF. Is it anticipated or is there any provision in there or any other penalties for failure to report for any of the other categories?

Stace Mandl: So all of the data associated — so all of the – you just kind of have to work through the IMPACT Act itself to read it, but it does – all of the data, all of the standardized data requirements map to a payment reduction for failure to report. And so, on this particular slide, what's sort of unique in that, which is why I think it's on this slide, is that the skilled nursing facility is a brand new quality reporting program, and so this is its first foray into submitting data where — in which a failure to submit the data results in a penalty. So that's really why that's sort of hallmarked on there. Thanks, thanks Theresa.

Operator: Your next question comes from the line of Linda O'Bryan. Linda, your line is open.

Linda O'Bryan: OK, thank you. This is Linda O'Bryan from Kindred Healthcare. My question is similar to a couple of other folks' questions in relationship to the timelines, and it's directly related to the LTCH measures. So for slides 15 and 16, we have the October 1, 2018, date for the functional status and cognitive function, etc. And then for the incidence of major falls, we have October 1st, 2016. How does that interact? And I see our timeline on slide 35, but there's a little confusion in my head regarding the dates for the new care assessments that will collect — begin collecting the data for the functional status, cognition, falls, etc., in April. So can you just help me figure out how these work with the IMPACT Act?

Stace Mandl: Sure. This is Stace. So if I'm following correctly, you are with an LTCH, right?

Linda O'Bryan: Yes.

Stace Mandl: OK, so for those — for the function measure that satisfies the first domain within the act, pertaining to functional status, cognitive function, and changes in function, that is in an April 2016 release, although for the LTCHs, the IMPACT Act had a deadline basically of October 1, 2018. These — that measure that's being used is using the same data elements that would already have been proposed and finalized and implemented in that program of April 2016, so you guys are in good shape for satisfying the requirements of the IMPACT Act. I hope I answered your question.

Linda O'Bryan: OK, so it is the same measure. It's just that in terms of the IMPACT Act, it doesn't really go into effect for that purpose until 2018.

Stace Mandl: Actually, no, it goes into effect April 1, 2016, and it's all …

Linda O'Bryan: OK.

Stace Mandl: … delineated in the final rule.

Linda O'Bryan: OK, all right. Thank you.

Stace Mandl: Yes, yes. Those in the IMPACT Act, these are — by which date they have to be done.

Linda O'Bryan: OK, that helps, I think.

Stace Mandl: Um-hum.

Linda O'Bryan: Thank you.

Stace Mandl: OK, you're welcome. Thank you.

Operator: Your next question comes from the line of Karen Hurst.

Karen Hurst: Hi, good afternoon. Thank you for actually putting this all together. It's a lot to sink in, but I was hoping if you could just clear up one thing. Is this going to be a whole new system, or will the information be gleaned from the MDS submissions?

Stace Mandl: Sure, so I think that's a fantastic question. We touched on that a little bit in — that was a common question that we received through the Q&As prior to this National Provider Call. The statute in — deep inside of it, does ask that the existing assessment instruments be modified. So you will not have to be submitting something different from the MDS, and we would be — as proposed and finalized in — for SNFs, for example, they would be submitting the data as you always have through the key-based QIES-ASAP system.

Karen Hurst: Thank you.

Stace Mandl: Thank you.

Amanda Barnes: Thank you so much. Kalia, we have time for one final question.

Operator: And that question will come from the line of Jeff West.

Jeff West: Hi, Thanks for taking the question. I work with the QIN QIO. I'm trying to engage health care providers in medication reconciliation improvement, so I'm particularly interested in that measure here, and I heard you say it's claims-based. Is that to mean — is that different than the MDS-based for like SNFs? Are these standardized assessment tools?

Dr. Tara McMullen: It's a great question, Jeff. Thank you. Yes, actually we were just going to correct ourselves — it's an assessment-based measure, so apologies for that. The drug regimen review measures meet the mandate of medicine reconciliation and assessment-based. So in that we will be using items, assessment-based data items. They will be nested within the assessment instruments. So that of the MDS, the IRF-PAI, the LTCH CARE data set, as well as the OASIS.

Jeff West: And being that it is assessment-based, I don't know, I can't understand how somebody could fail to submit the data, especially for like MDSs …

Dr. Tara McMullen: Right.

Jeff West: … in nursing homes.

Dr. Tara McMullen: Right.

Jeff West: Does that make — all right. So that 2 percent of penalty would probably not apply to anybody who uses the MDS, is that correct?

Dr. Tara McMullen: Well, I mean, I think, it's a valid point, but, yes, the 2 percent will apply to that — the items that are used to calculate the quality measures that is being developed to meet the mandate of the IMPACT Act, that 2-percent penalty, APU does apply to those items.

Jeff West: Sure.

Dr. Tara McMullen: So if a provider does not submit on those quality items, those items for that — that are used to calculate that quality measure, yes, they will get the ding.

Jeff West: I got you. OK.
Dr. Tara McMullen: OK.

Jeff West: Well, thank you.

Dr. Tara McMullen Yes, thank you.

Stace Mandl: And thank you. I just want to clarify one thing, sort of back to Justin Hunter's question regarding the IRF-PAI Training Manual. We appreciate the desire to have that training manual posted in time for implementation for the information for the assessment data collection, and we will work to ensure that that is posted in time for the implementation by the IRFs. I appreciate that. Thank you.

Additional Information

Amanda Barnes: Thank you so much. Unfortunately, that's all the time for questions we have today.

An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release an announcement in the eNews when these become available.

On slide 45 of the presentation, you will find a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments and evaluate your experience.

Again, my name is Amanda Barnes, and I'd like to thank our presenters and also thank you for participating in today's MLN Connects Call on Improving Medicare Post-Acute Care Transformation Act. Have a great day everyone.

Operator: This concludes today's call. Presenters, please hold.

-END-


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