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Centers for Medicare & Medicaid Services
SNF Value-Based Purchasing Program Call
MLN Connects National Provider Call
Moderator: Hazeline Roulac
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Contents

Operator: At this time, I'd like to welcome everyone to today's MLN Connects® National Provider Call. All lines will remain in a listen-only mode until the question-and-the answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I'd now like to turn the call over to Hazeline Roulac. Thank you. You may begin.

Announcements and Introduction

Hazeline Roulac: Thank you, Holley. I am Hazeline Roulac from the Provider Communications Group here at CMS. I am your moderator for today. I would like to welcome all of our participants to this MLN Connects National Provider Call on the Skilled Nursing Facility Value-Based Purchasing Program. MLN Connects Calls are part of the Medicare Learning Network®.

During this call, you will learn how the implementation of the Skilled Nursing Facility Value-Based Purchasing Program will affect your Medicare payment. We will cover the legislative background, the readmission measures, scoring methodology and performance measures, and the quarterly confidential feedback report. A question-and-answer session will follow the presentation.

Before we begin, just two announcements. There is a slide presentation for this call. You should have received the link to the presentation in your registration email. If you have not already done so, please view or download the presentation from the CMS website at go.cms.gov/npc; that's G-O as in go dot C-M-S dot G-O-V forward slash N-P-C, and select today's call from the list and click on slide presentation under Call Materials. And last, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website under Call Materials. You will receive an email when these are available.

At this time, it is my pleasure to turn the call over to our presenter, Stephanie Frilling. Stephanie?

Presentation

Stephanie Frilling: Thank you, Hazeline, and good afternoon to our callers. Thank you very much for your time. Again, I'm Stephanie Frilling, the program lead for the Skilled Nursing Facility Value-Based Purchasing Program, or the SNF VBP Program. The program is overseen by the Division of Value, Incentives and Quality Reporting at the Centers for Medicare & Medicaid Services.

Value-Based Purchasing reflects a historic change in how CMS pays for care. Instead of linking payment to only the volume of services provided, VBP programs tie a portion of payment to the quality of these services. The SNF VBP Program is one of many

value-based purchasing programs whose aim is to reward quality and efficiencies and improve health care.

Before we begin today's presentation, I would like to thank those of you who submitted questions prior to today's call. You will find that many of the questions will be answered in this presentation. For those of you who submitted questions that are not addressed, I'll be glad to answer them during our question-and-answer session at the end or refer you to our additional resources that can help you.

So, if you turn to slide two, that's the disclaimer that Hazeline covered, and then slide three will be our agenda.

Today, I'd like to provide you with some background information on the SNF VBP Program, which will begin to affect payment beginning on October 1st, 2018, and will include a quality payment incentive for skilled nursing facilities. There are specific legislative requirements that make the SNF VBP Program unique in comparison to other CMS programs. And I will provide an overview of the program statute.

We will begin with the origin and intent of the program, and continue with some discussion of the readmission measures that we have finalized to date. We will take a look at the scoring methodology, performance standards that were finalized for the program, and I will spend some time explaining the quarterly confidential feedback report, as well as additional resources for you on the program.

Origin and Intent of the SNF VBP Program

On slide four, I'd like to present the CMS Quality Strategy guide. This guides our agency's quality improvement activities. It's based upon the Health and Human Services National Quality Strategy, which governs our aim to improve health-care services and patient health outcome. The next few slides will explain the strategy in more detail.

On slide five, you can see that the strategy is based on three governing principles—better care; healthy people, healthy communities; and smarter spending across care settings. We believe the SNF VBP Program will incentivize progress towards all three aims by encouraging the provision of high quality, care which results in healthier patients and smarter spending.

On slide six, we've identified the CMS Quality Strategy goals that reflect the six priorities found in the Health and Human Services National Quality Strategy, and promote the three broader aims of the strategy. As you can see, our first goal is to make care safer by reducing harms caused in the delivery of care. The second goal is to strengthen person and family engagement in all health care. The third goal is to promote effective communication and coordination of care. Another goal is to promote the effective treatment and prevention of chronic disease. Another goal is to involve – involves working with communities to promote best practices for healthy living. And the final

goal is to make care affordable. CMS is actively pursuing these goals so that we can continue to improve and transform our health-care infrastructure.

On slide seven, you'll see that Value-Based Purchasing is a great example of how CMS is supporting its Quality Strategy aims and goals. Value-Based Purchasing provides payment incentives for quality care. Payment is directly linked to provider's performance on certain quality metrics. The better the provider performs on these metrics, the higher its payment. CMS has already implemented several other VBP Programs listed on this slide. And each one of these programs has adopted quality measures that aim to align with some of the CMS Quality Strategy goals.

Unlike other VBP programs, which score multiple measures aligned with the CMS strategy goal, the SNF VBP Program is limited to the single measure. We realize a single quality measure is more challenging because total performance will reflect only the performance on that measure, thereby limiting a SNF's opportunity to balance performance across multiple measures. But this limitation is required by the statute.

On slide eight, we mention our Delivery System Reform. So, in January of 2015, the administration set two goals listed on the bottom of the slide for tying Medicare payments to quality and also invited private payers to meet or exceed the goals. Specifically, that 30 percent of Medicare payments will be tied to quality or values through alternative payment models by the end of 2016 and 50 percent by the end of 2018. And the 85 percent of all Medicare fee-for-service payments will be tied to quality or value by the end of 2016 and 90 percent by 2018.

In March 2016, the administration announced that we had achieved its goal of tying 30 percent of Medicare payments to quality or values through alternative payment models. CMS continued to use the tenets of the National Quality Strategy and the administration strategy to move from volume-based to value-based payment environment. The SNF VBP Program is an important part of achieving these goals.

On slide nine, we've illustrated CMS's historical performance at tying payment to quality and our goals for future years. We have adopted a framework that categorizes four ways payments are given to providers. Category 1 is fee-for-service, Category 2 is fee-for-service where SNF VBP is in this category that we link it to quality, Category 3 is the alternative payment model, and Category 4 is population-based payment.

So, that's the background of the CMS Quality Strategy and where the SNF VBP Program fits within that strategy. And now I'd like to turn our attention to our legislative basis. So, beginning on slide 10, the SNF VBP Program was authorized by the Protecting Access to Medicare Act or PAMA of 2014, which was enacted into law on April 1st of that year. Section 215 of this law added subsections G and H to Section 1888 of the Social Security Act. PAMA also furnishes prescriptive guidance to the payment methodology and

specifically requires us to make value-based incentive payments based upon achievement and improvement.

The statute also requires CMS to rank facilities' performances based on their scores from low to high. The highest ranked facilities will receive the highest payments. And pursuant to the statutory requirement, the lowest ranked 40 percent of facilities will receive payments that are less than what they would have otherwise received without the program. PAMA also requires the total full of incentive payments, total not less than 50 percent of the amount withheld from the facilities, and no more than 70 percent of that amount. There are no exclusions from SNF VBP Program for any reasons, including case volume or facility size.

Readmission Measures

On our next slide, slide 11, you'll see that in the fiscal year 2016 SNF PPS final rule, we adopted the skilled nursing facility readmission measure known as the SNFRM as the first measure for the SNF VBP Program. This measure will be used for implementation of our program in fiscal year 2019. The measure estimates the risk standardized rate of all-cause, unplanned hospital readmissions of SNF Medicare beneficiaries within 30 days of discharge from their prior hospitalization. Hospital readmissions are identified through Medicare hospital claims and not SNF claims. So, no readmission data is collected from the SNF, and there are no additional reporting requirements for the measure.

Readmissions to a hospital within the 30-day window are counted regardless of whether the beneficiary is readmitted directly from the SNF or if they have been discharged from the SNF as long as the beneficiary was admitted to a SNF within 1 day of discharge from their hospital stay. The measure excludes planned readmissions since these would not indicate poor quality of care and is risk-adjusted based on patients' demographics, principal diagnosis in prior hospitalizations, comorbidities, and other health status variables that affect the probability of readmission.

On our next slide, slide 12, we offer these specific exclusions for the SNFRM calculation, and they are included on the slide. So, as you can see, patients hospitalized with cancer, for example, are excluded; and patients without Medicare Part A coverage for the full 30-day window and for the full 12 months preceding the discharge are also excluded.

On slide 13, we have given you some of our analysis on data from our '13, '14, and '15 years. So, on the next few slides, we'll be presenting that data for you. Our observation is that the rates overall have remained fairly consistent since 2013. They are, however, decreasing year-over-year. Based on 2013 data, the mean readmission rate for all SNFs was 19.8 percent.

As you'll see on slide 14, in 2014, the mean readmission rate was 19.5 percent; again, decreasing very slightly.

And then our slide 15, and this is calendar year 2015 data, the mean readmission rate was also similar at 19.4 percent. Additionally, the maximum readmission rate observed in the data decreased from prior years. So, as you can see the rates are very similar year to year. And in addition the overall trend for SNF readmission rates is decreasing. We believe the SNF VBP Program will incentivize SNFs to continue to work to achieve lower readmission rates and higher quality of care.

On slide 16, we'll give you some summary statistics from our 2015 data. So, on this slide, we're showing some high-level statistics on the pool of SNF providers around the country. Again, based on the '15 data, there were 16,631 skilled nursing facilities receiving Medicare payment under the PPS. And compared to 2013, we identified 330 new provider IDs and 350 SNFs that are no longer active. You'll also see from our analysis that Texas, California, and Ohio have the largest number of SNFs; while Arkansas; Washington, DC; and Puerto Rico have the fewest number.

On slide 17, we'll turn our attention to the number of stays. And we can see here that the Medicare volume between 2013 and 2015 that we have found that the average number of SNF stays each year are about the same. We observed a small decrease between 2013 and '15. The graph on this slide is a cumulative distribution function, and it illustrates along the Y axle – axis, excuse me, the cumulative percentage of SNFs that had a certain number of stays in 2015. As you can see from the chart, 50 percent of SNFs had fewer than 70 stays and 5 percent of SNFs had more than 310 stays.

On slide 18, as you can see we mentioned earlier that readmissions are going down. They are decreasing year-over-year since 2013. The chart on this slide shows the decrease as a cumulative curve as it moves to the left since 2013 for the lower readmissions. We note the SNF community at large is working very hard to reduce readmissions and again the SNF VBP Program will further incentivize these kinds of changes.

On slide 19, we'd like to share some of our definitions and methodologies with you. So, this slide presents some key scoring concepts and definitions for the program. We note that in calendar years presented on the slide as the baseline and the performance period are key to the payment year 2019 SNF VBP. We will update these periods annually through the rulemaking process. We will discuss how the achievement and improvement thresholds and benchmarks are used to determine a facility's performance score for a given year of the SNF VBP Program in subsequent slides.

The SNF VBP scoring methodology is described in detail in the fiscal year 2017 SNF PPS Final Rule, which was published in the *Federal Register* on August 5th of this year. At the end of this presentation, there'll be a link to that final rule.

On slide 20, we present our performance standard. So when we think about performance standards and readmission rates for the SNF VBP Program, the lower the

readmission rate, the better. We have inverted every SNF's readmission rate by one minus their SNFRM. So, since readmission rates are going down, the achievement threshold has gone up. The benchmark has also gradually increased from 83.24 percent in 2015 to 83.60 percent in '15.

On slide 21, we show the 2015 performance standards using the risk standardized readmission rates. The threshold represents the 25th percentile of the national SNF performance on the quality measure during 2013. And the benchmark is the mean of the best decimile of national SNF performance on the quality measure during '13.

SNF VBP Scoring Methodology and Performance Measures

On slide 22, as we noted previously, the SNFRM rate represents a percentage of qualifying patients at a SNF who are readmitted within the risk window of the measure. So, we'll calculate the scores under the SNF VBP Program by first inverting the SNFRM rates using the calculations found on the slide. SNF scores will be based on the equation shown here, which is one minus the facility SNFRM rate. For example, if a SNF had a readmission rate of 0.20449 in 2015, the facility's inverted readmission rate would be 0.79551.

On slide 23, we'll give our scoring methodology. So, consistent with the requirements listed in Section 1888 H3b of the Social Security Act, the SNF VBP Program has adopted the scoring methodology that includes levels of achievement and improvement. Again, we note that the baseline and performance used to assess facility performance will be updated for each year of the SNF VBP Program. And for fiscal year 2019, SNF VBP Program achievement scoring compares a SNF CY 2017 performance to the performance of all facilities during CY 2015.

A SNF can score zero to 100 points for achievement. For improvement scoring, on the other hand, compares a SNF's CY 2017 performance to its own performance during CY 2015. A SNF can score zero to 90 points for improvement. We will use the higher of a SNF's achievement and improvement scores to serve as the SNF's performance score for a given year of the SNF VBP Program.

This way, a facility can increase its score if it shows an improvement over its previous performance while it strives to reach higher levels of national performance on the measure. More details regarding the SNF VBP Program proposed scoring methodology can be found in our fiscal year 2017 final rules. And, again, a link is provided at the end of this presentation.

On slide 24, we'd like to actually walk you through an example of our scoring methodology. So, in the next few slides, we will – you'll see the SNF's baseline period inverted readmission rate. For this example is 0.8275. Then if you click to slide 25, you'll notice that the SNF's performance period inverted rate, which has been calculated as 0.83. And on slide 26, you'll get the achievement score where we're comparing the

individual SNF's readmission rate during the performance period to all SNFs' performance during the baseline period using the achievement threshold and the benchmark shown.

And on slide 27, here you'll see the achievement range, which we use to illustrate the achievement points calculation. Again, the achievement range goes through the achievement threshold to 26 percentile to the benchmark, which is the mean of the best decimile. So, in this example, the SNF would receive 41 points for achievement. The actual number of points awarded will be calculated based on the formulas adopted in our fiscal year 2017 PPS final rule.

On Slide 28, we can now consider the improvement range. So, the improvement range is a scale between the SNF's prior performance rate on the measure during the baseline period and the benchmark. This SNF would receive 20 percent – 20 points, excuse me, for improvement.

On Slide 29, CMS will use the higher of the achievement and improvement scores. So, in this example, the SNF would receive 41 points.

So, in the interest of transparency, on slide 30, CMS has used the actual readmission rates for 2013 and 2015, and simulated what the program would look like using the performance standards calculated from the 2013 data. And that's what's been shown on the previous slides. This chart shows the simulated achievement scores calculated from the 2015 data. We have calculated 3,910 unique scores for achievement. And out of a possible score of 100, 12,986 SNFs would receive achievement points and 504 SNFs would receive the maximum achievement score of 100.

On slide 31, we'll show the simulated improvement scores using the 2013 and 2015 data. And here, there are 8,281 unique improvement scores. Nine-thousand-two-hundred-and-forty-nine SNFs would receive improvement points, and 968 SNFs would receive the maximum improvement score of 90.

And on Slide 32, finally, in this chart, we'll show the simulated results of the performance scores, which represent the higher of each SNF's achievement and improvement score. Using that calculation, we have identified 6,888 unique scores. So, you'll see that 70 percent of SNFs scored less than 50 points. It is important to know that these results, while based on real 2013 and 2015 SNF readmission data, are simply meant to simulate what the real program will look like when it begins in fiscal year 2019.

On slide 33, we're introducing the idea of the exchange function. So, in order to convert SNF performance scores into value-based payments, an exchange function is used. The exchange function is the relationship between a SNF's performance score and the amount of money the SNF will receive as a value-based incentive payment. CMS sought comments on four different exchange functions to translate SNF performance scores

into Medicare payments: a straight line or linear function on the top left, the concave curve or cube root function on the top right, the convex curve or the cube function on the bottom left, and the S-shaped curve for logistics function on the bottom right. We intend to propose the exchange function in future rule making.

Quarterly Confidential Feedback Reports

On slide 34, we'll turn our attention to our quarterly confidential feedback reports. So, the SNF VBP Program statute requires that we provide these reports to SNFs on their performance. We'll provide these reports via the QIES CASPER system.

And on slide 35, there is a glimpse of what that report will look like. And so, you can see that we're reporting out the number of eligible states, the number of readmissions, the national average readmission rate, and the risk-adjusted readmission rates.

On slide 36, we have adopted a review and correction process, as required by statute. And the SNFs will have the opportunity to review and provide corrections to their performance information that will be published on Nursing Home Compare. This data is then used for the readmission measure. The quarterly reports will include four data elements from the specified time period. So, I've mentioned those.

On slide 37, we have adopted the two-phase process to submit corrections. So, the corrections must be submitted to the SNFVBPinquiries email address that's listed, along with the following information. We'll need the SNF's CMS Certification Number, the name, and the correction requested and the basis for the correction and any supporting documentation.

On slide 38, as I mentioned earlier, there will be a two-phase of correction process. So, Phase One corrections will be limited to review and correction of your SNF's quality measure information only. Phase Two corrections will be limited to your performance score and ranking information. We'll propose more specific requirements for Phase Two in future rulemaking. Phase One corrections will be accepted to your quarterly report's contents until March 31st following that specific quarterly report's delivery date.

On slide 39, we'd like to just introduce our Potentially Preventable Readmission measure. So, as I mentioned earlier in the presentation, the SNF VBP Program is limited by statute to a single measure at a time. In the fiscal year 2017 final rule, we adopted the SNF 30-day Potentially Preventable Readmission measure, known as the SNFPPR.

This measure is a subset of all readmissions. It assesses the risk standardized rate of unplanned, potentially preventable readmissions for Medicare fee-for-service SNF patients within 30 days of discharge from a prior hospitalization. The measure is harmonized with other potentially preventable hospitable readmissions for post-acute care settings to the greatest extent possible.

Potentially preventable hospital readmission conditions for post-acute care are defined using the existing evidence, empirical analysis, and technical expert panel consensus. The key difference between the SNFRM and the SNFPPR measure is that the SNFPPR measure focuses on potentially preventable readmissions rather than all-cause readmissions. We'll propose to replace the SNFRM with the SNFPPR in future rulemaking.

Thank you for the opportunity to discuss the SNF VBP Program today. I will now turn the call back over to our moderator.

Keypad Polling

Hazeline Roulac: Thank you, Stephanie. So, in just a few moments, we will start the question-and-answer portion of our call. But before we do, we will pause to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. There will be a few moments of silence while we tabulate the results. Holley, we are ready to start keypad polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter nine. Again, if you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter nine.

Please hold while we complete the polling. Once again, please hold while we complete the polling. Please continue to hold while we complete the polling. Thank you for your participation. I'll turn the call back over to Hazeline Roulac.

Question-and-Answer Session

Hazeline Roulac: Thank you, Holley. So, we're going to start the question-and-answer portion of our call. I'm going to turn the call back over to Stephanie, who will address some of the questions that were received during the registration period. Stephanie?

Stephanie Frilling: Yes. Thank you, Hazeline. I know I've given you a lot of information today, and I'm glad that I'll have the opportunity to answer more questions. But as I stated in the beginning of the presentation, we did receive several questions during registration for this call. And I believe that I have addressed many of them in the presentation, but there were some that we wanted to address at this time.

So, one participant had a question about whether a nursing home will be able to earn back 100 percent of withholdings. The short answer is yes. By statute, CMS can only

provide back, at most, 70 percent of the money withheld to SNFs. The highest-performing SNFs will receive more than the 2 percent withheld from them. So, yes, the nursing home will be able to earn back 100 percent of what was withheld from them.

Another participant asked, are evaluation periods measured in calendar years and reimbursement withholding evaluated on fiscal years? And, yes, SNF's performance on the SNFRM will be evaluated during calendar years. The baseline and performance periods and the actual withholding incentive payments will occur during the fiscal year. So, for the first year of the program, the baseline period will be calendar year 2015, the performance period will be calendar year 2017, and the payment year will be fiscal year 2019.

We also received a question as to whether the SNF VBP Program impacts CAHs swing bed units. No, CAHs are not paid under the SNF PPS and, therefore, are excluded from the quality payment adjustment.

Another question received is, how do bundled payments interact with value-based payments? So, the SNF PPS bundled payments for Medicare skilled nursing facility services, and the net result of a SNF's incentive multiplier will be applied to each Medicare payment as part of the PPS payment methodology.

Another person wanted to verify when claims-based measures will begin to impact payment. Changes to the SNF payments are due to the SNF VBP Program to begin on October 1st, 2018.

We also received some comments and questions about circumstances regarding your specific SNFs – like clinical appropriateness to the hospital readmission or a clinical assessment of patients. So, in this one, we have a couple of approaches. We can refer these questions to our SNF VBP helpdesk for further review. And we've also invited on the call our measure developers so they may be able to answer those questions directly here.

We've also added some additional resources on slide 42 that could be beneficial. And we are glad to take questions, Holley, at this time.

Operator: To ask …

Hazeline Roulac: So, (Holly), before you queue up, I just want to remind everyone that this call is being recorded and transcribed. Before asking your question, please give your name and the name of your organization. In an effort to get to as many questions as possible, we ask that you limit your question to just one. If you would like to ask a followup question or have more than one question, you may press the star one to get back into the queue, and we'll address additional questions as time permits. Also,

I would like to remind those responding to questions if you would identify yourself before you answer the question.

OK, Holley, we're ready to take our first question.

Operator: To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key. Please remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking a question, so anything you say or any background noise will be heard in the conference. Again, press star one to ask a question. Please hold while we compile the Q&A roster.

And our first question comes from David Gifford.

David Gifford: Yes. My name is David Gifford from American Health Care Association. And maybe this is best answered in followup, but it's about the measure specifications. The NQF endorsement has a minimum denominator size. I did not hear a discussion about what to do with small sample sizes nor in the formula whether the national average and the covariates and the risk adjustment are updated every time it's recalculated or you keep them constant. That may affect the change – the small change you've seen over time. Thank you.

Stephanie Frilling: Thank you. Yes. I'd like to direct the call to Joel Andress.

Joel Andress: Thank you. This is Joel Andress with CMS. I want to say yes. The measure does have a minimum of 25 patients. And that is incorporated in the, within the program itself. With regard to the updating the – with regards to updating the coefficients within the model, I'm going to turn that over to Laurie Coots, who works with RTI, and helps – and who's responsible with me for developing the measure to discuss how we do that. Thank you.

Laurie Coots: Sure. Thanks, Joel. And actually I wanted to clarify on the first point about the minimum. That minimum threshold of 25 is something that we've used for other PAC hospital readmission measures, and it's mostly centered around public reporting. So, if a given PAC provider has fewer than 25 eligible stays during a measurement period, then their readmission rate wouldn't be publicly displayed. However, the SNFRM -- and for the purposes of this program -- does not incorporate a minimum threshold in the calculation. So, if a SNF provider has at least one eligible stay during the measurement period, which is a calendar year, then it is included.

With regard to the second question, it's correct that this measure is re-estimated based on a full year of data. So, we don't use coefficients from previous models to estimate the measure. Instead, consistent with how CMS calculates these measures for other programs, the model is re-estimated for every measurement period.

David Gifford: Thank you. And you guys did a great job presenting a very complicated program on the slides today.

Stephanie Frilling: Yes. Thank you very much.

Hazeline Roulac: Thanks, David. Next question, please.

Operator: Your next question will come from the line of Coral Lindahl.

Coral Lindahl: Hi. This is Coral -- Solutions. My question is you said that within the PAC stay there's a list of potentially preventable conditions and then there'll be a separate or different post-discharge list. Where can we find that list? And I'm assuming these are going to be ICD-10 codes? Thank you.

Stephanie Frilling: Thank you for your question. I think maybe you're referring to our Potentially Preventable Readmission measure that we will transition to at a later date? Is that – or was your question for the SNFRM, the All-Cause or the Potentially Preventable? You know, we did get a question through the registration also about the exclusions for the SNFRM. So, Laurie, would you mind just going over those and then that might answer your question.

Laurie Coots: Sure. And my interpretation of the question was that it may have been specific to the Potentially Preventable Readmission measure that the SNF VBP Program will be transitioning to in the future. And so, just to provide some details on the definition of Potentially Preventable Readmissions. We would direct you to the SNF VBP CMS website. And on that website, if you scroll down to where it says, "What Measures Will Be Used in the SNF VBP Program?" You'll see some links under the SNFRM, that's the All-Cause Readmission measure that Stephanie mentioned. And beneath that, in bold, you'll see the title for the Potentially Preventable Readmission measure. And under that section, there are a couple of links that would be the link to the final measure specifications from July of this year. And in the appendix are the lists of conditions for which hospital readmissions would be considered potentially preventable.

And so, as you said, there's the – there are two sets of lists. There's a list of conditions that would be considered Potentially Preventable if the patient is readmitted directly from the SNF. That's considered a Within Stay Readmission. So that generates one set of PPR conditions, Potentially Preventable Readmission conditions. And then the second list is for SNF patients who were subsequently discharged from the SNF and readmitted after SNF discharge, and those are the post-discharge list of PPR conditions.

And in the appendix, you'll see that we have the list provided in ICD-9 as well as a draft list in ICD-10. We say draft because we, at this point, have only been able to calculate

the measure on one quarter of claims data that include ICD-10, and we expect that there may be the possibility that we encounter some things where we might need to make slight revisions to the ICD-10 crosswalk.

I think that gets at the first part. Hopefully, that's helpful information. In terms of the measure exclusions, as Stephanie mentioned, again, if we look on the CMS SNF VBP website and under the two links, you'll see a technical report for the SNFRM measure. And in that document are the measure exclusions. And then, again, as I'd mentioned for the PPR measure, there are the July 2016 measure specifications.

So, Stephanie, would you like me to briefly walk through the specific exclusions?

I think we've got them on the slide that you walked through.

Stephanie Frilling: Yes. I think they're on the slides. They're on slide 12 …

Laurie Coots: OK. And additional information is available on the rationale for each of the exclusions. And in that case, again, I would direct you to the technical report that was posted last year with the rule. Thanks.

Stephanie Frilling: Thank you, Laurie.

Operator: And your next …

Hazeline Roulac: Thanks for your question, Coral. Go ahead, Holley.

Operator: Your next question will come from the line of Barbara Goodspeed.

Barbara Goodspeed: Hi. I have a question about the observation stays. And if they are included and if they are, are they are measured the same as any other readmission?

Stephanie Frilling: Laurie, do you want to take that one, too?

Laurie Coots: Sure. Let me make sure I'm understanding the question. It sounds like you're asking about whether observation stays are counted in the outcome of this measure?

Barbara Goodspeed: Yes.

Laurie Coots: OK. No. This measure is – and both measures actually are hospital readmission measures. And so they are only looking at readmissions to the acute care level of – the acute care setting or acute level of care. It does not include observation stays.

Hazeline Roulac: Thanks for your question, Barbara. Next question?

Operator: Your next question comes from the line of Kimberly Gimmarro.

Kimberly Gimmarro: Thank you. Kimberly Gimmarro from Botsford over in Farmington Hills, Michigan. I had a question on slide 38 related to the correction timeframe for the quarterly report referencing March 31st. My question is, for instance, with the quarterly report for the period ended June and the period ended December be due by the same March 31st?

Stephanie Frilling: Yes. I'm going to ask Michael to answer that one.

Michael Lee: Hi. This is Michael Lee from The MITRE Corporation. Yes, that's right. The intention here is to allow as much time as possible to accept correction requests to any quarterly report while balancing that allowance with CMS's need to complete calculations and begin the scoring process.

Kimberly Gimmarro: Thank you.

Hazeline Roulac: Thanks for your question, Kim. Next question?

Operator: Your next question will come from the line of Gail Polanski.

Gail Polanski: Good afternoon. Gail Polanski with Tara Cares. I have tried to read the regs several times, and I think it's very difficult to understand the scoring methodology. So, I thought you did a really nice job of trying to explain it. But the thing that I still don't understand, when you look at the achievement score or the improvement score, you know, I could be a facility and we know that they come, and we have different challenges and different locations, and I can work really, really hard and I may improve my score but I'm still not going to get my Medicare dollars back. I'm not sure I understand how that's an incentive.

Stephanie Frilling: Right. So, again, this program as a VBP Program includes the Medicare Savings, right? So, it is including the principles of a penalty as well as the opportunity to earn more. And so it's required by statute, and we feel that laying it out for the program the way we've proposed and finalized the methodology that we're actually weighting improvement to the largest extent that we can because we're exceeding the 2 percent payment withhold. So facilities would have, you know, an opportunity to earn more, right?

And so, that is what we are working now. How those numbers would flush out, that's something for next year's rule that we'll be proposing. But that is the incentive piece of earning back the 2-percent withhold amount or more. And then the penalty piece really is that net negative for the 40 percent. So, we do believe that it is an effective incentive

instrument, and the fact that we are directing the Medicare Program dollars to the highest achievers and holding the bottom 40 percent as the net negative.

Gail Polanski: Well, thank you. Again, you did a nice job.

Stephanie Frilling: Thank you very much.

Hazeline Roulac: Thanks, Gail. Next question.

Operator: Your next question comes from the line of Appalenia Udell.

Appalenia Udell: Hi. Good morning. Thank you so much. That was really wonderful. From a medical director standpoint, apart from the obvious, are there any indicators of what a medical director can do to help achieve both the achievement thresholds and the performance thresholds?

Stephanie Frilling: Thank you for that question. It's a great question, and it's something that we are in the process of considering resources for facilities and providing those on our websites for links and, you know, possibly even holding educational systems around some of those ideas. So, it is something that we're currently considering.

And, you know, I'm glad to hear that that would be something that would be receptive by the industry because this is definitely something that we feel could be valuable, you know, especially for maybe rural facilities or smaller facilities that kind of have to do this on their own. So, yes, I appreciate that question. It's definitely our intent to furnishing this. If you have suggestions for us, please send them to our SNFVBPinquiries mailbox.

Appalenia Udell: Thank you.

Hazeline Roulac: Thank you.

Operator: And your next will come from the line of Susan LaPadula.

Susan LaPadula: Good afternoon. This is Susan LaPadula with ICMRS. How are you?

Stephanie Frilling: We're good. Thank you.

Susan LaPadula: Wonderful. Stephanie, this question is for you to clarify the date of October 1st, 2018. Would that be the start date that money would be withheld, the 2 percent, or when the payment would be paid out for the achievers?

Stephanie Frilling: So, it is a fiscal year program. So that would be the date. That is the first day of fiscal year 2019. So that is the date that the payment will be – the payment incentive will be applied. But I think maybe the question that you're considering here is

that – that we're holding 2 percent and then may be paying back later whatever ratio of production a facility earned on the payment exchange function. But that's all done in a single computation.

So, it's all done at same time. The withhold and then the exchange function for the payment is done in a single value that is applied to the SNF PPS payment formula.

Susan LaPadula: So, we're not holding the …

(Crosstalk.)

Stephanie Frilling: Yes, we're not holding 2 percent …

(Crosstalk.)

Stephanie Frilling: Yes, we're not holding 2 percent back and then paying it out, you know, months later. It's all done at – on a per-claim basis.

Susan LaPadula: And will that be clearly stated on the remittance advices from the MACs for reconciliation purposes?

Stephanie Frilling: Yes, yes, definitely like other VBP programs do, hospital programs; there's a CMS process for reporting that on claims. Yes, like …

Susan LaPadula: Wonderful.

Stephanie Frilling: … if I clearly stated?

Susan LaPadula: Yes. Thank you so much, Stephanie, and to your team.

Stephanie Frilling: Sure. You're welcome.

Susan LaPadula: Thank you.

Stephanie Frilling: You're welcome.

Hazeline Roulac: Thanks, Susan. Next question?

Operator: Again, to ask a question, please press star then one on your telephone keypad. If your question has been asked or you'd like to withdraw your question, press the pound key. Again, star one to come into the queue.

Our next question will come from the line of John Perticone.

John Perticone: Yes. Hi. My name is John Perticone. I'm with Consulate Health Care. And I'm referencing slide 11, in which you talk about readmissions being tied to a 30-day period regardless of whether those readmits come from the skilled or the patient has been discharged. So, I guess I can probably answer my own question, but patients who are discharged home that subsequently are readmitted within that 30-day window would be included, I suppose.

Laurie Coots: That's right. This is …

Stephanie Frilling: Yes, that's correct.

(Crosstalk.)

Stephanie Frilling: Go ahead, Laurie.

Laurie Coots: I'm saying the same thing. This is Laurie Coots from RTI. Yes, that's a correct interpretation. So, really, the window is a fixed 30 days. And depending on the patient's SNF length of stay, they may be in the SNF the entire 30 days or they may, in your example, have been discharged from the SNF, go home, and then subsequently be readmitted within the 30 days. And in both cases …

John Perticone: Could it …

Laurie Coots: Yes, go ahead.

John Perticone: Yes. One other question ancillary to that, could it be the reverse where a patient was discharged from the hospital goes home within the 30-day window for skilled, comes into skilled 4 days after and then is readmitted. Could it occur that way as well?

Laurie Coots: So, it sounds like there would be a break in between the prior hospital discharge and the index SNF admission?

John Perticone: Correct, yes.

Laurie Coots: It wouldn't – no. In that case, it essentially needs to be a direct transition from hospital …

John Perticone: Direct …

(Crosstalk.)

Laurie Coots: … discharge to SNF admission.

John Perticone: OK. Thank you.

Laurie Coots: Yes.

Hazeline Roulac: Thank you, John. Next question?

Operator: Your next question comes from the line of Stacey Silvas.

Stacey Silvas: This is Stacey Silvas at Elcampo Memorial. We are a small rural PPS swing bed facility. So, I'm assuming that this does apply, correct?

Stephanie Frilling: It does. And thank you very much for your question. We didn't include it in this data set, but we had actually done some analysis on the impacts for rural facilities. And we're happy to report that there are – we've seen no negative impacts on the data that we've seen. And we make that presentation on a national – on the rural national provider call a few months, and that presentation is on our SNF VBP CMS website if you'd like to see those slides.

Thank you.

Operator: And your next question comes from the line of Bob Sobanski.

Bob Sobanski: Hi. Bob Sobanski with Saber Healthcare. I've seen a document that the CMS document from September of '16, and it's labeled Skilled Nursing Facility Quality Reporting Program, acronym SNF QRP. Does that relate to today's discussion?

Stephanie Frilling: No. The QRP is accompanying the rollout of the SNF VBP. So, we have – but we are different authorities and different acts. So, with the VBP Program was a PAMA Act, the QRP is from the IMPACT Act, and it supports other post-acute care settings. So, those are – it is true your facility is implementing the QRP Program as well, but it does not affect this presentation at all.

Laurie Coots: And I think another thing to add on, Stephanie, if I may -- this is Laurie from RTI -- is that there is a readmission measure that was developed to meet the requirements of the IMPACT Act that was recently adopted into the SNF QRP. And it's not the same measure as either of the measures that have been adopted for this SNF Value-Based Purchasing Program.

So, it can get a little confusing when you see SNF QRP and you might see a measure that sounds like the SNF Potentially Preventable Readmission measure. But it's actually a different measure because that is a – the measure that has been adopted for the QRP focuses on readmissions during the 30-day post-SNF discharge period.

Bob Sobanski: Thank you.

Hazeline Roulac: Great question, Bob. Thank you. Next question?

Operator: Our next question comes from the line of Cindy Schultz.

Cindy Schultz: Hi. This is Cindy Schultz calling from Pepin Health and Rehab, part of Mission Health. And my question is, goes back to the 2-percent variable date of 10/1/2018, and I'm wondering what dates will be included in that then. Are we looking at 10/1/2017 to 9/30/2018 for that? Or what dates are going to be part of that achievement and performance number?

Stephanie Frilling: Michael, do you want to answer that question?

Michael Lee: Yes. This is Michael Lee at the MITRE Corporation. So the statute says that the program "shall apply to payments for services furnished on or after October 1st, 2018." So, while CMS is going to propose some of the further details about the payments in future rulemaking, our interpretation at the moment is that – it will be for claims submitted for services paid – excuse me, for services provided on or after October 1st of 2018. So, it would not reach back as far as 10/1 of '17.

Cindy Schultz: OK.

Hazeline Roulac: Thanks for your questions, Cindy.

Operator: Your next question comes from the line of Rebecca Hynes.

Rebecca Hynes: Hi. I'm wondering in terms of the achievement score versus improvement score – I'm sorry, from Shea Post Acute. We're with the Ensign Group. We were a newly acquired facility in calendar year 2015. Will we have the opportunity to even qualify for an improvement score? Or would we just have an achievement score for our facility?

Stephanie Frilling: You're just going to have an achievement score.

Rebecca Hynes: OK. Thank you.

Stephanie Frilling: Sure.

Hazeline Roulac: Thank you, Rebecca.

Operator: Your next question comes from the line of Michael Hensley.

Michael Hensley: Hi. My name is Mike Hensley and I'm from Burgess Square, an independent facility. And my question is maybe not for right now, but in the future, are you going to be correlating the achievement scores of the SNFs with the corresponding

ACOs or CJR programs or BPCI programs to see if there are any outlier? Or is that going to impact in the future our rates?

Stephanie Frilling: No. Our payment authority is limited to facilities paid under the SNF PPS. So, facilities that are participating in ACOs or any demos to the CMMI authorities, they are not paid under the PPS. So, they wouldn't apply. That's why CAHs don't apply as well, right? They are paid under a different source besides the PPS. Medicare Advantage is the same. It doesn't apply. They are not paid under…

Michael Hensley: Thank you.

Stephanie Frilling: Yes. Sure. You're welcome. It's a good question. Thank you.

Michael Hensley: Thanks.

Operator: And your next question comes from the line of Jere Swinson.

Jere Swinson: Hi. I'm with Beth Sholom Home in Richmond, Virginia. And my question is under the 30-day readmission, does that include new acute diagnoses? Because it says All-Cause Readmission.

Laurie Coots: Yes, so …

Stephanie Frilling: Yes.

Laurie Coots: Stephanie, I can take that. I think although I just want to clarify that I understand correctly. So, in your example, perhaps the initial hospitalization prior to the SNF admission was for, let's say, CHF and then the readmission was for hip fracture. Is that essentially what you're asking?

Jere Swinson: Yes.

Laurie Coots: If it's something unrelated …

Jere Swinson: Yes.

Laurie Coots: Because it's an …

Jere Swinson: Yes.

Laurie Coots: Yes. So, it's a good question. So, it is an All-Cause Unplanned measure. So, the readmission doesn't have to be clinically related or unrelated. It's just all readmissions. However, importantly, the measure does not include readmissions for procedures that are potentially planned. And so you'll see in the technical report and

some of the documentation there that there are a couple of ways that we have developed definition for planned readmissions.

One is the CMS Planned Readmission Algorithm that's used in the Inpatient Quality Reporting Program and on Hospital Compare measures. And in addition to that, RTI, under contract with CMS, developed a list of additional planned procedures that are more specific to post-acute care. So, if the reason for the readmission is included on either of those lists, then it would be considered planned and would be excluded. But to answer your question, it is an All-Cause measure and so it does not need to be – it doesn't take into account the reason for the prior hospital stay.

Jere Swinson: OK. Thank you.

Hazeline Roulac: Thank you. Next question?

Operator: Again, if you'd like to ask a question, press star then one on your telephone keypad. If your question has been answered or you'd like to withdraw from the queue, press the pound key.

And our next question comes from the line of Mary Ellen DeBardeleben.

Mary Ellen DeBardeleben: Thank you very much. I wanted to follow up on a question asked earlier about the incentive payment. On slide 10, the incentive payment must settle 50 to 70 percent of the amount withheld. So, you said they can earn more than 2 percent. So can they earn up to 70 percent more than 2 percent? So, they'd get their 2 percent back and then an additional 1.4 percent?

Stephanie Frilling: No, no. What that means is the total. This is the total. So, you know, if we look at the payment system, I think $36 billion, we estimate – per year, we would estimate the redistribution…

Michael Lee: Two percent.

Stephanie Frilling: …of 2 percent of that, which is around…

Mary Ellen DeBardeleben: Oh.

Stephanie Frilling: … $600 million.

Mary Ellen DeBardeleben: OK.

Stephanie Frilling: Yes, $600 million. So, that would be the pool of…

Mary Ellen DeBardeleben: OK.

Stephanie Frilling: …of redistributed fund.

Mary Ellen DeBardeleben: So, that's like a large – from a larger perspective? At an individual…

Stephanie Frilling: Yes.

Mary Ellen DeBardeleben: …facility level, what is the max that a facility could get as incentive?

Stephanie Frilling: Right. So, we're currently modeling exchange functions and that will be…

Mary Ellen DeBardeleben: OK.

Stephanie Frilling: …a proposal that we'll be making, you know, in future rulemaking.

Mary Ellen DeBardeleben: OK.

Stephanie Frilling: But, I mean, so there's different levels. I can't speak to directly, but it would exceed the 2 percent.

Mary Ellen DeBardeleben: OK. Thank you very much …

Stephanie Frilling: But how far …

Mary Ellen DeBardeleben: … for clarifying.

Stephanie Frilling: …and how many facilities could qualify, that's still something we're modeling.

Mary Ellen DeBardeleben: OK. Thank you so much.

Stephanie Frilling: Sure. You're welcome.

Operator: Your next question comes from the line of Sandy Lancaster.

Sandy Lancaster: Sandy Lancaster with Silverado in Salt Lake City, Utah. You were just talking about the readmission causes. And given that the hospitals are the one that make that determination, are they – the educational effort to make sure that the hospitals understand the impact on SNF, how thorough is that being pursued?

Stephanie Frilling: Yes. We are looking at some coordinated training between the hospital program and the skilled nursing facility program. So we do – you know, we do

plan to communicate this program with them. You know, they are also held to readmission measures as well. So it's something that they're already looking at.

And then also we'll – you know, we plan to make some presentations like places like QualityNet and places like that where we'll have just to kind of a broad representation of health-care providers. So we are – actually this call really is kind of our first communication effort. So there will be a lot more coming. And we do plan to coordinate with the hospitals.

Sandy Lancaster: Thank you.

Stephanie Frilling: Sure.

Hazeline Roulac: Thanks, Sandy. Next?

Operator: Your next question will come from the line of John Sheridan.

John Sheridan: Hi, good afternoon, this is John Sheridan. I've read your requirements listing all the various risk covariates. It would be very helpful to some of us trying to model this if you would provide an example or two as followup because some of these planned readmissions – planned things that could be excluded for being unplanned have a value of like 0.85. So does that mean that this counts as 85 percent of an admission? Or does it count as 15 percent of an admission? Or how is that covariate applied?

Laurie Coots: Yes. So this is Laurie from RTI. Are – so in the technical report for the SNFRM measure, you're correct that we do detail the specific risk adjusters that are used in the standardization to calculate the measure. And we do include results of the models including the coefficients. So that information is currently available.

In terms of – I want to try and answer your question and I'm not – I'm trying to think of what types of examples you may be looking for.

John Sheridan: You know, just take a set of the covariates, put together the formula, and outcomes number, which is a readmission number. That's the example because, you know, are we taking 1 minus the covariate? Is the covariate just being applied in the formula? You know, I didn't – I've read the rule, and I didn't actually even see in the rule an example of how the covariates were used. And I think you just said that wasn't available. So maybe I misheard that but …

Laurie Coots: Oh, it is available. Yes, I'm sorry to interrupt. It is available on the technical report.

John Sheridan: All right.

Laurie Coots: So – but I understand a little bit more about what you're getting at, almost like a – I mean it's a complex measure calculation and the model itself is, you know, has over 250 risk adjusters. And so…

John Sheridan: Yes.

Laurie Coots: But I think, you know, what we can evaluate is maybe the feasibility of preparing some sort of worksheet or something that would help provide some information about the different impacts that the various, you know, a made-up, you know, example of SNF patients may have.

John Sheridan: Well, that's right, and as people try to do improvement in this measure—because there are both monies to be lost and monies to be gained—having an example might help some of us prioritize where we put our efforts. Because this is such a complex measure that if we just apply it everywhere, we may see no results.

Mel Ingber: Excuse me, this is Mel Ingber. Laurie, do you mind if I add something?

Laurie Coots: Oh, please do.

Mel Ingber: Yes. The risk adjusters actually don't guide you very much as to how to act. What they're doing is allowing a sicker person to have a higher probability of a readmission. That will not be counted against you in the end because the person is sicker. So the whole point of that list of there is not these are things to concentrate on or not, either your patients have these underlying conditions or they don't. And what we're looking for in the end is the readmissions you have compared to the readmissions that would be predicted based on the characteristics of your population. So if it's an all-cause readmission, the diseases and model don't help you so much as looking at the coordination of care at the frontend, the backend, where they're transferring out into the community again, and the period in which they are under care and which they could be having a problem.

So understanding how the technical report works, it will focus a little bit differently from the risk adjusters, which are merely saying we're going to put people on a level playing field with respect to their case-mix when we calculate this number. And the things that you are being dinged on, which are the readmissions that actually occur, adjusted for this probability.

John Sheridan: Yes, I kind of get that from the report. But the – the example, you know, the States when they pay a nursing home on case mix will give you an example as to how that's calculated every quarter.

Mel Ingber: In this case…

John Sheridan: Having an example would just be very helpful that everybody could understand is all I'm saying. And maybe I'm incorrect in saying where to apply the effort. But these are complex things to be coded. And you're matching nine covariates off of claims to 46 or 47 or 48 covariates off of MDS. It would be kind of nice to just have an appreciation for that. And I think that would only be fair, to be honest.

Laurie Coots: Yes, I think …

(Crosstalk.)

Mel Ingber: So if you calculate a raw probability of an individual to show what that occurs, but the calculation of the facility level number is more complex than just adding up the people, it's a little more complicated than that.

Laurie Coots: Yes, one point of clarification is that this measure is a 100-percent claims-based, and so we don't use the MDS in the risk adjustment at all.

John Sheridan: So, it's the QRP measure that has the risk adjustment for the MDS?

Laurie Coots: It's the Nursing Home Compare measure that was recently being reported on Nursing Home Compare. So that measure uses both claims and MDS data.

John Sheridan: But this one does not.

Laurie Coots: That's correct.

John Sheridan: OK.

Laurie Coots: And the SNF QRP Readmission measure does not either at this time. But…

Joel Andress: And I think the …

Laurie Coots: Yes.

Joel Andress: I'm sorry, Laura. I think the final takeaway for this is that to clarify that we – we will look into how we can make the calculation and how the measure is calculated more transparent to the community, whether that be by worksheet or some other method. So, we will certainly take that under consideration and think about how we can communicate that more helpfully to you and the rest of the community.

John Sheridan: Thank you. Now there's three measures, I think there's a lot of people who'd appreciate just having the ability to segregate them. As you can tell my confusion was clearly present. Thank you so much.

Hazeline Roulac: Thank you, John. Just for the transcriptionist purpose, that was Laurie, Mel, and Joel responding to John's question.

OK, next question.

Operator: Our next question comes from the line of Kimberly Hollifield.

Kimberly Hollifield: Yes, Kimberly Hollifield from Deerfield Episcopal Retirement Community. I just want to go back to that October 2000 payment. At that point, should we expect to see a delay in our payments, coming later than 14 days, because I can pretty much know on clockwork when my payments should start to come in? So, I just want to see if there's going to be a delay because if there is, that way I can prepare for that now.

Stephanie Frilling: No, there won't be a delay.

Kimberly Hollifield: OK, that's what I needed to know. Thank you.

Stephanie Frilling: Sure, you're welcome.

Operator: Our next question comes from the line of Leslie Hanson.

Leslie Hanson: Hi, this is Leslie Hanson from Lakes Regional Healthcare, and I have a question about the CASPER reporting system. I tried to run a report, and I am unable to. I didn't know if that was just going to be active October 1, or if I just have to contact them to gain access to the report?

Stephanie Frilling: Yes, are you by chance a hospital-based facility or…

Leslie Hanson: Yes…

(Crosstalk)

Stephanie Frilling: Yes, so this is something that – so, yes, we will be sending some, setting up some resources for this because we do understand that you're used to quality, you know, QualityNet, quality.org, for getting these reports and not the CASPER QIES system. So, we do have some messaging that we're going to be putting out on our website that will direct you to the helpdesk. But I think, Laurie, do you happen to have that web address handy?

Laurie Coots: Yes, I do. I'm sorry, it's taking me a just a second to – make sure – OK, here we are. So, the helpdesk to contact in order to access CASPER, if you don't already have access to the CASPER reporting application, is help@qtso.com, so help@qtso.com.

Leslie Hanson: OK. And then I just let them know I need the value-based purchasing program report?

Laurie Coots: So I think – I'd like to provide a little bit more information on the reports themselves, so…

Leslie Hanson: Perfect.

Laurie Coots: …so the – there are a couple of mechanisms by which we have been disseminating information about the reports. The first is that in July, August, and September we included information in the Nursing Home Compare preview report about the SNF Value-Based Purchasing Program and about the measure. And in the August – I'm sorry in the September report, we included some benchmarks for 2013 and 2014. Those reports, however, only go to providers that are certified for both skilled nursing and nursing facilities. So, in your case, that doesn't sound like it would apply to you.

And so then the next piece of information is that we are in the process of making the quarterly reports available. October 1st actually falls on a Saturday this year. So it's an – so it's going to be around October 1st. And those will be made available via CASPER. However, in the meantime, on the SNF VBP CMS website, you'll see that there – it has been updated to include a hyperlink to a template of the example report, and that's the first report that we will be distributing on its own; so independent SNF VBP report will be this example report. So as you're obtaining access to CASPER and kind of getting oriented there, in the meantime you can certainly visit that CMS website to get a sense of how the example report is structured. And that's the format that will be used for subsequent reports.

Leslie Hanson: OK, thank you.

Hazeline Roulac: Thanks, Leslie. Next question?

Operator: Again, if you'd like to ask a question, please press star then one on your telephone keypad. If your question has been answered or you'd like to withdraw your question, press the pound key. Again, that's star one to ask a question.

And your next question is a followup from Kimberly Gimmarro.

Operator: Kimberly, go ahead.

Kimberly Gimmarro: I have a question on the payment rate. On the slide that talks about it, I'm wondering if we're establishing a yearly payment rate? And what frequency it's adjusted with? So, for instance, once we're into the payment application, is the

comparison going to be a rolling 12-month adjusted quarterly? Or are you locked into an annual rate that's reset annually for the purposes of the program?

Stephanie Frilling: Yes, it will be an annual rate.

Kimberly Gimmarro: Thank you.

Stephanie Frilling: Sure.

Hazeline Roulac: Thanks, Kim. Next?

Operator: And your next question comes from the line of Sheila Schuck.

Sheila Schuck: Good day. Thank you for your presentation. I just had a quick question just to clarify on the patients who are readmitted to a hospital-based SNF and the ones who are considered planned readmissions, is – because we are connected to a hospital, we have many patients that come over for two, three weeks getting antibiotics before they can have their procedure, be it a revised hip or a wound closure, flap, pending other surgery, cardiac surgery, whatever, waiting for the antibiotics to clear up their infection before they can have their next procedure that the doctor is waiting on. Are all of those excluded from being dinged on this?

Laurie Coots: Yes. For the measure – I guess there – it sounds like there are parts to your question, where they're getting antibiotics, are they actually getting discharged from the SNF or it's …

Sheila Schuck: No.

Laurie Coots: OK.

Sheila Schuck: They are discharged from the hospital, admitting to the SNF, and then they're here for a couple of weeks getting antibiotics, getting therapy to keep them from being debilitated, and then the doctor has a set date that, sometimes the date moves depending on how well the patient is doing before his next procedure. Like say, he'll have an antibiotic spacer in his hip because he had an infection previously from the hip replacement. So he'll be here for a few weeks, getting antibiotics. And if the doctor writes planned readmission for the hip revision and then after two to three weeks we send him back to the acute, which is connected by halls, and he's discharged from here and then admitted back to the acute hospital.

Laurie Coots: Yes. And it sounds like a number of the examples that you provided are listed in our planned procedures. So I would encourage you to review the documentation on that. There are …

Sheila Schuck: And I was looking for that online …

Laurie Coots: Yes, there are …

Sheila Schuck: … while I was listening to everybody.

Laurie Coots: So in the technical report for the measure, it would be in the appendix – I'm also happy to direct you there if you'd like to email us.

Sheila Schuck: That would be wonderful.

Laurie Coots: Yes, because I think it's just hard to answer, give like a blanket answer for – given that you had a few different examples in there.

Sheila Schuck: Yes, we like to have more detail so we know …

Laurie Coots: Yes, that's great. Yes, so like I said, a number of them are planned procedures that would be excluded. I can't say for certainty whether all of them would be considered planned procedures. If it is considered a planned procedure, then it wouldn't be counted for this All-Cause, Unplanned Readmission measure. But if it's considered unplanned, then it would certainly be something that would be assessed and used in the measure calculation.

Sheila Schuck: So if the doctor writes in his discharge orders, discharge to SNF, planned readmission in 2 weeks, does that cover us? Or is that not necessarily be – it needs to be – it needs to meet some criteria in this other form that you have?

Laurie Coots: Yes, it actually would need to be on the claim. So for – when the patient is readmitted to the hospital, it's the hospital claim that we look at and the diagnoses and procedures that are coded on the claim. And that's the source of information for using the planned readmission algorithm and additional lists of planned procedures that we evaluate to determine whether it's planned or unplanned.

Sheila Schuck: OK. And your email is?

Laurie Coots: Yes, Stephanie would – sorry, I don't …

Stephanie Frilling: Yes, you can send to the SNFVBPinquiries@cms….

Sheila Schuck: Got it, I have that, OK. Thank you.

Stephanie Frilling: Sure.

Hazeline Roulac: Thank you. Next question?

Operator: Our next question comes from the line of David. David, please go ahead.

David: OK, yes, I wanted to ask about that website also or email address. That was my question. What is the email address we can send you guys a question for some information?

Stephanie Frilling: Sure, so there's – yes, absolutely. There is a link on slide 42. But it is – the SNFVBP, which is S-N-F-V-B-P, you know, no spaces…

David: Yes.

Stephanie Frilling: … inquiries@cms.hhs.gov.

David: Thank you.

Stephanie Frilling: Sure, you're welcome.

Operator: Again, if you would like to ask a question, press star then one on your telephone keypad. Again, that's star one to ask a question.

Laurie Coots: I also wanted to add, this is Laurie from RTI, that on slide 42, there is a link directly on that slide that will take you to the technical report for the All-Cause Readmission measure for the program. I think I had also mentioned that you can navigate through it on the CMS SNF VBP website. But also in Stephanie's slide deck here, there is the exact website.

Hazeline Roulac: Thanks, Laurie. So, Holley, do we have any more questions at this time?

Operator: At this time, there are no further questions.

Additional Information

Hazeline Roulac: OK, well, this has been a really great discussion. I want to thank all of our participants who asked questions today to make this conversation what it was. I think it was excellent. If we did not get to your question, you can email it to the address listed on slide 42 of the presentation that Stephanie and Laurie just referred to. An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will place an announcement in the MLN Connects Provider eNews, and you will receive an email when these are available.

On slide 43 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your MLN Connects Call experience.

So my name is Hazeline Roulac. I would like to thank our presenters and everyone who responded to questions today, and also thank you, our participants, for participating in the MLN Connects Call on the Skilled Nursing Facility Value-Based Purchasing Program. Everyone, have a great day. Thank you.

Operator: This concludes today's call. Presenters, please hold.

-END-


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