MLN Connects®

National Provider Call Transcript

Centers for Medicare & Medicaid Services
IMPACT Act: Data Elements and Measure Development Call
MLN Connects National Provider Call
Moderator: Leah Nguyen
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Contents

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 Leah Nguyen. Thank you. You may begin.

Announcements and Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I'd like to welcome you to this MLN Connects Call on IMPACT Act: Data Elements and Measure Development. MLN Connects Calls are part of the Medicare Learning Network®.

During this call, CMS experts will discuss how data elements are used in measure development. Find out how information from assessment instruments is used to calculate quality measures. The Improving Medicare Post-Acute Care Transformation Act of 2014—or IMPACT Act—requires the reporting of standardized patient assessment data on quality measures, resource use, and other measures by post-acute care providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals.

Before we get started, I have a couple announcements.

You should have received a link to the presentation for today's call in previous registration emails. If you have not already done so, please view or download the presentation from the following URL: go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. You will receive an email when these are available.

Lastly, registrants were given the opportunity to submit questions. We will address some of these questions before the question-and-answer session.

At this time, I would like to introduce our first presenter.

Michelle Brazil has been at CMS for over 3 years. She is a registered nurse with 16 years' experience working in post-acute care and public health. She is currently the Technical Advisor for the Division of Chronic and Post-Acute Care in the Center for Clinical Standards and Quality here at CMS.

I will now turn the call over to Michelle.

Presentation

Michelle Brazil: Thanks, Leah.

Hi, everyone. We're going to move on to slide number 4, the agenda. So, today's call, we're going to begin by providing a background on the National Quality Strategy and how it relates to the CMS Quality Strategy. We'll then focus on the importance of quality measures in the health care setting and how data elements from assessment instruments fit within the measure development process.

Next, we'll discuss how data collected from providers informs the measure development process. And then we'll end with examples of the process using the Pressure Ulcer measure. And at the end of the presentation, we'll also have some time for questions and answers, and have included some general resources for your reference.

How Data Elements and Quality Measures Fit Together

So moving on to slide 5, we will begin our first topic on understanding how data elements and quality measures fit together.

On slide 6, the National Quality Strategy. Well, this lists the aims and the priorities of the National Quality Strategy or NQS, as we like to call it. The IMPACT Act provides a tremendous opportunity to address the three broad aims of better care, healthy people and communities, and affordable care.

These three aims can then be achieved through six priorities, which focus on reducing harm; engaging patients and caregivers; effective communication and coordination; effective prevention and treatment practices; healthy community practices; and

affordable care for individuals, families, employers, and governments. All quality reporting activities are intended to be guided by the National Quality Strategy.

Slide 7, the CMS Quality Strategy. So, building on the National Quality Strategy, CMS has developed its own quality strategy to guide its many initiatives. Each of the National Quality Strategy priorities, as listed on slide 6, has become a goal in the CMS Quality Strategy. And for each of the six goals listed here on the slide in front of you, CMS has further outlined strategic results and specific objectives and desired outcomes for how we plan to achieve the objectives as well as current initiatives in place that support these goals and objectives.

Slide 8. So why do we have quality measures? So, what is a measure? Many would say they are the heart of quality improvement programs. But they are also one component. As a noun, we define measures as a plan or a course of action taken to achieve a particular purpose or a standard unit to express the size, amount, or degree of something.

As a verb, though, a measure can be defined to a certain size or amount or degree of something by using an instrument or device marked in standard units or by comparing it with an object of known size. In health care quality programs, we typically focus on the noun definition of a measure. Measures can reflect a concept or made up of components reflected by data elements collected with tools or instruments, such as the OASIS or the MDS instruments, as examples.

Measures also serve as inputs for many activities. But they primarily serve as a standardized base from which to examine a specific concept and make comparisons to inform understanding and recommendations. Measures provide a shared language with structure and focus.

Slide 9. So, today, we're going to cover each one of the components illustrated on this slide and show how they illustrate how data elements or items fit within the measure development process. At this point, it's important to see the interrelatedness of these components. There is a single concept that drives the development of data elements or items in quality measures, as you can see by the illustration on this slide.

I'm now going to turn it back over to Leah.

Keypad Polling

Leah Nguyen: Thank you, Michelle. At this time, we will pause for a few minutes to complete keypad polling.

Ronni, we're ready to start polling.

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 one. 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 nine.

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 Leah Nguyen.

Leah Nguyen: Thank you, Ronni.

I'd like to introduce our second presenter. Dr. Tara McMullen is a Senior Health Analyst for the Division of Chronic and Post-Acute Care and Technical Lead for work focused on understanding post-acute care assessment data and quality measures as mandated by the IMPACT Act.

I will now turn the call over to Tara.

Presentation Continued

Tara McMullen: Thanks, Leah. And hi, everyone. Good afternoon.

We are going to begin our presentation once again on slide 10. And today, for the next few slides or for the duration, actually, of this presentation, we're going to discuss generally how data items or elements fit into quality measures and how quality

measures really are developed. And this is a broad topic. We're going to touch on many of the key areas.

If you have any questions, we welcome your questions and we are happy to talk through some of these more complex areas of the quality measure development from the CMS perspective. This presentation serves as a primer to help educate the audience, or you all, on our processes as developers for post-acute care for CMS.

So, also, for this presentation, it's really important to add that we will use the terms "items" or "data elements" – "data items" and "data elements" interchangeably. However, depending on where you fall as an expert in this field, whether you're a psychometrician or you're an individual who works in the technical aspects of quality measure development, these two words may mean very different things. But, for sake of the presentation today, items and elements will be used interchangeably. They mean, basically, that core critical element for development of quality measurements.

So, nonetheless, let us get started on slide number 10.

How Data Elements Fit within Measure Development

So within the Division of Chronic and Post-Acute Care we have many measures that are essentially leveraged for our Post-Acute Care Quality Reporting programs. And many of you on this call know those programs consist of the Long-Term Care Hospital Quality Reporting Program, the Inpatient Rehabilitation Facility Quality Reporting Program, the Skilled Nursing Facility Quality Reporting Program, the Home Health Agency Quality Reporting Program, and we also have the Hospice Quality Reporting Program.

So the measures that are leverages in these quality reporting programs are calculated or driven by data elements or data items that are nested within our commonly collected assessment instruments. And you guys all know this as well, the assessment instruments as the MDS or PAI long-term care data sets, or we call it. the LCDS or the OASIS.

These assessment instruments are quintessentially like item banks in that they hold data items or data elements and they are the vehicle that CMS uses for collection of these data items or data elements by hundreds and thousands of providers in the United States. And CMS uses these assessment instruments and the associated items within the

assessment instruments for purposes of collection for benchmarking or reporting of quality for our quality reporting programs.

Data items nested within our assessment instruments have many uses. And for those who have been on some of our IMPACT Act presentations, you'll know that we have a graphic where we show the uses – the many uses of data elements. And within that graphic, it delineates that items can be used for quality reporting—indicator use—survey certification, payment, use for care planning, discharge planning, and really, beyond. Thus, simplistically, data items or elements are the crux to all quality measure work and all work for data collection by CMS, in part that they have definitive uses that drive specific outcomes that are of interest to CMS.

Under the IMPACT Act, CMS is not only to standardize quality measures, which are specified by standardized data items or elements, but CMS is also to standardize data items overall. So, we see this as a one-to-one comparison, modifying our assessment instruments as required by the law to collect data that serves multiple purposes such as multiple purposes as delineated by the item purposes just discussed: care planning, discharge planning, and beyond.

Slide number 11. So for those who've been with us also in many of our presentations about the care tool, this graphic may look familiar to you. It's the graphic where we delineate how – kind of the overall vision, data follows the person. In this graphic, we're going to specifically focus on why data items. Why does CMS use data items to develop quality measures, to collect data?

So, CMS is standardizing data items to emphasize the appropriateness and reliability – the most appropriate and reliable use for each and every item in our assessment instrument. Because we recognize that data truly follows the person. And through this, we leverage the assessment instruments and those items.

The intent of developing a data item is that it's useful within and across settings. So, to understand – and we use that – these data items in our assessment instruments to understand the extent to which patients are treated in different settings or how advances can be gained in measuring acuity, treatment needs and outcomes as well as improving information transfer between these settings – these post-acute care settings.

By leveraging the data elements via the item banks—and what I mean by that is our assessment instruments—and using the data item in – data items for collection of data and calculation of quality measures, CMS is able to conduct a wide range of testing and reporting. For example, with a wide range of items, CMS is able to assess the difficulty of a concept or an item that's used to assess a concept such as function. And we do this in order to make inferences, to test performance of that item, and diagnose problems. Using data elements or items allows for interoperability as well, where all providers and researchers are speaking the same language in a manner that is consistent and structured.

And, then, you see on this slide that information really follows the person and items allow for that information to follow the person. And what that does is it allows for person-centered care and that type of support, standardization, of course, leveraging existing standards developed for interoperable exchange, aligning with very important requirements of other statutory mandates, and reducing costs, reducing data collection and burden, and increasing the ability to report data to CMS.

How Data Informs Measure Development

Slide number 12. So how do data collected from providers inform the measure development process? So, data items are used to calculate measures. We've just established this. Data items also drive outcomes. They are collected by means of each assessment instrument in post-acute care. The items allow CMS to test, administer, or distribute, via public reporting, data consistently. Data items drive interoperability. Data items have many uses and, within quality measures, can be used to risk or case mix adjust. So, the data submitted – there's a lot of going on with the data items and their many uses, and there's many outcomes for why items – or outcomes for items. And that really delineates why they're important.

On this slide we also discuss NQS. And we like to note that data submitted via the collection of these data items inform measure maintenance on existing measure, which includes application to NQF. The submitted data inform annual maintenance, comprehensive re-evaluation, which occurs every 3 years, and can even trigger an ad hoc review if feedback gleaned from the data warrants immediate attention to the measures, the items themselves, what the data is telling us from the collection of those items.

The submitted data from the data items inform future measure development and data element development. The submitted data help move the needle in health care by creating a foundation from which to build clinically complex and meaningful measures that provide greater insight into patient and caregiver experiences and outcomes.

Slide 13. So, we've established why items are important. And now we're going to reach back to slides 8 and 9. So items are developed from a core concept usually driven from the National Quality Strategy or other clinical needs, as identified by CMS or our stakeholders, the general public, researchers, research in general. And going back to – I think it was slide 9 – you can see that – how a core concept grows. It almost looks like a tree. You have a concept, it grows, and question and response, how it's coded, how it's collected. To us, that's standardization.

So CMS, with our measure contractors, developed questions guided by response options, or what we call coding options, that are intended to explore a measurable clinical outcome or identify gaps in care. The data element is the crux in identifying where we are potentially lacking or where we can improve in care practice, though it's not limited to that.

Through this development, CMS develops basically item banks or item libraries which address health issues, medical treatments, vaccination status for one example pressure ulcer status. And from this point, CMS defines who will be assessed—basically the population or a population within a specific care setting or a population overall—and how the measure will be calculated, adjusted to appropriately assess for populations and their differences. So, we have items. We have the item banks, which are assessments. We use those items. We define a population that will be used to collect for those items. And then we basically move into other facets of measure development such as calculation, risk adjustment, case mix adjustment, and so on.

So this is a thousand-foot overview of the concepts in measure development, building through the work from the core item to the outcome. And each part of a QM addresses that outcome. And we hope that the outcomes are sufficiently addressed appropriately through our measure development. And that measure development starts with an item.

And you will see here that we really kind of break that down from concept to data element to response options, the quality measure, and the assessment instrument. And

it is cyclical, right? So the assessment instrument houses that data element, and the assessment instrument allows us to collect on that data. We use that data element to inform a concept. Those data elements drive development of a measure. That measure has all sorts of applications to it—risk adjustment, calculation. And then we go and we move forward. We propose that measure, hopefully finalize if we do, and collect on it via the assessment instrument. So, it's a circle.

Slide 14. So, this is a thousand-foot overview. I know hearing it for the first time, it kind of sounds like a lot. And, now, we are going to walk through how CMS has specified this or put this kind of measure development into action.

Sample of Process Using Pressure Ulcer Measure

So, we are going to use the example of the pressure ulcer measure. And many of you in this audience probably are very familiar with the pressure ulcer new or worsening quality measure. It has been proposed and finalized in all four of our post-acute care settings under the IMPACT Act. But this measure really has a long history in post-acute care in that in 2011 it was first endorsed for nursing homes by the National Quality Forum. And even before that, we were using – I think it was in 2010 we were specifying data items to collect on pressure ulcers, whether they were new, worsened, what was going on at that time, the status and frequency.

So this slide tees up where we're going to start. So, we start with the concept before even maybe sometimes the element or we might have the element and we start with the concept. But, with the pressure ulcer, we knew that there was a focus on prevention of pressure ulcers and that we had to look at the treatment of pressure ulcers. We had to somehow benchmark that quality.

So, see – and it was a priority for CMS. So, in 2010 CMS went about developing data items to be able to assess for that prevention and safety. And the focus really came about new and worsening from our technical expert panels because folks felt that that was a gap area that needed to be filled by CMS for reporting.

Fast forward to the IMPACT Act and now we have this measure. The items have been specified. The items now are used in quality measure development. The quality measure has been endorsed by NQF. And now we're reusing or reconstituting this measure, adjusting it for appropriate case mix under the IMPACT Act.

Slide, I think, 15 walks through where we have drawn the items for this quality measure. And you'll see here our commonly used assessment instruments.

Slide 16 focuses you on really the process of the development of this measure. So, we have this measure. It originated from nursing homes and now it's applied – proposed and finalized to our post-acute care programs. And what you see in this slide is that this measure is collected via very specific data elements or items in our assessment instruments. You'll see the point of collection in the second column. And, then, in the third and fourth columns, you see the exclusions and the numerator and denominator. And in the fifth column you see the covariates.

What you're looking at in these columns are data items. So you see M0800A. You have H0400 as a covariate. You have M0800B. These are all data items that are used for specific purposes. So, remember, going back a couple slides, data items are used to calculate and specific quality measures. However, data items have many purposes. And, so, now we are going to delve into the quality measures. So, a data item can be used not only to specify a quality measure, but also to risk adjust for a quality measure, to be able to stratify for populations, and to be able to help with specific outcomes.

Now, turn your attention to slide 17 to give an example of this. So, slide 17 shows you one item, H0400, bowel continence. This is an example of how the item currently looks in the MDS. So this is an example of a data item that is accompanied by elements. So you have bowel continence as the items, and it has a breakdown of response options and how you can collect that through a scale. And then you enter your code.

So, this is an example of a covariate that we use for the pressure ulcer quality measure new and worsening. And what I mean by covariate is it's an item that we use to risk adjust in our overall risk model. The item H0400 assesses the presence of a condition and the frequency of that condition. This item is leveraged in the pressure ulcer measure. The data item is used to calibrate or adjust for case mix differences so that the measure calculation or the total outcome we're able to assess for – kind of get a better look, like a clean look at that population via that case mix.

So better stated, the leveraging of H0400 in our risk adjustment model – so, using that data element for risk adjustment allows CMS to look at a specific population after adjusting for the effects of that population for those patient characteristics because

characteristics vary across populations. And, so, if we are trying to get a fair look, we needed to adjust out some of those effects.

Without using this item, as well as other covariates in our risk adjustment model, CMS or researchers cannot draw appropriate conclusions from the data. They'd be incorrect mainly in that patient or resident outcomes are not driven just by quality of care but they are driven by things like age, comorbid status or comorbidities, social factors, functional factors, things like that. So, we use data items to calculate outcomes. But, we also use data items to basically allow us to assess a population fairly.

So, slide 18. So now we know that H0400 is used in our – as a covariate in our risk model to allow us to get a more generalizable look for the outcome of pressure ulcers new or worsening. Now, we're breaking it down here for how to code the question H0400. And what we're showing you here is that in the coding that this type of binary coding, yes or no – and if it's a yes, how frequent, and if it is a no, is it not rated – that CMS uses this feature to assess patterns and outcomes and to identify issues. Coding in this specific matter of a data item or a data element allows for more precision, that is, it allows CMS to optimize the probability of a more accurate outcome for data analyses.

So we're showing you this to show you that on slide 18 and slide 17, that data elements are used for many purposes. In the pressure ulcer measure, we have H0400 that's used for risk adjustment. We risk adjust in a model with elements to balance out characteristics, patient characteristics across settings. And we code these specific items in specific ways such as yes or no. And if yes, what's going on with that person to increase the probability of more reliable or accurate analyses for those outcomes so that when CMS reports our data, we are reporting the most reliable, efficient, feasible data that we really are collecting from the providers, from you all on the phone.

So, slide 19. And slide 19 kind of gives us an overview of what we're talking about today. So, you have the quality measure. The quality measure is really driven by your item and the concept. It has a numerator, a denominator, your exclusions, and your covariates. So a quality measure is really a comprehensive set of specifications that are applied to one idea to be able to give us a good outcome. And it takes time to develop that quality measure. And I know on prior presentations we've discussed really the quality measure timeline and how it could take years to develop a good quality measure.

Slide 20 is just kind of more of an FYI that we use assessment instruments to leverage these items.

And slide 21 shows you really the implementation of the specific measure, the pressure ulcer new or worsening measure. And you'll see that it has a really rich history in post-acute care dating back to – I know it was started in 2010 but really first leveraged by the Nursing Home Quality Initiative in 2011 and now in our quality reporting programs under the IMPACT Act for a different outcome. And that's for standardization.

And slide 22, once again, walks you through how data elements or quality measures fit together and why. And, once again, we know that this is a really broad topic and there was a lot of information just given to you. But, remember that everything's driven by a concept and a gap. So, if CMS finds that there's gap in quality and we need to measure that gap, we're going to find a way to develop an item that is efficient and effective and interoperable and find a way to make that item meaningful in a quality measure. And then we'll follow through with the statutory processes and the National Quality Forum.

And I will now turn it back to Leah for Q&A.

Question-and-Answer Session

Leah Nguyen: Thank you.

Now our subject matter experts will take your questions and listen to your insights and thoughts on data elements and measure development. Before we begin, I would like to remind everyone 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. If you would like to ask a followup question or have more than one question, press star one to get back into the queue, and we'll address additional questions as time permits.

All right, Ronni, we are ready for our first caller.

Operator: To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the 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.

Our first question comes from Joel Van Eaton.

Joel Van Eaton: Thank you. I just had a question about slide 16 and the grid there that talked about the different pressure ulcer measure and the development there. Could you tell me whether the information on that slide is representative of the current IMPACT Act measure or if that's representing something else – as far as long-term care and the MDS is concerned?

Tara McMullen: Yes. So, are you asking about the nursing home measure or the SNF QRP measure? Because the MDS long-term care would be the SNF QRP measure. I think that's 0679 with NQF. And if so, yes, this is representative of that measure.

Joel Van Eaton: Well, this is – this is representative of the NQF measure for IMPACT as opposed to…

Tara McMullen: IMPACT would be the SNF QRP, so the Skilled Nursing Facility Quality Reporting Program. And, yes, that measure is currently calculated by the data item M0800.

Joel Van Eaton: So the question I have then is that this year in August, you all released another document in – that changed that to the data elements M0300B1, M0300C1, M0300…

Tara McMullen: Oh, no no no no. That is – I know that document that you're talking about. That document was our public comment document to gain comment on the use of M0300 for the calculation of that measure. This measure for the SNF QRP to this day, as finalized, still leverages or calculates M0800.

Joel Van Eaton: Thank you very much. That's helpful clarification.

Tara McMullen: Yes. Thank you.

Leah Nguyen: Thank you.

And I'm going to turn it back over to Michelle to talk about some of the questions that we received through registration.

Michelle Brazil: Thanks, Leah. And we'll open it back up to live questions in just a moment. But we wanted to be sure to get to the questions that were submitted through participants prior to today's call. So we want to read through 10 questions that were received by participants before we go back to the live Q&A.

The first question we received is, "What is expected from acute care hospitals when discharging patients to post-acute care providers?" As a second part of the question, "Are we required to have certain paperwork or information that is required to be shared with these post-acute care providers?"

So CMS, for these types of clinical matters, recommends that the provider follow current clinical guidelines and direction from their particular agency for that. And this is a similar question to one that we receive quite often, so we want to make sure to give that direction to everybody.

The second question we received is, "Are you aligning your data elements with ECQM or chart-abstracted data elements used in the inpatient setting?"

So the IMPACT Act legislation does not apply to data elements used in inpatient settings. However, efforts are made as part of standard measure development practices to align with conceptually similar measures across settings if and where possible.

Third question. "Does the impact – does this impact hospices?"

Within the IMPACT Act itself, there is a section that pertains to hospices. But that is related to surveying hospices, not related to standardizing data elements for hospices. And so, the IMPACT Act specifically requires the submission of standardized data by long-term care hospitals, skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities.

Fourth question. “For home health, are there any data elements that will be needed to be collected and transmitted outside of data from the OASIS or Medicare claims?”

So, the IMPACT Act-related data elements will only be collected within the existing assessment instruments used in each of the settings under the IMPACT Act. So this would be the MDS, or Minimum Data Set 3.0, for skilled nursing facility residents; Long-Term Care Hospital Continuity Assessment Record and Evaluation, or LTCH-CARE, data set for long-term care hospital patients; Inpatient Rehabilitation Facility Patient Assessment Instrument, or IRF-PAI, for inpatient rehabilitation facility patients; and the Outcome and Assessment Information Set, or OASIS, for home health patients.

And the next question we received, “What are the common domains and common data elements in the IMPACT Act that are measured and/or go across care settings? Examples are home health – home care, hospice, inpatient hospital setting, rehab hospitals, etc.”

So for this particular slide, we’d like to refer people to our website where all of the timelines and the domains and the categories are listed. And, so, if you go to cms.gov and query “IMPACT Act of 2014,” we provide some helpful information to all of our stakeholders there, including past presentations where you can find specific timelines.

So our next question. “When will the medication review measure be developed and implemented?”

So the drug regimen review conducted with followup for identified issues has been developed and finalized in several of the rules, the IRF rule, the SNF rule, and the LTCH – excuse me, the LTCH PPS rules for each of the settings under the IMPACT Act beginning in FY 2016. This measure will not be used in public reporting and payment determination, however, until FY 2018. The Home Health Rule right now has not been finalized. But if everybody has read in the *Federal Register*, this is still under the proposed statute, you can read more information there.

Next question. “Does this apply to swing bed facilities as well?”

So SNFs that receive a SNF PPS are required to submit data by means of the MDS per the requirement set forth by the IMPACT Act with the exception of swing beds and critical

access hospitals. Therefore, SNFs that receive the SNF PSS with the exception of swing beds and critical access hospitals are included in the Quality Reporting Program. We refer readers and participants to the SNF PPS FY 2016 Final Rule for additional information.

Our next question. "How can I choose the appropriate level of discharge for my patients to reduce the chances of a readmission?"

So for this clinical matter, we recommend that the provider please follow their current clinical guidelines and direction from their specific agency.

Our next question. "Is the data standardization a mandate or voluntary-based?"

So the submission of the standardized data is mandatory as part of providing Medicare and Medicaid services. However, the IMPACT Act related data elements will only be collected within the existing assessment instruments used in each of the settings under the IMPACT Act.

And as we previously discussed, that'd be MDS for SNF residents, the Long-Term Care – excuse me – or the LTCH CARE data set, rather, for short, for long-term care hospital patients, the IRF PAI for inpatient rehabilitation facility patients, and the OASIS for home health patients. These assessment instruments have been and will continue to be updated by CMS, as needed, to accommodate the implementation of the IMPACT Act. There is no additional assessment instruments for providers that they'll have to complete.

So, I'll turn it back over to Leah now for our live Q&A.

Leah Nguyen: Thank you, Michelle. Ronni, we'll – get ready to take our next question. And if your question has been answered, you can press the pound key to get back out of queue.

Operator: Your next question comes from the line of Susan Battaglia.

Susan Battaglia: Hi. Thank you for taking my question. Hopefully, I'll say it pretty succinctly or easily. Does indicating a dash for a covariate item such as the pressure ulcer measure—say you dashed weight—impact the calculation of that measure?

Leah Nguyen: Hold on one moment.

Tara McMullen: So, let me – let me see if I'm getting your question right. So, if you add a dash to a covariate in the risk adjustment – what was the last part about the weight?

Susan Battaglia: Well, I was using, for example, weight, which is used to calculate the BMI for the pressure ulcer.

Tara McMullen: Oh, weight. Not as in weight the data but as in weight the covariate.

Susan Battaglia: Correct, correct.

Tara McMullen: Right. Sorry. I'm thinking data weights.

Susan Battaglia: Yes. No. Sorry about that. So, yes, if you entered a dash for that, you couldn't calculate the BMI. So, therefore, what is the impact for the measure?

Tara McMullen: Yes. That's a really good question and observation. So, CMS expects the use of the dash to be a very, very infrequent occurrence and that, I believe in the guidance manuals, depending on the setting for which you are calling from, that there are – there's guidance around if you're not completing, like going in for the dash in the weight.

But, yes, without that information, that does affect the outcome of the measure. It will be difficult to do an appropriate overall calculation, which is why CMS expects like the dash use to be leveraged as little as possible.

Susan Battaglia: And I understand that. And, so, there would be – that does fall under the 80 percent of dashing, so to speak.

Tara McMullen: Yes…

Susan Battaglia: But there are residents in SNFs that no longer do want their weight to be taken. So, the facility could potentially be penalized because of a resident choice.

Tara McMullen: Yes. That's a tough one. And I know that there's not an option specifically for patient denial on that option.

Susan Battaglia: Right.

Tara McMullen: So, hypothetically, if they do deny it, the only way out is a dash. The system will give you a warning, though, because it expects that type of information because it's tied.

Susan Battaglia: I appreciate it. I just...

Susan Battaglia: Okay. I just wanted to clarify because on the ODF last week...

Tara McMullen: Yes.

Susan Battaglia: ...that is not the same response. So, just a…

Tara McMullen: What did they – what was the ODF about? What was ODF last week?

(Unidentified female): Well, with ODF…

Susan Battaglia: The SNF Open Door Forum. And it was – the question was posed. And the commenter or representative – CMS representative believed there was no impact. But, that is not what we learned in the training. So...

Tara McMullen: Yes. No.

Susan Battaglia: ...I just wanted to clarify.

Tara McMullen: Yes. No. Definitely, I'm getting confirmation as well from some of our other analysts. That was – this is an item that you would have to probably add information on. Right? If you cannot add information, there's no way out but a dash.

Susan Battaglia: Right.

Tara McMullen: The system will give you a warning. So you should probably add that information.

Susan Battaglia: Right.

Tara McMullen: Yes. It's a commonly leveraged item for risk adjustment. It's a mandatory one, you know.

Susan Battaglia: Right. I guess it just puts – it just puts SNFs between a rock and a hard place.

Tara McMullen: Yes. I understand and I hear you.

Susan Battaglia: Okay.

Tara McMullen: And, actually, that is really good insight. And I will take that back to our team.

Susan Battaglia: I appreciate that. Thanks very much.

Tara McMullen: Okay. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Cynthia Morton.

Cynthia Morton: Hi, Tara. Thanks for taking the call. It's a great presentation. I'm thinking ahead just a little bit. All these measures with the data elements presume that we've gotten all the data elements right or – that go into the formulas. But what if we don't? What is the specific process that – I know – I know you have a life cycle of measures and you have generally talked about going back and looking at measures to make sure they're accurate. But could you put just a couple of specifics around that? Maybe initially, how fast do you go back and look at a measure formula to make sure it's

accurate? And how do you – what indicators are out there that tell you there is a problem with a measure? Thank you.

Tara McMullen: Thanks, Cynthia. That's a really good question. So monitoring an evaluation is something of a process that we leverage on our data team here at CMS, zeroing in on post-acute care. As you know – and I don't know if others on the call know – and we can probably give a presentation to this at some point.

But we are in a 2-year assessment release cycle. And this cycle, for updating – we receive data quarterly. And as that data come in, we look at that data, we track and trend, we monitor and evaluate to look for inconsistencies, errors, human error or error in, you know, gaming, things like that in the data.

So looking at the quality development life cycle and knowing that we're getting data in on a rolling quarter basis, we are consistently looking at the data and updating – kind of coming to conclusions on how our measures are acting, if they're acting the way that they should be acting. And if they're not, based on the specification, how do we revise of modify those measures in a way that the measures are consistent and acceptable, I think, is the proper term for that.

NQF helps greatly in this process because of the measures that we do get endorsed, we have to do the annual maintenance update, which requires a further look – more in-depth look at our measures. And then we do the tri-annual update, which requires a full look. So on top of the evaluation and monitoring that we're doing anyway from the quarterly data, we're doing an overall look at the measures for purposes to maintain endorsement. So it's an active process. And, of course, that all relies on the data coming in.

So, for example, with function in Section GG, we've just started collecting in nursing homes October 1st. So we'll begin this process once we have data coming in for a full quarter.

Does that help, Cynthia?
Cynthia Morton: Yes. Therefore, you will be looking at the functional process measure. Even though it's a process measure, you will look at it at the measures driven off at Section GG, after…

Tara McMullen: Correct. So – yes. Correct. This is a really good example, actually, for everyone on the call. So Section GG houses data items. And those items are used to calculate the function process measures for SNFs. And when that data comes in, we will look at how the measure's doing overall, in part, by the collection of those data items.

Cynthia Morton: Thank you.

Tara McMullen: We need – we need at least a quarter of data. And so, knowing that that new section – the specified application date was October 1st – when was that – like 2 weeks ago – we're actively collecting now. And then we'll begin to monitor the efficiency of that quality measure.

Cynthia Morton: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Myra Varnado.

Myra Varnado: Yes. Thank you for taking my call. I work for Corstrata Wing Telehealth Company. My question is in reference to pressure ulcer staging. How are we to handle pressure ulcers or pressure injuries that are deep tissue injury, unstageable, involve mucus membranes that are not cutaneous and are not staged yet they are an injury that should be captured? How is that being handled, because you have stage – you have stage 2, 3, 4.

Tara McMullen: Yes. That is a very good question. I know that we discussed this a little bit in our guidance manuals. But if you will submit that question to the Post-Acute Care Quality Initiatives mailbox, we actually have a wound care expert on – as a clinician analyst on our group who will be able to give full guidance on that, better guidance than I could give you today.

Leah Nguyen: And that is on slide 25.
Myra Varnado: Okay. Great.

Tara McMullen: Yes. But, thank you. That's a very good question. And the reason I say that is that it's a common question. And I want to make sure we give you the most reliable response as possible.

Myra Varnado: Well, – and, I think, the biggest concern is for folks is if a patient comes in with deep tissue injury, that can very quickly deteriorate and now, all of a sudden, they are being like held responsible for a stage-4 pressure ulcer ...

Tara McMullen: Yes.

Myra Varnado: ...you know, that was not present upon admission. So the deep tissue injury piece is really as big deal as well as, like, the terminal component such as the Kennedy terminal ulcer and looking at skin failure, you know, and skin changes at life's end. Those are all things that, you know, just seems like needs to be kind of maybe discussed a little bit more or...

Tara McMullen: Sure. Yes. And understanding how all this plays into the assessment via – or collection of those data elements via our assessment instruments. We had leaned to that discussion.

Myra Varnado: Yes.

Tara McMullen: So I do think we have some guidance that we'll be able to provide here. And I'm getting the affirmative from our expert that we do. So send that into the PAC inbox. Send that in and we will get you a response. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Dheeraj Mahajan.

Dheeraj Mahajan: Hi. Thank you. I'm a – I'm a long-term care physician. And my question is, I think this is very welcome work, that we are doing universal assessments through all the levels in post-acute. We all agree that the physicians or the physician in post-acute is the captain of the ship. And we do have our own ongoing transitions on value and quality reporting programs. I think, a lot of these data elements and the

measures that are being developed – physicians have and should have more skin in the game.

And if we could align these measures with the ongoing MACRA-related and MIPS measures that physicians report, there will much more success in achieving the triple aim of better quality and better cost. So, just wanting some – either relaying the information or asking if there are plans of having some physician quality measures aligned with these IMPACT quality measures.

And, Cynthia, thank you. You enlightened me a couple of weeks ago when we met about how this is Part A versus Part B. But I think it would be a really good idea if Part A and Part B also talked and a lot of those performances are aligned. Thank you.

Tara McMullen: Hi. It's Tara. I remember when we spoke, you enlightened me, too. Now my memory's triggered. Nice to talk with you again. Yes, this is a great question and a great comment, and we appreciate it. And at this time, I think what we're doing is we're being active listeners and taking notes. And we appreciate that. And thank you for the comment.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Alice Black.

Alice Black: Hi. Given that this IMPACT Act is supposed to achieve standardization, I think what's going to happen going forward because it's already started happening is that more items are going to be shared between – where they can be, between these assessment tools, the MDS, the Long-Term Care, the IRF-PAI, and the OASIS.

So my question was if there was a person or persons who are providing some kind of an overall oversight of those instruments to make sure that as items are shared, they are standardized. And the reason I ask that is because we've – it started this year and there's already been a mistake.

There was an item added to the IRF-PAI called Active Diagnosis that has three items where you check if the patient has peripheral vascular disease or diabetes or none of the above. That same item – and that's the IRF-PAI that went into effect October 1st –

the same item was added to the OASIS that's going into effect January 1st, and they left off the "none of the above."

So – and I'm not necessarily asking you address that issue. I've already emailed oasisanswers.com to try to figure out what's going on there. I think it was just an oversight. But it did make me wonder if there's someone kind of managing all these assessment tools to make sure that that kind of thing doesn't happen and that when items are shared, they are shared the same so that any data you collect, obviously, is the same across all the assessment tools.

Tara McMullen: Yes. Hi. It's Tara McMullen. That's a good question. I would like to respond to that and add a point of clarification. So, good point about the active diagnoses. I can see where that can cause some confusion. I'd like to clarify that that is not an item that is currently standardized. So as the item appears in the IRF-PAI and appears in the OASIS, it is how the item appears today.

So – but it's a good catch. Those types of comorbidities may be standardized in the future, maybe not. I don't know. But that item is currently not an item that has been proposed and finalized for standardization.

In terms of who's monitoring that type of standardization and item, kind of like sharing between providers –so I work in the Division of Chronic and Post-Acute Care, and we develop the assessment and the measures and we help build the quality reporting programs from soup to nuts. And we do a lot of the monitoring and evaluation of the data that are coming in. So I think it can link back to us.

The one thing I want to tell you is that the items that are being standardized to meet the mandates, to meet the law, the IMPACT Act – those are mandatory items for collection. They affect a person's or a provider's or a facility's APU. So, if you have, for example, item J1900C, which has been proposed and finalized for the falls with major injury quality measure in IRFs, SNFs, and LTCHs, providers are collecting on that one item as it's a mandatory collection, it's a failure-to-submit item. And that data are coming into CMS.
And then CMS leverages systems, technological – like systems you know through the vendor services. And we monitor the data that are coming in, making sure that the data

are accurate, if there's errors, they're not – you know, they're attributable – we know why the error exists. And then we're able to link and compare that data.

So the comparison is a statistical discussion. That's a whole another, you know, discussion for another day. But we're able to see if that data are coming in. The data are a mandatory collection. So there's a whole group at CMS who monitors and really collects – really is seeing if that data is coming in.

To that end, on our assessment instruments, J1900C is the only item that's used for standardization for falls with major injuries. There are no major injury items that compete with that. So if it's a mandatory collection, all providers are hypothetically or parenthetically collecting on it.

Does that help a little bit?

Alice Black: Well, it sounds like...

Tara McMullen: …there's only a small handful of items that are finalized to this day right now.

Alice Black: It sounds like you are saying it's only those items that we can be sure will be the same across instruments. Anything else is kind of up for grabs.

Tara McMullen: Well, no, not up for grabs. There are a small number of items that are used to calculate a small number of measures that are standardized to this point. The other items – so, the assessment instruments still stand along—the OASIS for home health, MDS for SNF and home – nursing home, IRF-PAI for IRF. There are items that are appropriately – that are in those assessment instruments that are appropriate for that – for those populations. So it's not up for grabs.

Alice Black: Right, I understand that.

Tara McMullen: Yes. It is not up for grabs per se.

Alice Black: Well, what I mean is it was the same item added to two instruments differently. And, like I said, I think one is just a mistake. But, it just made me wonder if

there was someone looking at both instruments at the same time. And it sounds like unless the item is a standardized item, like you were saying, that that maybe is not happening.

Tara McMullen: Yes. Different – remember, going back to slide 8 or 9, items have many uses. So different items appear in different assessment instruments for different reasons.

Alice Black: But, it looked like on slide 16 that that was standardized item. It's M1028 on the OASIS, the covariate in your pressure ulcer measure.

Tara McMullen: Yes. These items are used for different reasons.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Therese DiSilvestro.

Therese DiSilvestro: Hi. Thank you for taking my question. So, first, this is a comment. I was actually on that SNF Open Door Forum call last week, and I was actually the person that asked the question about dashing the weight because, in some cases, the RAI manual does instruct you to dash. For example, if the patient has severe pain and can't be weighed, then you are to dash it. And it's just unfortunate that the centers are, you know, going to be subject to that 2-percent penalty under the Quality Reporting Program.

The response from the person doing the ODF was that they didn't know if that dash would be, you know, held against us under that 2-percent reporting requirement. But you just said that, yes, it would be – we would get dinged for that. So that's just my first comment.

But my question is, I actually attended the Quality Reporting Program training that was held in Chicago in August. And I'm looking at the slide deck. And for the numerator for pressure ulcers, it is the M0300. But your numerator on the slide are the M0800. And we did get an update just for the pressure ulcer spec. So, now I am confused because earlier you were saying that that was not an update?

Tara McMullen: Yes. Hi. Thank you. It's Tara McMullen again. I was going to provide an update at the end of the questioning. You are correct. M0800 is used for the long stay measure. M0300 is used as a denominator exclusion in the SNF QRP measure. The confusion is that for the same denominator exclusions for IRF and LTCH, they use M0800.

Therese DiSilvestro: Okay.

Tara McMullen: So, that's right. We will ensure that slide is updated for the MDS and defend – really begin to delineate the MDS being either SNF or nursing home. So thank you. And thank you to the first gentleman who pointed that out. I appreciate that.

Therese DiSilvestro: Okay. And, then – thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Christi Sifri.

Christi Sifri: Hi. Yes. Thank you for taking my call. So, I am with an LTCH in Washington State. And on slide 11, we talk about how the data elements are to follow a patient through – from acute care through their post-acute care experience to home and into the community. And my question is, How are these data elements weighted when the patient that is in the LTCH post their short stay hospital experience is far different than the patient that may be discharged to skilled nursing as far as the number of comorbidities, the number of days they were in the ICU, the presence or absence of mechanical ventilation?

So, if that data element – any given data element is following that patient through, how are these risk adjustments made to really understand the difference in the patient populations at each of these levels?

Tara McMullen: Yes. Thank you. It's Tara McMullen again. That's a really, really great question. And I appreciate it. I appreciate all these questions. So I'm going to walk through this one a little bit.

So, when we're developing – so, you're right. We want to – we want data to follow the person. It's what that graphic shows. And in doing that, how we have conceptualized standardization under the IMPACT Act is taking a core data element and adding it into the assessment instruments to be able to collect on the same data at different cut points or periods in time and to figure out a way statistically or analytically, to compare that data. And that's kind of where we are now. How do data really compare? Do you pull data? What can we do to give a good generalizable outcome?

However, when we use that item in the quality measure, of course, we talked about risk models. And we have banks of items that are used. I mean, it could be hundreds of items that are used in a risk model to level out that playing field. That is one way that we kind of weight out what we're assessing between the LTCH and, say, the home health. The risk models aren't – do not have to be identical under the act.

We've looked at this and we've assessed this. It's nearly impossible to compare an LTCH to a home health under the same risk model because the case mixes are very different. So we risk adjust appropriately for the case mix to be able to determine or weight out some of those major differences in the population.

Another thing we do is we look at stratification. We look at different denominator exclusions. I mean, a lot of our exclusions are the same across quality measures. But, if you notice, some of the standardized measures leverage different exclusions. That's something that we do to be able to weight out and help with comparable outcomes. Of course, there's also weight data outcome. But, we're not to that point yet.

Christi Sifri: Okay. So, in the example of the pressure ulcer measure, the covariates, the risk adjustments that are listed there – are those complete?

Tara McMullen: Oh, they're always – we're always working on that risk model. So, at the point in time of when this slide was developed, and it is, again, as we just pointed out a little bit outdated – at the point in time, these covariates are what were finalized for the quality measure – the standardized quality measure. But we are always looking and testing for different coefficients to see how they act.

Christi Sifri: Okay.

Tara McMullen: So, completed…

Tara McMullen: …It's sort of a fluid process. You see – as we get the data in, we're always monitoring that.

Christi Sifri: Okay. And, so, presence or absence of dialysis per se, where an LTCH – you know, or LTCH patients that come to us with pressure ulcers frequently are on dialysis, and that impacts their ability to transfer to their next level of care and for the ability of that pressure ulcer to heal. That would be, for example, a covariate that you would be looking at down the road before you added it into the risk adjustment piece.

Tara McMullen: Yes. Or it is probably a covariate that we've already looked at. It just wasn't significant.

Christi Sifri: Okay.

Tara McMullen: So, it wasn't included in the final model. We have, you know, the data sets and we test – I mean, we test hundreds of covariates to see how they act within a model among one another, and it just may have not been significant. Dialysis is one that I'm very familiar with, that and hospices, they're kind of some of the usual suspects that we take a close eye to.

Christi Sifri: Yes.

Tara McMullen: And, sometimes they're just not significant, depending on the quality measure. And that doesn't mean anything. It's just how the data talk, how their – what the data show us. But we continuously go back and, as the data come in, we re-review those models.

Leah Nguyen: Thank you.

Christi Sifri: Thank you.

Operator: Your next question comes from the line of April Mundy and Diana Devine.

(Unidentified female): Hi there. We were just curious if we have a projection date for the IRF Compare site for the data elements.

Leah Nguyen: Hold on one moment.

Michelle Brazil: So, you know, we're currently building the infrastructure for both the compare sites, specifically IRF and LTCH. But we don't have a definitive date. As we get closer to the timeframe, we'll post an announcement through our Spotlight page on the IRF QRP Spotlight. We'll also send out a Listserv announcement. I know they posted in the rule, I believe—and correct me if I am wrong—that it would be sometime late fall, early winter. And so that's on target.

(Unidentified female): Okay. Thank you.

Leah Nguyen: Thank you.

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

Scott Reid: Hi. Yes. A question for you about the pressure ulcer measure. What portion of the total does that account for? That is, the success on reporting that individual measure – is that 5 percent of the total or 20 percent of the total? I'm just trying to kind of get a sense for how much it counts for relative to all the other vendors.

Tara McMullen: This is Tara McMullen. There is no response to that. Are you talking about the data outcome overall for comparability?

Scott Reid: Yes.

Tara McMullen: We don't – we don't compare in that manner.

Scott Reid: Okay.

Leah Nguyen: Thank you.

Scott Reid: Thank you.

Operator: Your next question comes from the line of Shanthi Narayanan.

Shanthi Narayanan: Hi. Thanks for taking my question. This is – this pertains to pressure ulcers. How do you account for – on size variation during the course of treatment and the treatment plan captured as data elements?

Tara McMullen: Yes. Thank you so much. Once again, if you can send that question into our Post-Acute Care Quality Initiatives mailbox, we have a clinical expert on our team who will be able to help with that type of guidance and respond.

Shanthi Narayanan: Okay. And my next question is, Is the quality measure number developed for reporting pressure ulcers for 2017?

Tara McMullen: Let me repeat that question. Did you – did you state that the – what for 2017? That we are proposing a quality measure or...

Shanthi Narayanan: Yes.

Tara McMullen: Okay. So, for SNF and IRF and LTCH...

Shanthi Narayanan: Yes.

Tara McMullen: ...we proposed and finalized the quality measure pressure ulcers new or worsening for a specified application date of 2016. So, we're actually collecting on that IMPACT Act measure now. And for home health, we proposed and finalized in our calendar year '16 rule that measure as well. And the specified application date or the start date of collection is January 1st, 2017.

Shanthi Narayanan: Thank you.

Tara McMullen: Does that – does that help? Okay.

Leah Nguyen: Thank you.

Shanthi Narayanan: Thank you.

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

Your next question comes from the line of Snezhana Muzechuk.

Snezhana Muzechuk: Yes. Hello. My question is a more general one. Who and how do they select concepts and, also, who and how selects and weighs in on data items in the measures?

Tara McMullen: Hi, Anna. This is Tara McMullen. That's a really good question. I'm glad you asked that. It's kind of one of my favorites. So, gaps in quality of care – of course, we have experts at CMS who look at, you know, the field and they're looking at the National Quality Strategy.

But a lot of what we know internally are driven by people like you—who sit on technical expert panels, who supply comments in public comment period, who write in to us and tell us what you are seeing in the field. And so a lot of what we're doing and churning out is – you know, of course, it's driven by Congress and what we're seeing by our strategies, but a lot of what our stakeholders and the general public are telling us.

And so, as we go through the measurement cycle—and we have this information on the Post-Acute Care Quality Initiatives webpage in a specific slide deck—there's a measurement life cycle we go through in development of items and measures. And within that life cycle, there are many opportunities—we call them consensus vetting with the public – for the public to become involved in our development. So, it's not like – it's not everything's developed in a box or a silo.

We reach out to the public through technical expert panels and we post our specifications and ask for comment through solicitations of comments. And we gather groups of clinical experts and we post our information and ask for feedback to our mailboxes like the Post-Acute Care Quality Initiatives webpage.
And many times, we end up meeting with organizations to see – to kind of pick their brain and see what we are doing, if we're headed in the right direction.

Snezhana Muzechuk: Okay. Thank you.

Operator: Your next question comes from the line of Diana Kornetti.

Diana Kornetti: Hi. Thank you for taking my call. I'm referring to the graphic on slide 11. And looking at the develop – you know, the data elements, how they fit within measure development—and I'm asking you to maybe to project into the future—but with all the data you're crunching, my question is, If we're carrying this information forward as patient-centered care, is there the opportunity in the future as the data comes in and to look at those post-acute settings where people go for their first stop after acute care to have a way of – or develop some sort of analytics or some sort of recommendation for the presentation of the patient at time of discharge from acute care is predetermined based on – based on how they do in these different settings with these different measures? I hope I made that clear.

Tara McMullen: Hi, Diana. It's Tara McMullen.

Diana Kornetti: Hi.

Tara McMullen: Hi. I'm not exactly sure what the question is. Are you asking about data transfer at discharge?

Diana Kornetti: Yes. Well, what I am looking at is, I see that the arrows go both ways. Everything's geared towards patient-centered care. And right now we are looking at how these measures perform across the post-acute setting.

Tara McMullen: Right.

Diana Kornetti: And I know they don't impact acute care. But my question is, as the data comes in down the road, I'm wondering if it has the ability at – with patients that look a certain way, that they are more successful or there's better outcomes in certain post-acute settings for certain types of conditions or severity of conditions.

And I was wondering if the intent or the possibility exists where, you know, when we look at pressure ulcers and we look at how they function, we look at, you know, how they present on these different measurements – OASIS, IRF-PAI, MDS – if that has the ability to say we're finding best success in this type of post-acute setting; therefore,

there will be analytics or data that supports discharge to a specific setting upon – from acute care.

Tara McMullen: Yes. Diana, that's a really great question, a really great observation. And, I think, that's what we are attempting to be able to assess overall longitudinally. Building those longitudinal data sets is basically everything that you just encompassed in that question. How are the data acting? Are we improving care coordination, discharge planning? Are we improving even communication between providers who are in the same care setting? You know – so, a lot of this is yet to be determined.

As you know, we're moving in phased approaches with the IMPACT Act, and we really have just begun a lot of our collection of that data. So we're hoping that sometime in the future that we can see these trends and we can speak to them, and then really look beyond post-acute care to home- and community-based settings, to acute care settings and be able to see what's going on through interoperable data collection and exchange.

Diana Kornetti: Well, thank you. And my final – my final comment on that is if we look at those national quality strategies, one of them is the prevention. And so, if we see how these items perform, I'm wondering, you know – and that's down the road, of course; this's just projected...

Tara McMullen: Yes.

Diana Kornetti: ...how they would look if we can contribute to more of a preventative sort of mindset and never ending up in the hospital to begin with.

Tara McMullen: Right.

Diana Kornetti: So, thank you very much.

Tara McMullen: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Joel Van Eaton.

Joel Van Eaton: Thank you. And thank you for validating the issue with the M0300 versus M0800. I just wanted to make a comment on the NQF 0678. In the Quality Measure Manual Version 10, the NQF endorsed a quality measure. It continues to use M0800. And, obviously, for that, that's appropriate. If there could be some clarification—or I don't know if there's a different number, but they're two different measures with us, a totally different SNF denominator in each of those measures, but they are using the same number currently.

So, maybe a comment would be just to either clarify that or update either the QRP specifications or the MDS 3.0 Quality Measure Manual. And then, also, I know that I've read somewhere, but I just want to validate the issue that the risk-adjusted items do account for data items that would be missing in relationship to the 2-percent reduction. So, thank you.

Tara McMullen: Yes. Exactly. It's Tara McMullen. Yes, exactly, for the 2-percent deduction. And we absolutely hear people's concerns about weight specifically for that. And I have taken notes. So, thank you to everyone who has pointed that out. We will look into that.

And, Joel, for 0678, yes, there are two versions of the measure that have been endorsed. The endorsement has run – so, 0679, I believe, was for nursing homes and 0678 stems into an expansion endorsement for IRFs and LTCHs. So, that kind of is the existence or reasoning for why there's two different packages.

But, I think, you raised a valid point. And we will make sure that we can clarify the numbering and which goes where. We know that there are a lot of measures and a lot of settings and it can create some confusion. So we will be more clear or clearer in that approach. Thank you.

Joel Van Eaton: All right. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Mary Madison.

Mary Madison: Good afternoon. Mary Madison with Briggs Healthcare. Thanks to Joel for both of the times that he called in with that question. That was exactly my question because we are using M0800 for the quality measure short stay and M0300 for the SNF QRP. So, thanks to Joel on both counts.

My question as I lead the ability to speak at this time is, Will we see the slide number 16 corrected from the MDS for the skilled facilities, that the numerator is not the M0800, it is M0300?

Tara McMullen: Yes, you will. We will break it out for nursing home and SNF. So, just a clarification, Mary, and I guess for everyone on the phone. There is a nursing home measure for long stay and there is a SNF QRP measure for Part A stays. Okay. So, there's two measures.

Mary Madison: Right. Yes.

Tara McMullen: That's the confusion, I think, that's coming up. And, I think Joel raises a good point. So, we will revise this slide. We will put the nursing home, long stay measure, which is currently leveraged on Nursing Home Compare for the Nursing Home Quality Initiative. And we'll also put the SNF measure, which is currently being collected for the SNF Quality Reporting Program as mandated under the IMPACT Act and those differences.

Would that be clearer for everyone?

Mary Madison: That would help. Anything to lessen the confusion. We have enough of that.

Tara McMullen: You got it. You got it…

Mary Madison: Thank you, Tara. I appreciate it.

Tara McMullen: Yes.

Leah Nguyen: And this is Leah Nguyen. The revised slide presentation will have the same URL as this presentation. And then we'll also have post-call clarification document on the call information page as well that notes this change.

Mary Madison: Thank you very much.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Andrew Baird.

Andrew Baird: Hi, there. This is Andrew Baird with HealthSouth. Thanks for taking the time to talk through some of these issues. My question really stems from a comment that was made a few minutes ago about a lot of the design of these items and elements being generated from feedback from the general public.

It's been our experience when these are being developed, you know, at the blueprint level, at the very initial level, any sort of data item or element, that they are coming mainly under contracting from a CMS contractor. Oftentimes, those comment periods have been less than or about 2 weeks in length. And it's become very difficult to provide meaningful, substantive feedback within such a short amount of time. In some cases, they are as short as 10 days. So, my question is – and it's more of a request – would you all be willing to consider opening up those public comment timelines to lengthier periods, if not a 30-day – you know, if not a full 60-day comment period, which many people are accustomed to, at least – at least a month, at least 30 days.

And the other question that I have regarding those public comments is, Would it be possible to make the feedback that CMS receives in those initial blueprint phases truly, you know, available to the public? I think most people understand public comment periods to be ones where when comments are submitted, it enables people to go and see, you know, what has been said, sort of what the community is saying about certain things. And that feedback is often really helpful for, you know, other people in the community sort of in an open source format to consider what is the consensus or what is the thinking around these ideas.

So, those two questions – you know, could you all extend the period a little longer to enable us to provide more meaningful feedback? And would you be willing to open up

those comments for public viewing, you know, after they've been reviewed and considered? Thanks.

Tara McMullen: Hi, Andrew. It's Tara. This is one of my favorite questions. And the answer is, yes, we can grant that for you. So, the blueprint public comment period – CMS is at a – via the blueprint, is at kind of a stance where we have – we should open the public comment period at least 2 weeks. So, it's not 10 days. So, we're opening comments for at least 2 weeks or more. That's at the discretion of CMS and not CMS's measures contractors but CMS itself. But, yes, we can lengthen out our public comment periods.

In fact, you'll see this case in point. We have a couple comment periods that will be posted for IMPACT Act quality measures, and the comment period will be 30 days for those measures. And right now we have an active comment period on our SNF Quality Reporting Program measures that we're developing for function. And we have lengthened out that comment period to 30 days. And I believe the transfer of health measure that CMS will be developing will be a 30-day public comment period. So, yes, your answer – the answer is, yes, we can do that.

For the second question about posting comments, I would like to draw everyone's attention to – when CMS develops public comment summary documents, look at the back of that summary document. CMS posts all public comments verbatim. And we post that – those public comment summary documents on the Public Comment Summary Page, the MMS page – you can Google that – or on the Post-Acute Care Quality Initiatives webpage. All comments are always posted verbatim.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Nadine Heideman.

Nadine Heideman: Yes. Thank you for taking my call. All of this is for Medicare A patients. What are we doing about the HMOs for looking at resident-centered care and quality measures?

Tara McMullen: So, yes, I think – thank you. It's Tara McMullen. You're speaking to SNF QRP, I'm sure, the SNF Part As. At this time, we're assessing different populations for collection. Thank you.

Operator: Your next question comes from the line of Robert Latz.

Robert Latz: Hello. Thank you. First off, I wanted to mention that it's a great presentation, great discussion that's going on. Really appreciate it. The two questions that I have are both related to the data elements within Section GG. And the first question related to that is if you have any idea if and when these data elements will be added to the home health OASIS assessment document.

And the second question related to this is looking at slide 11, when we talk about the data flow from acute to post-acute care settings, if data elements such as Section GG data elements are not collected in the acute care setting, how will they flow—or we recognize that they won't flow. So is there an idea to require those data elements in that setting at some point?

Tara McMullen: Thanks, Robert. This is Tara McMullen. These are good questions. I can't speak to all the plans. The only thing I could say is under the IMPACT Act for the home health setting for the OASIS assessment instrument, there is a specified application date of January 1st, 2019, for functional status data. Thank you.

Leah Nguyen: Thank you.

Robert Latz: Thank you.

Operator: You have a follow-up question from the line of Joel Van Eaton.

Joel Van Eaton: Thank you. Just one note real quickly, because I knew I'd read this somewhere. There was a document posted – it was a transition document – to the SNF QRP website. It was called "SNF QRP Questions from Training, August 2016." And in that document it is clear that the risk-adjustment items will impact the 2 percent. So anybody who wants something printed that actually says that or needs that, that's where that's located. Thank you.

Leah Nguyen: Thank you.

Operator: And there are no more questions at this time. I'd now like to turn the call back over to Leah Nguyen.

Additional Information

Leah Nguyen: Thank you.

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 MLN Connects Provider eNews when these are available.

On slide 24 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary.

Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's MLN Connect Call on the IMPACT Act. Have a great day, everyone.

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

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