Centers for Medicare and Medicaid Services
Skilled Nursing Facilities Long Term Care
Open Door Forum
Moderator: Jill Darling
Thursday, August 2, 2018
1:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time all participants are on listen-only mode. During the question and answer session you may press Star 1 then one if you would like to ask a question. Please be advised today's call will be recorded if you have any objections you may disconnect at any time. Now I would like to turn the meeting over to Ms. Jill Darling. You may begin when ready.

Jill Darling: Thank you (Britney). Good morning, good afternoon everyone. I am Jill Darling in the CMS Office of Communications and welcome to today's Skilled Nursing Facilities Long Term Care Open Door Forum. We appreciate your patience we are waiting to get more folks in because one of today's - or all of today's topics. So before we dive in I have one brief announcement.

This Open Door Forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press you may listen in the please refrain from asking questions during the Q&A portion of the call. If you have any inquiries please contact CMS at press@cms.hhs.gov. And we'll begin today's call with John Kane.

John Kane: Thanks very much Jill and thank you everyone for being on the call today. On April 27 CMS had released CMS-1696-P otherwise known as the FY 2019 SNF PPS proposed rule. The comment period for that rule had ended on June 26 and we have received 296 comments. We just want to thank everyone for

the comments and questions that have received and that were submitted on the proposed rule.

On Tuesday, July 31 CMS issued a final rule CMS-1696-F outlining fiscal year 2019 Medicare payment updates and quality program changes for skilled nursing facilities. Additionally effective October 1, 2019 CMS will be using a new case mix model the patient driven payment model which focuses on the patient's condition and resulting care needs rather than the amount of care provided in order to determine Medicare payment. The final rule also modernizes Medicare through innovation in SNF, meaningful quality measure reporting, reduced paperwork and reduced administrative costs. I'll speak to the technical rates of the updates in this final rule as well as the new case mix classification model.

With regard to the SNF PPS market basket update and associated rate changes for fiscal year 2019 we estimate that payments to SNFs in FY 2019 will increase by $820 million as a result of the FY 2019 SNF market basket increased factor of 2.4% as required by the Bipartisan Budget Act of 2018. We would note that this increase - this estimated increase in payments is different from estimate provided in the proposed rule due to an updated SNF baseline figure provided to us by our Office of the Actuary.

Moving now to the finalized changes to the SNF PPS case mix classification system. In this final rule we finalized the proposed policies associated with the Patient Driven Payment Model or PDPM Effective October 1, 2019 CMS will use PDPM as the basis for classifying SNF patients in covered Part A stays for purposes of determining Medicare payment. We believe the PDPM represents a market improvement over the RUG IV model most notably because it improves payment accuracy and appropriateness by focusing on the patient's needs rather than the volume of services provided, significantly reduces

administrative burden on providers thereby allowing greater contact between clinicians and patients and reallocates the SNF payments to currently underserved beneficiaries without increasing total Medicare payments or compromising access for any SNF patients.

I would also note that this payment model is the result of significant stakeholder input and feedback. We greatly appreciate your contributions in building this revised payment model and look forward to continued interactions with stakeholders as we prepare to implement PDPM. PDPM focuses on clinically relevant factors rather than the volume based services for determining Medicare payment by using ICD-10 diagnosis codes and other patient characteristics as the basis for patient classification.

Further PDPM adjusts Medicare payments based on each aspect of a residents' care thereby more accurately addressing costs associated with medically complex patients. We would note that on the basis of stakeholder feedback we finalized a change to simplify the way in which some of the ICD-10 information will be reported to CMS. Additionally PDPM further adjusts SNF per diem payments to reflect varying costs throughout the stay and incorporates certain safeguards to ensure that beneficiaries receive care consistent with their unique needs and goals.

We also finalized revisions to the schedule of required assessments under the SNF PPS. Specifically PDPM eliminates the need for frequent patient assessments and allows clinicians to focus more time on treating the patient by using just admission and discharge type of assessment schedule with another assessment available in case of any significant changes in the patient's care planner needs. We estimate that based on the changes to the assessment schedule associated with PDPM providers will benefit from approximately $2 billion in reduced administrative cost over the next ten years.

In addition to these finalized changes we also finalized a combined limit on group and concurrent therapy of 25% as we and a number of stakeholders believe that this best ensures that SNF patients will continue to receive the highest caliber of therapy services that are best attuned to their individual needs and goals. Finally we would draw your attention to the impact analysis associated with PDPM. While PDPM will be implemented in a budget neutral manner the policies and revisions finalized under PDPM reallocate and realign how money is paid out under the SNF benefit are distributed.

For example nonprofit SNFs and hospital based SNFs which typically treat some of the more medically complex patients fare better under PDPM Providers in rural communities also fare better under PDPM. Finally Medicare beneficiaries that are also enrolled in a state Medicaid program often referred to as duly enrolled beneficiaries who also tend to be the most expensive and medically complex to treat fare better under PDPM then under the current SNF payment model. We believe this reallocation of funds will help to ensure the greatest access to high quality care under the SNF benefit.

As we prepare to implement these finalized changes to the SNF PPS we plan to provide significant outreach to stakeholders in the form of education and training so as to ensure a smooth transition for both providers and beneficiaries. With that I will turn the call over to (Casey Freeman) to talk speak to the Quality Reporting Program.

(Casey Freeman): Thanks John. Good afternoon everyone. I'm (Casey Freeman) the SNF QRP Coordinator and I'd like to provide you with an update on this program. In the fiscal year 2019 SNF PPS final rule no measures were added to or removed from the SNF QRP however we did finalize a change to the public reporting of the following claims based measures Medicare spending per beneficiaries

post-acute care skilled nursing and discharge to community post-acute care skilled nursing.

These measures will now be calculated and reported based on a two year period of data collection. Previously these measures were calculated on one year of data. This change allows a greater number of SNFs to meet the minimal threshold for these measures. Additionally we will also be publicly displaying data in calendar year 2020 on the following four assessment based measures change in self-care score which is NQF 2633, change in mobility score NQF 2634, discharge self-care score NQF 2635, discharge mobility score NQF 2636. With that we've concluded the SNF QRP rule update and I will be turning the announcement over to Celeste who is going to be speaking to value based purchasing.

Celeste Bostic: Thank you (Casey) and good afternoon everyone. As (Casey) mention my name is Celeste Bostic. And I am the program lead for the SNF VBP program. For today's call I will briefly highlight the policies that we just finalized and also provide an update on the annual performance score report for the fiscal year 2019 program year. In this year's final rule we finalized an approach to ensure accurate performance standard calculation, we adopted the fiscal year '19 as the performance period and fiscal year 2017 as the baseline period for the fiscal year 2021 SNF VBP program year. For all future program years these periods will automatically advance by one year from the previous program year.

In addition we finalized a scoring adjustment for SNFs that have fewer than 25 eligible stays during the performance period and/or the baseline period. And lastly we finalized an Extraordinary Circumstance Exception or ECE policy for SNFs that experience circumstances beyond their control that may impact their performance on the programs readmission measure. We would

like to thank all of those who submitted public comments and we look forward to next year's rulemaking cycle.

For a brief update on the annual score reports we are very pleased to announce that reports were made available today August 2 via the Certification and Survey Provider Enhanced Reporting or CASPER system. This is a confidential feedback report that contains each SNFs individual performance that will be made public in the fall. SNFs will receive a memo with additional information about this report and will continue to receive reminders about the performance score reports and the Phase 2 review and correction deadline.

The report contains four tabs, a cover sheet, a complete list of calendar year 2017 eligible stays, facility level data which includes SNF VBP performance scores, rankings and incentive multipliers for the fiscal year 2019 payment as well as a data dictionary. We have also developed an annual performance score report training video that provides a walk-through of the information included in the PSR.

This tutorial will be made available on the cms.gov SNF VBP page as well on the CMS YouTube channel directly. Please look out for additional information regarding the availability of this video in upcoming memos. Lastly we developed a frequently asked questions document that is located at the bottom of the cms.gov Web site. That is all I have for SNF VBP. I will turn the call over to (Lorelei).

(Lorelei): Thank you Celeste. Staffing data from April 1 through June 30 must be submitted no later than 45 days from the end of the quarter. The final submission deadline for this quarter is August 14, 2018. We strongly encourage providers to submit data throughout the quarter and not wait until the last week before the deadline. Only data successfully submitted by the

deadline is considered timely and used on the Nursing Home Compare Web site and in the Five-Star rating calculation.

Once a facility uploads their data files they need to check their final validation report which can be accessed in the Certification and Survey Provider Enhanced Reporting or CASPER folder to verify that the data was successfully submitted. It may take up to 24 hours to receive the validation report so providers must allow for time to correct any errors and resubmit if necessary. Please note that the final validation report only confirms that data was submitted successfully it does not confirm that the data submitted is accurate or complete.

As a reminder CMS is now using PBJ data to calculate staffing measures and facility star ratings. For more information please see Quality, Safety and Oversight memo QSOO-18-17-NH. We want to remind nursing homes of the importance of RN staffing and the requirement to have an RN on-site eight hours a day seven days a week. Nursing homes reporting seven or more days in the quarter with no RN hours will receive a one star rating in the staffing domain which will drop their overall composite star rating by one star for a quarter. This action was implemented in July 2018.

To improve quality CMS may change the threshold for expected number of days with no RN reported that results in a one star staffing rating in the future. As of June 1, 2018 we no longer collect facility staffing data through the CMS-671 Form. The staffing portion of the form has been removed. If you are given an old version of the form with the staffing data section still on it is not necessary to complete that portion of the form after June 1.

Also CMS has been posting the number of hours submitted for nursing staff for the last few quarters. In July we began posting the number of hours

worked by other staff, i.e., non-nursing staff. This includes the hours submitted for all other staff listed in Table 1 of the PBJ policy manual. We also distinguish between hours submitted for direct employees and contract staff. The information is posted on data.cms.gov. Our goal is to post information that stakeholders can use to understand the type of care and quality a nursing home may provide and that can also be used to improve quality and outcomes. Thank you for your efforts to support this program. I'll now turn it over to Dan Turner.

Dan Turner: Thank you (Lorelei). Today I'm going to talk about long stay hospitalization quality measure and health inspections rating freeze. TMS continues to focus on reducing hospitalizations to improve the health and safety of nursing home residents. Hospitalizations are expensive, disruptive and place residence at risk for an increased decline in health. Over the last several years CMS has launched initiatives aimed at reducing hospitalizations such as the Skilled Nursing Facility Value Based Purchasing Program and the initiative to reduce avoidable hospitalization among nursing facility residents.

In 2016 CMS added a quality measure to Nursing Home Compare to the Nursing Home Compare Web site in Five-Star quality rating system which reported the percentage a short stay residents who were rehospitalized. Posting this quality measure was aimed at informing stakeholders about the rates of rehospitalizations for each nursing home and incentivizing nursing homes to implement interventions to reduce these instances and improve quality.

Similarly CMS began posting rates of hospitalizations of long stay residents for the same objectives. For the month of July CMS provided rates of hospitalizations for long stay residents in each confidential Nursing Home Compare Five-Star ratings of Nursing Home Provider Ratings Report. In

October 2018 the long stay hospitalization measure will be posted on the Nursing Home Compare Web site is a long stay quality measure. In the spring of 2019 this quality measure will be included in the Five-Star quality rating system.

In February 2018 CMS implemented a temporary freeze of the health inspection domain of the Nursing Home Compare Five-Star quality rating system by holding these facilities health inspection rate constant for approximately one year. During the freeze inspections conducted after November 28, 2017 are not included in the facility star ratings calculation. This action is part of CMS's implementation of a new health inspection process and Phase 2 of the revised requirements for participation for the long term care facilities.

In October 2019 we will resume posting the average number of citations per inspection for each state and nationally. CMS is monitoring outcomes of the new inspection process and plans to resume health inspection ratings calculations in the spring of 2018. CMS will communicate more details about this prior to its implementation. For questions related to this information please email bettercare@cms.hhs.gov.

Jill Darling: All right thank you Dan and thank you to all of our speakers today. And (Brittany) please open line for Q&A.

Coordinator: Now we will begin our question and answer session. If you would like to ask a question please press Star then 1 and record your name clearly when prompted. If you need to withdraw that question you may do so by pressing Star then 2. Our first question comes from Joel VanEaton. Your line is now open.

Joel VanEaton: Hi. This is Joel VanEaton of Care Centers Management Consulting in Johnson City, Tennessee and just a couple of questions real quick for John. First with PDPM, and this may be premature so if it is that's fine, but just a question on therapy reporting and how that's going to happen. We know that at least in the proposed rule it indicated that we would all be reporting that on the discharge assessment

And I think that's in the final rule also does that mean on a PPS type of assessment with PDPM Section O recording of therapy will no longer be required? And then the second question I have is could someone help us - we've downloaded our SNF VBP performance program scorecards with the incentive payment multiplier could someone explain how that number will affect our ability to retain some of that 2% reduction coming up this fall? Thank you.

John Kane: Hey Joel, this is John. So with regard to your first question and then I'll turn it over to Celeste for the second part of your question about VBP. So for the first part of your question with regard to therapy reporting we - what had talked about in the final rule in the proposed rule was adding items to the NPE or the PBS discharge assessment that would allow us to capture basically the amount of therapy that have been provided over the course of the entirety of the Part A stay.

And we have felt that this was particularly important because we wanted to make sure that therapy provision both before and after implementation of PDPM was consistent and that is still followed with the patient's needs. There is obviously, you know, we've heard from commenters that there is concern that therapy services could change under PDPM with the potential for them to decrease. From our perspective if a patient needs 720 megs of therapy on September 30 and they still need that therapy on October 1 and so the

payment system shouldn't be a change for that or a justification for a change for that.

So what we talk about in the proposed and final rules is adding therapy items to the discharge assessment to allow us to capture that information and assess the impact of this policy to determine what sort of further actions are necessary. That being said we hadn't - I don't think we proposed and finalized changes to anything else in relation to therapy reporting. As far as the MDS is concerned it was mainly just focused on the discharge assessment and the items that we were adding. And with that I'll turn it over to Celeste to answer the VBP portion of your question.

Celeste Bostic: Sure thank you. So if I understand your question correctly the incentive payment multiplier on your report is the amount that will be applied to the federal adjusted per diem rate. So it'll be multiplied by that value. So - and if you want to - if you take a look at the last tab of the report the data dictionary you'll see an example there…

Joel VanEaton: Okay.

Celeste Bostic: ...if you risk - yes does that help? If you are a SNF who this is after the 2% is withheld this is how much the SNF will received back. So if you're receiving 1% back after the 2% withhold that multiplier would reflect .99 for example.

Joel VanEaton: Okay. Okay and so how does that, just to follow quickly, now how is that - is that applied at the outset of the year, or is that applied throughout the year somehow or how does that work in terms of how that incentive is then paid back to the facility?

Celeste Bostic: It's applied to all Medicare Part A claims that are processed.

Joel VanEaton: Oh okay, okay. All right thank you.

Celeste Bostic: You're welcome.

Coordinator: And our next question comes from (Cynthia Morton). Your line is now open.

(Cynthia Morton): Thank you. And thanks to everyone at CMS for holding these calls. I wondered of (Casey) would repeat what she said about the different measures that were going to be publicly displayed I think you said in 2020. And I know one of - a couple of them were the functional change measures. Could you run over that quickly? And then I also had another question about where does sequestration the 2% sequestration on all providers where does that come out of the rates? Is it baked is that already baked into the baseline, is that come off the 2.4% payment update just not sure about that? Thank you very much.

(Casey Freeman): Sure. Thanks so much for your question. So we will begin publicly displaying data from calendar year 2020. The four assessment based measures that we will be adding are change in self-care score and that's NQF 2633, change in mobility score and that's NQF 2634, discharge self-care score NQF 2635 and discharge mobility score which is NQF 2636. And in response to your second question I believe John Kane was going to answer.

John Kane: Hi (Cynthia). So for your second question related to (unintelligible) oh sorry. For your second question related to sequestration, sequestration is taken at the end of everything it's after sort of all adjustments are made, everything is done you get to that final rate and then at that point sequestration is applied.

(Cynthia Morton): Thank you John.

John Kane: No problem.

Coordinator: And our next question comes from (Elizabeth Hart) your line is now open.

(Elizabeth Hart): Hi. This is (Elizabeth Hart). And I was wondering if we are not doing PPS right now does this affect us? We have a small critical access hospital and we do skilled care on the swing bedside on the hospital side?

John Kane: So if you're under the SNF PPS then this does affect you if you are not under the SNF PPS then no this would not affect you.

(Elizabeth Hart): Okay and I have another question that I'm not sure if you can answer or not about quality measures and low risk for incontinence is that any of your guy's field?

John Kane: Yes shoot.

(Elizabeth Hart): We're continually getting people that I'm quoting on the MDS, you know, as fully dependent for transfers or bed mobility that should be an exclusion, we're having our residents counted as low risk in our - low risk quality measures are really poor when we only have maybe one or two incontinent frequently incontinent patients that are low risk for residence for residents sorry.

And I'm wondering what - where the information is aggregated to account for that? Is it something I'm doing within the MDS or is it something that applies to it afterwards because I don't feel that I have any actions but to say what their incontinence level is and what their ADL scores functional score within the MDS?

Tara McMullen: Hi it's Tara McMullen with the SNF QRP. So if I'm understanding your question correctly you're asking about the aggregated outcome?

(Elizabeth Hart): Yes.

Tara McMullen: Okay yes. So we have a nursing home it's called the MDS 3.0 QM User's Manual. And in that manual in Chapter 6 or Chapter 7 I forget which one it is that measure is there and we delineate or we basically stratify out the specification. If you are coding and you're basically coding for your residence and there's exclusions applied your measure outcome will look different. What CMS does for reporting is it does aggregate to the national mean.

So what we can do if you want to email us your question we can go and take a look at your data quarterly and tell you what we're finding and why the outcome is looking the way it is. But basically it's about how you're coding that measure and in that manual we can tell you - it will show you - and I can talk you through this if you want to give us a call. So it shows you based on your outcome that's dependent on how you code that measure and then we aggregate to the national (unintelligible).

(Elizabeth Hart): Okay what's your email and phone number?

Tara McMullen: (Cheryl).

Jill Darling: So we have a SNF ODF inbox it's SNF_LTCODF-L@cms.hhs.gov. It's also on the agenda as well.

Tara McMullen: Hi. It's Tara. Thank you Jill and one more thing please do not send any patient data. If you just want to send your question we can go and look into that data but please do not send any (unintelligible) via email. Thank you so much.

(Elizabeth Hart): Understood. Thank you.

Coordinator: And our next question comes from (Mary Mosley). Your line is open.

(Mary Mosley): Yes. I have a question since PDPM is going to be dependent on ICD-10 are we going to - is there any reach out for CMS to the hospital so that we can get the ICD-10 diagnoses a little sooner than later?

John Kane: Hi. So this is - so you're absolutely correct. So we do under PDPM you'll be using the ICD-10 diagnosis codes as the basis for patient classification. But the main thing I want to make very clear though is that the ICD-10 code that you would be coding on the MDS is not the primary reason that they were in the hospital it is the primary reason that they are in your SNF which may or may not be the same reason that they were in the hospital. There's a variety of things that can happen while they're in the hospital for which they would need aftercare or need SNF care.

And so what we're asking you for is to code on the MDS the primary diagnosis for why they are in your SNF. Now obviously that bears relation to the type of care they received in the hospital. So as should be practiced now we do encourage you to work with the hospital that is being - that from which the patient is being transferred and information from the admission summary or discharge summary at the hospital should be able to provide important information in terms of understanding what type of care that, that person requires in the SNF. But the diagnosis information that we are using as the basis for PDPM classification is the primary diagnosis the primary reason that they are in the SNFs not the primary reason that they were in the hospital.

(Mary Mosley): Okay, thank you.

Coordinator: And your next question comes from (Jared Lanrick). Your line is now open.

(Jared Lanrick): Yes I had a question kind of revolving around the 25% group concurrent methodology. Now are - is that 20 - I have kind of a two part question. Is that 25% allocated to both the group and concurrent combined or is that 25% total congruent 25% total group at the accumulated part of the discharge assessment or is it in a combination of up to 25% both group concurrent?

And also kind of alongside with that how is that 25% then factored in or allocated at the end of the discharge assessment to make sure that we're not getting, you know, because from I was looking or reading at that there is a, you know, there's a warning that will come out or there is obviously an alert that will say, you know, the overutilization of the practice will not be, you know, looked at as a positive. So obviously wanting to make sure our therapists aren't over utilizing that 25% and how that's going to be monitored or recorded before that discharge assessment is completed if that makes sense?

John Kane: It makes a great deal of sense and thank you very much for the question. So what we finalized is that there would be a combined 25% cap that would be used against both group and concurrent which means that if we're looking at the discharge assessment and would look at the therapy measures that have been reported if added together concurrent in group okay and this is at the patient level if we see that the amount of therapy that was provided in both concurrent and group modes added together comprises more than 25% of the overall therapy that, that person received then that would trigger the warning on the validation report.

So it's not two separate caps of 25% on each of group and concurrent but it's a combined cap that adds those two together to ensure that no more than 25% of group and concurrent therapy taken together is provided to any given patient. And just one of the things I would note is that this is done at the discipline level. So this is looking at each discipline of therapy individually. So for PP, OT and speech it's looking at each one of those disciplines individually.

(Jared Lanrick): Okay that makes - and how - and then how by the end of that discharge assessment will be alerted that we're meeting that 25% amount like is that something that the therapists are going to have to track on their own accord or either in their documentation system to keep that percentage, you know, because obviously, you know, as therapists treat they'll say like oh we can group and concurrently now. And, you know, all of a sudden you have way over utilization of that without it being really, you know, monitored. You know, it would be something to the extent of, you know, how would that be - how could we educate them to ensure that they're not over utilizing that, you know, that phenomenal service that we're able to take advantage of.

John Kane: Right so a few thoughts. One is that in terms of just keeping track of it. So the way that it would be reported is that on the validation report that you got if we saw that again if it exceeded that 25% threshold then that you would get the warning message. Now in terms of tracking that obviously we would be tracking that through, you know, the discharge assessment. But it is something that we would expect that providers would be tracking as well to ensure that they're not providing that sort of excessive level of group or concurrent therapy.

And it seems like, you know, this is something that, you know, the SNFs are already doing currently. I mean is that one of the things that we've noted

actually over the past few years is that the SNFs have demonstrated an ability to track therapy minutes rather closely as it relates to the therapy RUG thresholds. And we've seen, you know, an increasing percentage of people receiving just enough therapy to get over the threshold into a certain RUG group. So I mean tracking therapy minutes seems to be a pretty standard practice within the industry currently and so this would be just tracking the group and concurrent minutes as opposed to tracking, you know, overall therapy minutes.

The other thing I would note in terms of the utilization of this service as that currently we're seeing that approximately .3% approximately so 1/3 of a percent of therapy is being reported to us is on the concurrent or group basis. So we do expect that, that number is likely to increase and we, you know, we hope that, that increases respective of the needs of the patient. But given, you know, the ability to track those minutes should be something that is within the ability of the SNF. And so, you know, we want to make sure that the patient is receiving services consistent with their needs and so, you know, whether that be concurrent group or individual so that should be something that, you know, hopefully each provider is able to do.

(Jared Lanrick): Absolutely. No that's perfect. I truly appreciate it. That's - that answers my question perfectly. Thank you.

John Kane: Thank you.

Coordinator: And our next question comes from (Coco O'Connell). Your line is no open.

(Coco O'Connell): Thank you. I just wanted to confirm about the inspection rating on the Nursing Home Compare because I might have heard it wrong. But what I just

heard was that the star rating portion will remain as we are seeing now under the freeze until 2019 spring and it won't change in October 2018?

(Evan): Hi. This is (Evan) (unintelligible). Thanks for your question. That's correct but just to clarify the health inspection domain of the Five-Star rating system will not change until the spring of 2019 as it hasn't since February of this year. The rest of the domains in the Five-Star quality rating system will continue to be updated for example in October we will update the quality measure and staffing domain as we normally do each quarter.

(Coco O'Connell): Okay, thank you. We've been assuming that star rating will be changing in October 2018 so thank you for the clarification.

(Evan): Sure.

Coordinator: And our next question comes from (Velvet Thorn). Your line is now open.

(Velvet Thorn): Hi. I'm (Velvet Thorn), thank you all. I just want to first start off by saying that I'm a nurse care coordinator and I'm on this call for learning. I'm just trying to get some understanding of how skilled nursing works with respect to patients being admitted in a subacute rehab in the skilled nurse facility.

And with respect to this new model PDPM I want to know with respect to how Medicare pays for a patient when they come in for a subacute rehab. I understand that the criteria is that they pay up to the first 20 days but I also wanted to know isn't this based on medical necessity at the time of service because my concern is over utilization of that service that even though Medicare pays up to approximately 100 days but if it has to be based on medical necessity criteria at the time of service in order to pay up to the 100 days. Am I correct?

John Kane: So okay so a few things I want to unpack in what you just said. So first of all in general this is just sort of just a general statement that nothing in terms of the coverage requirements associated with the SNF benefits changes under PDPM. So in terms of the need for skilled services that those services be delivered on a daily basis all of those other criteria that we use as a very general basis for SNF coverage do not change as a result of PDPM. So that's one of the things I just want to sort of note generally in relation to what you just said.

(Velvet Thorn): Okay.

John Kane: Second so what you said is accurate that for a given benefit period for (unintelligible) patient they are allotted 100, up to 100 days of skilled - of basically SNF benefit. So they could stay in a SNF for up to 100 days. Now that is as you said on the basis of having a skilled need basically that the services that they were receiving justify that they're, you know, should be covered under the SNF benefit for that length of time. Now the average length of stay within a SNF is probably about two weeks between two weeks and three weeks. So we don't see a lot of people who where there is that justification to remain for a 100 days. So that's just, you know, you could remain 100 days but it doesn't - usually we don't often see that.

The other thing that you said and I want to make sure this is clear and I may have misinterpreted what you said but you had said that under PDPM that therapy services would be paid for for the first 20 days, that's slightly inaccurate. What therapy services under PDPM both under PDPM and under RUG IV are paid for however long that person is within the SNF covered by Part A. The main difference under PDPM -- and this might have been what you were making reference to -- is that under PDPM or pardon me under RUG

IV we utilize what we refer to as a constant per diem rate which basically means that you receive a per diem rate of let's just say $500 for a given patient. And on day one that rate is $500 and on day 90 that rate is $500.

Under PDPM we had finalized what we refer to as a variable per diem rate. And what that ultimately means is that the per diem rate on day one is different than the per diem rate on day 90 to track with what the data demonstrated for declining costs over the course of a stay. So the way that the schedule works for therapy specifically for the PT physical therapy and occupational therapy components is that the rate would remain the same for the first 20 days of the stay and then would decline by 2% every seven days thereafter. So there is still therapy payment beyond day 20 it's just that there is a declining payment to track with the declining cost trends that we observed in our data.

(Velvet Thorn): Interesting. Okay I certainly appreciate that. You said normally you don't see where you all have to pay up well Medicare doesn't have to pay up to 100 days usually you don't really see that as much. But I had a situation where a patient had according to the skilled nurse facility had exhausted their 100 day benefit. But based on the information that was given to me it didn't seem to meet medical necessity criteria for up to those days so I was concerned about that.

John Kane: Right, no that would certainly be concerning to me too. I mean even if they were there for seven days or even one day if they didn't meet the need for - if they didn't meet medical necessity or the skilled criteria that would certainly be problematic. So I think any length of time that they are there not meeting the skilled criteria should be a cause for concern.

(Velvet Thorn): Yes because she was saying that the patient was homeless and I said well Medicare doesn't pay for homelessness. So…

John Kane: That is extraordinarily well put.

(Velvet Thorn): Right. So that was a concern. And again I felt like I needed to escalate that for some type of research because there was a suspicion from my perspective based on what was being told to me of fraud.

John Kane: Yes, no there are resources available if there are suspicions of fraudulent behavior, if there are suspicions of patient abuse or anything like that there are resources available. If you want to email into us it's something that we could probably talk about off line just to make sure you had all the resources that you want.

(Velvet Thorn): Okay I certainly would appreciate that. I definitely need to talk off line...

John Kane: Absolutely.

(Velvet Thorn): …because I like to have the right resource because this - my responsibility as a care coordinator is to reduce healthcare cost by way of care coordination and chronic care management. So we look at a cause and effect in this regard. So I think over utilization of services certainly escalates cost. So that's why this is a major concern to me based on what was stated to me about this particular event when they told me that the patient was still there because she had nowhere to go she was homeless that that's a social economic issue that's not Medicare doesn't pay for that.

John Kane: No thank you very much. Again if you - if there's an email on the agenda if you want to email into that and then we can connect off line. And then we can

talk about the concern you have and I can point you to the right resources if there's anything you want to do.

(Velvet Thorn): Okay in the email that I should be looking at is the one that says Nursing Home PBJ not that one right?

John Kane: No it's snf_ltcodf…

(Velvet Thorn): Oh okay. I see that. All right good.

John Kane: Yes right. All right thank you very much ma'am.

(Velvet Thorn): Thank you kindly.

Coordinator: And our next question comes from (Jennifer LeVay). Your line is now open.

(Jennifer LeVay): Hi. Thank you for this. I'm just wondering what kind of training CMS is going to be planning on giving us on PDPM? Is it going to be multiple training sessions, will it be live, will it be remotely based similar to what was presented this week in Baltimore for the QRP training and do we have any idea of a date?

John Kane: We are still working through dates and things like that. Fortunately there's a wide variety of potential options for us to work through. We're looking at the potential for Webinars, special (unintelligible), national provider calls, online or in person training so we're looking for a variety of different options as quickly as possible to make sure that we're able to provide the training education that's necessary.

I would also just note that there's actually a lot of training that's actually already going on. My Twitter feed has actually been pretty live with existing training options. I actually sat in on a Webinar recently that was very excellently done about PDPM And so I would say just make yourself - I would say to avail yourself of any of those training options that are currently available and then stay up to date on our Web site as we'll be posting materials, posting educational tools as well as posting for events and Webinars and things like that, that we're planning on doing.

(Jennifer LeVay): All right thank you. Are those training that you're referring to John third party not CMS at this point?

John Kane: Yes all of those are third party. Those are, you know, I'm not advocating for any specific one of them just saying that there are trainings available out there and so if there's anything that you find information is always good.

(Jennifer LeVay): Okay, thank you.

Coordinator: And our next question comes from (Carol Mayor). Your line is now open.

(Carol Mayor): Hello. This is (Carol Mayor). And thank you for the opportunity to ask questions, I actually have two. The first one is about the Part APPS discharge additions for next year. Will the therapy on that Part APPS discharge only be for the seven day look back or is it for the entire stay is question number one? And question number two will there be updates to the ICD-10 mapping that had been released with the proposed rule? I'm particularly concerned about the fracture codes and hoping that the seven character D will be added as not be returned to provider? Thank you.

John Kane: Thanks Carol. So to your first question the items that are being added to the PPS discharge for the purposes of therapy collection would have a look back period over the entirety of the Part A stay. So that does differentiate them from the therapy items that they're currently collected which as you just noted accurately that have a seven day look back period. We felt it was important again to have the full Part A stay look back period for the discharge items to ensure that we're able to see over the course of an entire stay both before PDPM implementation and after to be able to make sort of an apple to apple comparison in terms of therapy provision under each system.

With response to your second question on ICD-10 yes just in sort of a general way you are correct that the ICD-10 mapping is something that's going to require sort of maintenance going forward. As you know ICD-10 codes change, there's new codes added, there's, you know, a whole bunch of different things that happen with ICD-10 codes each year. And so we will be making sure that we're maintaining that and that we're providing that mapping consistently to providers. So and if there are suggestions, comments, issues that you have with the mapping please feel free to send those to us and we can certainly take this into consideration.

(Carol Mayor): All right. Thank you very much.

Coordinator: And our next question comes from (Ashley Aultmeyer). Your line is not open.

(Ashley Aultmeyer): Hi there. We are a distinct part skilled nursing facility attached to a critical access hospital. We have a very difficult time discerning what applies to us and what does not. Do you guys have any resources or contacts to assist us with our unique questions? And also we would like to know how would the PPS new ruling affect us seeing how our 20 bed skilled nursing is all long term residents? And then the final question would be how often is the long

stay ratings updated on the Five-Star rating like how frequently it happens? I know somebody said quarterly but our current data selection is from April 17 to March 18 so I was just trying to get that clarified.

John Kane: Hi. So with regard to your first level question in terms of sort of what affects you and whether or not specifically a PDPM would affect you. I think probably one of your best sources is going to be your Medicare administrative contractor to whom you submit your bills to. So, I mean, that's ultimately the question is, are you - is your facility paid under the SNF PPS sort of Part A Medicare benefit?

So if you're paid under the SNF PPS, you know, you're doing five days, 14 days, 30 days, you know, (COTOM) rows all that stuff kind of now then yes PDPM changes would affect you. If you're not doing any of that because you're paid under a different system then no then PDPM does not relate to you. But again I think probably the best starting point of contact for that would be your MAC to address the, you know, what - under what system you're being paid. And then for the second part of your question, can you I'm sorry can you repeat the second part of your question or the last of the last part of your question?

(Ashley Aultmeyer): Let's see part was with the quality measures when we're talking about the Five-Star rating. I know that somebody said it was updated quarterly but I was wondering how - so our quarter would have ended in June but our data is not updated for a whole year from April 17 to March 18. So I was just trying to figure out when would…

((Crosstalk))

(Ashley Aultmeyer): …changes so you take information quarterly. And the quarter ends at the same length of the PBJ reporting in June?

(Jonathan Friedlander): Hi. My name is (Jonathan Friedlander). I'm another data analyst in the Division of Nursing Homes. So the way the long stay QMs work is that there's - they're updated every quarter but there is a quarter lag from the - so the year period of data and there's a quarter lag from when they're posted to when the - that end of that year is. So right now the year ends at the end of March and we just posted that in July so that's the three months from July to March is that lag. By the way in October we'll be posting through July.

(Ashley Aultmeyer): Okay. I was wondering because I knew there was some kind of lag but I wasn't sure, at one time it had shown more frequent so I was just trying to clarify that.

(Jonathan Friedlander): It's been that way for a while anyway but yes so it's updated every quarter and there's a quarter lag to the most recent…

(Ashley Aultmeyer): And then when I go on, like, CASPER and I look at the reports that they send me on there, it always says less than 20 because we have less - we have 20 residents in our facility. So they never can give me like, you know, any information quarterly so I'm trying to figure out how I can track it better and to determine what residents are causing my quality numbers to be so low?

Tara McMullen: Yes hi. It's Tara McMullen to add on to my colleague John. So we report based on case minimum case so that's what you're looking at for the less than 20. If you can email us we can go and pull your data and, you know, tell you what's going on. However in your report it should show you in totality what is going on with the data that you're submitting however the 20 case minimum is what is required for reporting and compare to ensure that, you know, so

basically data won't be skewed that you have enough case size to report an accurate report with less noise today.

(Ashley Aultmeyer): Okay. So we like we always only have one person that has long term fully so our number is always awful for that.

Tara McMullen: Yes.

(Ashley Aultmeyer): And we're trying to figure out how, you know…

Tara McMullen: Yes.

(Ashley Aultmeyer): All righty. Well...

Tara McMullen: All right.

(Ashley Aultmeyer): …(unintelligible) thank you so much.

Coordinator: And as a reminder if you would like to ask a question please press Star then 1. Our next question comes from (Deborah Brown). Your line is now open.

(Deborah Brown): Yes I was reviewing the new reports that got posted today and we're - we have a chain of homes. And one of our homes doesn't have all four tabs it's missing the facility data. What causes that and what can I do about it?

Celeste Bostic: Hi. This is Celeste from the SNF VBP that is probably not correct. So if you wouldn't mind emailing your question and your facility CCN to the SNF the VBP…

(Deborah Brown): To the help desk?

Celeste Bostic: Yes inquiries at, yes.

(Deborah Brown): Okay.

Celeste Bostic: So that we can take a look and be sure to, you know, perhaps re-upload a report for you all. Sorry about that.

(Deborah Brown): Oh okay. Thank you so much. And this is great, thanks so much.

Celeste Bostic: Absolutely.

(Deborah Brown): Bye now.

Coordinator: And our next question comes from (Robert Watts). Your line is now open.

(Robert Watts): This is (Robert). Hello this is (Robert Watts). My question is related to the RAI manual and the timing of that will be released. And in particular in relation so that we have it for training for October 1 of this year there's a lot of changes and we're going to need time to have that information for that. The second part of the question is related to the new J 2000 sub items and the addition of those to the MDS and the timing of when those will be added such that software vendors have time to prepare and update the MDS in the systems before day one, thoughts?

(Christine Teague): Hi. This is (Christine Teague) from the Division of Nursing Homes. The RAI user's manual is scheduled to be posted publicly on the CMS Web site the first week of September.

John Kane: And then in relation to second question about J 2000 and when I think fundamentally your question is when draft classifications will be made available for those - for that item as well as any other changes. We're working through those now and we'll be making sure to work with software vendors and other stakeholders to ensure that the draft specs are released with sufficient time for doing whatever kinds of changes that you guys want to make. So we do understand the need to have those as early as possible and we will be sure to try and do that.

(Robert Watts): And I appreciate that. And regarding the RAI manual the first week of September doesn't give us much time before October 1 for us to train our people. And I'm just thinking in Baltimore it was a two day training that you go through for the QRP for us to get training together and get it out to folks in our buildings it takes time. So I just encourage as soon as possible. Thank you.

(Christine Teague): Understand your concern. Thank you.

Jill Darling: All right well thanks everyone for joining today's call, a lot of great questions. If you were unable to get a question in please feel free to send it into the SNF Long Term Care Open Door Forum email. Thanks everyone.

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

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