

Centers for Medicare & Medicaid Services
Special Open Door Forum:
The IMPACT Act and Standardized Patient Assessment Data Elements
Wednesday, July 25, 2018
2:00-3:00 pm Eastern Time
Moderator: Jill Darling

Coordinator: Welcome, and thank you for standing by. Today's conference is being recorded. If you have any objections you may disconnect at this time. All participants are in a listen-only mode until the QA section of today's conference. At that time you may press star 1 on your phone to ask a question. I would now like to turn the conference over to Jill Darling. Thank you, you may begin.

Jill Darling: Hi, thank you (Sarah). Good morning and good afternoon everyone and thank you for joining us today for this special Open Door Forum, The Impact Act and the Standardized Patient Assessment Data Elements.

Before we get into today's presentation, I have one brief announcement. This special open door forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press you may listen in, but please refrain from asking questions during the Q and A portion of the call. If you have any inquiries, please contact CMS at Press@CMS.hhs.gov.

And I will now hand the call off to Maria Edelen from the RAND Corporation.

Maria Edelen: Thank you, hi, yes, I'm Maria Edelen and I'm senior psychometrician at the RAND Corporation and director of this RAND project to help CMS identify standardized patient assessment data elements for post-acute care.

So I'm going to be talking a little bit and then handing off to my colleague Jaime Madrigano, who is sitting in for Emily Chen, who's on this title slide. So (Charlayne Van) is not able to join us, but we have Tara McMullen from CMS on hand to listen and answer questions as needed, and similarly Emily Chen is not available but Jaime's going to step in and do some of this talking as well.

So welcome, on slide two. And moving right on to slide three, the focus of this Special Open Door Forum is to discuss the RAND contract work that's been ongoing to help develop and evaluate candidate standardized patient assessment data elements for use in post-acute care in support of the Impact Act.

And we've sort of somewhat recently come up with SPADE as this acronym for the data elements that we've been working on, and so I'm going to, you might hear SPADE rather than data element throughout the talk, and that's what I'm referring to, the standardized patient assessment elements that we've been developing and evaluating.

So we'll first provide a brief overview of the contract work and our progress on the national beta test. Next I'm going to hand it off to my colleague Jaime, who's going to give you some results on what we've been hearing from staff members at the participating facilities and agencies who've been conducting the beta assessments. And finally there are just a few wrap-up slides where I'm going to highlight a few of the upcoming engagement activities that are

scheduled before the end of the year, and then we'll open it up for your questions.

So on slide four, just as a reminder, CMS contracted with the RAND Corporation to help meet the mandates of the Impact Act, and our overarching project goal is to develop, test, and implement standardized post-acute care assessment data. Our project has roughly been broken up into three phases. The first was information gathering, which took up a majority of our first year of work. And then we got into pilot testing, which comprised most of the second year of work. And finally we - our most recent year we've been focusing on the national beta test.

Originally this national beta test field period was scheduled to end on May 31, but we've extended it through August 15 to collect more data. A majority of providers have continued to participate into the summer months.

So on slide five, our focus has been on clinical categories that were specifically outlined in the Impact Act, including cognitive status, mental status, pain, impairments, including continence and vision and hearing, special services, treatments and interventions, and we've also been considering a few other categories including care preferences, global health, and medication reconciliation.

Then within each of these categories we have a number of data elements that have been considered at various stages of our project and have been tested in beta.

Now on to slide six. Throughout all of our project activities, our evaluation of the candidate SPADEs has been guided by consideration of these four components. So first of all we want to determine the data elements' potential

for improving quality, and this again is always across all four of the settings, and I should remind you I don't have this here but the settings are home health agencies, skilled nursing facilities, long-term care hospitals, and in-patient rehab facilities. Those are the four post-acute care settings that are covered by the Impact Act.

So again the potential for improving quality across those four settings, the extent to which the candidate data elements are valid and reliable across the four settings, the feasibility for using these in these four settings and the data elements' utility for describing case mix.

Now on slide seven, we've had several opportunities for input on candidate SPADEs for a diverse set of activities, which is shown here. And of course a major focus of this year's work has been the national beta test, which you see at the bottom. Beta test performance is feeding into our evaluation of the candidate SPADEs.

But leading up to that, we formed a technical expert panel in the first year, and that group has stayed with us and reconvened throughout the project period, and we've periodically provided them with updates on our progress and have gotten their input. We've also had a series of formal and informal discussions with stakeholders and have conducted two sub-regulatory public comment periods to gather feedback on candidate SPADEs.

More recently, we've been getting feedback on workflow issues relevant to the candidate SPADEs and have obtained valuable feedback from staff assessors from participating facilities and agencies about their experience collecting the data through both the survey, which Jaime's going to talk about soon, and also a series of focus groups, which we're conducting this summer.

Now on to slide eight. In the next few slides I'm going to provide an update on the beta data collection process. So just as a reminder, the goals of the national beta test are to test reliability and validity of the candidate data elements, and identify the best, most feasible subset for standardization across post-acute care to meet the requirements of the Impact Act. The field test is happening now, it's going to end in two and a half weeks with a random sample of eligible providers who reside in 14 randomly selected geographic metropolitan and rural areas across the country.

Then the beneficiaries within those participating facilities and agencies are Medicare-only or duly eligible Medicare/Medicaid patients in residence that are admitted to participating providers during the field period.

Now on slide nine, the test is being conducted in these 14 markets across the country as shown here. And slide ten is just a reminder that the protocols are being used, that the protocols that are being used in the beta test are posted on the CMS web page. The URL for that is shown on this slide ten. And there are three protocols in total. There's one for communicative patient admissions, and one for communicative patient discharge, and one for non-communicative.

And as I've said in other forums like the Special Open Door Forums, the communicative, non-communicative distinction is really an artifact of our data collection process because we have three data elements that have been developed specifically for use with patients who are unable to communicate. If things are standardized, that distinction will dissolve in practice. And I can talk more about that if anybody has follow-up questions.

On slide 11, this table shows the number of participating providers, both who originally enrolled in the project and those that have continued beyond May

31, so you can see that we started, we've collected data successfully from a total of 136 providers, and 107 of those providers have stayed on through the extension into the summer.

We also have the number of assessments that have been submitted, these numbers are all current as of earlier this month. And as you can see, we've collected a large amount of data, and we're really getting excited to see what we learn from all these data about the candidate SPADEs.

Slide 12 shows a map with the distribution of submitted assessments across the 14 markets. You can see there's a wide range of variability in the number of assessments completed across the 14 markets, but at this point all the markets have made substantial contributions to the project.

And I was just speaking about analyses. On slide 13, just a little bit of a preview of what we're planning to do. We're just now starting to analyze the data based on an interim data delivery from the field, and this work is going to be ongoing throughout the summer and early fall. And it will include analyses to provide cross-setting information regarding feasibility, reliability, validity, and optimal format for the candidate data elements that are being considered in beta.

Now I'm going to hand this off to Jaime, who's going to talk about our beta provider survey.

Jaime Madrigano: Sure, thanks Maria. So yes, I'm going to be talking about the beta provider survey, and just, the purpose of the survey was to obtain information on the activities and experience of beta assessors. And it was designed to provide some additional information on several concerns that have been identified through some of the stakeholder activities that have already taken place.

So the survey was fielded over a period of one month in April of this year. And assessors were contacted via e-mail, and the survey was administered via a web-based platform called Survey Select. We had about a 57% response rate from those e-mails, and of those responses about 65% of them were complete surveys.

So on slide 15, all of the markets were represented in the survey, with each having between four and 12 respondents. As you can see from the respondent breakdown on this slide, this representation was largely reflective of the proportions of settings in the beta sample. On slide 16, we're showing the data element groupings that questions were asked about on the survey.

And then on slide 17, broadly you can see about the types of questions we asked about. So broadly we asked about clinical utility, assessor and patient burden, and the factors that impacted an assessor's ability to collect data. But the clinical utility and burden questions, respondents answered questions according to the data element groupings that you just saw on the previous slide. So for example respondents were asked how clinically useful the pain interview was based on a five point scale.

Now for those data element groupings that had multiple items, such as the pain interview, which contained items like pain presence, pain interference, et cetera, we additionally asked respondents to rank items within that data element grouping relative to the other items within that grouping. And I'll present all of those results in the coming slides.

So slide 18, this shows you an example of the clinical utility question that participants saw. So it's a, thinking generally about the data elements within the following categories and the categories that we previously showed were

listed, how clinically useful are these sections of the assessments. And then respondents could answer from “not at all useful,” “slightly useful,” “somewhat useful,” “moderately useful,” and “extremely useful.”

On slide 19, we present some of the results from the clinical utility questions. So across data element groupings, the ratings ranged from just above slightly useful to just above moderately useful. You see the range there was overall, on average 3.2 to 4.25. We saw the highest ratings for data element groupings: pain interview, expression and understanding, and hearing and vision. And the lowest clinical utility ratings were for things like staff assessment of mood, PROMIS anxiety, global health and depression.

Slide 20 shows the full list of data element groupings and their average rating across settings. So as a reminder here, just as you’re looking at this scale, 4 would correspond to a rating of moderately useful, and 3 would be considered somewhat useful. You can see that on average each of the data element groupings fell between those classifications.

On slide 21, we are looking at some of the differences by setting. So across settings, the pain interview was rated as 1 or 2 for clinical utility. But LTCHs and SNFs rated expression and understanding as number 1, as highest, and home health agencies rated medication reconciliation as the highest.

In general, participants from the IRF setting rated data element groupings lower than other settings. And the special services and treatments and interventions was generally rated high across settings, except in the IRF setting, where it fell close to the bottom of the clinical utility list.

Moving on to slide 22, as I mentioned earlier for data element groupings with multiple items, we asked respondents to rank each item within a grouping

relative to each other. So for example, participants were asked to rank the six items within the bladder continence data element grouping, 1 to 6 relative to each other.

So you can see here for each of these grouped data element categories which items were ranked most useful and least useful. So for the continence bladder grouping, we saw that the highest ranked item was frequency of incontinent events, while the lowest ranked item was need for assistance or appliance management. For continence bowel, frequency of incontinent events again was considered the most useful, while appliance use in the current setting was considered the least useful.

Pain presence overall was considered the most useful within the pain interview, while pain interference of other activities was considered the least useful. And with the special services, treatments and interventions, oxygen therapy was considered the most useful and radiation was considered the least useful.

Slide 23 shows that those rankings did vary by setting. So for example with the bladder continence items, we saw that home health and IRF thought frequency events was most useful, while appliance use was least useful. But for SNF, appliance use was considered most useful, and for SNF need for assistance was considered least useful.

So I just wanted to point out on this slide that there was some variation by setting for these rankings. You can see that for something like the pain interview, pain presence was highest still across all of the settings, and pain interference for other activities was lowest across all of the settings.

Now on slide 24, we're moving on to the questions about burden, and we asked both about burden to the assessor and the patient in this survey. This slide shows the question that we use to gauge burden to the assessor. So thinking generally about the data elements within the following categories, how difficult was it for you as the assessor to collect information for the following sections of the assessment.

Again, respondents had a list of all of the data element categories and they could respond with choices of "not at all difficult," "slightly difficult," "somewhat difficult," "moderately difficult," and "extremely difficult."

And on slide 25, we see the results for this question. Now I'll remind you that a score of 1 would be, would correspond to not at all difficult to collect, and 5 will correspond to extremely difficult to collect. So on average across the settings data element group ratings range from just above not at all difficult to just below somewhat difficult.

The least difficult ratings were seen for hearing and vision, expression and understanding, care preferences, pain interview and BIMS. And the most difficult rating, data element categories considered the most difficult were medication reconciliation, PROMIS anxiety, and PROMIS depression.

On slide 26, you can see the ratings for all of the data element categories. The average scores for all the data element categories across settings. On slide 27, you can see that there was some variation of assessor burden by setting. So for home health and IRF, assessors tended to rate the hearing and vision and expression and understanding the least difficult, whereas for SNFs and LTCH, assessors found the pain interview nutritional approaches and special services, treatments and interventions least difficult.

Although assessors from all the settings rated medication reconciliation as relatively more difficult to collect, home health assessors appear to have less trouble with this data element compared to the other settings. So now on slide 28, to shed some more light on assessor burden we asked respondents to answer what factors impacted their ability to collect information for data elements that were the ones that they considered more difficult to collect.

You can see that timing constraints and availability of data were the most frequently endorsed factors overall. And by setting, home health and IRF assessors cited availability of data as most frequently as a factor impacting their ability to collect information, whereas LTCH and SNFs assessors cited timing constraints as the main factor.

Slide 29, here we finally asked participants to think generally about the data element groupings and answer how burdensome it was for patients and residents to provide information for the different data element groupings. So this was to assess burden to the patient or resident. And here the scale was 1 for not at all burdensome, 2 for slightly burdensome, and 3 for somewhat burdensome.

And the average ratings ranged from between not at all burdensome and slightly burdensome to, actually I think that's somewhat burdensome. The score of 3.

Things that were thought to be least burdensome to the patient were the pain interview and care preferences, while the data element groupings that were perceived to be most burdensome to the patient and resident were PROMIS anxiety and depression. And these results were fairly consistent across the settings.

So on slide 30, just to conclude on the beta provider survey, want to note that these results are preliminary. We'll be presenting, likely more detailed results will be coming. There were some free response questions, which we're looking through for themes. And these results may be presented in upcoming Special Open Door Forums. As Maria mentioned, this summer we're currently holding focus groups with providers to acquire more detail about some of these findings, and the results of this beta provider survey will be included as part of a published report on the SPADE beta testing.

Jill Darling: Thank you, Maria, and Jaime. (Sarah), we'll open the lines up for Q and A, please.

Maria Edelen: Oh, actually Jill I have a few more slides here. This is Maria.

Jill Darling: Okay, I'm sorry. Go ahead.

Maria Edelen: Sorry about that. Yes, I was sort of waiting for Jaime to hand it back to me but that's fine.

Jaime Madrigano: Sorry.

Maria Edelen: No, that's okay. It's actually really interesting to see I'm excited to be able to present some results, so thanks for your willingness to go through that. So I just have a few more slides, just as a reminder on slide 31, we have an important upcoming mini-conference, which is to be held in Washington, DC tentatively in late 2018. We'll hear, we'll provide more information about that as we firm up the details.

We're still, it's still in ongoing discussions, but the purpose is to discuss the findings of the testing and the engagement activities that we've been involved

with over the past year, answer questions and hear feedback on the candidate data elements.

On slide 32, just sort of a reminder, we've automatically put this timeline into our Special Open Door Forum slide decks every time, and this one unfortunately is not, wasn't properly updated prior to some recent finalizations that we've done. We've made some changes to some of these milestone dates, so I just want to run through that since it's all out there.

We have a final data delivery here that says June 8, but as you know we're still in the field because we extended our field period. So our final data delivery is now in mid-August.

Secondly, we recently decided to hold the fall technical expert panel in late September rather than in November. And regarding the Special Open Door Forums that are indicated on here, because this particular, because this June Special Open Door Forum has been delayed, and because we have the upcoming forum event, we at this time are not planning to hold a Special Open Door Forum in September. So that should not be on this calendar.

And finally we're now planning to hold the forum sometime in November rather than in October. So I apologize again for the errors in this timeline. I hope that that was clear enough, it was just a few of these last milestones that are a little bit off based on recent activities.

Now on slide 33, just to remind you, as always we welcome your input sincerely. If you have questions, comments, concerns please don't hesitate to reach out either to our partners at CMS or to the RAND team. Thank you so much.

Jill Darling: Okay, thank you Maria and Jaime. (Sarah), now we'll open the call up for Q and A, please.

Coordinator: Certainly. If you would like to ask a question, please press star 1 from your phone and unmute your line. Speak your name and organization clearly when prompted. If you would like to withdraw your question, please press star-2. Again, if you would like to ask a question, please press star 1 and speak your name and your organization clearly when prompted.

One moment while we wait for the first questions. Again, if you would like to ask a question, please press star, then 1. One moment, we do have someone queued. Our first question comes from (Tony Likich), with Dr. (Likich). Your line is open.

(Tony Likich): Yes, the question was on the range of responses, it seemed there wasn't that much of a range, and I wondered if it reached the level of significance in the study sample.

Maria Edelen: Yes, thanks, this is Maria Edelen. So you're referring to the survey results that Jamie presented.

(Tony Likich): That's correct.

Maria Edelen: Right, okay. So the range, remember these are average ratings that we're presenting. So I actually think the range is, it's certainly a little bit skewed, but not too bad when you think you're looking at averages. But yes, I mean very few people were generally, people don't like to say they don't like things. So when we were asking about utility, people were less likely to say not at all useful or only slightly useful. They were more likely to use the more, you know, positive end of the scale.

But we did get, even when we looked at the means, I mean, was really quite, you know, the range was reasonable. We didn't do any significance testing for differences. So that's one of the follow-up analyses that we may want to do if we want to delve more deeply into some of these responses.

So for example it might be interesting to know whether the average rating of the pain interview for clinical utility, which was 4.25, is really significantly higher than the ranking or the rating that we received about PROMIS depression, which was 3.2. Or which of these numbers are significantly different from one another. We haven't done that with these data yet.

(Tony Likich): Okay, thanks.

Maria Edelen: Yes.

Coordinator: Our next question comes from Maria Radwanski with Health Call Home Health Agency. Your line is open.

Maria Radwanski: Hi, yes, thank you. Thank you for the results that you've presented here on the clinical utility. I was interested in finding out if there is any kind of measurement of utility as well as inter-rater reliability for the functional measures coming.

Maria Edelen: So hi, thanks, this is Maria again. We are evaluating inter-rater reliability in the large national beta test. So that's sort of a separate, that's a separate test of the performance of the data elements themselves. This survey, these results that we've presented today are based on our survey of the field staff who conducted the assessment, to ask them what they thought about the utility.

So we're conducting now some empirical analyses on the actual data elements and their performance. That will be coming in subsequent reports. Does that answer your question?

Maria Radwanski: Yes.

Tara McMullen: Hi, it's Tara McMullen, I do want to jump in. I think I heard for function on there and I do want to add a quick note that for this field test we are not testing any measure of function, and so the question may have been for, the functional assessment standardized data elements were the measures, and I can affirm that test of IRR or inter-rater reliability as well as other reliability testing, validity testing, testing for utility has occurred and that information is online, on our post-acute care downloads and videos web page.

Maria Radwanski: Okay, thank you.

Coordinator: Our next question comes from (Grace Willmer) with Main Line Health. (Grace), your line is open.

(Grace Willmer): Thank you. Referring to slide 29 with regards to patient burden, can you clarify for me who assessed patient burden? Was that reported by the patients or reported by the assessors?

Jaime Madrigano: That was as reported by the assessor.

(Grace Willmer): Thank you very much.

Coordinator: Our next call is (Janice Thornburger) with Point Click Care. (Janice,) your line is open.

(Janice Thornburger): Hi, thank you for sharing the results of your beta test. We were just wondering, when is this targeted to actually be required? So the elements from, the questions from your testing, when can we expect those to be required within the assessments?

Tara McMullen: Hi, it's Tara McMullen from CMS. As with the delayed proposal language that we had in our first PointClick, in the SNF final rule this year, I think you guys are asking about SNFs, we are looking to give an update on where we are with the SPADEs, or the standardized patient assessment data elements, in the fiscal year '20 rule. So I cannot tell you when it will be required, but I can tell you that updates are coming.

(Janice Thornburger): Okay, great, thank you.

Coordinator: And next we have Alyssa Keefe with the California Hospital Association. Your line is open.

Alyssa Keefe: Hi, thanks for taking my question, appreciate the updates. Just a quick question. Most of the surveys of the assessors use the five point scale, yet the patient burden was a three point scale or, can you just give me a sense of analytically why you switched scales? And then secondly, in your, can you discuss kind of the process by which you may want to consider quantifying administrative burden through the focus groups? I wondered if that was an agenda item for discussion with your focus groups. Thank you.

(Crosstalk)

Maria Edelen: Oh, sorry. Jaime, you can answer the first part if you want.

Jaime Madrigano: Yes, I was going to answer the first part. The patient burden was, used the same five point scale. I think it just maybe since we didn't, I didn't show the question again, that was a little confusing, but it's, the range of the answers fell within the, sort of those three points. But it was using the same type of five point scale.

Maria Edelen: Right, and I also should apologize for Jaime too because I'm the one who put that, many of these slides together and then I asked her to present them, so she was a little bit at a disadvantage. But right, so we did use the five-point scale throughout, but the range was from 1.59 to 3.05 for the burden.

As far as quantifying the burden further, in our test of the data elements we are getting time estimates, so that will have that actual numeric information, and we are also having, we are also talking to the assessors in these focus groups and burden is something that is coming up.

So when you say administrative burden, you mean to the assessors when they're asking the questions. Do you have, we have a few focus groups left to conduct, do you have particular aspects of burden that you're most curious about?

Alyssa Keefe: I think time is one, quantifying that time with regard to also additional staff resources or any additional burden, either financial or staffing in particular, did it take different types of staff to appropriately obtain the information to accurately capture the data elements, the timing of training, et cetera. So I know a lot of this is kind of being kind of quantified as part of the larger beta test.

I was just curious if you were probing that in your focus groups and giving folks an opportunity to just kind of opine on what they perceived as most

difficult versus least difficult, to help again better understand the variation between settings. I think that's what I was trying to see if there was an opportunity through the focus groups to better understand the setting variation with regard to the burden as well as the clinical integrity questions. Again, just to better understand a little bit these findings and unpack them a bit.

Maria Edelen: Yes, yes, thanks, that's an interesting perspective. So one of the difficulties with getting that type of information about beta is that this is, you know, the beta assessment was, it was administered, you know, as a full-on assessment in addition to what the sites already had to do, the MDS or the Oasis, or whatever, depending on their setting.

And so it's not, it wasn't implemented in the way that it would be in practice. You know, if some subset of data elements were to be integrated or were to be standardized, they would be integrated into the current assessments. And so the burden per data element, I think information is pretty accurate, and then maybe the difficulty or sort of the knowledge that you need to actually ask the question in a useful way is relevant but then the other parts of it, like timing of, you know extra staffing and those kinds of issues are a little harder to tease out because of the way that, because of the differences between this test and, you know, subsequent implementation.

Coordinator: And our next question comes from Andrew Baird with Encompass Health. Andrew, your line is open.

Andrew Baird: Thank you and thanks for sharing some of this information on the earlier turns of the beta test so far today. My question is maybe a little more general in nature. I'm looking back at slide number six of this presentation and just wondering if all of this type of work is work that is going on right now, or if a lot of this work is sort of work to come. What I mean specifically is, is that

this presentation really seemed to focus on sort of two mental boxes here about reliability and feasibility, and mainly feasibility of these SPADE items.

And so I'm wondering more about the boxes, about you know, research and sort of formal CMS/CMS-contractor work around the other two boxes at the top and the bottom, the potential for improving quality and utility for describing case mix, and what type of work RAND or others are doing around those either now or in the future, and sort of how those two pieces fit into this current data collection process right now. It's almost like a, you know, process question but also asking what is that work and what is it going to look like.

Maria Edelen: Yes, this is Maria. I think your assessment is pretty spot on, where, that we're, you know, the beta activities are mostly focusing on validity and reliability and feasibility. I think working up to, working up to our identifying candidate data elements for testing, especially in our discussions with clinical advisors and with our technical expert panel, we were asking for their opinions about the potential for these various candidate data elements to improve quality, and maybe their possible utility in describing case mix.

I think, I'm not sure if maybe Tara wants to add a little bit to that, but I think I agree that, you know, the goal is for these data elements to ultimately have all of these contributions in all of these properties. But the two in the middle are the ones that we're primarily focusing on with the actual beta results.

Tara McMullen: Yes, thanks Maria. It's Tara McMullen. I would have to say, and I think it's a good question, but all four are occurring in tandem. You can't move forward with one or two of these evaluation criterion without affecting the, you know, you can't move forward with two without affecting the other two, I guess, everything's working together.

So while RAND is currently focusing on - Maria and her team are focusing on the analytical aspects to what the data are telling us, in order to inform outcomes, whether that means, you know, internal decision-making, outcomes of the data elements, we at CMS are also working on the other two criterion to look at candidates for data elements.

And what I mean by that is we, CMS and RAND work together to talk about the data elements and in concert with our other contractors, I can tell you daily, I'm talking about the utility for describing case mix. Certain items, what certain items may do to help put the focus back on the person or may help improve a care planning process via a quality measure.

And it's all thinking about trajectories moving out. And so while we don't talk about those trajectories, we're always thinking years ahead. And so right now, today I was talking about some of these candidate data elements and how that may support clinical decision making, and you know what our folks, we are talking about nurses, but what are folks doing, clinicians are doing in the field and looking at the collection of data elements from their viewpoint and what that might mean in terms of quality, but how that quality would affect payment and payments quality, and quality payments.

So a lot of these discussions go on in tandem, and it's our everyday work. So while today RAND presents to you some of our preliminary data findings, we work together on all four of these buckets.

Andrew Baird: Cool, thanks, so I think a follow-up question if it's possible is to ask, if it's just a discussion around utility describing case mix, what, you know I guess hard analysis is either being done to your point or is planned to be done to, I guess you could say, prove out or to make a case for those types of, you know, discussions about how well something describes case mix, how well

something has the potential to improve quality. Are there actual studies that are going to be done along those lines?

Tara McMullen: We'd probably have to defer to our colleagues in the Center for Medicare for that one, since while I bridge the universal gap between CM and CCFQ and for folks on the phone who don't know what I'm saying, while I bridge the gap between payment and quality in my role as technical advisor at CMS, I'd probably have to defer to the folks who lead that work.

But I can tell you that payment, like quality, it's not stagnant. We have to be doing the analyses to ensure the stability of everything that we're developing and testing. And so to answer that from the quality lens, I can tell you yes, we're doing the analyses right now to look at, I call it the universality of an item, and how well that item would be able to account for acuity, how well that item would be able to account for a performance outcome.

I imagine that our partners in CM are doing the same, but I'd probably ultimately would have to defer to them for like a definitive response on the type of reports and analytic techniques and models are doing.

Andrew Baird: Great, thank you guys.

Coordinator: Our next question comes from (Cindy Fraiks), with Certer. (Cindy), your line is open. (Cindy Fraiks), your line is open. Our next question then comes from Jane Schoof, with Providence Health Care Management. Jane, your line is open.

Jane Schoof: My question was already asked and answered, thank you.

Coordinator: Again, as a reminder if you would like to ask a question, please press star 1, unmute your line and speak your name and organization clearly when prompted. Again, if you would like to ask a question, please press star, then 1. One moment while we wait for any final questions. And we have no further questions in the queue.

Jill Darling: All right, well thank you (Sarah). This is Jill, I'll just hand the call off to Maria or Jaime for any closing remarks.

Maria Edelen: Thanks, Jill, yes I just wanted to say thanks to everybody for tuning in and listening to the most recent update. We always love to communicate and hear your reactions to our work, and we hope to do this again soon. Thank you.

Jill Darling: Thanks everyone, have a great day.

Coordinator: And thank you for your participation in today's conference. You may disconnect at this time.

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