Centers for Medicare & Medicaid Services

Special Open Door Forum:
The IMPACT Act and Improving Care Coordination

Moderator: Sheila Mulligan

September 28, 2017

2:00 p.m. ET

Operator: Good afternoon. My name is (Amy) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare & Medicaid Services -- the IMPACT Act and Improving Care Coordination Special Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' 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 question, please press the pound key.

I would now like to turn the call over to Miss Sheila Mulligan. You may begin.

Sheila Mulligan: Thank you, (Amy). Good morning and good afternoon everyone. My name is Sheila Mulligan in the CMS Office of Communications. Thank you for joining us today for the IMPACT Act and Improving Care Coordination. We apologize for the delay in starting today's call and we appreciate your patience.

Before we begin, I have one brief announcement. The Special Open Door Forum is not intended for the press. Any remarks are not considered or on the record. If you are a member of the press, you may listen in but please refrain from asking questions during the Q&A portion of the call. If you have inquiries, please contact CMS at press@cms.hhs.gov. I'll repeat that, please contact CMS at press@cms.hhs.gov. Thank you.

I will now turn the call over to Charlayne Van for opening remarks.

Charlayne Van: Thanks Sheila. I'd like to thank everyone for joining us today for the Improving Medicare Post-Acute Care Transformation Act Special Open Door Forum. I'm joined by Dr. Maria Edelen, who will be updating us on projects that – I'm sorry, activities related to the RAND contract for item development. These updates will include pilot testing results, plans to the upcoming national field test and identifying opportunities for providers, consumers, stakeholders, researchers, and advocates to become involved in our project over the next year.

So with that said, I turn it over to Dr. Edelen.

Maria Edelen: Great. Thanks Char. My name is Maria Edelen. I'm the Director of the RAND contract who help with the development and maintenance of standardized patient assessment data. So, I think you all have access to the slide deck and I'm just going to refer to slides by number as I move through them.

I'm going to start with slide four now, the overview of the contract.

So if you've attended others of these, some of this is going to look familiar to you. Our project goal is to develop, implement and maintain standardized post-acute care patient assessment data. The project has three basic phases, and our phase was mostly comprised of gathering information around what patient data should be collected and should be considered for standardization and that had a lot of various activities around it.

Then we did some pilot testing in – starting in August of 2016 and we just came out of the field recently with our second feasibility test in July. And we're just gearing up now to do a national beta test which – where we're going to be training data collectors throughout October and November with rolling field start.

Our focus has been on the clinical domains outlined in the IMPACT Act including cognitive status, mental status, medical conditions, impairments,

and some other clinical topics including care preferences and medication reconciliation. And also – actually it's not on the slide but special services treatment and interventions have been a focus as well.

So the next slide shows our general timeline. We set this green line going across the top that shows that we are – we've been working on information gathering and also – so even though the sort of formal information gathering phase ended, we've been still doing a lot of continuing to develop data elements based on what we're learning from stakeholders, from our public comments, and also from our feasibility testing.

So the feasibility testing Alpha 1 is in yellow. We also had a blueprint public comment period in our first year. We've – even had several activities associated with preparing the proposed rules for Fiscal Year 2018. We had – we just – as I said finished our Alpha 2 and there was sort of a public comment in that phase. And the national beta testing is coming up and there will – there will be final public comment in May and June of this coming year and some final report. So that's sort of a big overview of the contract.

So, the focus of our information gathering in the next slide was really to just to gather as much information as possible to decide on the candidate data elements to meet the requirements as outlined in the IMPACT Act for each of these, our clinical categories.

So, in addition to close consultation with CMS and with other contractors so as not to work at cross purposes, we also did pretty extensive literature review. We developed an organizing framework around each of the categories to try to determine what aspects of this clinical category ought to be assessed.

We conducted focus groups for reach post-acute care setting. We also convened a technical expert panel with representatives from across all the setting as well the consumers. And we had ongoing interactions with clinical and expert advisers. And through all of that, the goal was to come up with to identify candidate data elements for feasibility testing and for consideration for standardization.

And if you go to the next slide, you'll see that – as we worked through this environmental scan, the – our evaluation of the candidate data elements focused on these four points. One is the potential for the data elements to improve quality, can the data element improve care transitions, care practices, can it be used for quality comparisons, might – it support clinical decision making. So a lot of these are actually came out of the text of the IMPACT Act as well sort if the, you know, these are the goals of the IMPACT Act.

And so, the data elements that are developed and standardized as part of the IMPACT Act should fulfill the goal – those goals. We also want to make sure that whatever data elements we consider have sufficient psychometric properties, they're valid, they're reliable, they're measuring what we – they're assessing what we expect them to be assessing. We want to make sure particularly for the IMPACT Act obviously that they're feasible for use across all settings and that's been a really challenging piece of this.

We want to make sure that whatever data elements we're considering are reasonable and feasible to collect in home health, in skilled nursing facilities, in in-patient rehab facilities as well as in long-term care facilities. And we want to – we would like them to be clinically appropriate across those four settings and relevant to the workflow.

And finally we hope to identify data elements for standardization that are useful for describing case mix and hopefully can be used in payment models and inform severity levels or resource needs tracking.

So if we go to slide eight. At the end of – towards the end of our environmental scan, we had a – a large group of data elements, candidate data elements and we put them into two tracks. And for one track, we determined that – or sort of decided that we – we thought that there was sufficient evidence available already for a subset of these data elements.

Mostly that evidence is from the – from the PAC-PRD, the Post-Acute Care Payment Reform Demonstration. We had many data elements that we were considering that were used in the PAC-PRD. And the PAC-PRD was cross-

setting and so there was already some feasibility evidence for the cross-setting use of these data elements.

And so, those we put into a track that said, OK, we don't need to test this anymore. What we need to do is get some public comments on them and think about putting them into the proposed rule. So, this track was the fiscal year 2018 proposed rule track.

– we also identified a lot of additional data elements that filled some gaps that weren't covered by the data elements in that track one. But really weren't ready for rules, really needed a lot of more development and feasibility testing, and so that second track was the track of data elements that went into our testing.

So where we are now – the track one status, the data elements that we identified for the fiscal year 2018 proposed rule including cognitive function and mental status, special services treatments and interventions and impairments, were not finalized.

And the reason for this decision were – were mostly to be responsive to stakeholders comments, primarily that the addition of these data elements at this time felt like too much too soon, that they're needed to be – that there was – there was an interest in or a wish to be provided more time to recover from one cycle to the next of the – these major releases of new data elements and measures.

Also a sentiment that even though there was this cross-setting feasibility and performance information that it might be a little bit too old and geez, there weren't – you know, they weren't a lot of LTCHs in that PAC-PRD and there weren't really a lot of home health. And so even though there was a sense that there was some feasibility data for cross-setting that the comments, the sentiment from the comments was that – that was in – it wasn't sufficient or it could be better.

So, holding up on the rule allows for additional reliability/validity testing. And then also allows to get – to have more time with stakeholders and technical expert panels to try to build additional consensus and get a little bit

better feel for what – for what the stakeholder community is most interested in having finalized.

So, the track two status is a – a whole other group of data elements that actually just went through a public comment posting. The majority of them and also went through our feasibility testing. The feasibility testing we talked about in previous open door forums, these were multi-site but small. And like about 100 – 120 or so patients and residents per – per Alpha test.

But the majority of the data elements were shown to be feasible to administer and had really strong psychometric properties especially the inter-rater reliability which very, very good. But there were some data elements that didn't perform very well in Alpha 1 and then they were sort of modified and refined, and retested in Alpha 2. And most showed improvement and – and have been further refined in preparation for beta.

We also got a lot of qualitative feedback from assessors and we used that to help us evaluate and improve our training, also our instruction manuals and also just exactly how the data element is specified in the assessment protocol. And we use the qualitative and the quantitative information from this feasibility test to sort of narrow the scope of the data elements that we would – that we consider – continue to consider for post-acute care cross-setting standardization.

Moving on to slide 11.

Our next steps are to identify the data elements from both tracks of work for the national field test. And I'm going to actually walk through that with you what – what we're planning to test, you know, in our beta test.

We also – in addition to it or at the same time that we're out in the field testing these data elements, we also want to conduct several outreach and consensus building activities for the data elements that are being tested to find out from the stakeholders -- what your opinions are about these data elements.

So we're planning focus groups of clinical staff representing each setting. We're hoping to have feedback sessions with facility staff and administrators

that are participating in the field test to gain an understanding of the workflow constraints and issues, identify ways to mitigate burden. We're going to have – continue to have stakeholder webinars like the special – the special open door forums to report on the interim findings from the beta test.

And not on this slide but other things that we're talk – we're planning, we're also going to have another public comment period that will be in May and June of 2018 and that will be all of the data elements that are being tested in beta.

And we've also just met – and are talking about several other stakeholder activities - attendance at conferences and other activities to try to strengthen our support among the stakeholder community.

So the national beta test is the final phase of data collection, I'm on slide 12 now, to test the reliability and the validity of the candidate data elements that from both tracks of work.

So because the track one data elements were not finalized, we're now circling back around and we're going to test those as well. The field test is going to take a place over a six-month time period, as I said, it's kind of a rolling start. Some of the markets will start in mid-October. Everybody will be up and running by the end of November and it will run through the end of May.

We've got 14 geographic areas that we are representing. They were randomly selected from a group of – over 60 regions that would be based on (HRRs). And then within those metropolitan areas, we selected – randomly selected eligible providers. And we've been calling them and to try to recruit them to join our beta participation. But it is voluntary.

So the list is random and the eligible providers are a random list and then – but we're calling them and, of course, if they don't want to join that – that's – that's up to them as well. But we've been quite successful.

So the next slide shows a map of – this was on – we generated this on September 19th. We have a lot more now. But this just shows the different

markets and the numbers of providers and type of providers within each market that we had recruited by the 19th, not today, the 28th.

We have more which is kind of exciting. We're continuing even though our training is starting, some of these markets aren't going to be trained until the end of November. So we still have time especially for the markets that are being trained later for people to get on board.

The next slide shows similar information in a table form, and again, it's slightly dated because we've got more now but we – at the time of this printing, we had a 169 recruited facilities out of a goal of 210, and I think that's about 70 percent. We're really close but the recruiters have been working really hard, calling all over the country and trying to get facilities on board for this exciting test. So we have – you can see our targets and the numbers recruited per market.

Some of the markets have been a little – more challenging than others, part of that has to do with the availability like, for example, in Durham, there weren't a lot of – it's not a really a dense market to begin with. And so we started sort of burning through our list and ended up – well, we're still working on it but we're not sure that we're not going to get to the 15 or the 13 that we're targeting.

But other markets like San Diego are a little bit above. And so we're still feeling like at the end of the recruitment period, will be very close to our target of 210. And that number was determined to provide sufficient power to be able to make strong conclusions about the performance of the data elements within each setting, but also, to be able to consider case mix and to be – not just to have statistical power but to have the sufficient representativeness.

So if you look at the next slide, slide 15, you can see that the – we're targeting that to include 28 LTCHs and 28 IRFs, two per market on average. But we want to include many more SNFs and Home Health Agencies. And this is just because that, you know, that's the distribution of these setting types across the

country. There are many more SNFs, Skilled Nursing Facilities and Home Health Agencies than there are LTCH and IRFs.

And then, within each we're targeting to perform 30 admission assessments in the LTCHs and IRFs in 25 admission assessment in the SNFs and home health.

And then the target number of discharge assessments is really just an estimate based on the number of enrolled patients and residents that we anticipate will be discharge within the field period. So, any enrolled – any patient or resident who's enrolled in the study in the field test and completes an admission assessment will be targeted to also complete a discharge assessment if they are discharge before the field period ends. So we're estimating that we'll get approximately 4,055 discharge assessments.

The data collection is going to be completed electronically on handheld tablets. We tested this out in Alpha 2 and it went pretty well, so we're feeling confident that this will work. It really simplifies data delivery and data entry and I think it's more feasible for the assessors as well.

The protocol includes both patient interview data elements as well as data elements that – where you get the information by reviewing the medical record in the nursing notes and observing the patient or resident talking to their family, et cetera.

A subset of the assessments will be completed by both facility staff and the project research nurse so that we can evaluate inter-rater reliability. And a subset of those patients and residents will also be assessed repeatedly over different look back dates so that we can get more information on that.

The look back period – the optimal look back for these data elements was one of the issues that came up pretty consistently in the rule comments and that we are doing everything we can to address with the data in our beta test.

So on slide 17, I would say again that the assessment categories that are the focus of our beta field test. So we have some data elements reflecting cognitive status, mental status, pain, impairments, special services treatments

and interventions. And then three other categories, not specifically listed by the IMPACT Act but of interest to us, are care preferences, global health, and medication reconciliation.

So the rest of the talk is just walking through each of these categories and describing a little bit about the actual data elements that are included in the test.

So, slide 18 shows the data elements for the cognitive status category. We have questions asking about ability to express ideas and ability to understand others. As far as what we've done with this in our activities to date, these items were in the first public comment period.

And we're going to test two versions of these items and, you know, it's going to be included in the repeat assessment of looking back asking the question at admission day three, admission day five, and admission day seven to determine whether there's any difference in response frequencies, et cetera, if we ask on different dates.

The – we're also testing the brief interview for mental status. This was in public comment one and it was also in the draft rule and it's going to be included in the repeat assessment, the three, five, seven repeat assessment.

Similarly the CAM, signs and symptoms of delirium, also within public comment one and in the draft rule and will be in the repeat assessment subtest and behavioral signs and symptoms.

The presence and frequency of the behavioral signs and symptoms was in public comment one and in the draft rule, but we've also added a few other aspects of behavioral signs and symptoms. There are the impact on their – the persons care whether they were rejecting care and also whether the behavioral signs and symptoms had, like what – was it hurtful to themselves or hurtful to others. And so these are all going to be included in the three, five, seven test as well.

And finally, we have for cognitive status, the staff assessment of mental status. And this is – we have a separate protocol for patients and residents

who are unable to communicate and there are three categories that we're assessing for those patients. They were all tested in Alpha 2 and all were presented in public comment two and all will be included in beta. And actually the beta test is going to include a sub sample of patients who are unable to communicate, specifically in order to test these non-communicative protocols.

The next slide shows the data elements for the mental status category. We have the PHQ-2, the – which is sort of a screener and if the patient screens positive based on their first two questions then they're asked the following seven, so it could be the full PHQ-9, but for the majority of patients and residents, they'll answer only the first two questions. This was in the – it was in public comment one and within the draft rule. Actually the PHQ-2 is in the draft rule, but this – this PHQ-2 as a screener followed by the rest of the seven was tested in our first feasibility test, Alpha 1.

We're also testing a subset of items -- depression items from the PROMIS item library. And these were reviewed by our technical expert panel as well as the group of stakeholders to identify the subset of PROMIS depression items that would be most relevant for post-acute care settings. There are eight items in the set and we're going to test two separate versions.

Similarly, we are testing PROMIS anxiety that was tested in alpha-2 and also was put out for public comment in our second public comment period and we will test two versions of that. And the versions are – the PROMIS items – the traditional PROMIS items ask about symptoms experienced in the past seven days and we want to test an alternate version that asks about the past three days just to be more in line with the language of the other data elements in the PAC setting.

Finally, we have the – in the mental status category, the staff assessment of mood, which is the PHQ-9 observational version and this was tested in Alpha 2 and was included in our – in the public comment two and this is our – this is part of our observational protocol for patients and residents who are unable to communicate.

In the pain category, we have a nice pain interview that includes pain presence, pain frequency. Actually – well, the pain presence is sort of a gateway question, so if you don't – if the patient or resident doesn't have – hasn't had any pain in the time period being under question, then they won't be asked the rest of the questions.

But if they do have pain we'll ask about their frequency, severity, effect on sleep, interference with therapy and non-therapy activities as well as the extent of relief that they're getting from their pain. And these items were mostly in public comment one. No, actually, in public comment one, we had the presence and severity, but we tested this whole protocol in alpha-1 and put them all out for public comment in public comment two.

We're going to be testing two versions of this pain interview. One will ask about pain in the past three days and the other version will ask about pain in the past five days. And both of these versions will be tested in the – will be included in the day – the multiple day three, five, seven look back test.

We also have an observational protocol for pain or distress that's assessed by the staff. This was included in Alpha 2 and in public comment two and it's designed to assess pain or distress for patients and residents who are unable to communicate.

Slide 21, the beta data elements for the impairments category. Well, first, we have the sensory impairments, ability to hear and ability to see. These were both included in public comment one and in a draft rule and will be tested in beta.

We also have some continence items that ask about the patient or resident's perceived problem or burden with their incontinent events if they have any. And this was tested in Alpha 1 and was presented in public comment two.

And finally, we have a series of continence questions about appliance use and whether they need assistance with their devices and when was it placed. These were tested in Alpha 1 and included in public comment two.

And for this we can – these are going to be – the status of these items will be recorded on admission, the day of admission, day one, also day three, and day five, and day seven, and also on their discharge day, as well as two days prior to discharge.

For special services treatments and interventions, we have a list of special services treatments and interventions that we are wanting to assess. They were in public comment one and they were in the draft rule. We also have nutritional approaches, essentially the I.V. or feeding tube in diet questions.

These are check boxes whether this is occurring or not occurring and they'll be recorded similarly to the continence items on admission days one, three, five and seven, also on discharge date and discharge date minus two.

And I should say too that the full protocol will – aside from the observational assessments which will just happen at one time, all of these data elements are going to be collected at admission and at discharge.

And finally we have another category which I mentioned at the – at the top of the talk that includes care preferences, specifically preferences around decision making, and then whether or not there's a designated health care agent. These were tested in Alpha 1 and then revised and tested again in Alpha 2, and also put forth in our second public comment period.

We're also testing the PROMIS global health 10, which is a 10-item sets that's used to evaluate general health-related quality of life. This was in public comment two and this was also discussed in our TEP. And as with the PROMIS anxiety and depression items, we're going to test two versions and one version asks about experience in the past seven days and the other will ask about the past three days.

And finally, we have a series of items documenting the occurrence of the several steps of medication reconciliation and this was tested in alpha-1 and then revised and tested again in alpha-2 and was also put forth for public comment in our second public comment period.

Finally, we have – the final slide has the – or the second to the last slide is a timeline for the upcoming contract year. So this is the start of option year two. It's just a couple of days ago, actually. We are about to do our training of our research nurses and field data collectors in the 14 markets for beta.

We'll be doing data collection from mid-October through May. And then the – we'll also be having the three, five, and seven look back data collection which we're going to fold in, in January.

We have several stakeholder outreach activities planned throughout this entire time period, including the special open door forums, but also some focus groups and conference attendance and other activities and we have the public comment as I mentioned before and that goes from May and June of 2018.

And I think that's – the last slide is just a reminder that if you have any – if you have any questions or would like more information, you can either send an e-mail to the CMS IMPACT mailbox or directly to the RAND team that's developing – that's doing this contract work. And we are happy to hear from you and we'll respond as quickly as possible if we do. Thanks.

Charlayne Van: Thank you, Maria Edelen. We will go into our question and answer session. (Amy), who's at the callers and we'll have the – ask the question.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please go ahead and press star then one on your telephone keypad. If you would like to withdraw your question please press the pound key.

Please limit your question to one question and one follow-up to allow other participant time for question.

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

Your first question today comes from the line of (Carolyn Deand). Your line is open.

(Carolyn Deand): Thank you very much. It's good presentation. I appreciate it very much. I must admit that where it says on the timeline October 1st, Draft LCDS mark-up. What is LCDS?

Maria Edelen So, good question (Carolyn). So, I actually saw that on the timeline and kind of winced, because I didn't mean for it – I'm not sure it needed to be on this timeline. It's more of an internal guideline for us that the LCDS is – we're using that to represent the long-term care dataset for the LTCH.

So, what we're – that just the sort of – by that time we wanted – at least have a pretty good idea of what we're thinking about, so that's why that's all in there.

(Carolyn Deand): Long-term data set.

Tara McMullen: (Carolyn Deand). Hi (Carolyn), this is Tara McMullen

(Carolyn Deand): Hi.

Tara McMullen: Hey, how you doing?

(Carolyn Deand): OK.

Tara McMullen: The LCDS is the acronym that we use for the LTCH care dataset

Maria Edelen: LTCH hospital...

Tara McMullen: Yes. It's a very long, long name, but the LTCH care dataset is the long-term care hospital, continuity assessment record and evaluation data set.[LTCH CARE Data Set]

(Carolyn Deand): OK, and then as final beta data delivery to whom?

Maria Edelen: Oh, that's really to RAND. So basically, the data come in and we don't – you know, we sort of look at it in batches. So the final batch that has the whole beta sample will be sort of on our computers ready to analyze at that delivery date.

(Carolyn Deand): OK. Thank you. I'm sure you'll have others but, I'll e-mail you.

Operator: And your next question today comes from the line of Therese Disilvestro. Your line is open.

Therese Disilvestro: Hi, thank you. So, we have centers that have volunteers for the RAND project. And our question has been – has CMS determined how or if centers will have access to their own data? So, has that been determined yet?

Charlayne Van: We've not talked about that recently.

Maria Edelen: Can we clarify what the question is (she referring to)?

Charlayne Van: My understanding of the questions is, whether the facilities that are participating in beta will whether they'll have access to their own patient data from the Beta test.

Tara McMullen: Hi, it's Tara McMullen. There are few things going on to help inform facilities to participate in the national test to keep apprised of their outcomes and what's going on. The first is that CMS will be enacting what we're calling right now a feedback loop.

So once your facility participates in the national test after we collect data and we're done, you know, analyzing that data, what we'll do is we'll go back with your facility and debrief on what we found in terms of those items and those outcomes, if the new set that we're enacting to make sure that we're interfacing with our facilities and then that continue with process.

The question pertaining to the actual data, the raw data, this is something that we're still discussing internally. And we can keep folks apprised on our website of those determinations.

Therese Disilvestro: OK, thank you. And then there's a follow-up, when would we – just looking at this timeline on the slide – it would be 24. At what point along this timeline would you say a center could expect you have that debriefing?

Tara McMullen: The feedback process is to happen once CMS and our contractors have collected that data and have analyzed it and are in a place where we're ready

to prepare briefing on it. So these feedback loop processes and sessions won't happen until 2018.

But, however, if you're a facility that's participating in the national test and if you have any questions, you can reach out to RAND anytime. It's an open process. It's a collaboration.

Therese Disilvestro: Thank you.

Tara McMullen: Thank you. Appreciate it.

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

Cynthia Morton: Hello, thank you for the presentation today. I got on a little late and I think I've missed what you're referring to when you say draft rule in the chart as you were going over the various data items or data elements that you're testing.

What does draft rule refer to? Thank you.

Maria Edelen: In the – oh, oh, in those charts, what I was referring to is that the data element that is being tested in beta was in the draft rule, the fiscal year 2018 draft rule.

Tara McMullen: The proposal.

Maria Edelen: Proposed draft. OK.

Tara McMullen: It is for proposed rule-making.

Maria Edelen: Yes.

Cynthia Morton: OK, it was – one – OK, yes, I recall there were number of elements towards the end of the rule that were for the future.

Tara McMullen: Right.

Cynthia Morton: OK.

Tara McMullen: Right.

Cynthia Morton: And it looks like those won't be ready or all the testing won't be finished if I understand the chart on page – I don't know, your last – second to the last page, they won't really be finished until closer the end of summer next year in 2018.

Tara McMullen: That's right.

Cynthia Morton: OK. Thank you.

Operator: Your next question comes from the line of Mary Ellen Debardele. Your line is open.

Mary Ellen Debardele: Hi, good afternoon. Thanks to RAND and CMS.

I saw the slide that talked about the intent of the project and the different testing of the pilots. I saw feasibility and validity but I wanted to ask about the burden of this assessment measure collection. I know that was one of the reasons listed for postponement was the idea of too much too soon. And we know there are been a lot of measures put into the different post-acute tools as part of the IMPACT Act.

And so, instead of just too much too soon, at what level is it just too much? I know in the IRF world, our tool has lengthened by about an hour and a half since the quality program got underway.

So, at what level are you also testing for the amount of time in addition that it takes to complete all of these different measures for the patient assessment data?

Maria Edelen: Well, we're definitely paying a lot of attention to the time that it takes to complete the assessments. And so we're going to have really precise time estimates per setting. We might even be able to look at that according to the case mix.

So, we'll have really nice time estimates but I'm going to let Tara add to that.

Tara McMullen: So hi, Mary Ellen …

Mary Ellen Debardele: OK.

Tara McMullen: … it's Tara. So, on top of being able to asses for the time it takes to complete an item and all the items in total, CMS will also be taking into account the use of the items, long-term outcomes, (longitudinal) data, standardization, possible use and payment models, risk adjustment, the survey and certification processes, and above all the time that it takes to complete – the facility to complete the assessment. It's our charge – it was the charge of the administration, so we're taking that into consideration.

I'm going to pass this to (Stella Mandl) for further comment on burden.

(Stella Mandl): I think that you wrapped it up nicely.

Tara McMullen: OK. Thank you, Mary Ellen.

Mary Ellen Debardele: Thanks. I have one follow-up question. I've been – it's been difficult to find the CMS websites for Call for Public Comment and Technical Expert Panel. Have those been moved or taken down?

Tara McMullen: So, Mary Ellen, this is Tara again. I noticed that they are actually working on the web pages right now.

Mary Ellen Debardele: OK, OK.

Tara McMullen: Yes. So that's beyond the scope of us here in the division. That's more of a CMS wide effort with the communications group or whoever…

Mary Ellen Debardele: OK.

Tara McMullen: … runs that page.

Mary Ellen Debardele: OK.

Tara McMullen: Those should not be taken down. I fully expect everything to be back up soon.

Mary Ellen Debardele: OK.

Tara McMullen: I know that they're working on the pages. Yes.

Mary Ellen Debardele: All right, thank you.

Tara McMullen: Thank you.

Operator: Your next question today comes from the line of Troy Hillman. Your line is open.

Troy Hillman: Hi, guys and thanks for a great presentation and for keeping us up-to-date on what's going on.

I wanted to refer to slide 18 and I had some questions about the data elements that are being tested or part of this beta -- data collection on the screen.

A number of these data elements are already being collected as part of the Inpatient Rehab Facility Quality Reporting Program and also have recently been implemented as part of quality measures in the Skilled Nursing Facility Quality Reporting Program.

Things like the (BIMs) and the staff assessment for mental status and expression and understanding are already data elements that are being collected.

And I guess I wanted you guys to expand on what specifically is being tested here and how might this impact the quality measures that already utilizing some of these data elements and, you know, the numbers that already being reported out and some of the quality reporting programs.

Maria Edelen: Yes, thanks for that question. There are a lot of data elements that we're testing that are used in one or more of the standard assess – existing assessments. And that comes into play. What we're hoping to do is with this is standardizing across all four settings. And so, really what comes into play there is like in each setting, what are these being used for, what is the look back that's used.

So, what we're trying to do is determine the best specification of the data element that will be most useful across all four settings. And so that's why we have the look back piece of it.

So for the IRF, we're not going to ask you to test – you know, to ultimately have two versions of the BIMs but somehow, you know, it's possible. Ultimately, we want one version of the BIMs that everybody can test.

Troy Hillman: Great. And just to follow-up. If you're testing to find that there's a different review period, should we be expecting changes to the quality measures that already adopted or the risk adjustment coefficients that are used for the quality reporting items that already utilized these items?

(Stella Mandel): It's a (Stella Mendel) at CMS. I think it's way too early to respond to that level of a question. Right now, we're going into the field to evaluate the items.. Thanks.

Troy Hillman: All right, thank you guys very much.

(Stella Mandel): Thank you, yes.

Operator: Your next question comes from the line of David Mansolino. Your line is open.

David Mansolino: Yes, thank you very much for the opportunity to talk about this kind of stuff.

My question is a little bit different. I just had a question when we were going through this and you were talking about the data that you're going to be collecting over the next six months and so. And I was just curious if that data was going to have any impact on the Advance Notice of Proposed Rulemaking FY 2019 where CMS is proposing to modify the SNF payment methodology.

Will this information that you're gathering kind of impact that or you're going to look at that differently when you get this data or the two things mutually exclusive?

Tara McMullen: Hi, it's Tara McMullen. Right now, it's a little bit out of scope of this contract talking about the payment model for SNF or anything that's going on with that work, so we can't answer that.

Like Stella Mandl just said, you know, we're going into the field and we're testing these items and that's where we're at right now.

David Mansolino: OK, thank you.

Female: Thank you.

Operator: Your next question comes from the line of Mary Carr. Your line is open.

Mary Carr: Yes, hi, everyone. I have a question on slide nine. Can you comment how your decision not to finalize these assessment items impact the Home Health 2018 proposed rule?

Maria Edelen: We're unable to comment on that.

Female: Yes.

Maria Edelen: Thank you.

Mary Carr: All right.

Operator: And your next question comes from the line of Tom Ferrone. Your line is open.

Tom Ferrone: Thanks for having us today. Looking at the timeline on the second to the last slide, I think that there's a public comment three period from April 30th to June 29th. Could you tell us a little bit about what you're opening up to public comment?

I'm a little confused because I see that there's final beta data delivery to kind of the middle of that comment period. So it doesn't look like we would have a chance to comment on when the analysis of the data that is delivered by June 8th. So could you maybe clarify that a little bit?

Maria Edelen: Yes, that's a good question. We were just talking about that. It's unclear to us – one of the things that we will do is have some interim data deliveries from, you know, from the field onto our computers essentially to get some preliminary sense of what's going on with these data elements.

And we were just talking about the fact that we would have the option to possibly put some of that into the public comment posting. But we're not sure if we would do that or not. So it might – we haven't decided yet.

We – I think the public comment posting will look a lot like the postings that we've had where you list the data – we're listing the data element and specifications and the information the best information that we have about it. So whether we decided to put interim data results in there or not, we've not decided yet.

Tom Ferrone: Will there be a follow-up public comment opportunity once RAND has had a chance to do a final analysis of the data?

Tara McMullen: Yes, we intend to.

(Inaudible)

Tara McMullen: Our public comment is part of the process. The blueprint public comment.

Maria Edelen: Yes, we seek public comment as part of the process as we have …

Tom Ferrone: OK.

Maria Edelen: … you know, outside of rulemaking. Yes.

Tom Ferrone: OK. So it sounds like you will make a public comment period available after the final data analysis?

Tara McMullen: And there will be many opportunities to be able to opine on what we're looking at in terms of the data items, and what's going on in terms of what CMS is considering for a next steps. We'll make sure that everyone will have a say in that.

Tom Ferrone: Thank you.

Operator: Your next question comes from the line of Melissa Keefe. Your line is open.

Melissa Keefe: Hi, thanks. Appreciate the presentation today.

Just a quick question. I know you all have stated this previously but I don't know that I heard it today. The data collection is going to be done on (tablets) but will you have printed version of the data collection tools in the instructions for the beta test participants post it to the website? And if so, when might we expect to be able to take a look? I think that's my first question.

Maria Edelen: Well, we can do that. That's actually a really nice suggestion. So, I think we should – we need to talk about it. We haven't – we hadn't thought about posting that or making it available but we'll certainly talk about it. It's a good idea.

Melissa Keefe: Great. And should those evolve of over time as you learn throughout the six months, that will be helpful to have them reposted, I think to the extent that we continue to keep the broader field, engaged around the data elements, how they were tested in the instructions. This is discussed I think earlier this year the stakeholder meeting, I think it would be beneficial as we move into rulemaking next year. So, I appreciate the consideration of that request.

I would also like to add my hope that CMS will make the decision that those that do participate will get their data back from RAND that was a limitation of the PAC-PRD. And we'd really like to see that feedback loop come back in data files to those participants. There's tremendous opportunity for learning internally that we hope you guys will consider as you move forward. So, thank you.

Charlayne Van: OK, thank you.

Operator: Your next question comes from the line of Samantha Kolbe. Your line is open.

Samantha Kolbe: Hi, yes, thank you. Medicare has new-ish admission requirements for LTCHs and our Medicare and non-Medicare patient populations can be substantially different.

So given that – this data test is only applying to Medicare patients, I was wondering if you could talk about how you were going to be assessing the burden for LTCHs for our non-Medicare patients who would also have to – who would also be subject to these assessments if they are finalized. Thank you.

Maria Edelen: Well, we're including the dually eligible.

Tara McMullen: That's a very good question and if you can e-mail the IMPACT Act mailbox, it's pacqualityinitiative@cms.hhs.gov , we will get back to you with a response and we will also posting questions and answers document on our IMPACT Act website so that everyone can see the response to that. Thank you.

Samantha Kolbe: Thanks.

Operator: And your last question in queue for now comes from the line of Robert Moore. Your line is open.

Robert Moore: Good afternoon. My name Robert Moore, thank you for the presentation today and thank you for taking my question.

One of the questions that I have is, would you be willing to share the specific documents and forms that comprised the data elements for each of the categories or if that's already available? Is there anywhere specifically that we could possibly go and download those?

Maria Edelen: Yes, thanks. Actually, a previous question just recommended that we make those – that information available and so we need to – we hadn't thought about

it, so we're going to take under advisement and we'll let – if we can make it available, we'll let you know soon.

Robert Moore: All right, excellent. Thank you.

Operator: And there are no further questions. Thank you.

Tara McMullen: Thanks everybody.

Maria Edelen: Thank you.

Sheila Mulligan: Thanks everyone.

Charlayne Van: Thank you for joining the call.

Operator: Thank you for participating in today's open door forum conference call. This call will be available for replay beginning today, September 28th at 5:00 Eastern until October 2nd at midnight.

The Conference ID number for the replay is 66557294. The number to dial for the replay is 855-859-2056.

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

END