

CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Jill Darling
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2:00 p.m. ET

Operator: Good afternoon. My name is Brianna and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare & Medicaid Services Special Open Door Forum, Understanding the IMPACT Act Measure Alignment and IMPACT Outcomes.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your questions, press the pound key.

Thank you. Jill Darling, you may begin your conference.

Jill Darling: Thank you, Brianna. Good morning and good afternoon everyone. My name is Jill Darling in the CMS Office of Communication. Thank you for joining us today for this Special Open Door Forum.

Just a small note before we begin, the Special Open Door Forum is not intended for the press. So, if you are press, please send your inquiries to press@cms.hhs.gov.

Just a note, if you did receive the announcement for this Special Open Door Forum in the middle of the announcement is an email box to submit your questions beforehand and if there's not enough time during the call, please send your questions and comments to the inbox after the call as well and there is also a link for PowerPoint slide to follow along with the call.

So, now I will hand the call off to Alan Levitt.

Alan Levitt:

Well, thank you, Jill. My name is Alan Levitt and I'm the Medical Officer in the division of chronic and post-acute care at CMS. Today, I'm here with colleagues from my division, Dr. Tara McMullen, senior analyst, and Stella or Stacy Mandl, Deputy Director, and we are here to discuss Understanding the IMPACT Act, Measure Alignment and IMPACT Act Outcomes to be followed by a question and answer session.

Next slide. I'll first start with-a brief review of CMS' post-acute care quality reporting programs. The Department of Health and Human Services and CMS began launching quality initiatives in 2001 to ensure quality healthcare for all Americans through accountability and public disclosure. As part of the national nursing home quality initiative launched in 2002, quality indicator information became available to the public via the Nursing Home Compare website.

In addition, since fall 2003, CMS has posted quality performance information on the Home Health Compare website. The home health quality reporting program was mandated in the Deficit Reduction Act of 2005. For calendar year 2007 and for subsequent years, home health agencies are required to submit quality data or be subject to a 2% reduction in payment rates.

Section 3004 of the Patient Protection and Affordable Care Act authorized quality reporting for long-term care hospitals, inpatient rehabilitation hospitals or facilities and hospice programs. Starting the in fiscal year 2014, quality data needed to be submitted or else providers in these settings were subject to a 2% reduction in their market basket increase. This quality data also needed to be publicly available after the ability of the providers to review the data. As finalized in this past year's rule, starting in fall 2016, quality measures will begin to be publicly recorded in the inpatient rehabilitation facility and Long-Term Care Hospital Quality Reporting Programs. Plans for public reporting of quality measures in the hospice quality reporting program will be announced in future rulemaking.

Section 2015 of PAMA, the Protecting Access to Medicare Act of 2014, mandates CMS to establish a Skilled Nursing Facility Value-Based Purchasing Program or SNF-VBP which will apply to payments for services furnished on or after October 1, 2018.

Finally, as I'll mention later, the IMPACT Act requires that CMS establish the Skilled Nursing Facility Quality Reporting Program or SNF-QRP.

Next slide. The recognized need for standardized patient assessment data goes back a long time, but for the purposes of today we will start with MedPAC, who recommended in 1999 a core set of assessment information across post-acute care settings and have reiterated this recommendation up until the present day.

In 2000, as part of the Benefits Improvement and Protection Act or BIPA, Congress required CMS to report on developing standardized assessment instruments. In 2005, Congress directed CMS to test the concept of a common standardized assessment tool in the Post-Acute Care Payment Reform Demonstration or PAC-PRD. As part of the PAC-PRD, CMS developed the Continuity Assessment Record and Evaluation or CARE item set.

In 2011, CMS reported back to Congress on the successful consensus building development and reliability testing of the standardized items in the CARE item set, positive feedback on these items and that patient characteristics can be used to explain variation in resource use.

In 2013, Congress held a hearing on post-acute care reform, and sent a letter to stakeholders soliciting feedback on the subject. As Congress later noted, "the resounding theme across the more than 70 letters received was the need for standardized post-acute assessment data across Medicare PAC provider settings."

Next slide. And so came the IMPACT Act the following year, overwhelmingly supported by both parties and both chambers of Congress have signed into law by President Obama on October 6, 2014. The IMPACT Act requires standardized and interoperable patient assessment data that will

enable data element uniformity, quality care and improved outcomes, comparison of quality and data across post-acute care settings, improved discharge planning, exchangeability of data and coordinated care.

Next slide. Specifically, the IMPACT Act requires post-acute care providers to report standardized patient assessment data, data on quality measures with respect to at least six domains including functional status, cognitive function and changes in function and cognitive function, skin integrity and changes in skin integrity, medication reconciliation, incidence of major falls and providing for the transfer of health information and care preferences, and data on resource use and other measures with respect to at least the domains of resource use measures including total estimated Medicare spending per beneficiary, discharge to community and measures to reflect all condition risk adjusted potentially preventable hospital readmission rates.

I'll now turn to Stacey Mandel to continue today's presentation.

Stacey Mandel: Thank you and good afternoon and good morning to the folks in the west coast areas of the nation. I'm Stacey Mandel I'm starting on slide six, "driving forces of the IMPACT Act." There are multiple purposes I would like to highlight which is actually not on the slide but that the IMPACT Act really had an intent – that through it, it brings forward with it, person centered care-- - where information and data can file the person.

What's very unique about the IMPACT Act is that the information and data are to enable real time use of information to help inform care coordination as an individual transitions across multiple settings and their trajectory of care. So, overall for the improvement of Beneficiary outcomes, supporting exchange of information among post-acute care and other providers, is critical. As folks are probably very aware, post-acute care providers were not included in the incentivized funding for EHR adoption and engagement in health information exchange.

The IMPACT Act puts into place what may enable post-acute care providers in their adoption of health information technology and engagement in health information exchange –through the use of standardized data. Because of the

uniform data, providers will have access to longitudinal information to facilitate coordinated care and to be able to transfer that information as appropriate across provider types to inform the receiving facility.

Furthermore, the standardized data, really more from a perspective of uniform data, will enable comparable data and quality across post-acute care provider types. Also as you are aware, part of the requirements in the IMPACT Act is the use of comparable data to improve hospital discharge planning through the use of measures and information-- for enabling patient and individual centered decision making, in deciding where they want to go in their trajectory of services.

And why the attention on post-acute care, one is sort of the obvious escalating costs associated with post-acute care. The other is the lack of data standards and interoperability across post-acute care providers not only across post-acute care providers but also with the other provider types, and movement away from a fragmented system of communications to an integrated system through standardized information. And then to enable research related to a payment model that is based on individual characteristics rather than on a provider type.

On to slide seven, when we talk about cost, this slide presents the four separate provider types LTCH, IRFs, home health, agencies and nursing homes where the cost combined on an average annual amount for Medicare spending is about \$60 billion – that's billion with a B. So, this slide is really to just sort of provide the business case in part for part of what was behind the IMPACT Act. So, I won't belabor or read out loud the four different types of providers but it is interesting information about the services and costs.

The next slide is slide eight and there is quite a bit of information on this slide and really this is what the standardized data look like and what it is enabled.

So, on the top left corner, there is a picture of an assessment question pertaining to function and specific questions pertaining to function and the options on how to respond to the question on the left where it says coding.

When we talk about standardized data elements and response codes that is what we're talking about.

When we discussed the ability to exchange information, the questions in here and the response codes, when standardized are more likely to be able to be transferable across, in the sort of the technical sense, across providers.

Furthermore, as we begin to develop uniform definitions and approaches to communicating, the more standardized one becomes and their communication becomes more efficient such that information can be not only transferred electronically but it also can be communicated more effectively in general. So, it is in part about coming up with uniform definitions scales and so on and so forth.

For example, an important part of the importance behind standardization is the ability to collect once so that one particular data element and response code, or question and response code, pertaining to function could inform all of the following: care planning and decision making, quality improvement at the local level by the provider, payment, quality reporting and care transition.

So, information on where an individual is performing in their functional assessment could be used in real time for all of those purposes. And that is part of the importance of understanding the power behind, collecting information once, and using it multiple times. Obviously, the largest (effect) that we are seeking is better care, healthier individuals, smarter spending.

And at the bottom of the slide is simply again the pictures of all the four provider types affected specifically by the requirements under the IMPACT Act under Section 2A.

Thank you. And now I would like to turn the presentation over to my colleague, Dr. Tara McMullen.

Tara McMullen: All right, thank you, Alan and Stacy, for this discussion about the IMPACT Act and now we're going to build on this discussion and walk through the requirements set forth as mandated by the IMPACT Act.

To start, we draw your attention to the graphic on slide nine. The IMPACT Act legislation is packed with a lot of information and details and dates. Overall or in particular for this presentation, we're going to focus on two key areas. The IMPACT Act mandates, two very large tasks: the development of standardized measures for post-acute care that is for home health agencies, long-term care hospitals, inpatient rehabilitation facilities as well as skilled nursing facilities, and the standardization of data items or data elements -and those are defined by clinical assessment categories.

To start on the next slide, slide 10, we're going to review the mandates for the standardization of measures. So looking at slide 10 here you see a couple quality measure domains and timelines.

The IMPACT Act requires that CMS develop and implement measures from five measure domains using standardized assessment data, quality measures to be standardized by CMS fall under the following domains skin integrity and changes in the skin integrity, functional status, cognitive function, and changes in function and cognitive function, medication reconciliation, incidence of major falls, and the transfer of health information and care preferences when an individual transitions.

In addition to these five measure categories, the Act also defines resource use of other measure domains with measures in the following domain categories, resource use measures including total estimated Medicare spending per beneficiary, discharge to the community and all condition risk adjusted, and potentially preventable hospital readmission rate.

On slide 10, you'll see here that we have three of the first domains listed – functional status, skin integrity and medication reconciliation and we have some dates associated with those domains. So, specifically with domain number one, functional status, cognitive function and changes in function and cognitive function, you see the following specified application date for the four post-acute care settings.

A specified application date of October 1st, 2016 for SNFs and IRFs and specified application date of October 1st, 2018 for LTCHs and a specified

application date for home health agencies of January 1st, 2019. For the domain of skin integrity and changes in the skin integrity you see specified application date of October 1st, 2016 for SNFs and IRFs, specified application date of October 1st for LTCHs and specified application date of January 1st, 2017 for home health agencies.

For medication reconciliation, you see for home health agencies a specified application date of January 1, 2017 and a specified application date of October 1st, 2018 for SNFs, IRFs and LTCHs.

On slide 11, you see on domain number four incidence of major falls, with a specified application date for SNFs and IRFs and LTCHs of October 1st, 2016 and a specified application date for home health agencies of January 1, 2019. For our fifth domain, the communicating the existence of and providing for the transfer of health information and care preferences, you see a specified application date of October 1st, 2018 for SNFs, IRFs and LTCHs and a specified application date of January 1st, 2019 home health agencies.

And finally in our domain buckets of resource use and other measures, the total estimated Medicare spending per beneficiary, often acronym is “MSPB”, discharge to community, and the potentially preventable hospital readmission rate measure, you see a specified application date of October 1st, 2016 for SNFs, IRFs and LTCHs and a specified application date of January 1st, 2017 home health agencies.

It should be noted that the measures domains provided in the Act are not exhaustive and can be extended any time as specified by Secretary.

Moving in to slide 12, so you see that October 1st, 2016 is the earliest of implementation dates delineated in the Act and there are remaining timeframes for the measure implementation and they're kind of tiered, you see them tiered by setting and by measure category, that should be noted as a feature that the IMPACT Act is in phases.

CMS in addition has interpreted the IMPACT Act to have specific steps or phasing in terms of the implementation of these defined quality measures. So,

along with the phasing of the actual specified application date, the statute also calls out steps to the measures the development and the specification of these measures to include the implementation of these measures, to propose these measures in rule making and specify how that data collection will occur.

This step of phasing also includes the development of private provider reports. That is, CMS must provide private provider feedback reports one year after the implementation of these measures or the quality measures followed by public reporting two years after the implementation of the measures by the specified application date.

The second and third phases that you see listed in this slide on slide 12, speak to the measure vetting by a consensus-based entity such as the National Quality Forum. CMS adds our measures to the annual Measures Under Consideration list often termed the MUC list, to be reviewed by the Measures Application Partnership otherwise known as the MAP.

CMS has added measures for review to 2015 MUC list as well as the 2014 Ad Hoc MUC list. Both of these lists from 2014 and 2015 have been reviewed by the MAP. Overall, CMS recognizes that the implementation of measures will take time. This will; will take some time to develop fully.

To meet the October 2016 implementation date for measure domain specified under the IMPACT Act, CMS has taken the following considerations: Measures must address the current area for improvement that is tied to a stated domain within the Act, consideration of measures already previewed have to have support by the MAP, they should be endorsed or implemented or proposed to be finalized in the post-acute care rules for the use in the QRPs. Measures should minimize added burden to the providers. Where possible, measures should avoid any impact on current assessment items that are already being collected and where possible measures, should avoid the duplication of existing assessment concepts.

Moving in to slide 13, 14, 15 and 16 for sake of time – we will – we'll touch on these briefly but these slides delineate the measures that have been proposed and finalized in the fiscal year and calendar year 2016 rules.

So, on the first slide 13, this slide goes over the long-term care hospital measures that have been developed and finalized in the fiscal year 2016 rule- measures that meet the domain as specified by the IMPACT Act specifically to meet the domain of skin integrity. CMS has proposed and finalized the measure the percent of residents with pressure ulcers that are new and worsened.

To meet the domain of incidence and major falls, CMS has proposed and finalized the percent of residents experiencing one or more falls with major injury quality measure. And to meet the domain of function, CMS has proposed and finalized the application of the percent or the percent of LTCH patients with an admission and discharge functional assessment and care plan that addresses function.

Moving on the slide 14, for the home health quality reporting program for calendar year 2016, CMS has proposed and finalized under the domain of skin integrity the quality measure, the percent of residents or patients with pressure ulcers that are new or worsened.

On slide 15, for the SNF quality reporting program for in the calendar or fiscal year 2016 rule, CMS as proposed and finalized under the domain of skin integrity, the quality measure, the percent of residents with pressure ulcers that are new or worsening. Under the domain of incidence and major falls, the quality measures, the percent of residents experiencing one or more falls with major injury. And under the domain of function, the quality measure, the application of the percent of LTCH patients with admission and discharge functional assessment and the care plan that address this function.

On slide 16, you have the Inpatient Rehabilitation Facility Quality Reporting Program. This is IRFs. So, for the fiscal year 2016 rule under the domain of skin integrity, once again, CMS has proposed and finalized the quality measure, the percent of residents with pressure ulcers that are new or worsening. Under the domain of incidence of major falls, CMS has proposed and finalized the percent of residents experiencing one or more falls with major injury. And under the domain of function, CMS has proposed and

finalized an application of the percent of LTCH patients with admission and discharge functional assessment and the care plan that address this function.

Further for this QRP, CMS has proposed and finalized four additional outcomes based functional assessment measures, you see them listed here. They have the NQF measure ID of 2633, 2634, 2635, and 2636 – these are proposed and finalized, an addition we wanted to highlight as these are outcome based quality measures.

So moving in to slide 17, the second requirement as mandated by the IMPACT Act is the standardization of data items implemented underneath or within specified clinical assessment categories as mandated by the IMPACT Act. The categories as delineated in the Act that guide item development and standardization are: functional status such as mobility and self-care; cognitive function such as the ability to express ideas and to understand mental status, depression, and dementia; special services treatments and intervention such as ventilator use, dialysis, chemotherapy, central line TPN; medical conditions and co-morbidities such as diabetes, congestive heart failure, and pressure ulcers; impairments such as incontinence and the impaired ability to see, hear or swallow; and there are also other categories deemed necessary and appropriate by the secretary.

Moving in to slide 18, I believe yes, this is 18 – so, you'll see on the slide here that building from slide 17 that the use of standardized assessment data must be applied no later than, for SNFs, IRFs and LTCHs, October 1st, 2018 and for home health agencies no later than January 1, 2019. Data must be submitted with respect to admission and discharge for each patient or resident or person, or more frequently as required.

So now moving into 19, we're going to get into the crux of really what is standardization. So now that we know that IMPACT Act asks us to do: to standardize quality measures and asks us to standardize data items, the next question a lot of people ask us is, so what is the standardization?

So what you'll see here on Slide 19 is a – is a graphic of an item by item standardization. So CMS understands that standardization begins

quintessentially at the atomic level, the core clinical data element. In this slide, Slide 19, we demonstrate how standardization occurs at that element level, that one element is standardized, collected, encoded the same way across all settings, those post-acute care settings, to create standardized data outputs.

In our current states, CMS collects many items at the surface level are standardized, such as eating; however, when you assess how this item is collected, how it's coded, what are the response and question options- The items are not standardized to one another nor are they interoperable. They cannot talk to one another across each of the assessment instruments that we currently have for post-acute care. Those are the MDS, the OASIS, the IRF-PAI, the LTCH CARE Data Set. Thus, there is no one common language for data, and data are not interoperable. They're not standardized.

CMS by means of the IMPACT Act and before the IMPACT Act have taken steps to begin moving towards the ideal data standardization and interoperability at the data element level and we're doing this with many of our quality measures, but we're going to highlight one of the functional process quality measures that have been finalized in the IRF, LTCH and SNF Fiscal Year PPS Rules.

The functional process measure titled, the Percent of Patients, Residents and Persons with Admission and Discharge Functional Assessment and a care plan that addresses functions, uses the data source of CARE data from the CARE item set. This quality measure is finalized and is comprised of data elements such as eating that are nested within each of the settings' quality measure. Eating is in the IRF, the LTCH and the SNF quality measures and it's also collected via the IRF, SNF and LTCH assessment instruments in a new section called Section GG, functional abilities and goals.

This section has been finalized and you can find this assessment instrument mock-ups on our CMS web page. So in this way, we are collecting analogous information across PAC settings in a manner that is consistent in order to standardize to allow for data comparisons and outputs.

And then moving into Slide 20, we see a graphic here and what we're trying to say now in this graphic is that we know that while standardizing at the item level, we also recognize that standardization is not limited to this item to item alignment. The more that we move to the process of item and quality measure development and domain development, the more apparent it is that standardization quintessentially has a ripple effect.

So we see standardization through many lenses. It begins at that core atomic level, the core item with that data elements and then it grows into the alignment of response scales, the question and response options, into the measures, alignment through the assessment instruments, alignment through the reporting of and the collection of data, alignment into how we compare that data, alignment into how that data is used by the senders and receivers, and the collection of that data and so on.

So moving in to Slide 21, we have a few slides here that show you how CMS is beginning the standardization or the road to standardization through this item alignment and we're going to give you examples of the three quality measures that we have proposed and finalized in the IRF, LTCH and SNF rules, and one measure for home health.

So, the percent of LTCH patients with admission and discharge functional assessment and a care plan that addresses function, you'll see here on Slide 21 and 22 a graphic of the items that we have proposed to be nested within the new Section GG and where those items align.

Specifically on these two slides, you'll see that the direct alignment and standardization of the items in highlighted rows, highlighted in yellow. Those items that are highlighted in yellow are the items that are used to standardize and are used to calculate the standardized quality measures that have been proposed and finalized in our rules.

Moving into Slide 23, the percent of residents experiencing one or more falls with major injuries, you'll see that one item –J1900C has been proposed and finalized for in the IRF, SNF and LTCH rules. This item is used to calculate the quality measure overall and you'll see this item alignment.

Moving into Slide 24, to discuss the quality measure, the percent of residents with pressure ulcers that are new and worsened. This quality measure has been proposed and finalized in the IRF, SNF, LTCH and home health rules. You'll see here two items, M0800 and M1313 for the OASIS. These items are used to calculate the standardized quality measure.

So now we're going to shift and begin to close our discussion today. On Slide 25, you'll see here that we just speak to stakeholder engagement and how we work to get the general public become engaged in our work. Without you guys, we really – we really can't do this. Your input is invaluable.

You'll see on this table delineated are the measures that are currently under development and have been added to the 2015 Measures Under Consideration list, some key dates for technical expert panels as well as public comment periods. Just a note, if you're interested in adding comments for the total estimated Medicare spending for beneficiary measure, that comment period has been extended and is opened until this Friday, 11:59 p.m. that's the 5th of February.

So moving into Slide 26 and 27, you'll see that CMS is currently engaging in many outreach and communication efforts to get the information out to the general public and to our stakeholders and providers and everyone alike, also the caregivers –on what is really going on as we move to implementing the IMPACT Act.

So on Slide 26, you'll see that we have special open door forums like this one you're listening to today. We give updates through our eNews, and listening sessions. We are updating through MLN that's the Medicare Learning Network. We are developing YouTube videos and speaking at conferences.

And on Slide 27, you'll see here a few more outreach efforts through our Listserv and our special web page enhancements. So now, I'm going to turn it back to Dr. Levitt to complete the presentation and thank you.

Alan Levitt: Thank you. Thank you, Tara. We're up to Slide 28. Finally just to mention that the IMPACT Act requires CMS to establish the Skilled Nursing Facility Quality Reporting Program or SNF QRP.

Beginning with Fiscal Year 2018, skilled nursing facilities that do not submit data shall have payment rates during such fiscal year reduced by 2 percentage points. As Dr. McMullen noted earlier on Slide 15, in the Fiscal Year 2016 SNF PPS Final Rule, we adopted three cross-setting quality measures for the SNF QRP to meet the requirements of the IMPACT Act.

We can turn to the next slide. For more information on the IMPACT Act, please go to our web page. The link is provided on the slide – or submit your questions or comments to our e-mail box, PACqualityinitiative, P-A-C-quality initiative, no S at the end of initiative, @cms.hhs.gov.

So if you go to the next slide, speaking of questions, we do have a handful of questions that were submitted prior to today that we will now go through.

Stacey Mandel: Hi. Thank you. This is Stacey Mandel. Yes, just sort of a handful of questions that came in.

One pertains – it's the same question, but pertains to two measure domains under the IMPACT Act, the total estimated Medicare spending for beneficiary domain and the potentially preventable readmission domain, which actually had a longer title to it, but I would probably pass that.

So the question is does the risk adjusted readmission rate become part of the SNF CMS Five-Star Rating System and when does data collection starts. We wish to use this opportunity to clarify that the Nursing Home Compare Five-Star Initiative is a separate initiative from the SNF Quality Reporting Program established to satisfy the statutory required public reporting requirements of the IMPACT Act.

And then the second question that we tend to often get that we want to clarify is does the IMPACT Act require the submission of the single assessment instrument and I would – we would like to once again clarify that the IMPACT Act does not require the submission of a single solitary assessment instrument.

We always refer folks to review the statute to understand the underpinnings of the requirements that are – that are written within it, but it does clarify the existing instruments that would be modified. The secretary has discretion in this, but we do want to just reiterate that there is not a requirement for a single solitary assessment instrument.

The next question topic, which has come up, it pertains to hospice. The question is can you tell me if this will affect hospice agencies. We refer the listeners to the IMPACT Act again under Section III, which addresses requirements pertaining to the hospice survey schedules and other specifications and all the requirements that are within that section separately.

We want to reiterate that the IMPACT Act mandates standardized assessment data, data on quality measures and data on resources and other measures for the skilled nursing facilities, the long-term care hospitals, inpatient rehab facilities and the home health agencies.

And the next question pertains to critical access hospitals and swing beds. The question number one is does this affect critical access hospitals and have swing beds – and that have swing bed programs. Number two are swing bed providers part of the SNFs and affected by the IMPACT Act of 2014?

Again, we refer listeners to review the IMPACT Act for details pertaining to SNFs in relation to swing beds and swing beds within critical access hospitals. Currently our interpretation is that SNF QRP swing beds other than critical access hospital swing beds must submit data as required under the Act.

And that concludes sort of the high-level questions at this time allowing time for additional questions.

Jill Darling: Thank you to all of our speakers today. So (Brianna), we will open up for our Q&A session please.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Please limit your questions to one question and one follow-up to allow other participants time

for questions. If you require any further follow-up, you may press star one again to rejoin the queue.

Your first question comes from the line of (Gary I). Please state your organization. Your line is open.

(Gary I): Hello. Hello. My name is (Gary I) with TheraCare's in Park, New York and I was wondering I didn't – can't say specifically heard, but what is the date that penalties begin for not submitting information on the quality measures and what quality measures are going to be selected for skilled nursing facilities.

Stacey Mandel: So thank you for the question. So this is Stacey Mandel. For the quality – So every quality measure, you have to really look through the IMPACT Act for the measures and the timelines, but for the SNF Quality Reporting Program, we finalized last year in the SNF and that Fiscal Year 16 SNF PPS that the measures for these three domains, skin integrity, incidents of major falls and function would be implemented on October 1, 2016 for the Fiscal Year 2018 payment determination. And so you really want to – the details related to (timeframe) matter, submission of data and the associated annual payment update penalty, you want to just make sure that you're reviewing the federal register.

Alan Levitt: And the Fiscal Year 2018 payment begins on October 1, 2017.

Stacey Mandel: Right.

(Gary I): Right.

Stacey Mandel: OK. Thank you.

(Gary I): (Where) for more information on this be found in the federal register?

Stacey Mandel: You would want to look into the Fiscal Year 16 – Fiscal Year 2016 Skilled Nursing Facility Prospective Payment System federal register, so SNF PPS.

(Gary I): OK.

Operator: Your next question comes from the line of Robert Latz. Please state your organization. Your line is open.

Robert Latz: Latz with Trinity Rehab Services and my question is regarding the standardization and interoperability that was discussed on slides 19 through 22 and the question is related to LOINC codes and the fact that there were originally on the (Care two) of data set there were LOINC codes assigned and as I understand they are not LOINC codes with the Section GG, which is going to make it harder for us to do the interoperability. Do you know when those will be assigned or if you were looking toward that at this time?

Stacey Mandel: Hi. Thank you. We appreciate the question. We're currently working at mapping the standardized items to their HIT vocabularies including LOINC, SNOMED and so forth so that information we're actually, you know, that's one of the parallel tracks that we're on right now is working with the organizations like (Reagan Street) to obtain the necessary HIT vocabularies. It's a great question and thank you.

We are – There's a whole lot of sort of scrubbing and body checks going on pertaining to HIT vocabularies. We would encourage you to ...

Operator: Your next question comes ...

Stacey Mandel: ... if you haven't registered yet for the National Provider Call pertaining to HIT and standardization as a result of the IMPACT Act that's occurring this Thursday, February 4th ...

Female: From 2 to 3:30.

Stacey Mandel: from 2 to 3:30.

Stacey Mandel: Yes, if you go to the MLN Connects website, you can register there to join that call.

Operator: Your next question comes from the line of Doug Josephson with Hometown Pharmacy. Your line is open.

Doug Josephson: Thank you for the – for this conference. It's very interesting. One of the measure domains that's going to be standardized is medication reconciliation and I haven't heard a lot about how that is going to be standardized, what's being done to standardize the domain, what reporting will be done, quality measures, et cetera, can you speak to that at all? I know that that's kind of out there in 2018.

Stacey Mandel: Hi. This is Stacey Mandel again and I may have to defer to our senior analyst as well. The measure, the requirement of the IMPACT Act is the use of standardized items for this particular measure domain that has been under – went through public comments recently and that – forget when that comment period closed and the items associated with that.

The statute requires the implementation of that measure in home health agencies where the specified application date is January 1, 2017 and for IRF, SNF and LTCHs, October 1, 2018 so.

Tara McMullen: Yes, so the measure has been added to Measures Under Consideration list and actually the four measures for consideration were reviewed by the Measure Applications Partnership. The Measure Applications Partnership actually reviewed those four measures on December 14, 2015. That summary report is now on the NQF web page and you can actually link to the specifications on that the Measure Applications Panel reviewed. There are three specific items that are used to calculate that quality measure.

Doug Josephson: Great. Where is that located again, was it the NQF web page?

Tara McMullen: Yes, so I don't have the – off the cuff, I don't have it, but if you Google PAC LTC MAP, so Post-Acute Care ...

Doug Josephson: Yes.

Tara McMullen: ... Long-Term Care, Measure Application Partnership, it will come up. The front page will come up, the last page there.

Doug Josephson: Excellent.

Tara McMullen: Yes. And if you reach out to us if you have any other questions, we can link you to those reports as well.

Doug Josephson: Excellent. Will do. Thank you so much.

Alan Levitt: As well as the public comments document for the measure, which also goes over those items more specifically.

Tara McMullen: Yes.

Doug Josephson: OK.

Operator: Your next question comes from the line of Lisa Satterfield with ASHA. Your line is open.

Lisa Satterfield: Thank you. This is the American Speech-Language-Hearing Association. We have a question that can be looked at in Slide number 10, the quality measure domains and timelines that concerns domain number one functional status, cognitive function and changes in function and cognitive status.

Tara McMullen: Hi, Lisa. This is Tara McMullen. I could – I could barely hear you. I know you're asking about function, but I can't make out. Can you speak a little bit into the phone?

Lisa Satterfield: Sure.

Tara McMullen: Sorry about that.

Lisa Satterfield: Is this any better?

Tara McMullen: Oh yes, perfect. Thanks.

Lisa Satterfield: All right. The question is for the domains of functional status and cognitive function, how is CMS viewing who should be scoring these measures? These are not like ulcers or discharge, which you know you know where somebody is being discharged and you can measure an ulcer it's pretty observable and straightforward.

The level of education and training and expertise needed to judge cognitive function and often other types of functional status really seems to be the domain of a specialist and I'm hoping that you all can clarify whether or not these measures will be reported by specialist.

Stacey Mandel: Thanks for the question. It's a question that's been asked in previous years with the minimum data set and other assessment instruments such as the LTCH care data set and I believe even IRF-PAI.

CMS does not prescribe who needs to be performing assessment. Those are we defer really to the regulatory requirements for state and local municipalities and just a little – I'm a nurse and I will let you know that, you know, pressure ulcers can be evaluated by clinical nurses and we received this question often, so thank you for that comment. But we really – we don't dictate or prescribe who must be performing the assessments pertaining to function whether it's cognitive or physical assessments.

Lisa Satterfield: Given the high likelihood that these measures would be used to risk adjust the data, is CMS feeling confident that it is going to be getting quality data about functional status when it is not filled out by someone who knows the domain well?

Tara McMullen: So it's not about filling out the domain, it's about collecting on the items that are used to standardize the measure and the collection of those items in your assessment instrument now through means of, you know, the follow-up and assessing the patient. We feel that the items represent self-care and mobility activities that are common and take place, and we feel that those items would be useful for further measure development and if we use it for risk adjustment – risk adjustments.

Lisa Satterfield: Well that would be fine if the measures were based on observable behavioral (performance), but some of the measures that have been used and I think are under consideration require subjective judgments that are rated on a scale of how severe a person appears to be. This goes beyond an observable moment. I will stop talking. I think I've made my point. Thank you.

Tara McMullen: We appreciate that, Lisa. Thank you so much for that comment.

Stacey Mandel: Yes, we – and CMS always encourage providers to ensure training as training is necessary for assessments, and as part of the implementation of the IMPACT Act, we are working to be able to be providing training, such as train the trainer training for the assessment instruments.

Tara McMullen: Yes.

Stacey Mandel: ... that in November with LTCHs.

Tara McMullen: Tomorrow we have actually LTCH follow-up training where we do talk about Section GG items that are, you know, which items could be observable such as eating and, you know, tying your shoes and things like that, so we welcome everyone to dial in to that and there's information on our CMS web page about that follow-up webinar tomorrow.

Jill Darling: (Brianna), we'll take one more question, please.

Operator: OK. Your final question comes from the line of (Donna D'Cruz). Please state your organization. Your line is open.

(Donna D'Cruz): (Regina).

(Regina): The question is how often do we need to submit data, what is the frequency?

(Donna D'Cruz): This is Laguna Honda Hospital.

Stacey Mandel: Well hello to Laguna Honda Hospital. I know where that is. This is Stacey Mandel. The data – the assessment data submission timing is specific to the instruments and I would – I would I guess refer you to the manuals associated with the specific assessment instruments whether it's the LTCH's Quality Reporting Program Manual or the MDS RAI Manual and so on and so forth.

(Regina): Thank you.

Stacey Mandel: The assessment submission is an ongoing process.

Female: Yes, (they) mentioned discharge assumption of care.

Jill Darling: All right and then thanks everyone for joining today's call. We have some closing remarks.

Alan Levitt: Yes, again, this is Alan Levitt again and just wanted to thank everyone for joining and for participating in today's call. If you didn't have a chance to ask your question today, again, you can submit your comments or questions to our e-mail box at PACqualityinitiative@cms.hhs.gov, and everybody, have a great day.

Operator: This concludes today's conference call. You may now disconnect.

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