Centers for Medicare & Medicaid Services
Special Open Door Forum:
Designing A Skilled Nursing Facility Value-Based Purchasing Program
Thursday, March 10, 2011 1:30 – 3:30 PM ET
Conference Call Only

The Centers for Medicare & Medicaid Services (CMS) will host a Special Open Door Forum on designing a value-based purchasing (VBP) program for Skilled Nursing Facilities (SNFs). The purpose of this Special Open Door Forum is to solicit input from all parties interested in the development of the plan for implementing a VBP program in SNFs.

Section 3006 of the Affordable Care Act requires the Secretary of Health and Human Services to develop a plan to implement a value-based purchasing program for payments to SNFs under the Medicare program. The Secretary must submit a report containing this plan to Congress not later than October 1, 2011. Currently, we are in the process of identifying and analyzing key components of an effective VBP program for skilled nursing facility care.

After a brief presentation by CMS on the statutory requirements and the goals and objectives for today's call, we will open the phones to comments. CMS is seeking stakeholder input on a number of topics defined in the statute including:

1. The ongoing development, selection, and modification process for measures of quality and efficiency;
2. The reporting, collection, and validation of quality data;
3. The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality, the size of such payments, and the sources of funding for the value-based bonus payments;
4. Methods for the public disclosure of information on the performance of Skilled Nursing Facilities; and
5. Any other issues.

The following list provides additional questions from a literature review of existing VBP programs where we are interested in getting feedback.

1. **Target Population.** How should the VBP program consider differences in target population? For example, should the VBP program be limited to only the performance of care for SNF patients or all residents in the facility (e.g., Medicaid, private pay)?

2. **Quality Measures.** Which types of quality measures should CMS consider when measuring SNF performance under a VBP program?

3. **Measuring Quality Performance.** What issues should CMS consider in implementing a quality performance assessment model? Should CMS consider a single overall performance score or separate scores for each outcome/process domain? For example, CMS could link incentive payments directly to individual measures, or base payments only on overall performance.

4. **Ranking Quality Performance.** Should performance incentives be based on attainment, improvement, improvement with an attainment floor, a combination of these, or other?

5. **Payment Mechanisms.** What factors should be considered in making performance incentive payments or to collect penalties? How should performance incentive payments be funded?

6. **Data Infrastructure.** How should new measures be calculated with current data collection systems? Should any new data collection be required? What should be done to reduce the burden of data collection, and ensure timely and accurate submission?

7. **Public Reporting.** How should public reporting complement a SNF VBP program?

You are also encouraged to submit additional thoughts or feedback following the session to an email address established for this purpose: snfvbp@cms.hhs.gov
We look forward to your participation.
Special Open Door Forum Participation Instructions:
Dial 1-800-837-1935 Conference ID 41221059
Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880 and a Relay Communications Assistant will help.

An audio recording and transcript of this Special Forum will be posted to the Special Open Door Forum website at http://www.cms.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning on or around March 31, 2011.
For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at
http://www.cms.gov/opendoorforums/.
Thank you for your interest in CMS Open Door Forums.

Transcript & Audio File
http://media.cms.hhs.gov/audio/SNF_VBP031011.mp3

Centers for Medicare & Medicaid Services

Moderator: Barbara Cebuhar
March 10, 2011
1:30 p.m. ET

Operator: Good afternoon. My name is (Alicia), and I will be your conference operator today. At this time, I would like to welcome everyone to the Skilled Nursing Facility Value-Based Purchasing Special Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a comment session. If you would like to make a comment during that time, simply press star then the number one on your telephone keypad.

If you would like to withdraw your comment, please press the pound key. Thank you. I would now like to turn the call over to Ms. Barbara Cebuhar.

You may begin.

Barbara Cebuhar: Thank you, (Alicia) and welcome to our special open door forum where we hope to receive public input on crucial components of the implementation plan for the skilled nursing home value-based purchasing report to Congress. Today, CMS is in a listening-only mode. Our hope is to capitalize on your accumulated experience and insights to help guide our design of a value-based purchasing program for skilled nursing facilities as required under Section 3006 of the Affordable Care Act.

My name is Barbara Cebuhar, and I work in the office of External Affairs and Beneficiary Services. I am not an expert on value-based purchasing, but there are some colleagues on the line who are. However, today, we won't be able to answer or respond to any of your questions.

If you have feedback that you think would be valuable to the decision-making process, it would be very helpful if you could forward that information and comments to and I'm going to give you an e-mail address. It's SNF vbp@cms.hhs.gov. I will repeat that, SNFvbp@cms.hhs.gov.

We will be accepting written comments in this mailbox until close of business on March the 18th 2011. So, that's five o'clock. And if you all could send your comments to that e-mail address, that would be very helpful.

I'd like to introduce John Pilotte, who is the acting director of the Performance-Based Payment Policy Staff in our Center for Medicare, who will provide some background on this effort. And then, I will take you through the questions that are posted on the special open-door forum website and that were sent out as part of the invitation to this session. John, could you go ahead please?

John Pilotte: Thank you, Barb and thank you all for taking the time out of your busy day to join us for this open-door forum. We very much appreciate your time and effort and look forward to getting your comments in the areas that Barb will be walking you through later in the call. As Barb mentioned, the goal of today's call is to receive public input on the crucial components of the Skilled Nursing Facilities Value-Based Purchasing Report to Congress.

Barb mentioned this is the report that was authorized under the Affordable Care Act that requires the Secretary to develop a plan to implement a value-based purchasing program for payments to skilled nursing facilities under Medicare and the plan is due to Congress later this fall on October 1st. So, your feedback will be valued and is timely and will help shape what this report ultimately looks like. And we're particularly interested in your feedback in the number of specific areas that will be outlined today.

First is what type of measures including the development of new measures and modification of existing measures should we be – should we be looking at for inclusion in the skilled nursing facilities value-based purchasing initiative and particularly should we be looking at including in the report and the report to Congress both existing and sort of, you, know, future measures as well. How should the reporting, collection and validation of quality data be structured in order to minimize the administrative burden on nursing home, as well as to ensure the timely collection of data for quality reporting purposes? How should the value-based payment adjustments be structured including the determination of thresholds or improvement targets for quality and how should they be structured and how should they be used in adjusting existing payments or providing additional payments to nursing facilities?

And this is an important concept in many of our value-based purchasing initiatives that recognizes and rewards providers for both delivering high-quality care, as well as improving in quality over time. And we're particularly interested in your thoughts and comments in this area. And finally, what methods of public disclosure of information on performance results for nursing should be included and made available publicly by CMS and through CMS websites and other means?

With the goal here to promote more informed decision making on behalf of our Medicare beneficiaries and their caregivers in their selecting and use of nursing facilities, as well as in promoting greater transparency around our value-based purchasing initiative for nursing home as well as across the agency. Those are the areas that Barb has a number of targeted questions around. And we welcome your comments on, as well as other thoughts and ideas you have.

And we very much look forward to your comments today. I'd like to thank you again for taking the time out. And I'll turn you back over to Barb.

Thank you.

Barbara Cebuhar: Thank you, John. (Alicia), we were getting some feedback on the line. I don't know if everybody is in mute.

So, I appreciate your help. Our first question today relates to target populations for the skilled nursing facilities value-based purchasing. Medicare pays for only a relative small portion of all the services provided by nursing facilities that are certified as Medicare skilled nursing facilities.

The majority of services provided in these facilities are not skilled nursing services covered by Medicare. Non-Medicare coverage services are paid by Medicaid and/or private payers. Our questions are, how should the value-based purchasing program consider differences in target populations?

For example, should the value-based purchasing program be limited to only the performance of care for skilled nursing facility patients or all residents in the facilities. That would be Medicaid or private-pay patients as well.

(Alicia), if you could instruct people how to queue up again, we just appreciate your comments and really look forward to hearing your insights.

Thank you.

Operator: As a reminder, if you would like to make a comment, press star then the number one on your telephone keypad. We will pause for a brief moment to compile the comments roster. Our first comment comes from the line of Linda Bergofsky with the U.S. Department of Veterans Affairs.

Your line is open.

Barbara Cebuhar: Hello, Linda.

Linda Bergofsky: Yes, hi. This is Linda Bergofsky from the Department of Veterans Affairs. In response to the first question, with regard to whether or not only skilled services, it's not just Medicaid and private payers, VA also purchases skilled nursing care in nursing homes all over the country.

We have separate contracts with those nursing homes. We also have an effort where we do onsite visit both before an individual is placed and during the course of their care, their contract care with the provider. So, my reaction to this is that it would be overstepping perhaps or potentially conflicting to have CMS Medicare in particular addressing care delivered to veterans where VA is paying where Medicare may have paid for a few days but generally it's VA placing the individual in the nursing facility for skilled nursing care under VA's contract, under VA's standard of care.

And VA is accountable for the quality.

Barbara Cebuhar: Thank you, Linda. Our next comment, please.

Operator: Our next comment comes from the line of Doug Burr with American Healthcare. Your line is open.

Larry Lane: Yes, this is Larry Lane with the – I am the chairman of the value-based purchasing workgroup for the American Healthcare Association. I appreciate this listening session. Given the narrowed format, I just wanted to emphasize

the point that we made when we – when we met with (Dr. Weiner) and the RTI consultants that AHCA is using and that is just a patient-centered site neutral post-acute payment methodology.

It is far more preferable than the single setting silo kind of thought that is going into what Congress had in its mandate. We believe the Secretary had brought authority to explore alternative ideas for advancing value-based performance. And we would say that rather than run forth the siloed provider-centered payment methodology that exists, the required report to Congress should promote immediate steps to rationalize Medicare outlays across the post-acute service embracing the fundamental concepts that the Medicare purchasing should be designed to meet the needs of the beneficiary rather than the historic cost of providers.

And I might point out that RTI has done extensive work under contract with CMS on this particular point. But given the limits that acquired make one other comments that is significantly important. Payment adequacy is the prerequisite to advancing value-based purchasing.

And in the letter that we did share with you and we will reiterate again in comment, the issue of coordination between Medicare and Medicaid has created significant problems. And Dave Grabowski up at Harvard has written extensively on this about the bifurcated coverage and the fact that neither program has the incentives to internalize the risk and create the benefits. So, we appreciate this opportunity, but we do believe that the report to Congress that is being discussed in the narrow parameter at U.F. are way too narrow, way too premature.

The demonstration had just gotten underway and you don't even have any data from it. And the quality measures that are being under consideration of you can't get there from here. We don't have validated quality measures being offered.

So, maybe, the best advice would be to slow this town and work with your stakeholders and less focus on the post-acute broader issue of rationalizing post-acute care.

Barbara Cebuhar: Thank you very much, Mr. Lane. Our next comment, please.

Operator: Again, if you would like to make a comment, you may press star then the number one on your telephone keypad. We have no further comments at this time. I turn the call back over to the presenters.

Barbara Cebuhar: Thank you very much. Our second question is about quality measures. Measuring quality is the first step in linking payment to the quality of care provided by skilled nursing facilities.

Ideally, the set of measure used for payment will capture different elements of care. Currently, several types of measures are used by Medicare to measure skilled nursing facility performance. These measures include information based on health inspection, surveys and staffing in addition to physical and clinical quality measures.

Taken together, these measures include a range of categories including utilization, potentially avoidable events and functional and clinical outcomes. CMS has invested heavily in assessing the quality of care in nursing homes. Most of these efforts are data collected by the periodic inspections of facilities, the minimum dataset and Medicare claims data.

Our question is which type of quality measures should CMS consider when measuring skilled nursing facility performance under a value-based purchasing program? (Alicia), if you could instruct people how to queue up again, please, I'd appreciate it.

Operator: As a reminder, if you would like to make a comment, press star then the number one on your telephone keypad. We will pause for a brief moment to compile the comments roster. Our first comment comes from the line of Virginia Moseley with St. John's Mercy.

Your line is open.

Virginia Moseley: Yes, we had a couple of questions. We were wondering how would CMS get private pay patient data if we currently don't do MDSs on our private pay patients.

Barbara Cebuhar: We are not responding to questions. I'm sorry, Virginia. If you have that question, please go ahead and submit it to the e-mail address that I gave you earlier.

It's SNFvbp@cms.hhs.gov. And we will see somebody can get back to you about that.

Virginia Moseley: So, we should submit any of those questions?

Barbara Cebuhar: Yes, ma'am.

Virginia Moseley: OK. Thank you.

Barbara Cebuhar: Thank you.

Operator: Again, if you would like to make a comment, you may press star then the number one on your telephone keypad. Our next comment comes from the line of Tim Conroy with Capitol Lakes. Your line is open.

Tim Conroy: Hello. Thank you for doing this call. My comment is regarding the survey requirements of satisfaction survey that there would be a way that providers not have to pay to do this when our payments from you will most likely eventually be cut down.

Thank you.

Barbara Cebuhar: Thank you very much, Mr. Conroy. Our next comment, please.

Operator: Our next comment comes from the line of (Janet Dalman) with Colorado State Veterans. Your line is open.

(Janet Dalman): Yes, thank you for the opportunity to speak. I had just recently received the National Quality Forum endorsements of 21 measures for nursing homes. My impression was that those were going to be used as part of the data collection for quality measurement, quality improvement.

And I'm wondering if this is – I think if you're going to be looking at some things in order to pay for performance it should be something above and beyond this basic quality issue or somehow numerically indicating that this is excellent care.

Barbara Cebuhar: So, what would that look like, (Janet). I'm sorry.

(Janet Dalman): What it look like? Well, if everyone is collecting – if this data is collected from everyone, which, you know, would be just like the QI/QMs where in the past the MDS 3.0 information and there is some new information here. National quality performance has stated that there should be a consumer survey for a discharged resident and for a long stay resident, which, you know, includes both the Medicare A stays and the long-term care stays and a family member instrument as well.

So, there are three different surveys that are included in this that are satisfaction type of how was care survey on top of the other percentage type measurements. For example, percent of residents with urinary tract infection long stay. Those types of question.

Barbara Cebuhar: That's helpful, (Janet). Thank you very much.

(Janet Dalman): Thank you.

Barbara Cebuhar: Our next comment, please.

Operator: Our next comment comes from the line of (Mary Horvath) with East Bank Center. Your line is open.

(Mary Horvath): I would like to continue with that, with the quality measures because of the five-star ratings. It's post monthly. So, with the additional quality measures on the urinary tract infections as the previous lady said, that's within a 30-day loopback.

So, if you have an acute facility or a long-term facility, you know, I don't – I still don't understand how it's being publicly viewed as like a one- or two-star

when in actuality the facility, you know, in opinion is possibly doing better than what the stars indicate. So.

Barbara Cebuhar: Thank you for your comment. Our next comment, please.

Operator: Our next comment comes from the line of (David Gifford). Please state your organization. Your line is open.

(David Gifford): In response to your question about the.

Barbara Cebuhar: (Mr. Gifford), your organization, please?

(David Gifford): I am currently non-affiliated with any organization.

Barbara Cebuhar: OK, great. Thank you.

(David Gifford): I would not recommend using the survey process because the frequency of survey process varies and the good data suggest that the survey process varied across the country even though it's set to a standard set of criteria. So, because of that variation, it would not be a good thing tied to the value-based purchasing and also probably is not as well correlated with value as in other areas. Some of these are staffing levels and staffing data while some correlation with overall quality is really not as well structured in our value-based system.

I think you want to do more of the outcome-based payment more related to the outcomes of the functional and clinical outcomes that are there. I would say one of the limitations with the current NQF endorsed measures is that for the prosecute group; there is not enough that probably stands the true outcomes that are needed and desired by the beneficiary and by Medicare who is paying for those beneficiaries' care. And there need to probably be additional set of metrics that are added in to that process.

And if you look at the NQF report, there was a number of discussions of domains and clinical outcome where no measures where submitted to NQF for voting on that. So, I think expanding and looking at measures that are not

only just currently NQF approved that are needed to be added. It would be very important in developing a value-based purchasing system.

Barbara Cebuhar: Thank you very much, (Mr. Gifford). And our next comment, please.

Operator: Our next comment comes from the line of (Victor Lee) with Catholic Health. Your line is open.

(Victor Lee): Hi, thank you for allowing us to talk today. My comment is in support of what (Mr. Gifford) just said. In terms of using survey, the potential metric for a value-based, we know that the availability and consistency among the survey is and the process are not consistent until we resolve that.

That's not really a fair way to engage in our quality.

Barbara Cebuhar: Thank you, (Mr. Lee). Any other comments, (Alicia)?

Operator: We have a comment from the line of David Juba with Fundamental Clinical. Your line is open.

David Juba: Hi, it's David Juba. I just want to comment about the various cons of metrics and especially sort of survey or consumer survey or satisfaction surveys. I think it's very important that these instruments are used for public reporting.

That the results be representative of the population. And my concern always is that self-reported sort of convenient samples of surveys could potentially be very biased to execute one way or the other with respect to the numbers. And so, if they are going to be publicly reported and used for payment purposes, I think net doesn't heavy built in that the survey sampling frame be reasonably confidently designed to be representative of everybody and not based upon folks who for whatever reason decide that they want to be a respondent.

Thank you.

Barbara Cebuhar: Thank you, Mr. Juba. Do we have any other comment, (Alicia)?

Operator: We do. We have a comment from the line of (Janet Dalman) with Colorado State Veterans. Your line is open.

(Janet Dalman): Yes, thank you again. I just wanted to share with you what part the survey scan play in a type of pay for per – excuse me, pay for performance such as we have in Colorado for the Medicaid program. There is a threshold if you've had in your last survey any actual harm, deficiencies or, you know, inadequate care, substandard care; then you're not eligible to apply.

Barbara Cebuhar: Thank you, (Janet). Are there other comments?

Operator: We have more comments. So, our next comment is from the line of Bill Boso with Southern Indiana Rehab. Your line is open.

Bill Boso: Yes, again, my name is Bill Boso with Southern Indiana Rehab Hospital. We are IRF-based SNF and would – comment is to consider the short stay facilities. Our patient can stay as 11 days all opposed to acute surgical.

So, very different quality indicators perhaps in long-term facility items such as discharge at home, improvement in ADLs and reduction in pain after surgery would be more relevant to our population. Thank you.

Barbara Cebuhar: Thank you. Other comments?

Operator: Our next comment comes from the line of Phyllis Glinkowski Charles Cole Memorial. Your line is open.

Phyllis Glinkowski: Hello. I think we have to speak to some very objective measures here. For instance, the UTIs or catheters in the bladder.

Things like that you can count or even for the skilled nursing facilities, the Medicare payment may be stick with how many types they are readmitted to acute care. These are things that you can count in either is or it isn't. I'm really uncomfortable with doing surveys that can be eschewed by the patient – the person doing the survey or the patient interpreting the question.

I'm more for speaking with the objective measures and using them for all residence in your facilities, not just a small portion of them.

Barbara Cebuhar: Thank you, Phyllis. Any other comments?

Operator: Our next comment comes from the line of Barbara Miltenberger with Husch Blackwell. Your line is open.

Barbara Miltenberger: Yes, this is Barb Miltenberger with Husch Blackwell. And I believe that the data have shown that they – the zip code is the most reliable predictor of survey data. So, and I think that the government reports have also shown that survey data is not consistent throughout the United States.

And I think that that would be improper to use that as a method for value-based payment.

Barbara Cebuhar: Thank you, Barbara. Do we have other comments?

Operator: We have comments from the line of (Sandra Fixler) with American Healthcare. Your line is open.

(Sandra Fixler): We cannot use – for example, if we can use a MDS based quality measures unless we do some work to them. Those patients who are managed care private pay, that information is not included in the care of quality measure. And actually, that can affect the denominator size of the measure and can result and if not being reported.

So, if we're going to use measures for payment, we have to find the way where this can be picked up everyone and consistently applied across all facilities with a MDS.

Barbara Cebuhar: Thank you, Sandy. Do we have other comments?

Operator: We do. We have a comment from the line of (Phyllis Stanford) with St. Anthony's Medical. Your line is open.

(Phyllis Stanford): Thank you. I appreciate the opportunity to comment on this. I work in the quality management office and involved in the acute care side of reporting quality measures.

And what I would suggest is that you consider collaborating with other providers, so that the quality measures are more consistent from provider

group to provider group rather than existing an isolation. And I'll give you an example, readmissions for heart failure patients. Currently, an acute care that's one thing that is being considered through value-based purchasing.

What we find when we talked to the long-term care side when we transfer the patients there is that the work that we have done with our patients on weighing themselves daily in fluid restrictions and other interventions are not carried through in the same manner in the long-term care facilities because the culture is different. And weighing everyday is not something that is part of their usual routine. So, I think that if we could find some commonality as we look at the transitions of care and really try to get our – the most bank for our buck in this Affordable Care Act environment, I would consider – I would ask you to consider to look at that across settings.

Barbara Cebuhar: Thank you, (Phyllis). Do we have other comments?

Operator: We do. Our next comment comes from the line of Linda McDonnell with Hebrew Health. Your line is open.

Linda McDonnell: Thank you. Good afternoon. I just wanted to make a comment that the value-based purchasing should be similar to how it is in the hospital, which does not rely on survey data and, of course, they don't use the MDS.

In long-term care and skilled nursing facilities, using the MDS data makes it easier for the staff, but it might not be the best way to collect data. And two measures that I think should certainly be included would be influenza and pneumococcal vaccination as that would – that's positive outcomes for all nursing home residents regardless.

Barbara Cebuhar: Thank you, Linda. Our next comment, please.

Operator: Our next comment comes from the line of Wendy Bauer with St. Elizabeth Healthcare. Your line is open.

Wendy Bauer: Thank you very much for this opportunity. And it may be just sort of reiterating as I have been waiting for my turn. But we are a hospital-based unit and I was very concerned about the comment that was made earlier

regarding the use of readmissions to the acute side as very often and we find here that those readmissions may have absolutely nothing to do with the skilled need at the time that they were admitted to the unit.

But that's something else acute has occurred. And as we have people who return to us over year, we find that those people end up being readmitted to the hospital more frequently, again, with things that could not have possibly been anticipated. The other thing is that as a short-term post-acute hospital-based unit, you know, we find that very often with quality measures in the past, you know, we simply don't register.

We don't have the volume. So, anything that is volume-based, I think, can be problematic being the small unit. And so, you know, I would hope that as we look for measures, that some of that will be taken into consideration as there are truly differences between the hospitals both acute and as a longer-term skilled facilities.

Barbara Cebuhar: Thank you, Wendy. (Alicia), we are going to need to go to our next question if that makes sense. I know that others are in the queue, but we will get to you momentarily.

One of the ways that providers can be rewarded for higher quality care is through payment adjustments that serve as bonuses. Policy makers can provide separate payments or bonuses based on the score for each individual quality measure or they can use a single composite score for a single payment adjustment or bonus. Our questions are, what issues should CMS consider in implementing a quality performance assessment model?

Should CMS consider a single overall performance score or separate scores for each outcome process domain? (Alicia), if we could get people to queue up, that would be great. Thank you.

Operator: As a reminder, if you would like to make a comment, please press star then the number one on your telephone keypad. We will pause for a moment to compile the comments roster. Our first comment comes from the line of David Howard with Provena Life Connect.

Your line is open.

David Howard: My comment was on the previous question. I didn't have specific comments on this new question. Thank you.

Barbara Cebuhar: Well, sir, if you want to go ahead and give us your quest – your comments on the previous question. That's fine.

David Howard: Thank you. I just wanted to add my support for the comments made by others about the current survey process being demonstrably flawed as a measure of quality care subject to variations that have waddled to do with the care being provided by the skilled nursing facility. And I think that more effort needs to be put in to focusing on truly objective data that is not reliant upon the judgment of local state surveys.

And that will provide a more uniform and realistic assessment of quality at the various nursing homes throughout the country. Thank you.

Barbara Cebuhar: Thank you, Mr. Howard. Our next question, and if people could please comment on what issues should CMS consider in implementing the quality performance assessment model. I would appreciate it.

Thank you.

Operator: Our next comment comes from the line of Bruce Glanzer with Good Shepherd. Your line is open.

Chris Jones: This is Chris Jones, Director of Nursing at Good Shepherd in Minnesota. I was just thinking that the consumer or the providers of you well have not seen CMS's new QIs, the 21 proposed. But I can also say that we, as an agency, have enjoyed.

That's kind of a strong word. But the MDS 3.0 really lends itself much better to the process of caring for a person than the others. So, perhaps, this Q.I. indicators may be more measurable than in the past.

Barbara Cebuhar: Thank you, Chris. I appreciate it. Our next comment, please.

Operator: Our next comment comes from the line of Linda Bergofsky with the U.S. Department of Veterans. Your line is open.

Linda Bergofsky: Yes, I think the quality assistance process is the way that it's being proposed is as a multifactorial is perhaps specifically appealing and may appeal to those who are looking to completely objectify this process. But the whole issue of value taken from providers' perspective or a peers' perspective must also be taken into – one must also take into consideration the users' perspective. And so, the multifactorial approach may be very justifiable from a modeling perspective.

But it adds complexity to our consumer without necessarily adding value to their assessment of value.

Barbara Cebuhar: Thank you, Linda. Our next comment, please.

Operator: Our next comment comes from the line of Carol Ramsey with Pinnacle Healthcare. Your line is open.

Carol Ramsey: Hi, I just wanted to make the comment again to reiterate that even in the long-term care industry, many of our patients are there for very short time, two or three weeks for instance of rehab and then, they are leaving. And these are both Medicare patients and managed care patients. So, when we are looking overall at what we are doing in skilled nursing, the bulk of what we are involved with in our subacute resident programs is a 21- to a 28-day length of stay with intensive rehab and then, would return home.

And I'm not sure if the quality indicators that we're looking at measuring are capturing data on those patients. And those are the patients that are choosing our facility specifically for the rehab component that we're offering.

Barbara Cebuhar: Thank you, Carol. Our next comment, please.

Operator: Our next comment comes from the line of (Aileen Dahl) with American Health Association. Your line is open.

(Aileen Dahl): Hi, we'll just make two comments. First, as previously mentioned, the hospital-based system we might not even be in the pool that would be – the data wouldn't be enough to be measured. Also, the MDS 3 if you it for some of the measures previous loopback time for the ADLs in particular.

Therefore, it would not measure what's happening right now and would not give a great indicator of what the status of the resident truly is at discharge. Thank you very much.

Barbara Cebuhar: Thank you, (Aileen). Our next comment, please.

Operator: Our next comment comes from the line of David Juba with Fundamental Clinical. Your line is open.

David Juba: Hi, actually, my comment was way back at the earlier question about the – about the use of readmission rates as some kind of the indicator and my thought on that has always been that this is a very important problem. It's a problem that involves various participants along the continuum of care. And so, I'm always a little bit concerned when an attempt gets made.

So, to pin the readmission tail on some doggie and attribute the "problem" of readmission too to that particular entity. So, I think it's some – it's more complicated than a simple single metric for skilled nursing facilities or for acute care hospitals by themselves and isolation of the others would indicate. And so, I'm a little concerned about using readmission rates as a clinical indicator.

Thanks.

Barbara Cebuhar: Thank you. Our next comment.

Operator: Our final comment comes from the line of (David Gifford). Your line is open.

(David Gifford): Regarding your comment of aggregate versus individual measures for bonus payments, the answer to that is it depends on what the measures are in the aggregate or individual. Also, I think what you've heard on the call, so far, is this great heterogeneity in the types of patients that are coming in to SNF care.

And if you don't have the right measures in an aggregate, it may disservice and a number of facilitates may not qualify for any payment even though they provide a large amount of sniff care if the measures don't measure they types of patients that are coming in.

So, if one didn't look at, say, what functional status measure for hip patients, which is a large volume, it doesn't matter whether you aggregate or individual bonus payment. Probably, in the end, it makes more sense to do an individual bonus because of that variation and you don't have a broaden offset of measures to capture across the board unless you do some global payments with global measures like satisfaction or rehospitalization that people talk about.

Barbara Cebuhar: Thank you, (Mr. Gifford). Any other comments?

Operator: Our next comment comes from the line of (Victor Lee) with Catholic Health. Your line is open.

(Victor Lee): My comment about – in the adjustment is we have to consider a clinical complexity of each resident or each patient before we can adjust for results because they come in different forms and different complexities.

Barbara Cebuhar: Thank you very much, (Mr. Lee). Any other comments, (Alicia)?

Operator: We have no further comments at this time.

Barbara Cebuhar: Great. We will move to the next question, which is about ranking performance. In most value-based purchasing programs, single or multiple thresholds are used to identify providers that offer excellent rather than poor quality care. Typically, these thresholds determine which providers are eligible for bonuses and which owe penalties.

Two key standards have been widely used to identify providers eligible for bonuses and penalties under value-based purchasing, attainment and improvement over time. Under an attainment standard, skilled nursing facilities would be eligible for a bonus payment if they perform at a specific objective standard. Under an improvement standard, skilled nursing facilities

would be eligible for the bonus payment if they demonstrated specific levels of improvement relative to their performance in prior years.

Our question is, should performance incentives be based on attainment, improvement, improvement with an attainment floor or a combination of these or have you got other ideas? If you could instruct people how to get into the queue, Alicia, I'd appreciate it.

Operator: As a reminder, if you would like to make a comment, please press star then the number one on your telephone keypad. We will pause for a brief moment to compile the comments roster. Again, if you would like to a comment, you may press star then the number one on your telephone keypad.

Our first comment comes from the line of Michael Fishkin with Island Rehab Nursing. Your line is open.

Michael Fishkin: Hi, good afternoon. I'm the medical director at Island Rehab and thank you for this opportunity. I think it should be with improvement with an attainment cap because as we continue to improve and certainly quality has been going up a little less, five or ten years significantly, you get to a point where it just can't get much better.

So, I think bringing it up slowly with an attainment cap would certainly be fine. And just very quickly, I also involved with transitional care on a hospital-based environment and a lot of times, these patients go back to the hospital not because of quality issues but because they go back because they need either dialysis or monitoring in a telemetry setting that is not affordable in the transitional care unit. That would be accounted as a readmission to the hospital really has nothing to do with the quality in the transitional care unit.

And as far as surveys are concerned, I found significant input from families and nursing home patients that very significantly across the board. It's really not the patient who's filling out the surveys but many times the healthcare proxy who's filling out. And there are many dynamics that goes into with this situation when they fill out these forms.

And it's difficult to base payment on surveys when a motion comes into the form rather than fact. And certainly, there's a large difference in nursing facilities who have a subacute population of approximately 30 or 40 percent in the chronic care population of 60 percent as opposed to facility that has 90 percent chronic and 10 percent subacute. The types of patients that they see are very, very different to the types of problems that they have.

And whatever formula you come up with, you really need to understand that even though it's a skilled nursing facility, if it's significantly different type of subacute versus chronic, the quality issues are very, very different. Thank you.

Barbara Cebuhar: Thank you, Dr. Fishkin. Our next comment, please.

Operator: Our next comment comes from the line of Doug Burr with American Healthcare. Your line is open.

Larry Lane: Yes, it is Larry Lane, again, chair of the value-based purchasing workgroup for American Healthcare. We did comment on this in our written response to (Dr. Weiner). There really is a need to reward the high achievers and note with improving quality.

And we suggested at that time that their merit looking at some of the state pay for performance programs. You will find programs like Maryland have created in incentives not only for rewarding those who have consistently performed well but also for encouraging facilities that show improvement. We did in our common suggest that there is a need to look at this where we're rewarding all facilities who performed, meet, exceed the performance thresholds that they should be able to be rewarded.

So, that we don't create some artificial force ranking. We really hear our – you know, our experience under the five-star program as the classic example of CMS force ranking facilities in a manner that failure is assured. We want to have a program where failure is not assured but success is assured.

And that the goal should be to have as many that are both improving and knows who performed well received incentives. Thank you.

Barbara Cebuhar: Thank you, Mr. Lane. Our next comment, please.

Operator: We have no further comments at this time.

Barbara Cebuhar: OK, we will go on to our next question, which is about payment mechanisms. A skilled nursing facility value-based purchasing program could feature a number of different structures and bonus payment methods. One option would be to pay bonuses to top-performing facilities.

Another option would be to collect penalties from poor-performing facilities. These options could be combined with bonus payment made and penalties collected. Payment options could be implemented and paid annually or on a rolling basis.

For example, quarterly or more frequently. Our question is, what factors should be considered in making performance incentive payments or to collect penalties? (Alicia), if you could instruct people how to get in to the queue, that would be helpful.

Operator: Absolutely. As a reminder, if you would like to make a comment, please press star then the number one on your telephone keypad. We will pause for a brief moment to compile the comments roster.

Again, if you would like to make a comment, you may press star then the number one on your telephone keypad. Our first comment comes from the line of Peggy Pringle with Covenant Medical Center. Your line is open.

Peggy Pringle: Hello, thank you for allowing the time to comment. I am concerned about the possibility of penalty-type phase with this program especially if one of the quality in our performance indicators will be typed to the state survey process. In looking at that, if a facility is poor performing on the survey, they will be already subjected to penalties such as civil monetary penalties, denial of payments for new admission.

And then to have these additional penalties placed on op of them for the same things, it just seems like double jeopardy. Thank you.

Barbara Cebuhar: Thank you, Peggy. Our next comment.

Operator: We have no further comments at this time.

Barbara Cebuhar: If people would like to comment on the factors that should be considered in making performance incentive payments or to collect penalties, if you could press star one, that would be very helpful. We really do need your insight and ideas about this.

Operator: Our next comment comes from the line of Laura Fowler with Kingston Nursing Center. Your line is open.

Laura Fowler: Thank you. I just like to concur with the prior callers' comments concerning penalties. We were already in a very punitive environment with respect to taking care of our elders in long-term care and short-term care.

I don't say we're obtaining additional penalties, which served any purpose. I think we should be rewarded for the excellent care that we do provide. Thank you.

Barbara Cebuhar: Thank you, Ms. Fowler. Are there any other comments?

Operator: There are. Our next comment comes from the line of Teresa Mota with Quality Partner. Your line is open.

Teresa Mota: Good afternoon. I just wanted to concur with the other two statements getting collecting payment from poor-performing facilities. It can be problematic because any time fiscal issues and staffing issues is the reason why the facility may be having problem.

Leadership is also an issue. So, continuing to penalize facilities in this way, it kind of be intensified these facilities to improve. So, I think that that would probably not be the best option.

Barbara Cebuhar: Thank you, Ms. Mota. Do we have other comments?

Operator: Our next comment comes from the line of (Laurie Acosta) with Aging Services. Your line is open.

(Laurie Acosta): Yes, I would like to follow-up on the previous comment. After 40 years that I know of we have been using punitive incentives to bring about compliance or improvement in performance and that I know of, there are no studies to show that these have worked. We should take a page from the education system, which uses profit dividend incentives to get children to learn.

I think we are one of the few systems that used punishment to improve performance. And I think that's got to stop. Thank you.

Barbara Cebuhar: Thank you, (Ms. Acosta). Other comments?

Operator: Our next comment comes from the line of (Dinah Hale) with Lawrence Memorial. Your line is open.

(Dinah Hale): I would like to agree with everybody who's spoken about the negativism. However, and I don't know that there is an answer, I'm assuming that the only way there are going to be funds to pay for people's good performance would be to take it away from people with bad performance. And I don't know if there is somebody there who sits on this committee can respond to that.

But it's that the concept. Where are those funds going to come to pay rewards without taking away from somebody else?

Barbara Cebuhar: We probably can't respond to that one because we are in the process of formulating our thinking. And so, any ideas that you all have are welcome. Do we have another comment?

Operator: Our next comment comes from the line of Micah Johns with St. Bernards Medical. Your line is open.

Rhonda Holcomb: Yes, this is actually Rhonda Holcomb from St. Bernards. I'm the nursing director, so we're the transitional care facility. I also wanted to comment on payment.

And it's from my understanding that every survey that is done within a state, there is always going to be deficiencies noted. There is never a facility that is not found with deficiencies on their yearly surveys. Therefore, are we going

to automatically be penalized for having those deficiencies and payment taken away from us?

And I think that's something that the committee would need to look at to see, does every state health department that does these surveys with these SNF units always find deficiencies? And if so, does that not more or less set you up for failure?

Barbara Cebuhar: Thank you, Rhonda. I appreciate your insights. And do we have other comments?

Operator: Our next comment comes from the line of Bruce Glanzer with Good Shepherd. Your line is open.

Bruce Glanzer: Hi, this is Bruce Glanzer with Good Shepherd. And I just want to make the comment that punitive responses to whatever or never improved quality, they don't. All it does is causes fear and anger and frustration.

We need to reward positive things. Thank you.

Barbara Cebuhar: Thank you, Mr. Glanzer. Our next comment.

Operator: Our next comment comes from the line of (Janet Dalman) with Colorado State Veterans. Your line is open.

(Janet Dalman): Yes, I just, thank you, wanted to add a couple of things about, you know, where can you get the money for these incentives program unless it comes from the rest of the nursing home community. And what I mean by that is either OIG recoveries from skilled nursing facilities or nursing facilities in general. And also, each state does have their regulations as far as collecting penalties for substandard care that is not corrected.

I think that it give an adequate amount of time to correct whatever deficiencies a facility may have. I don't think it's unfair. I believe that facilities are interested in improving do work on their problems and improve them.

And I think they do it for the residents. I don't think they do it for the money. So, if that money is utilized inside the state for something, which we have in Colorado is our culture change coalition has grants that comes from our civil money penalties.

So, I'm not sure what happens elsewhere but something similar to that may be a potential source.

Barbara Cebuhar: Thank you very much. Do we have another comment, (Alicia)?

Operator: Our final comment comes from the line of David Juba with Fundamental Clinical. Your line is open.

David Juba: I have to get on the bank and I guess that these last two comments and I appreciate everybody has said. It has to do with whether penalties and should be collected from poor performers. I think this changes the whole dynamic of the process because collecting penalties is sort of the equivalent of traffic cop tax collector enforcement.

The incentive becomes with the government to see this as a source of revenue. And it has – and it carries with that all the implications of the tax collector. That as – what would be good performance on the government side?

And good performance would be somebody that collects a lot of – a lot of money. So, I really kind of wince thinking that the value-based purchasing program would be funded by cadres of inspectors whose job it is and whose annual performance ratings themselves would be based upon how much money they brought back to the system. I think it's a bad idea.

Thanks.

Barbara Cebuhar: Thank you, Mr. Juba. Any other comments, (Alicia)?

Operator: We have no further comments at this time.

Barbara Cebuhar: Great. We will move to our next question, which is about payment mechanisms. CMS will need to decide how to fund payment incentive to skilled nursing facilities under the value-based purchasing program.

One option is to fund bonus incentives from savings generated under the program. If no savings were generated, no bonus payments would be made. Other options could be to fund bonus payments to top performing skilled nursing facilities from either reductions in payments or reductions in annual updates for low-performing skilled nursing facilities.

Our question and many of you have offered thoughts about this is, what factors should be considered in making performance incentive payments or to collect penalties? How should performance incentive payments be funded? (Alicia), if you could instruct people how to get in to this queue, that would be helpful.

Operator: Absolutely. As a reminder, if you would like to make a comment, please press star then the number one on your telephone keypad. We will pause for a brief moment to compile the comments roster. Again, if you would like to make a comment, you may press star then the number one on your telephone keypad.

We have no comments at this time.

Barbara Cebuhar: OK, I hope that our conversation about this will have informed our listeners. The next question is about data collection. Skilled nursing facility data are currently available from Medicare claims, minimum data set, data collection, health inspection citations and then nursing home **CAHPS** survey.

However, lack of data and late submission of quality information can reduce precision, which could influence performance measure calculations. Some potential skilled nursing facility value-based purchasing performance measures could not be implemented with current data sources. Additional data collection might be necessary.

Also, lack of data and late submissions could introduce potential for gaming a value-based purchasing program. Our questions are, how should new measures be calculated with current data collection systems? Should any new data collection be required?

(Alicia), if you could ask people to join us in the queue, that would be helpful.

Operator: As a reminder, if you would like to make a comment, please press star then the number one on your telephone keypad. We will pause for a brief moment to compile the comments roster. Our first comment comes from the line of (Mark Pavelich) with (South Senior Care).

Your line is open.

(Mark Pavelich): Hi, I do want to comment on dataset collection mechanism. New data set collection mechanisms really do come from web-based cloud computing applications where individual buildings or chains of building can enter their data and almost automatically enclosed to real-time as possible. Those technologies are available today.

But they are extremely expensive and technologically quite complex. I totally solve that issue. I don't really see how we're ever going to get pass some of data integrity issues that you have already stated.

This is going to be expensive. And I'm not exactly sure how to pay for that either.

Barbara Cebuhar: Thank you, (Mr. Pavelich). Our next comment, please.

Operator: Again, if you would like to make a comment, you may press star then the number one on your telephone keypad. Our next comment comes from the line of Michael Fishkin with Island Rehab Nursing. Your line is open.

Michael Fishkin: Hi, I think this is a very important. But what I want CMS to think about is how this is going to be funded. Currently, at the nursing facilities that I am affiliated with, there is no staff to do this type of data calculation or submission.

With the MDS books now going up to multiple pages that we don't know about very well, the administrative support for the clinical situation that's our real job has become a major burden. And what I would like everyone to think about is I would hope that somebody – there is in charge of reality. And,

although, we all want quality, it has to come from somewhere and it has to be paid for by someone.

And with reimbursement down and certainly the climate in New York with the reimbursement to this, it's also been quite even further. It's very difficult to fund the personnel for this. So, when CMS comes up with the equation, please understand that we're going to have – to have some sort of mechanism to put this into place and be able to pay for it.

It's very nice to have all these things on paper. But the reality is they have to be paid for. Thank you.

Barbara Cebuhar: Thank you, Dr. Fishkin. Our next comment please.

Operator: Our next comment comes from the line of David Juba with Fundamental Clinical. Your line is open.

David Juba: Hi, thanks again. Again, our response – I guess, so take off a little more probabilities mentioned about cloud computing and the expense to complexity. I think this is one of those issues where somehow in the background, there is just notion of budget neutrality and somehow this program value-based purchasing match by definition be self-funded or in the best of our world, I guess, actually save money.

Maybe this is the case where – and I have heard of this recently from high place members of the executive branch that sometimes we have to do investment. And we can invest in high-speed rail. We can invest in windmills or whatever.

But, you know, maybe, we have to invest in information technology infrastructure in this country. And that, if we believe our own redbrick that investment in the – in I.T. will help in the longer run make the system more efficient and more cost-effective. And so, perhaps in the short run, what can go in to the VBT report is some notion that an initial upfront investment in cloud computing or technology of this nature in skilled nursing facilities over, I don't know, on period of some number of years, marks better able tension as I may over a couple of decades, actually, recover and pay for itself.

So, I guess, I just wanted to make that – to bring that investment picture to the table. Thanks.

Barbara Cebuhar: Thank you. (Alicia), do we have other comments?

Operator: We do. Our next comment comes from the line of Doug Burr with American Healthcare.

Larry Lane: Yes, it's Larry.

Operator: Your line is open.

Larry Lane: It's Larry Lane again from the AHCA value-based purchasing workgroup. Just add on the comments from Dave and from others, the larger issue of what new data. The first question is, what resources are CMS going to give us, so that we can get data.

The post-acute sector was pretty much shut out of the high-tech and the stimulus moneys issued is important as integration of the post-acute to the hospital sector cannot occur absent from infusion of resources into investing in our computer based capability. So, is the question here of – without knowing what standards you are looking for without knowing what data you would want to create, then it goes back to my initial comments that there is reason for delay. And the reason for delay of moving forward is we don't have the resources.

We don't know what we are measuring. We don't have valid measures. And we don't have the resources to implement the program.

The one comment I would add to an area earlier we have kicked around ideas such it does not have to be a financial reward only. There are issues that we have filled the bleachers with surveyors, overseers, validators, people with checklist all over the place. Maybe one of the ways that we build in to this program is some incentives that give relief for the own risk oversight it is done to nursing homes.

Thank you.

Barbara Cebuhar: Thank you, Mr. Lane. Any other comments, (Alicia)?

Operator: Yes. Our next comment comes from the line of Teresa Mota with Quality Partners. Your line is open.

Teresa Mota: Thank you. I would like to concur with some of the statements that have been already made and add that that you've made a comment that current data sources, you know, can't be used. I think that part of the reason why is because current data is not effectively exchanged between providers.

You could look at tying this into other initiatives that are going on ad high tech and how the formation exchanges because this is going to be a lot of data going back and forth hopefully, eventually. And regarding the question of collection of new data, at least in the SNF has many folks have already said that providers are already burdened with data collection and transmission and really do not have the staff to do this type of data collection – additional data collection.

Barbara Cebuhar: Thank you, Teresa. Our next comment.

Operator: Our next comment comes from the line of (Dinah Hale) with Lawrence Memorial. Your line is open.

(Dinah Hale): Yes, our skilled unit is – our SNF unit is in a hospital setting. So, we are already very much computerized in working on the CMS, meaning for use for the acute care side and that was my question, is CMS, would they be requiring us to submit the data electronically as they are on the acute care side? Would that be the same requirement and how our raised on being skilled units going to support that kind of initiative?

Barbara Cebuhar: Thank you, (Dinah). Other comments?

Operator: Our final comment comes from the line of (Mark Pavelich) with (South Senior Care). Your line is open.

(Mark Pavelich): OK, so, for disclosure, I forgot how to get out of the queue. So, I won't give some other comments. But I will say we are going to be taking about funding

for some these initiatives including staff resources, etc to be able to upload all of the data for analysis.

It does occur to me in paying for some of these things that the incentives, the financial incentives that we have or the financial abilities that we have to reduce the cost out care to CMS. In particular, I could talk about compare to effectiveness of medication. If we are to determine one medication for a certain subset of population is much better than other medical regimens.

We would save a lot of money. I would like to see some of that money get passed back to what's because we have achieved those savings.

Barbara Cebuhar: Thank you. Any other comments?

Operator: We have no further comments at this time.

Barbara Cebuhar: Great. Our next question is about data burden. Nursing home facilities currently collect and report a wealth of data.

This data can be enhanced to improve the measurement of quality of care and support incentive payments in a value-based purchasing program. Substantial improvements in the quality of data available for skilled nursing home facility value-based purchasing could be achieved by increasing the attention to data quality. While new data collection might enhance the range of performance measures possible for skilled nursing facility value-based purchasing, additional data collection would also add to the additional burden.

Our question is, what should be done to reduce the burden of data collection and ensure timely and accurate data submission? (Alicia), if you could instruct people how to get into the queue, that would be helpful.

Operator: As a reminder, if you would like to make a comment, please press star then the number one on your telephone keypad. We will pause for a brief moment to compile the comments roster. Again, if you would like to make a comment, you may press star then the number one on your telephone keypad.

We have no comments at this time.

Barbara Cebuhar: Thank you. Our next question and we have only two more. So, if people have insights that they would like to do, we will ask a last question about any other comments that you have regarding the value-based purchasing effort.

But our next question is about public reporting. The rationale for public reporting provider quality measures is to inform beneficiaries and discharge planners of agency quality, motivate skilled nursing facilities to improve their performance and introduce new performance measures before they are used for payment. Our question is, how should public reporting complement a value-based purchasing program?

If we could get people to line up for the queue, that would be helpful.

Operator: As a reminder, if you would like to make a comment, please press star then the number one on your telephone keypad. We will pause for a brief moment to compile the comments roster. Again, if you would like to make a comment, you may press star then the number one on your telephone keypad.

We have no questions at – pardon me, no comment at this time. And we do have a comment from the line of Bruce Glanzer with Good Shepherd. Your line is open.

Chris Jones: Yes, thank you, Chris Jones. I just again would like to echo what I've heard that, you know, the people say that thinking this process is really premature because we do not have access to these 21 proposed quality indicators. The information isn't out there.

And if the whole system, CMS is struggling to put that whole piece in place, then I'm thinking that we are really premature in this process.

Barbara Cebuhar: Thank you, Ms. Jones. And do we have other comments that have come in?

Operator: Our next comment comes from the line of Doug Burr with American Healthcare. Your line is open.

Lee Smith: Hi, this is not Larry Lane. This is Lee Smith with AHCA. And I just want to comment on the plethora of public reporting that really even does exist today and how it is going to mesh with increased public reporting.

For example, we would have this value-based purchasing program and we would have the five-star program because there is – and I cannot yet imagine the relationship between the two of these that these different programs, what happens when the facility receives, you know, let's say a low grade under the five-star. But those are extremely well under VBT and that may indeed happen. So, we felt strongly when we were speaking with RTI who is CMS's contractor that a lot of bullet has to be given to coordination of all of the systems and programs.

And that measurement programs such as VBT and five-star have to mesh in this regard. Thank you.

Barbara Cebuhar: Thank you, Lee. Do you have other comments?

Operator: We have no further comments at this time.

Barbara Cebuhar: This is an opportunity for all of you to share insights with the people working on the report to Congress. If you have other comments regarding the skilled nursing facility value-based purchasing effort, I would appreciate your joining the queue now. (Alicia), do you want to instruct them if you have any other insights that we didn't cover today that might be helpful as we consider this input, I would be grateful.

Operator: Absolutely. As a reminder, if you would like to make a comment, you may press star then the number one on your telephone keypad. We will pause for a brief moment to compile the comments roster.

Our first comment comes from the line of (Aileen Dahl) with American Health Association. Your line is open.

(Aileen Dahl): Hi, I wanted to make few comments about the data that we already collect. As I mentioned before, the MDS 3 does collect data. The tool itself was more clear and we would have more accuracy.

And it is possible to retool the MDS 3, so that it would reflect more current data than it reflects now. In other words the loopback really clouds the type of data that we need for current status of the client at discharge or during the stay. The other comment about data is the claims data.

As you mentioned, some of it can be, you know, game played. But also, nursing facilities are not very attuned to – into the diagnosis properly for the claim. And I believe the diagnosis is going to be very important in the value-based purchasing program.

Thank you.

Barbara Cebuhar: Thank you, (Ms. Dahl). Our next comment please.

Operator: Our next comment comes from the line of Anthony Manzella with Dunn County Health. Your line is open.

Anthony Manzella: Good afternoon. I think this will wean the taxpayers' money. I think as long as we have adequate reimbursement, there is efficient data to review all source of quality indicators.

And if you're going to talk about penalties of the same breadth as the set of payments, I think it's a waste of effort.

Barbara Cebuhar: Thank you, Mr. Manzella. Our next comment, please.

Operator: Our next comment comes from the line of Roxanne Tena-Nelson with CCLC. Your line is open.

Roxanne Tena-Nelson: Hi, this tends my overall comments. I would echo some of the things that were said but also add some and may just – as the development of this report is going on to maintain sufficient amount of reimbursement to the organizations that are providing this care, very important care and supporting the – we would support the rewarding of those who do better and integrating how a skilled nursing facility advances person-centered care might be a good focus for some recommendations as we move forward as it integrates throughout any possible measures that the CMS would consider. With regard

to one way of looking at things could be through process measures and making sure that the contribution to improving care transition is factored in.

Mainly because this brings efficiencies to the entire healthcare system. Things like implementation of interact or other types of evidence-based programs that are really trying to get at better quality and better efficiency or reporting to enormous incident reporting system, which doesn't exist. But things like process of how to improve – really rethinking how to improve care.

In the outcomes around meeting mean to really risk adjust for specialty populations. Here in New York, we have pediatric AIDS vent care as a – around the nation. But in particular, the specialty populations are doing something very different than a traditional or even subacute traditional long-term nursing home.

And that needs to be factored in addition to the sort of general taste mix of an – of facilities population. And the last couple of things as agree with the positive incentives to get the improvement any way we can get as that would be much appreciated. And finally, any opportunities that are available to improve quality and care transitions have to be talked about in the context of investing in health information technology and health information exchange in long-term care specifically to gain efficiency.

So, I appreciate the ability to comment and thanks very much.

Barbara Cebuhar: Thank you, Roxanne. Our next comment, please.

Operator: Our next comment comes from the line of Michael Christopherson with Avalon Healthcare with Avalon Healthcare. Your line is open.

Michael Christopherson: Yes, this is Michael Christopherson with Avalon Healthcare. My comment has to go back to rehospitalization. And we feel that this is really important in a value-based purchasing program and quality incentive.

The problem that's really got to be looked up here is the diagnosis codes and the reasons for the rehospitalization because we know that if we discharge someone to the hospital, the diagnosis code of the nursing home users and the

diagnosis codes on the hospital side do not always match. So, which one will be used in this kind of program. We feel like this really needs to be looked at and somehow that we've got to be able to standardize the two systems.

Barbara Cebuhar: Thank you, Mr. Christopherson. I wonder if we have another comment, please.

Operator: Our next comment comes from the line of Linda McDonnell with Hebrew Health. Your line is open.

Linda McDonnell: Thank you. My comment goes back to the first question about the target population. And upon listening to the session, I feel that the target populations should be limited to the Medicare Part A stays of patients in skilled nursing facility.

Thank you.

Barbara Cebuhar: Thank you. Our next comment, please.

Operator: Our next comment comes from the line of David Juba with Fundamental Clinical. Your line is open.

David Juba: Hi, thanks again. David Juba once more. I guess my last comment will be that, yes, I feel for CMS at having to write this report because it is value-based purchasing for skilled nursing facilities and it is mandated in the legislation.

But my feeling is that somehow this task you have been assigned is an example of the schizophrenia of the legislation and of national health policy in the sense. On the one hand, you are being asked to go up with a program that is, you know, the foundation of it is yesterday sort of news the old siloed pay different provider groups – different – using different systems. Where at the same time, the legislation – the agent protection of Affordable Care Act is looking forward to things like bundling and an accountable care organizations and patient-centered payment, which in the way are focused on the entire continuum care.

So, somehow, I think this report might be an opportunity to move – to move the government and Medicare specifically more in the direction of the continuum of care notion in a way – somehow to use this report to maybe put away forever or at least put it in – put it in some place. There is notion of siloed payments where SNFs are considered somehow independent of acute care hospitals and independent of home care and independent acquisition. And the payment mechanism is built upon that assumption and use this to move more toward the – toward the notion of paying bundles or paying for a continuum of care.

And I'm not being very articulate about this. But I think that part of the dilemma, I think, that I have and the other people have is that we feel like we're looking over a shoulder at things the way they used to be while removing head longing into a new world. So, that's my last comment.

Thanks.

Barbara Cebuhar: Thank you very much, Mr. Juba. Do we have other comments?

Operator: Thank you.

Barbara Cebuhar: (Alicia).

Operator: Yes, we do. Our next comment comes from the line of Teresa Mota with Quality Partners. Your line is open.

Teresa Mota: Hi, my comment is related to the question regarding what should be done to reduce data burden. Data collection in the SNF are – many master this. As folks know, reimbursement quality, survey verifications.

And I think in order to reduce the burden, CMS should consider collecting the specific data that CMS needs for the various components. Problem with that is that the data collection vehicles that are currently in place are also used to help facilities collect information for care planning. So, when you've got such to use a word that was use as – a schizophrenic use of one particular dataset.

And it could be very, very difficult to clean the data that CMS probably needs, as well as the providers need and all of the CMS components.

Barbara Cebuhar: Thank you, Teresa. Do we have other comments?

Operator: Our final comment comes from the line of Doug Burr with American Healthcare. Your line is open.

Lee Smith: Hi, thank you very much. This is Lee Smith with AHCA. I just want to make one last plea for CMS to wait for at least one year's worth if not two year's worth of the data that is going to come from the current value-based purchasing SNF demonstration in three states.

You've heard from others that, for example, rehospitalization and we know how important that rehospitalization issue is and I understand that some – a very interesting or helpful data may come out of this demonstration on rehospitalization. Remember that the statute itself, PPACA, in this section does encourage the Secretary to use the result of demonstrations. And this is the demonstration, which I would assume would provide a real input into this task.

And remember the burden that was placed the project, the demo is voluntary. But there have been very hardworking, productive providers in the demo states helping out with this demonstration. If the results of the demonstration are not going into this report, then what is the point – or what is the point of the demo and where are the results going.

At any rate, thank you very much.

Barbara Cebuhar: Thank you, Lee. Do we have other comments?

Operator: We have a comment from the line of Stuart Shapiro with PHCA. Your line is open.

Barbara Cebuhar: Mr. Shapiro.

Operator: Stuart Shapiro with PHCA. Your line is open.

Stuart Shapiro: Hello, can you hear me?

Barbara Cebuhar: Yes, we can.

Stuart Shapiro: It's very easy for the professionals at CMS to go barely forward to do some value-based purchasing program as this required in the Affordable Care Act. I would hope, however, that the professionals at CMS would say we're not ready. That they would sit back, say that no matter what the Act said, there's just no way that we could roll out a program going to get it right in the immediate future.

And I hope what the – what will echo that feel that you guys will simply sit back, take a breath and then say we just can't do the data in their – wait for the data that is going to take a year or so to come. But let's get this right that it just gets it done.

Barbara Cebuhar: Thank you very much, Mr. Shapiro. (Alicia), do we have any other comments?

Operator: We have no further comments at this time.

Barbara Cebuhar: OK, great. I am so grateful for everybody's input and insights. This has been a tremendously helpful call to the folks putting together the report to Congress.

I just want to remind the folks that there is an encore presentation of this call available by four hours after our session is over. So, that would be at about seven o'clock tonight, Eastern Time by calling 1-800-642-1687, and entering the pass code that is available for this call, which is 41221059. It's available until Monday, the 14th of March at midnight.

Just a reminder, you can send your ideas, insights and any comments to us at SNFvbp@cms.hhs.gov until March the 18th at five o'clock p.m. Once again, we do thank you all for your insights and your time and we appreciate your participating in today's call. (Alicia), we can probably encourage folks to disconnect now.

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

END