

Centers for Medicare & Medicaid Services  
Skilled Nursing Facility Long-Term Care  
Open Door Forum  
Moderator: Jill Darling  
May 1, 2018  
2:00 p.m. ET

Operator: Good afternoon. Name is (Amy) and I will be your conference facilitator today. At this time I would like to welcome everyone to the Centers for Medicare & Medicaid Services, Skilled Nursing Facility Long-Term Care Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, you may press the pound key.

I will now turn the call over to Ms. Jill Darling, please begin.

Jill Darling: Thank you, (Amy). Good morning and good afternoon everyone. I'm Jill Darling in the CMS Office of Communications and thank you for joining us today for this SNF/LTC Open Door Forum. And as always before we get into today's agenda, 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, but 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](mailto:press@cms.hhs.gov).

So, up first, we have Tara McMullen who has announcement about the update on the IMPACT Act Transfer of Health Measures.

Tara McMullen: Hi, everyone. Thanks Jill. It's Tara McMullen, just a quick update. This is a call for public comment. CMS has contracted with RTI and Abt Associates to

develop cross setting Post Acute Care transfer of health information and care preferences quality measures.

These are in alignment with the mandate by the Improving Medicare Post-Acute Care Transformation Act of 2014 also known as the IMPACT Act. The measures were developed under the domain or to meet the domain of the transfer health information and care preferences.

The call for public comment period of this period opened March 19th, 2018 and it closes May 3rd, 2018, I'm sorry I said 19. Closes May 3rd, 2018, COB, midnight.

The measures that we're seeking comment on are the medication profile transfer to the provider. The medication profile transfer to the patient, and again, the comment period closes in two days, May 3rd. Thank you.

Jill Darling: All right, thank you, Tara. Next, we have Lorelei Kahn, who has a PBJ update.

Lorelei Kahn: Thank you, Jill. Staffing data from January 1st through March 31st must be submitted no later than 45 days from the end of the quarter. The final submission deadline for this quarter is May 15th, 2018. We strongly encourage providers to submit data throughout the quarter and not wait until the last 24 hours before the deadline. Only data successfully submitted by the deadline is considered timely and used on the Nursing Home Compare website and in the Five-Star rating calculation.

Once a facility uploads their data file, they need to check their final validation report which can be accessed in their CASPER folder, to verify said that the data was successfully submitted. It may take up to 24 hours to receive that 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.

CMS announced several update to the PBJ program through Survey and Certification Memo QSO-18-17-NH which was released on April 6th, 2018. Here is the summary of those updates.

As of April 25th, we have begun using PBJ data to determine each facility's staffing measure on Nursing Home Compare and to calculate the staffing rating used in the Nursing Home Five-Star Quality Rating System. The staffing measures and staffing rating are being calculated based on the data for the fiscal year 2018 quarter one which is October through December 2017 that was submitted prior to the February 14th, 2018 deadline.

CMS has been and will continue to conduct staffing audit. Facilities whose audit identifies significant inaccuracy between the hours reported and the hours verified will be presumed to have low levels of staff. This will result in the facility receiving a one star staffing rating which will reduce the facility's overall composite rating by one star for a quarter.

Examples of significant inaccuracies are instances where the difference between the submitted hours and verified hours is large enough that it would change a facility star rating or change how the facility compares to its state's average.

Nursing homes that don't submit any data by the required deadlines or don't respond or provide adequate information to an audit request will also receive a one star staffing rating for that quarter which will drop their overall composite start rating by one star for a quarter.

We also remind nursing homes of the importance of R.N. staffing and the requirement to have an R.N. on site eight hours a day, seven days a week. Nursing homes reporting seven or more days in a quarter with no R.N. 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 will be implemented in July 2018 after the May 15th, 2018 submission deadline for data for 2018 calendar quarter one,, January through March 2018 data. Prior to July 2018, facilities meeting this criteria will have

an icon placed next to their name on Nursing Home Compare to indicate their status related to R.N. staffing. To improve quality, CMS may change the threshold for expected number of days of no R.N. reported, that results in a one star staffing rating in the future.

As of June 1st, 2018, we will 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, it is not necessary to complete that portion of the form after June 1st.

CMS will continue to provide technical assistance to nursing homes to improve their staffing and data submissions. Facilities should review their monthly provider preview in their CASPER folder for feedback on their most recent submission.

We also encourage nursing homes to run CASPER report 1700D employee report, 1702D individual daily staffing report and/or 1702S staffing summary report prior to their submission before the quarterly deadline to review their data and ensure accuracy and completeness.

CMS has posted public use files which include facility level data from quarterly submissions. These files include nursing hours and resident census data. The files and detailed documentation about their content and structure are available for viewing and downloading from [data.cms.gov](http://data.cms.gov). More information on the public use files can be found in the CMS memo 17-45-NH. The measures for nursing and physical therapy staff are the first measures to be posted on Nursing Home Compare using PBJ data.

However, we plan to develop additional measures like staff turnover and also post them on Nursing Home Compare. 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 use to improve quality and outcomes.

More information on these changes may be found in survey and certification memo QSO-18-17-NH which can be found at

<https://www.cms.gov/Medicare/Provider-Enrollment-and->

[Certification/SurveyCertificationGenInfo/Downloads/QSO18-17-NH.pdf](#).

Thank you.

Jill Darling: Thank you, Lorelei. Next, we are going to go over the Fiscal Year 2019 SNF PPS Notice of Proposed Rulemaking. So first we have John Kane who has – who will cover the Payment Rate Updates and Proposed Case-Mix Classification System Changes.

John Kane: Thank you, Jill, and good afternoon everyone and thank you for being on today's call. On Friday April 27th, CMS released CMS-1696-P, a proposed rule which outlines proposed Medicare payment updates for fiscal year 2019 and proposed program changes associated with the SNF PPS.

The comment period on this rule closes on June 26th, so please make sure to get your comments in to us by then. I will speak to the first two agenda items associated with SNF PPS proposed rule specifically the proposed rate update for fiscal year 2019 and the proposed case-mix changes that we refer to as the Patient-Driven Payment Model or PDPM.

With regard to the proposed 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 \$850 million as a result of the FY 2019 SNF market basket increase factor of 2.4 percent as required by the Bipartisan Budget Act of 2018.

We would note that the application of this statutory requirement, the FY 2019 SNF market basket update factor would have been 1.9 percent which reflects the FY 2019 SNF market basket index of 2.7 percent reduced by the multifactor productivity adjustment of 0.8 percent. This 1.9 percent update would have resulted in an estimated aggregate increase of \$670 million in Medicare payments to SNFs.

Moving now to the proposed changes to the SNF PPS case-mix classification system. We are happy to announce the proposed Patient-Driven Payment Model or PDPM. As you may recall in May 2017, CMS released an Advance Notice of Proposed Rulemaking or ANPRM, which outlined a new case-mix

model called the Resident Classification System, Version I or RCS-I, that we were considering to replace the existing RUG-IV case-mix model, used to classify patients in a covered Part A stay into payment groups under the SNF PPS.

Since the ANPRM, CMS continued stakeholder engagement efforts to identify and address the concerns and questions raised by commenters. Based on these comments, we made significant changes to the RCS-1 model resulting in the proposed PDPM. We proposed that this model be effective beginning on October 1, 2019.

We believe that PDPM represents a marked improvements over the RUG-IV and RCS-1 models 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 SNF payments to currently underserved beneficiaries without increasing total Medicare payments or compromising access for any other SNF patients.

We would additionally note that CMS released with the proposed rule a technical report on the development of the PDPM along with a number of other helpful materials available on our program website to support commenters in developing comments on the proposed rule.

There are number of aspects of the proposed model that we wish to highlight on this call. First, we would like to note the PDPM significantly reduces the administrative burden associated with the SNF PPS specifically the burdens associated with patient assessment.

While the current system requires substantial paperwork to track the volume of service utilization over time, PDPM eliminates the need for these frequent patient assessments and allows clinicians to focus more time on treating the patient.

We estimate that based on the proposed changes to the assessment schedule associated with PDPM, providers will benefit from approximately \$2 billion in reduced administrative costs over the next 10 years.

Next, we would like to highlight that PDPM is far less complex than RCS-1, which is a direct result of provider feedback on the RCS-1 model. We were able to reduce the number of payment group combinations by approximately 80 percent with a very minimal loss to payment accuracy. This was of great concern to commenters on the RCS-1 model, and feel this is a significant improvement in PDPM. Additionally, we simplified the variable per diem adjustment by having it operate on a weekly rolling basis rather than the schedule discussed in the ANPRM.

Looking back to RCS-1, a number of commenters have expressed concern with how that model would align with other CMS initiatives notably the IMPACT Act. We hope that the proposed rule provides further clarity of how PDPM would interact with other CMS initiatives focus on improving value driven and high quality care.

We would specifically highlight as this was also a source of comment on the ANPRM that the functional scores used to classify patients under PDPM are based on Section GG of the MDS rather than Section G as the current system uses and RCS-1 will be designed to use.

We believe that using Section GG as the basis for functional assessment and classification of SNF patients rather than Section G better aligns PDPM with other PAC systems and with other CMS initiatives.

Another aspect of the proposed PDPM to which we would like to draw your attention is the proposed limit on concurrent and group therapy. A number of commenters on the ANPRM and since have commented to us regarding the need under such a model as PDPM to ensure accountability for providers to deliver the highest quality of therapy services SNF patients.

To ensure that SNF patients receive therapy that is best attuned to their individual needs and characteristics, we proposed similar to that discussed in

the ANPRM, a limit on concurrent and group therapy. Specifically, we proposed that under PDPM no more than 25 percent of the therapy provided to SNF patients maybe delivered in either a concurrent or group setting.

We believe this proposal will help to ensure the SNF patients continue to receive the highest caliber of rehabilitation services while still allowing flexibility for therapists to determine the most appropriate course of treatment for a given patient. We also plan to monitor closely the amount and way in which therapy services would be delivered under PDPM if finalized and take action, should we discover that the patients' unique needs and characteristics are not the apparent basis for clinical decision making under the revised model.

Finally, we would draw your attention to the impact analysis associated with PDPM. While we proposed to implement PDPM in a budget neutral manner, the policies and revisions proposed under PDPM reallocate and realign how monies paid out under the SNF benefits are distributed.

For example, nonprofit SNFs and hospital-based SNFs which typically treat some of the more medically complex patients, fare better under the proposed PDPM. Further, facilities in rural communities do better under the proposed PDPM.

Finally, Medicare beneficiaries that are also enrolled in a state Medicaid program often referred as dually enrolled beneficiaries who also tend to be the most expensive and medically complex to treat, fare better under the proposed PDPM than 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 stated above, we are proud to propose this improvement to the SNF PPS and hope that this paves the way for future value and data-driven improvements in Medicare payment.

And with that, I will now turn the call over to Mary Pratt to discuss the Proposed Changes to the SNF Quality Reporting Program.



Mary Pratt: Good day everyone. Consistent with CMS's meaningful measures initiative priorities, which include making care a safer, strengthening person and family engagement, promoting coordination of care, promoting effective prevention and treatment, and making care affordable, we evaluated to see the appropriateness and completeness of our current set of quality measures for the SNF Quality Reporting Program.

All 12 of our measures are required by statute and none at this time are being considered for removal.

We are proposing to adopt an additional factor, eight in total now. This last factor making it eight when evaluating the potential for removal of a measure set. And that factor is the cost that's associated with the measure, does it outweigh the benefit of its continued use in the program.

In addition, we are proposing to increase for purposes of public reporting from one to two years of administrative claims data for our two claims-based quality measures, Discharge to Community and the Medicare Spending per Beneficiary. In addition – and that would be for public reporting in calendar year 2019.

In calendar year 2020, we're proposing the public display of four assessment based functional outcome measures and you can find further details on these proposals in the proposed rules. We certainly encourage your comments or any questions and of course the instructions for it can be found at the Federal Register website.

I can – OK, and then I'm going to turn it over to Celeste Bostic for updates on the SNF Value-Based Purchasing Program.

Celeste Bostic: Great. Thank you, Mary, and good afternoon everyone. As Mary said, my name is Celeste Bostic and I'm the program lead for the SNF VBP program. And I'll provide a brief overview of the four-key proposals included in this year's proposed rule.

First, we are proposing an approach to address the possibility of data or calculation errors if they should arrive when calculating performance standards. We will continue to publish finalized performance standards in each final rule. But if we identify an error in the calculation that affects the numerical values of the performance standards, we are proposing to update the performance standards one time to correct that error.

Our next proposal is to adopt fiscal year '19 as the performance period and fiscal '17 as the baseline period for the fiscal year 2021 SNF VBP Program year. For all future program years, we are proposing to have the performance period and baseline period advance by one year from the previous program year automatically. So, for example, the performance period for the fiscal year 2022 program year would be fiscal year 2020 and the baseline period would be fiscal year 2018.

Next, we are proposing to score SNFs that did not have any baseline period data or had less than 25 eligible stays during the baseline period on achievement only. And we will score those SNFs on improvement for any future program year during which they have 25 or more eligible stays. Similarly, we are proposing a scoring adjustment for SNFs that had less than 25 eligible stays during the performance period.

Under this proposal, we would assign SNFs the performance score that results in no net change to the SNFs adjusted federal per diem rate. We believe this policy is the most appropriate way to ensure that low volume SNFs receive reliable SNF performance scores.

And lastly, we are proposing to adopt an ECE or Extraordinary Circumstances Exception policy that provides relief to SNFs that are affected by disasters or other circumstances beyond the SNFs control that affect its performance on the program's readmission measure.

We will – we invite public comments on this proposals and I will now call the – return the call back over to Jill.

Jill Darling: Thanks, Celeste. Now, I'm just going to kick it back to Mary for an announcement.

Mary Pratt: Yes. no, I just wanted to – I have a few updates from the SNF Quality Reporting Program to provide and to let you know that we're relieved to announce that the needed corrections to the review and correct as well as the facility and resident level quality measure reports have been made. So you can refer to the spotlight page on our CMS QRP – SNF-QRP website for more information.

In addition, we'd like to remind you of the upcoming submission deadline for all MDS assessment data for calendar year 2017, that's all four quarters of data that must be submitted no later than 11:59 p.m. Pacific Standard Time on May 15.

You can view the list of required measures and data submission deadline, again, on SNF/QRP data submission deadline webpage. We recommend running applicable CASPER validations reports prior to each quarterly reporting deadline to ensure that all the data that's required to be submitted is done. We also encourage that you verify your facility information including your CCN and your facility name.

For our providers affected by hurricane Harvey, Irma, Maria, Nate or for the California wild fires, we have information on exceptions that can be found on our reconsideration and exception and extension webpage.

Finally, we've like to remind you about the importance of submitting all the necessary quality measured data that's collected on each patient and resident. This data are needed to ensure quality outcomes and accuracy in your Q.M. score calculations for your facility performance, for comparisons with other facilities and then for a public reporter – reporting later this year.

Remember that the risk adjustment of your quality measure scores that are reported reflect your unique resident complexities and may show up in the actual performance rate, meaning you have better scores with all the proper risk adjustments noted.

And again this information is found on our webpage. There are quick reference guides that are available to be downloaded. And remember that the penalty for the quality reporting program is applied, if not all – a 100 percent of their required data we need at least 80 percent of your MDS submitted. Thank you. That's our QRP update.

Jill Darling: All right. Thank you, Mary, and thank you to all of our speakers today. (Amy), we'll go into our Q&A, please.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please go ahead and press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Please limit your questions to one question and one follow-up to allow other participants time for question. If you require any further follow-up, you may again press star one to rejoin the cue.

Your first question today comes from the line of (Sherry Simmons) of Prospect Nursing Home. Your line is open. Miss (Simmons), you maybe on mute.

(Inaudible)

Operator: And your next question today comes from the line Joel VanEaton of Care Center Management. Your line is open

Joel VanEaton: Hey, thank you for taking my questions. Just a couple of quick questions here. First, on the new facilities for SNF value-based purchasing if you could clarify for us work with the facility that just received their certification this March. And so, of course, they won't have any achievement data or improvement data relative to the time frames that'll be evaluated and adjusted this fall. So, I wonder if you could answer to that for me.

Then also did somebody speak to the questions, this isn't part of what you all talked about today. But the question of the new Medicare identification cards they're starting to come out. Does the QIES Casper system and the data that

can be entered into the MDS currently accept the new numbers that are being assigned to patients and when was that – when will there be a time frame for that?

Our software starting to actually take those numbers out of our database and put them into the MDS and of course its not – the software is not allowing it, but – in the validation process. But I'm curious to know if those can be submitted in the MDS currently or is that something that will be updated and revised in the future update. Thank you.

Celeste Bostic: Hi. And this is Celeste from SNF/VBP. Thank you for your questions. That's a really good point that I think we would love to hear that in public comment. So, please submit that question via the Federal Register and public comment and we'll be sure to address in the final rule. Thank you.

Jill Darling: This is Jill Darling. Regarding the new Medicare card on the agenda for today at the very bottom, the Provider Ombudsman for the New Medicare Card and there is an e-mail address there. I'll mention it, it's [nmcproviderquestions@cms.hhs.gov](mailto:nmcproviderquestions@cms.hhs.gov). So you can send your question regarding the MBI.

Joel VanEaton: Well, just a quick follow up on that. Our vendor is currently not validating that number in the software. I don't even know it can be submitted. Does anybody know whether the MDS currently would be able to accept that number or is or how soon that would be?

Todd Smith: Yes. Joel, this is Todd. We don't have anyone in the room here that can answer that specific question. So, if you could just send in your e-mail to the address that Jill just laid out. We'll try to get it to the right folks.

Joel VanEaton: Thank you.

Todd Smith: Thanks.

Operator: Your next question comes from the line of (Therese Silvasto) of Genesis. Your line is open.

(Therese Silvasto): Hi. Thank you for taking my question. My question relates to the SNF Value-Based Program. Two questions actually. When does CMS anticipate that we'll have our Q3 2017 data and the Q4 2017 data? And then beyond that, I thought I've heard that we might be expecting the adjusting factor information by June or July. Can you confirm any of that?

Celeste Bostic: Yes. Hi, this is Celeste from SNF/VBP. You will – SNF will begin receiving reports on this summer beginning in August, which will include their performance score as well as incentive payment adjustment, as well as calendar year 17 data. So we're targeting the August 2018 for those report.

(Therese Silvasto): So you're targeting August for expense even have that information both Q3, Q4 and the adjustment factor. So you think its going to be August.

Celeste Bostic: Well, I – there's –you will also receive June quarterly report before then. But if you could submit your question we can provide a clear answer with the data that'll be in all reports, so [snfvbpinquiries@cms.hhs.gov](mailto:snfvbpinquiries@cms.hhs.gov).

Operator: Our next question comes from the line of Christy Beard of National Healthcare. Your line is open.

Christy Beard: Yes. I just wanted to answer the previous caller, the previous question about the Medicare number on the submitted of the (key) system. It does accept April the 1st date of an ARD going forward the software vendors, it does accept that and it doesn't give any kind of wanting on the validation report. So just let me know that that is current.

Female: Thank you.

Operator: You have a next question comes from the line of (Jordan Ramp). You line is open.

(Jordan Ramp): Yes. I actually I have some questions regarding DME and speech generating devices being covered through SNF. And I'm not sure if this is really the place to talk about that or if there's somebody we can contact to go over that.

Bill Ullman: I guess what – our question would be, are we talking about somebody who's receiving the items during the course for Medicare covered stay because that has the bearing on our policy place out.

(Jordan Ramp): OK. Yes. It's kind of like as DME covered as part of the SNF coverage or is it part of the per diem rate?

Bill Ullman: Well, if we're talking about somebody who's in a covered Part A stay then the answer is yes. DME is included in the PPS bundle and included in the SNF per diem payment for the covered stay.

(Jordan Ramp): OK.

Bill Ullman: There are certain high-end customized prosthetic devices that are carved out from the bundle and payable separately but DME as a class, it's included in the bundle.

(Jordan Ramp): Now, speech generating devices, I'm referring to specifically, they have a significant amount or significant cost. So, is that, you know, separate or is that still part of the per diem or how is that determined?

Bill Ullman: Well, again I – we need to check with our DME shot to see whether that falls in the category of prosthetic devices or whether its still included in the category of DME. If it's DME then it's concluded in the bundle. If it's considered a prosthetic device then the next step would be to check the exclusion list and see if it's, you know, if the code for that particular device appears when the exclusion was set that separately billable prosthetics and that's something you could check you – with your Medicare administrative contractor if you need some help there.

(Jordan Ramp): OK. Thank you.

Operator: And you next question comes from the line of (Jennifer Almer) of (Copper) Hills. Your line is open.

(Jennifer Almer): Hi. We have question regarding PDPM, regarding therapy – concurrent therapy and group therapy. Can you verified is the combination of both more than – no more than 25 percent.

John Kane: That's right. So the propose of the – in the ANPRM is that no more than 25 percent of therapy can be delivered in either concurrent or group. So as it come – as so – as the combination of the two, it can't be more than 25 percent.

Operator: And your next question comes from the line – a line of (Peter Degere) of Harmony Rehab. Your line is open.

(Peter Degere): Thank you. I have a question about (grouping concern). I think I understand it now.

One question that the PDPM, maybe it's too soon to ask or I should write it in, is about the classifications with PT and OT. It looks there are PT/OT case-mix group. And that stating that they need to have both services PT and OT or they separated?

John Kane: The two components are separate component. This is also an improvement that was made to the PDPM as compared to RCS-1 on the basis of stakeholder feedback. And so, the idea is that every resident would be classified into a group for each of those five components. And so, you know, base in the presumption that within certain characteristics but these (staffs) will be receiving those services and so simple answer is yes. Everyone is classified into a PT group and to an OT group and then for each of the other component as well.

(Peter Degere): Got you. OK. Thank you very much.

John Kane: OK.

Operator: Your next question comes from the line of Brad Myers or Carolina Therapy. You line is open.



Brad Myers: Good afternoon. I have another PDPM question. Will there be a minimum or a maximum amount of therapy, either daily therapy or in the look back period or will there only be the requirement of daily therapy.

John Kane: Yes. The minimum amount of therapy that should be delivered to SNF patients is the amount of therapy that they need. And so the presumption here is that as opposed to utilizing certain cut points that are used within RUG-IV model, you know, we have, you know, yes, 720 (inaudible) ultra high cut off point.

And as we talked about on the prior call within the prior publications that a number of (inaudible) tend to use that as the sort of limit as oppose to as – just a cut off point within the payment group. Under PDPM, we sought to eliminate those cut points and to allow clinicians to determine the amount of therapy that people require base on their unique needs. So the minimum/maximum/appropriate amount is whatever that person needs based on unique characteristics.

Brad Myers: Thank you very much.

Operator: Your next question comes from the line of (Theresa Thompson) of Heartland of Miami. Your line is open.

And your next question comes from the line of Brenda Marinaran of Chestelm Health. Your line is open.

Brenda Marinaran: I was just going to request that somebody review the (cast) running of the CASPER reports on quarterly before they're sent to CMS. So, I just wanted to – want you to review their – the CASPER reporting situation. And I don't think I was clear on that. If you could please review the reports in CASPER that were supposed to look at our quarterly reporting is accurate.

(Inaudible)

Lorelei Kahn: Which program are you referring to?

Brenda Marigan: So, a comment that one of the lecturers mentioned. And I think, you know, in reading the guide, you know, there's reports that are put up there monthly so just reviewing all of those reports and checking their accuracy, correct?

Evan Shulman: So we have a variety of programs here. We've got Payroll-Based Journal, PBJ staffing. We've got ...

Brenda Marigan: QRP.

Male: QRP.

Female: Thank you.

Brenda Marigan: I'm sorry.

Female: Thank you.

(Tara McMullen): No, that's fine. So, for the purposes of your quality measure scores and quality measure information, you've got the reviewing correct report as well as the facility and resident level quality measure report. And those will give you information depending on how you run them on the records that were submitted into the (ASAP). Let's see, what else here do we need to add?

Female: I guess— there was also question about ensuring quality, is it – are you asking about the process or how those ...

Brenda Marigan: Well yes. So you guys pull this data quarterly?

Female: Yes, yes.

Brenda Marigan: I mean, I know we – right. So, what is – maybe the timeframe of the cutoff of looking at the correction of it all?

Mary Pratt: So, the 4.5 months following the end of a quarter is typically the freeze date, we call it, for the correction of the data. Now, for calendar year 2017 data, the quarterly deadlines were extended so quarter to one through four can still be corrected until May 15th next couple weeks, 2018.

Brenda Marinan: All right, so going – and that's all for 2017?

Mary Pratt: Calendar year.

Brenda Marinan: And I would also – that would also include the first quarter of 2018 because that would be the ...

Mary Pratt: Correct.

Brenda Marinan: ... 4.5 months, right? OK.

Mary Pratt: Yes.

Brenda Marinan: All right. All right, thank you.

Mary Pratt: Well, the first quarter of 2018 is in August, the 4.5 months following the end of the quarter. So January, February, March.

Brenda Marinan: OK. Thank you.

Mary Pratt: For – yes and then 4.5 months after that is some time like mid-August I think.

Brenda Marinan: All right. All right.

Mary Pratt: Cool.

Brenda Marinan: Thank you.

Mary Pratt: You're welcome.

Operator: Our next question comes from the line of (Nelia Adeacy). Your line – sorry, from the (Church) Group. Your line is open.

(Nelia Adeacy): Hi. My question is something to do with the posting of survey deficiencies, the 2567 on Nursing Home Compare as suppose to what posted on the state, Department of Health website.

What posted in Nursing Home Compare and I'm talking specifically for the state of New Jersey, does not include deficiencies that are CO and contention like those that were still waiting for IVR or IIDR or – we're still waiting for that process or resolution through the process.

However, in the state website, whether or not – what like even if we're waiting for an IDR hearing, they already post the deficiency. When I reach out to the state, they said this was said directive from CMS. Can anyone please help me understand why there's a disconnect or difference in reporting?

(Evan Shulman): Hi. Their – states do manage their own websites. We at CMS do wait for IDRs and IIDRs to be completed prior to posting survey findings but states may have different policies about how they post findings on their website including they may post findings related to state licensure or state laws which we do not post on the nursing compare website.

(Nelia Adeacy): But when I asked them, they said, this was actually a directive from CMS. So because I understand if there was a state specific things and I did quote chapter seven that, you know, like there's an IDR, IIDR still pending and so I – that's where the confusion is coming from because I'm not getting anything from the state levels and they're referring it back to CMS instruction, so.

(Evan Shulman): Sure. So, for something specific like this, please e-mail, [bettercare@cms.hhs.gov](mailto:bettercare@cms.hhs.gov)

(Nelia Adeacy): OK.

(Evan Shulman): Yes, e-mail us, we'll get back to you.

(Nelia Adeacy): All right, thank you.

(Evan Shulman): Thank you.

Operator: And again, ladies and gentleman, if you would like to ask a question, please press star then the number one on your telephone keypad.

Your next question comes from the line of (Melissa Stall) of Queens Boulevard. Your line is open.

(Dr. Moetta): Hi. We just did a question regarding how the rationale behind reduction in the reinvestment (reimbursement) that is accorded to physical therapy for instance in the PDPM model overtime, is the length of stay increases the – there's a reduction in the amount of reinvestment that's going to be accorded to, you know, to the provider, you know, base on an increase and length of stay.

While that is, you know, reasonable in some circumstances, clinically speaking, it seems that if a patient is a massive stroke for instance in the beginnings that utilization of those rehab services is going to be likely not as much as it would be as they get stronger over time and those patients are the patients that typically would take a longer time on therapy and require a longer length of stay.

So, what is the rationale behind the model or maybe you may – maybe it's already incorporated in the model that ensure the patient, you know, maybe the cause of the therapy for the – for that particular diagnosis since this is condition driven, it maybe that it's already built in the budget that's accorded that patient for that particular episode of care.

Can you clarify where that to such is being – is (factored) in deciding to reinvestment for those patients, you know, with the classic example being those we thought by is CVA and a massive one that would require more therapy in the tail end of the rehab stay versus the initial part of the rehab stay.

(John Kane): So thanks very much for that question. The next one question and I think it's excellent comment that you submitted into [regulations.gov](https://www.regulations.gov) on the proposed rule. The only thing I would just note for you is in terms of understanding better the justification behind this policy, the very variable per diem adjustment.

I would suggest you look in primarily two places, one would be the proposed rule which we discussed in the preamble to that – in that rule. We discuss what's the justification is. I also refer you to the typical report that we posted

to our program website as that also gives a lot of the underlying cost data and analysis that was used as to support that particular proposal.

(Dr. Moetta): I'm sorry, my name is – this is Dr. (Moetta). I did looked in that, you know, I've been researching the 266 pages of the – of this proposal. I could not find documentation of the rationale, you know, whether such was consider especially in the writing reimbursement for stroke patients for instance, special – it looks like there is – maybe a generalization or making statement that physical therapy would be reimburse over a period of time.

Essentially, in a particular – condition specific but doesn't say exactly was the rationale was factored in deciding, you know, how the (inaudible) of reduction is set based on the patient's needs. So I'm not exactly sure that that was factored in. It's not clear from the 266 pages of the, you know, that I reviewed so far.

(John Kane): Right. So two things. One, again, I would refer you back to not just the (inaudible) technical report which I think have a little more of the specific data that you maybe looking for in terms of the underlying cost trends that were used as the basis for understanding the need for variable per diem adjustments.

The other thing I would just note is that if there are specific – if there's specific groups of patients, if there are specific conditions or anything like that where there's specific population do you feel was not represent appropriately or that should be looked at differently or apart from other groups but also something that is a wonderful comment. That was – we received a number of comments on the ANPRM that's – the point of us to particular types of populations for us to do additional analysis. Those were very, very helpful in re-looking at a lot of the things that we put into the RCS-1 model.

So again, if there are particular populations that you feel or not adequately being represented or that are being over just generalized or anything like that, that's also a wonderful comment to add on the proposed rule.

(Dr. Moetta): I think just as a follow-up, I thought that part of the rationale behind the speech and language pathology not seeing a reduction in the reimbursement overtime is because predominantly, they treat most of those stroke patients and those patients necessarily would require a lot of service where a protracted period of time. And such, I thought maybe what was instructive of the, you know, the decision making process for deciding on getting speech therapy, being unaffected in terms of reinvestment was probably because they see so many patients that are neurologically challenged.

So, I was wondering whether in the specific, you know, patients like those CVA patients when they are treated by occupational therapy, all physical therapy where the, you know, such factors were considered as well in that condition particularly.

(John Kane): Well, you know, can't speak to any particular populations specifically for a couple reasons, one, because I would need to refer back to our technical analysis in terms of how the particular population was looked at.

I believe that stroke patients and potentially CVA patients are specifically identified in our IMPACT analysis. So, you know, you can also check the IMPACT analysis procedure what the impact is of the proposed policies on those two populations but that also might be somewhat illustrative.

But again, I would prefer you back to the technical report for PDPM. You can also take a look at the technical report for RCS-1 because this is something that we had – we've also considered last year when we put out the ANPRM was the possibility of doing a variable per diem adjustment. And certainly the way the adjustment has been – what is proposed in this rule is different than what we had considered for RCS-1.

But the underlying analysis is relatively similar in terms of utilizing the cost data that's been submitted to us as the basis for their analyses. And so, I'd refer you back to that. But again, if there's a specific population that you feel is not been represented well or that a population that you think should be looked at distinct from the others that is something that we definitely need to

hear about because again, it was very helpful in the ANPRM stage. It will certainly be helpful on the stage as well.

(Dr. Moetta): Thank you very much.

Operator: Your next question comes from the line of Donna Elston of Spectrum Health. Your line is open.

Donna Elston: Thank you for taking my call. Just want to ask a clarifying question about the residents that will be classified and (off) five components in the new payment system. So if you have, for instance, the patient that comes in with wounds and is on bed rest and not receiving any therapy, they will still be classified in the therapy, OT/PT and speech, correct?

(John Kane): It is correct that all patients under the SNF benefit, under PDPM would be classified into a group for each of the five components, yes.

Donna Elston: OK. Thank you.

(John Kane): Thank you.

Operator: Your next question comes from the line of Luke Casey of Capital Health Management. Your line is open.

Luke Casey: Yes. I've seen some documentation that mentioned that therapy minutes would only be reported upon discharge under PDPM. Now, I wanted to see if that is in track accurate, and if so, to, you know, to what end, what are you going to do with those reported minutes?

(John Kane): So the answer is yes, but we are planning to collect therapy utilization data on the discharge assessment. In fact, there's a discussion in the NPRM that talks about some additional items that are being added to the PPS discharge assessment to account for that data collection. Still entails and carries some burden reduction but certainly we're adding a few items, so it's important to note that.



In terms of what we're using the data for, I don't think it should be terribly surprising or shocking to anyone to learn that the thing we'd be using that for is to evaluate how much therapy people are receiving both before and after PDPM goes into effect, because there are – more concerns that were raised during the ANPRM on RCS-1 that's providers may stint on care or may provide fewer amounts of therapy to beneficiaries as a result of the proposed policies or PDPM or for the ones that are being considered under RCS-1.

So, that's what we would be using that data for and should we discover that there is a significant change from what people felt (evidence) or patients need under RUG-IV versus what they need under PDPM and we'll evaluate what actions we feel appropriate.

Luke Casey: Thank you.

Operator: Your next question comes from the line of (Patricia Taylor) of (Focus Post). Your line is open.

(Patricia Taylor): Yes. I just have a quick question on the SNF review and correct report. I have two facilities that show dashes for the first quarter of last year. I'm trying to make sure that I get and corrected by the May 15th deadline. When I post the question to CMS, they told me that there was probably not enough data during that time period to calculate any percentage. But I just want to make sure when I look at it, I see a lot of data submitted so I don't know what the percentage is to qualify or not enough data. I want to make sure that I'm doing the correction that I need to be doing in order to prevent, you know, the percentage deduction for next year.

Also have another facility that shows only a 75 percent right – (oh) and submitting to section GG and when I look back through that period, I don't see anything that we didn't submit correctly. So, I guess my overall question is, how can I make sure that I'm doing the corrections in a timely manner without giving the deduction?

Mary Pratt: That was a great question and we want to be able to – we're talking here as you were talking. So, you have submitted questions to the mailbox, is that correct about this?

(Patricia Taylor): Yes, I did submit e-mail.

Mary Pratt: OK.

(Patricia Taylor): Yes.

Mary Pratt: And do you have like screenshots or examples so that we can see what you're seeing?

(Patricia Taylor): Well I would have to look – yes, I'd have to look back. I'm just seeing dashes on what about facility, all three areas, all three of quality measure areas show dashes on every single box. And when I submitted the question to the e-mail, I told them the specific facility and everything and I'm assuming they looked it up because they send it back with that facility's name, you know, attached to the answer and it said, there was probably not enough status submitted during that time period. And that's OK if that's true. I just want to make sure that before I stop trying to correct it that I'm not going to be penalized for it.

Mary Pratt: Yes, let's take this call offline and see what we can do to help you out.

(Patricia Taylor): OK.

Mary Pratt: So we can better understand that we're seeing the same thing. (Tara), do you – do you know the address ...

(Tara McMullen): If I were you, you have the address the SNF/QRP inbox, right? That was the inbox that you e-mailed before. This is (Tara).

(Patricia Taylor): It was.

(Tara McMullen): Yes, I would e-mail the inbox if you want to do that this afternoon and then my name is (Tara). Mary and I will loop back around on that e-mail.

(Patricia Taylor): OK. Thank you ...

(Inaudible)

(Tara McMullen): I understand what you're saying-- yes, thanks. Understand we're focusing in on quarter one so that will be helpful and if you could just delineate the issue, what's going on with the dashes are what not we'll see if we can help that.

(Patricia Taylor): Thank you. I appreciate that. I just don't want to be penalized.

Female: We'll see and look at it.

Jill Darling: And (Amy), we'll take one more ...

(Patricia Taylor): OK. Thanks.

Jill Darling: Excuse me. (Amy), we'll take one more question please.

Operator: We actually don't have any else in queue at this time.

Jill Darling: OK. All right, well, thanks everyone for joining today's call. Great questions. So we will look forward to hearing from you on the next call, so have a great day, everyone.

Operator: Thank you for participating in today's Skilled Nursing Facilities Long-Term Care Open Door Forum conference call. This call will be available for replay beginning today, May 1st, 2018 at 5:00 p.m. Eastern through May 4th, 2018 at midnight. The conference ID number for the replay is 32664331. The number to dial for the replay is 855-859-2056.

This concludes today's conference call and you may now disconnect.

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