Centers for Medicare & Medicaid Services
Skilled Nursing Facilities/Long Term Care Open Door Forum
Thursday, August 5, 2021
2:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time, all participants are in listen-only mode. During the Q&A session, if you'd like to ask a question, you may press star one on your phone. Today's call is being recorded. If you have any objections, you may disconnect at this time. I'd like to turn the call over to Miss Jill Darling. You may begin.

Jill Darling: Thank you, Ted. Good morning and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications and welcome to today's Skilled Nursing Facilities and Long-Term Care Open Door Forum. Before we begin today's agenda, I have one brief announcement. This Open Door Forum is open to everyone but 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 do have any inquiries, please contact CMS at Press@CMS.hhs.gov.

And we'll just dive right into today's agenda. First up, we have John Kane who will go over the fiscal year 2022 annual rate updates under the SNF PPS final rule.

(John Kane): Thank you, Jill, and thank you, everyone, for being on the call today. Good afternoon and good morning. On July 29th of this year, CMS issued rule CMS-1746-F for the FY 22 SNF PPS final rule. I'm going to speak about the payment portions and I'll pass it on to my colleagues to speak about the quality portions of this rule.

With regard to the payment portions of the rule, CMS estimates that the aggregate impact of the payment policies in this final rule will result in an increase of approximately $410 million dollars in Medicare Part A payments to SNF's for FY22. This estimate reflects a $411 million dollar increase from the update to the payment rates of 1.2%, which is based on a 2.7% market basket update less a 0.8 percentage point forecast error adjustment, and then less a 0.7 percentage point productivity adjustment as well as a $1.2 million decrease due to the proposed - probably due to the finalized reduction in the SNF PPS rates to account for the recent blood clotting factor exclusion.

In addition to these payment provisions, one other thing I wanted to mention before I pass it on to my colleagues in CCSQ - we have - in addition to the basic payment updates, we did finalize revisions and rebates of the SNF market basket, as well as finalized the changes to the PDPM ICD 10 mappings which are now on the PDPM Web site, as well as finalize the methodology for calculating the appropriate reduction for the recent blood clotting factor exclusion.

In addition to those, we had included in our proposed rule a potential methodology for recalibrating the PDPM parity adjustments that we had implemented in October of 2019. So as all of you know, in October of 2019, CMS has implemented a new case mix classification model that is called the Patient Driven Payment Model, or PDPM. When finalizing this model as we have with prior system transitions, we had attempted to implement this new model in a budget neutral manner, meaning that the implementation of this model would not result in any aggregate increase or decrease in overall SNF spending.

To accomplish this, we had imposed a certain adjustment factor on the case mix weights when implementing this new system. When looking at the data since implementation, we had discovered that there was an unintended increase in payments of approximately 5% or $1.7 billion in FY 2020. And so, we had included discussion of a potential methodology for recalibrating this adjustment to set a perspective - to set budget neutrality prospectively going forward.

We received a significant number of comments on this methodology, which we greatly appreciate all of the comments that we received from stakeholders. We are going to be taking all of those comments into consideration and reviewing those comments as we look forward to future rule-making and the FY23 SNF PPS proposed rule.

So, with that, I will now turn it over to (Heidi Magladry) to speak about the SNF Quality Reporting program. Heidi?

(Heidi Magladry): Thanks, John. So, this is Heidi. The SNF QRP's that pay for a reporting program, as you're aware, SNF's that do not meet the reporting requirements may be subject to a two-percentage point reduction in their annual updates. In this final rule, CMS adopted two new measures and updated the specifications for another measure. In addition, CMS made modifications to the public reporting of this inequality measures. The first measure - the new measure adopted is the skilled nursing facility healthcare associated infections requiring hospitalization measure.

This is a claims-based measure that will be adopted to the SNF QRP beginning with the fiscal year 2023. The SNF HIA measure uses Medicare fee for service claims data to estimate the rate of HAI's that are both acquired during SNF care and result in hospitalization.

Some of the healthcare associated infections identified in this measure include sepsis, urinary tract infections and pneumonia. The goal of the measure is to be able to assess those SNF's that have notably higher rates of HAI's that are acquired during SNF care and result in hospitalization when compared to their peers and to the national average HAI rates. Implementation of this measure provides information about a facility's adeptness in infection prevention and management, and encourages improved quality of care.

The second new measure is the COVID-19 vaccination coverage among healthcare personnel measure. CMS adopted this measure beginning with the fiscal year 2023 SNF QRP. This measure will require (SNFs) to report on the COVID-19 healthcare personnel vaccination of their staff in order to assess whether SNFs are taking steps to limit the spread of COVID-19 among their healthcare personnel, reduce the risk of transmission within their facilities, and help sustain the ability of SNFs to continue serving their communities throughout the COVID-19 public health emergency and beyond. They must report the vaccination data through the Centers for Disease Control and Prevention National Healthcare Safety Network beginning October 1, 2021.

A third proposal was - that was finalized - CMS updated the denominator for the transfer of health information to the patient post-acute care quality measure. In the past, the measure - the measure denominator's for both the transfer of health information to the patient's post-acute care and the transfer of health information to the provider post-acute care measures include patients discharged home under the care of an organized home health service organization or hospice.

And to avoid counting these patients in both of the transfer of health measures, CMS is removing patients discharged home under the care of an organized home health service organization or hospice from the definition of the denominator for the transfer of health information to the patient's post-acute care measure.

Our final - our final update is the resumption of the public reporting of quality measures with fewer than the standard number of quarters due to the COVID-19 public health emergency exemption. In March 2020, due to the COVID-19 Public Health Emergency, CMS granted an exception to the (SNF) QRP reporting requirements from Quarter one, 2020 and Quarter two, 2020.

CMS also stated that we would not publicly report any (SNF) QRP data that might be greatly impacted in terms of measure of affordability and reliability by the exceptions from Quarter one and Quarter two of 2020, and the absence of usable data that these exceptions created. This exception affected the standard number of quarters that CMS currently uses to display SNF QRP data. CMS updated the number of quarters used for public reporting to account for this exception. And that's all for the SNF quality reporting program. With that, I'll turn it over to Tim Jackson.

Tim Jackson: Thanks, Heidi. (Unintelligible) Smith, (unintelligible) purchasing program, we had one major policy that was finalized that I'll review and then speak very briefly on the future measures that will be included as part of the program under the Consolidated Appropriations Act.

So, as finalized, our scoring policy for fiscal year 2022, CMS will assign a performance score of zero to all participating SNF's irrespective of how they perform using a finalized scoring methodology to mitigate the effects of the public health emergency impacted results. CMS will reduce the federal (unintelligible) rate for each SNF by 2% and more SNF, 60% of that withhold, which results in a 1/2% payback percentage to all SNF's. SNF's that qualify for the low volume adjustment will continue to receive 100% of their withhold returns.

And now I'll speak briefly on the expansion of the SNF PPDP program. We were able to get the approval for nine additional measures with respect to payments beginning in FY 2024, which include measures of functional status, patient safety, care coordination or patient experience. And we stopped stakeholder input on these measures and any others that we should consider including measures to assess residents' views of their healthcare and measures assessing staff turnover. And we will take the comments into account in future rule-making. And that concludes my portion for this afternoon's update. Thank you.

Jill Darling: Thank you, Tim. Next, we have Kim Roche who will talk about the health equity in LTC regulation.

Kim Roche: Thank you. Good morning and good afternoon to all. So, I will be talking about health equity and long-term care regulation. CMS periodically conducts a comprehensive review of the current health and safety standards, the conditions of participation, conditions for coverage and the requirements for participation with the goal of evaluating the efficacy of the current standards and identifying opportunities for regulatory improvements. And as you know, the requirements are the health and safety standards the providers and the suppliers must meet to receive Medicare and Medicaid payment. They apply to all individuals that receive care in a healthcare organization, regardless of the payer type.

They vary by provider but generally cover issues such as care planning, governance, quality, emergency preparedness and resident rights. So, in accordance with President Biden's three executive orders addressing issues of health equity, we are now evaluating how we can address health equity and improve health disparities through the requirements. We are committed to advancing equality for all, including racial and ethnic minorities, members of the LGBTQ community, people with limited English proficiency, people with disabilities, rural populations, and people otherwise adversely affected by persistent poverty or inequality.

So, in order to achieve these goals, we're asking for information, input and ideas from the public on ways that we can address health equity within the requirements. We're asking for data research studies and any other information that can help inform any potential changes to the requirements that we may make in the future. So, in particular, we are looking for input on how health equity can be improved during the care planning process, how providers can partner with community-based organizations to improve a person's care and their outcomes after discharge.

We're looking for input on ways to hold a facility's governing body and leadership responsible and accountable for reducing disparities within their facility and advancing health equity policies and efforts, how the requirements can ensure that health equity that is embedded into a provider's strategic planning and quality improvement effort. What types of staff training and other efforts are necessary to ensure that residents receive culturally competent care, ways to combat implicit and explicit bias in health care.

We're looking for input on ways to increase vaccine uptake and reduce COVID infections for racial and ethnic minorities. Also, how the requirements can be improved to ensure that providers are not discriminating against individuals in underserved populations, particularly racial and ethnic minorities, those with disabilities, sexual and gender minorities, people with limited English proficiency in rural populations.

We're also looking for input on ways to reduce health disparities amongst rural population and access and increase access to care in rural areas. We're also looking for information on how the requirements can ensure that providers offer fully accessible services for their residents in terms of physical communication and language access.

And then finally, any other data or additional information on ways to ensure that a provider is addressing and reducing health disparities within their facility.

So, we're encouraging you to submit information and your input into the following mailbox. And the mailbox address is HE.outreach@CMS.hhs.gov, and that HE stands for health equity. So again, the mailbox is HE.outreach@CMS.hhs.gov. We will review the information that we receive and use it to inform potential future policy making.

So, at this time I'd like to turn it over to (Kianna Banks) to talk about rural emergency hospitals. (Kianna)?

(Kianna Banks): Thank you, Kim. I am (Kianna Banks) and I'm a policy analyst in the Center for Clinical Standards and Quality’s Clinical Standards Group, and I'll begin by providing some brief background information on this request for information that we published. There has been a growing concern over closures of rural hospitals and critical access hospitals that is leading to a lack of services for people living in rural areas. One of these key services is access to emergency care. Following these concerns, Congress enacted Section 125 of the Consolidated Appropriations Act of 2021 which establishes a new provider type called rural emergency hospitals.

The Consolidated Appropriations Act defines rural emergency hospitals as facilities that convert from either a critical access hospital or a rural hospital with less than 50 beds that do not provide acute care inpatient services. Rural emergency hospitals are permitted to provide skilled nursing facility services furnished in a distinct part unit. Furthermore, rural emergency hospitals will be required to furnish emergency department services and observation care and may provide other outpatient medical and health services, as specified by the secretary through Rulemaking.

The Consolidated Appropriations Act provides that the statutory provisions governing Medicare payment for rural emergency hospitals shall apply to items and services furnished on or after January 1, 2023.

We have published a request for information in the calendar year 2022, OPPS-ASC proposed rule to obtain feedback and comments from the public that we will use to inform our policymaking as we develop health and safety standards, quality measures and reporting requirements and payment policy for rural emergency hospitals.

Some of the targeted areas we are seeking input on are the extent to which the existing health and safety standards for hospitals, critical access hospitals and skilled nursing facilities should also apply to rural emergency hospitals, additional health and safety standards that should apply to rural emergency hospitals, quality measurement and reporting, payment policies, addressing health equity and data sources, additional considerations and unintended consequences that we should consider in the development of the policy for rural emergency hospitals.

We encourage you to provide your comments on the request for information for rural emergency hospitals via the standard process of commenting on notices of proposal making by visiting www.regulations.gov. The proposal will publish on - well, it went on display on July19th, and it actually was published in the Federal Register yesterday. So, it is available for you to go to regulations.gov and provide comments. And the comment period is open through September 16th, if I'm not mistaken. And the rule number is CMS-1753-P.

And that's all I have, and I'll turn it over to the next speaker on the discussion of modernizing CMS payment software.

Wil Gehne: Thanks. My name is Wil Gehne and I work in the provider billing group. I want to call everyone's attention to a new resource about our efforts to modernize Medicare claims processing software. On your agenda is a link to a fact sheet summarizing our progress and describing upcoming releases of Java versions of various programs. This should note that we are converting the Smith PDPM Grouper to Java version two coming up in October 1 of this year.

We released a test version of the JAVA software on the CMS Web site back in April. We hope that providers and their software vendors have taken advantage of the test version over the last few months. The final version of this software will be posted during the week of August 16th. So, please watch NDS 3.0 technical information page for this update.

If you have questions when you download the release, please contact our email resource box, and that's grouper beta testing -- all one word -- grouperbetatesting@CMS.hhs.gov. Thanks. I'll turn it over to Eric (Connors).

Eric (Connors): Thank you, Wil. Hi, everyone. My name is Eric Connors. I work on the human centered design team for iQIES, which is the Internet Quality Improvement and Evaluation system. The team is working currently on modernizing the approach involving MDS assessment submissions and the information and data that is pulled down for reporting using CASPER and other systems to understand from the user's perspective how you go about doing those activities.

So, we're here today to have a plea to - or a call for participation. The human-centered part of human centered design means that we like to speak and have people give us direct feedback about the different designs and systems that we're working on while we go through that.

So, I'm here today to introduce that we're seeking participants for that research, speaking with me on a semi-regular basis. I have different research studies that we go through on a regular basis to understand the user's perspective in all of these cases. My email address for that kind of volunteering is econnors -- and that's e-c-o-n-n-o-r-s at hugeinc dot com -- so that's h-u-g-e-i-n-c dot com. And basically, we're looking for any and all providers and any and all folks that are involved with MDS submissions from your particular facility.

And if you work with a vendor, we're also interested in what kind of vendor relationship you have when you're doing your MDS assessments on site. All of that information is very vital to us. If you're interested in participating, I would encourage you to email me or send contact through CMS to us and we'll get you on the schedule for our next study. And I'll hand it over at this time to (Lorelei Kahn).

(Lorelei Kahn): Good afternoon, everyone. This is just a reminder that staffing data from April 1st through June 30th must be submitted no later than 45 days from the end of the quarter. The final submission deadline for this quarter is August 14th, 2021. Only data successfully submitted by the deadline is considered timely and used on the care compare Web site and in the five-star rating calculations.

Once a facility uploads their data file, they need to check their final validation report which can be accessed in the certification and survey provider enhanced reporting, or CASPER folder to verify that the data was successfully submitted. It may take up to twenty-four hours to receive the validation report so providers must allow for time to correct any errors and resubmit if necessary.

The final validation report only confirms that data was submitted successfully. It does not confirm that the data submitted is accurate or complete. If the final validation has not been received within 24 hours, facilities should run the final file validation report. This will indicate whether or not the files were processed successfully. Providers can also contact the Help Desk for assistance by emailing iQIES@CMS.hhs.gov.

The submission deadline of August 14 falls on a Saturday and the Help Desk is only available Monday through Friday. So, providers should not be waiting until the last few days before the deadline to begin their submissions. CMS will continue to provide technical assistance to nursing homes to improve their staffing and data submissions. Facilities should review their monthly provider preview in their certification and survey provider enhanced report CASPER folder for feedback on their most recent submission.

We also strongly recommend that nursing homes run the following CASPER reports to review the accuracy and completeness of the data that they have entered – 1700D Employee Report, 1702D, Individual Daily Staffing Report and 1702S, Staffing Summary Report.

In addition, facilities should be running the MDS census reports that are also available in CASPER to verify that their census is accurate. All of these reports should be run leaving sufficient time to review and correct any discrepancies before the submission deadline has passed.

And at this time, I will turn it over to Heidi.

(Heidi Magladry): Hi, this is Heidi again for the SNF quality reporting program, and I just want to take this opportunity to remind providers that CMS provided notifications to skilled nursing facilities and non-critical access hospital swing beds that were determined to be out of compliance with the SNF quality reporting program requirements for calendar year 2020, which will affect the fiscal year 2022 annual payment update.

Noncompliant notifications were distributed by the Medicare administrative contractors and were placed into facilities (CASPER) folders in QIES on July 14, 2021. Facilities that received a letter of noncompliance may submit a request for reconsideration to CMS via email no later than 11:59 p.m. on August 13th, 2021. If you received a notice of noncompliance and would like to request a reconsideration, see the instructions in your notification letter - in your Casper folder - or on the SNF Quality Reporting, Reconsideration and Exception and Extension webpage.

Please note, as a reminder, any reconsideration that's submitted that contains protected health information will not be processed. All PHI must be removed in order for a reconsideration to be reviewed.

And with that, I will pass it back to Jill.

Jill Darling: Great. Thank you, Heidi, and thank you to all of our speakers today. Ted, will you please open the lines for Q&A?

Coordinator: Yes. The phone lines are now open for questions. If you would like to ask a question over the phone, please press star one and record your name. If you'd like to withdraw your question, press star two. One moment for the first question. First question in the queue is from Joel Van Eton. Your line is now open.

Joel (Van Eton): Thank you for taking my question today. Appreciate the conversation on the call today. It's good information, good update. I want to ask one question and then make a comment if I could. The question has to do with the COVID-19 vaccination for healthcare providers, quality measure for QRP. It was pretty clear in the final rule that the - this particular measure will impact the APU Adjustment each year, similar to the way that MDS submissions are required to be reported as well. My question is it wouldn't seem clear to me from the final rule or from the C technical specifications for this, how this will actually play into adjusting the APU?

So, for example, for MDS submissions, we have to submit 100% of the data to compute the quality reporting measures on at least 80% of the NDS's, or we stand to lose 2% off of our annual payment update. How will the COVID-19 vaccination reporting requirements play out in that regard in terms of a threshold? If it's possible, if you can answer that and how that will combine with or play into the same kind of thing in terms of if I'm complying on NDS, would I stand to lose my 2% if I wasn't compliant for COVID-19?

Heidi Magladry: Hi, this is Heidi. Thank you for your question. So, yes, the COVID-19 measure will be a part of the SNF QRP and it will be represented, as you pointed out, a new data source for us. The data will be submitted through the NHSN. The requirement will be that providers will submit one week of data per month. And those three weeks of submitted data will then be used to calculate the measure. If more than one week per month is submitted, the most recent week will be used to calculate the measure and the measure will be calculated by the CDC and sent to CMS.

So, you must submit - to comply with the requirement, you must submit that one week of data per month and then those three weeks will be used to calculate the quarterly rate.

Joel (Van Eton): Okay. So, I understand that. It was pretty clear in the final rulings -- the CDC Web site as well as far as technical specifications -- but my question really is similar to the NDS. If I don't net 80% of my NDS's or 100% of the data necessary, I lose 2%. Is there a threshold similar to that for this? And if I'm not compliant with the COVID-19, will that in and of itself affect my 2% to my APU, or does that combine in some way with my threshold from my MDS's?

Heidi Magladry: No. That will - that will impact your APU in and of itself.

Joel (Van Eton): So, if I'm 100% compliant with my MDS submissions but I miss one week or one of the periods of reporting requirements for COVID-19, I'll lose my two percent?

Heidi Magladry: That is correct.

Joel (Van Eton): Okay, that's the clarification I needed. Thank you very much. And then finally, a comment, if I could. On the (SNF) QRP noncompliance letters that you referred to just a moment ago, three facilities that I work with received those (unintelligible) are concerned on that front is that because we - because CMS truncated the timeframe for reporting requirements through COVID accepting the first two quarters, 2021 - I'm sorry, it's 2020. The timeframe making it more likely for noncompliance. These three facilities -- and I've heard some other facilities as well besides these three -- where they were compliant for the full 12 months but because the two months were very heavy COVID quarters, there were some noncompliance.

And all three of these have actually submitted a reconsideration but my comment really is, if you all could take that into consideration as you're reviewing these - these reconsideration requests for facilities that were compliant for 12 full months, for that period of time, for four quarters, that you would take that into consideration when you're considering those reconsideration requests. Thank you very much.

Heidi Magladry: Thank you.

Coordinator: Next question is from Robert (Latz). Your line is now open.

Robert (Latz): Thank you very much. Just a question. I'm trying to understand (unintelligible) the value-based payment program. And I understand what you state in the final rule, but inside of their - providers are being charged the 2% and being given back only 1.2% and that's across the board. And I'm trying to understand or trying to justify how CMS keeps 80% of that -- or, excuse me -- 40% of that 2% amount at a time when you're basically doing nothing during the next year with that. And I'm just trying to understand that justification further, especially with the amount of money we're talking about.

Tim Jackson: Hi. Yes, this is Tim, I'll take that question, thanks. So, with the suppression of the skilled nursing facility, 30-day all cause readmission measure, the scoring policies reference follow on based off of a previously finalized payback percentage policy. So, this actually came from the statute. The program must withhold 12 percent for the SNIF Medicare Part A, fee for service payments, and redistribute that withhold.

So, what I want to make sure you're understanding is that this came from the statute. So, as it was provided by Congress to us, that is the withhold process. And within that, we can return what is allowed and that is what is being returned. So that was the applicable - it sounds like you already read and understood the rule with the - the per diem rates...

Robert (Latz): Yes.

Tim Jackson: ...that was allowed. But that threshold was set by statute, not by regulation. Does that answer your question?

Robert (Latz): Partially. So, as I understand the statute, you had to return a certain amount, but CMS determined that amount up to 70% and you determined that to be 60%. And so, why not give 70% or why not this year give the full 100% back is what I'm confused with?

Tim Jackson: So that was not what was in the proposed rules. The policy maintained compliance again with the payback percentage policies. Again, if we must withhold 2% and the redistribution of that withhold must be kept in form of incentive payments that will be returned, we are not returning those but we are keeping what was less than would have been otherwise. So that is not removing accountability, which is also one of the factors that went into why it stayed at the threshold that it was to uphold the statute requirements. So, kind of - hopefully that's as clear as we can possibly get but it speaks back to essentially being complying with our requirements.

Robert (Latz): Okay, thank you. I still encourage review of that in the future, but thank you.

Tim Jackson: Thank you, we will. Thank you.

Coordinator: Next question is from Kimberly (Gemara). (Gemara), your line is now open.

Kimberly (Gemara): Kimberly (Gemara): Thank you. I had two questions and thank you for this session today. I wondered if the measure specs are now posted for the SNF QRP measures. And then for Eric Connors, with Internet Explorer support being retired, what other browsers are you successfully with (keys) and C Keys and CMS Net?

Eric (Connors): So, I can try to answer that question to my knowledge. Google Chrome works, but I would have to check with the team to know further. That's actually something that's a little bit out of the scope of what I've been working with. As far as iQIES is concerned, iQIES will work on all modern browsers, which is the replacement for QIES in the future. As far as the other question, I'm going to have to defer to someone else on the call.

Heidi Magladry: Hi, this is Heidi. And I believe your question was if the measure specs are posted for the SNF HAI measure, I'm assuming you're referring to, and the draft specifications are actually posted on the SNF QRP measure and technical information page and then the NHS and the COVID-19 vaccination coverage information is posted.

Kimberly (Gemara): All right. Thank you so much.

Heidi Magladry: You're welcome.

Coordinator: Next question is from Carol (Nare). Your line is now open.

Carol (Nare): Yes, thank you for taking my question. I have a question about the SNF value-based purchasing. I understand everyone's at zero and we'll get a 1.2% payback. And I'm wondering if you have the incentive multiplier for that 1.2%? We're so used to using our incentive multipliers to figure out our payments. And is there a .8 or 99 multiplier we can use?

Tim Jackson: This is Tim. I unfortunately do not have that multiplier available. We will make sure we source that and put that in future materials. Thanks for the recommendation.

Carol (Nare): Thank you. And could - could whoever was giving the lists of reports to run, run through those again? That was really quick. So, I have the census report and then I didn't know the numbers of all the others that you were talking about. The (Casper) reports to run - related to the QRP.

Heidi Magladry: Oh, hi, this is Heidi for the QRP. We didn't give a list of CASPER reports to run. I think that was with the payroll base, the PBJ.

Carol (Nare): Okay, right.

Heidi Magladry: (Unintelligible) from (Lorelei).

Lorelei Kahn: Yes, I can give you that list. It is - give me one second. Sorry. Okay, the list of those reports is 1700D. That's the (unintelligible)...

Carol (Nare): D?

Lorelei Kahn: ...part.

Carol (Nare): Is that D or?

Lorelei Kahn: D as in dog.

Carol (Nare): Okay.

Lorelei Kahn: 1702D which is the individual daily staffing report. And 1702S which is the staffing summary report.

Carol (Nare): Thank you.

Lorelei Kahn: You're welcome.

Coordinator: Next question is from Mary (Madison). Your line is now open.

Mary (Madison): Yes, good afternoon and thank you for taking my call. My question is twofold. I'm asking if we have some information on when to expect the updated Appendix PP - the requirement of participation. And the second part is I'm assuming there are no changes to the MDS items set going from October 1st of this year. Will there be an addendum or some sort of addition to the RAI user's manual and will we be looking for a PRA disclosure statement?

Heidi Magladry: Hi, this is Heidi, I can speak to the MDS items set. There is not an MDS item set. Any changes planned to the items set for October 1, 2021 twenty one, and at this point, we don't have any plans to issue an addendum and consequently, there will not be a new PRA. I can't speak to the appendix PP though.

Carol (Nare): Okay, thank you very much.

Coordinator: Next question is from Joel (Van Eton). Your line is now open.

Joel (Van Eton): Hey, thank you for taking another question. More of a curiosity to the individual who spoke - Tim, I think, related to the expanded VVP measures under consideration list - the 15 that were sort of posted in the final rule. Do you guys have a timeline on that? It's something that's going to be worked through in the rulemaking next year, fiscal year 2023, and then finalized next year, or is that going to be something that's going to be done sort of in the interim as those measures are developed? Can you give us some sense of the timeline related to these?

Man: Yes, that's a great question. But you kind of hit the nail on the head in terms of we'll look at how that expansion will progress based off of measures that are already required for long-term care facilities that include (SNFs) and nursing facilities. And then we will assess the quality of care that could be valued and which measures would be most important given the care settings and conditions that are currently being under review both within our beneficiary population and within the facilities at large.

So, we did get a lot of stakeholder input and some of the some of those prioritizations were very clear on what would be looking for in an earlier time period as opposed to future years in our proposed rules. So, you'll definitely see that in the next year. So, I just want to make sure that - we got a lot of feedback, it was very helpful. And there will be a scaling or path forward on how that expansion will proceed.

Joel (Van Eton): Will that -- just to follow up -- will that immediately expand to nine or will that be a progression? Do you guys have any idea on that yet?

Man: Yes, no, that's a very good question. It will not immediately expand so the challenge point also is the score and dynamics for the SNFs is also something that will be factored in. And for other value-based purchasing programs, you have more than one or two measures. What's the prioritization and precedence?

So, there's lots of thoughtful processing that was - that came in and we'll have that laid out in the proposed rules going forward. It's not just the measure expansion but it's also the SNF's value-based purchasing - the scoring, if you will, of the measures as far as they would move out. But no, there is a forward-looking process. Could we include all nine next year? It could. Is it likely? Not at this time. If that was the case, we would have had a very different approach, closing out the - the final rule this year. So hopefully that's helpful. I can't really speak to the future with any definition, but it should be a gradual and thoughtful process.

Joel (Van Eton): All right, thank you very much. I appreciate it.

Coordinator: I'm showing no further questions at this time.

Jill Darling: Great. Well, thank you, everyone, for joining us today. Greatly appreciate your questions and comments and so we will close out today's call. Have a great day, everyone.

Coordinator: This concludes today's call. Thank you for your participation. You may disconnect at this time. Speakers, please stand by.

END