

Centers for Medicare & Medicaid Services
Skilled Nursing Facilities/Long Term Care Open Door Forum
Tuesday, August 6, 2024
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Webinar recording:

https://cms.zoomgov.com/rec/share/uHKDGKR_1dLTR4HVUkzQ203Yw9jl2_BYxJIZUd6LyCbWL_Bj9eTZI3vVqVELOo.9ZhmPkEUt_22Mr8N

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Jill Darling: Hi, everyone. Thank you for joining us. We will give it a moment to get more folks in. Thank you for your patience.

Good morning and good afternoon, everyone, my name is Jill Darling, and I'm in the CMS Office of Communications. Welcome to today's Skilled Nursing Facilities/Long Term Care Open Door Forum. Before we begin our agenda, I have a few announcements. For those who need closed captioning, I provided a link in the chat function of the webinar, and I will provide it again for you. This webinar is being recorded. The recording and transcript will be available on the CMS Open Door Forum podcast and transcript web page, and that link was on the agenda that that was sent out, and I will share that in the chat as well.

If you are a member of the press, please refrain from asking questions during the webinar. If you do have any questions, please email press@cms.hhs.gov. All participants are muted upon entry. For today's webinar, I have the agenda slide up, and during Q&A, I will provide a resource slide.

We will be taking questions at the end of the agenda today. We note that we will be presenting and answering questions on the topics listed on the agenda. We ask that any live questions relate to the topics presented during today's call. If you have any questions unrelated to these agenda items, we may not have the appropriate person on the call to answer your question. As such, we ask that you send any of your unrelated questions to the appropriate policy component, or you can send your email to the ODF resource mailbox that I will provide, and we will get your question to the appropriate component for response.

You may use the raise hand feature at the bottom of the screen, and we will call on you when it is time for Q&A. Please introduce yourself with your organization or business you are calling from. When the moderator says your name, please unmute yourself on your end to ask your question and one follow-up question, and we will do our best to get to all of your questions today.

Now I will hand the call off to John Kane.

John Kane: Thank you, Jill, and thank you, everyone, for being on the call today. The first agenda item is with regard to the FY2025 SNF PPS (Skilled Nursing Facility Prospective Payment System) final rule. This rule was displayed on July 31 and incorporates all

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of the various policies and update for the SNF PPS for FY2025. I will speak on the payment portion of the rule and pass to my colleague to speak on the other part of the final rule.

With regard to the payment portion of the rule, we finalized a net update of 4.2%, which we estimate will result in approximately \$1.4 billion in increased Medicare Part A payments to SNFs in fiscal year 2025. This 4.2% increase is based on a SNF market basket percentage increase of 3.0% plus a 1.7% forecast error adjustment and less a 0.5% productivity adjustment. In addition to this overall rate update, we also finalized the rebasing and revising of the SNF market basket to reflect a base year of 2022. Additionally, we also finalized a proposal to update the SNF PPS wage index to use the most recent Core Based Statistical Areas, or CBSAs, for the calculation of the SNF PPS wage index.

Finally, on the payment portions of the rule, we had also finalized in this rule several changes to our PDPM (Patient Driven Payment Model) ICD-10 (International Classification of Diseases, 10th Revision) mappings, as we do each year, and we also had summarized the comments we received on the Request for Information, or RFI, related to the Non-Therapy Ancillary component of PDPM, and we thank everyone very, very much for all of the comments we received. We will take those comments into consideration as we consider any changes that we might do in the future.

With that, that ends the payment portion of the rule, and I will pass it to my colleague, Heidi Magladry, to talk about quality reporting. Thank you.

Heidi Magladry: Thanks John. So, I'm going to walk through the Skilled Nursing Facility Quality Reporting Program (QRP) we finalized in this rule. In this year's rule, we finalized to require SNFs to collect and submit through the MDS (Minimum Data Set), four new items under the social determinants of health category. These items will collect information on living situation, food, and utilities. SNFs will begin collecting these items on admission beginning October 1, 2025, for the fiscal year 2027 SNF QRP. These items are adapted from the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool and will expand the social determinants of health items already being collected on the MDS.

We are also finalizing a modification to the transportation assessment items currently collected on the MDS with the version that was developed for the Accountable Health Communities Health-Related Social Needs Screening Tool. This will lead to aligned formatting with the transportation items, with the four new items I just discussed, and it will improve and align data collection in three ways. It will specify the lookback period for identifying if and when the resident experienced a lack of reliable transportation. It will simplify the response options for the resident and requiring collection at admission only, which will decrease provider burden, since the current assessment item is collected at admission and discharge. We're expecting these new and modified items will help to identify social needs, so that SNFs may address those with the residents, their caregivers, and community partners as part of the discharge planning process.

We are also finalizing a policy requiring that SNFs participating in the SNF QRP participate in a validation process. Specifically, we are finalizing the adoption of a validation process for the SNF QRF that's similar to the process we adopted for the SNF Value-Based Purchasing (VBP) Program in FY2024 SNF PPS Rule. We are finalizing that approximately 1,500 SNFs will be randomly selected to share a very limited set of medical records for validation. CMS is required by the Consolidated Appropriations Act of 2021 to apply a process to validate the data submitted under the SNF QRP.

And finally, in this final rule, we summarize the feedback we received on the Request for Information on Future Measure Concepts under consideration for the SNF QRP. This year's RFI included immunization, pain management, and depression screening.

That's all I have for the SNF QRP proposal. With that, I will pass it off to my colleague, Chris Palmer, to speak to the SNF Value-Based Purchasing Program.

Chris Palmer: Thanks, Heidi. Good afternoon, everyone. It was a relatively light year as the SNF Value-Based Purchasing Program was concerned in this year's final rule. As a reminder, we did not include any SNF VBP Program measures as part of this year's final rule. We did have a handful of major proposals, which I would now like to highlight to you.

As part of this year's final rule, we incorporated a measure, selection, retention, and removal policy that aligns with policies CMS has adopted with other quality programs, including the SNF QRP. We finalized a technical measure update policy to allow CMS to update the numerical values of program performing standards for a program year, if necessary, to account for the implementation of non-substantive technical updates to the measure specifications between the baseline and performance periods of programming.

We adopted the measure minimum CMS finalized for the 2027 program year for the 2028 program year and subsequent program years. We applied phase 1 of our current review and correction policy in the SNF VBP to all claims-based measures and measures that are calculated using the payroll-based journal and minimum data set measures, and we updated instructions for requesting an Extraordinary Circumstance Exception (ECE) for the SNF VBP. We also included several updates to our SNF VBP regulation text to align with previously finalized definitions and policies.

That was it for the SNF VBP this year. I will pass it on to Akosua to discuss Nursing Home Enforcement.

Akosua Ghailan: Thank you.

Jill Darling: Akosua, are you there?

Akosua Ghailan: Can you hear me now?

Jill Darling: We can hear you, go ahead.

Akosua Ghailan: OK, it must have been muted. OK, thank you. Good afternoon. My name is Akosua Ghailan. I am an Enforcement Subject Matter Expert for the Division of Nursing Homes. I'll be presenting the revised Enforcement Regulations in the SNF PPS FY 2025 rule.

In support of the White House initiative to enhance accountability and oversight of the nation's nursing homes, the policies we finalized are aimed at expanding financial penalties to enable CMS to impose a CMP (Civil Monetary Policy) that is commensurate with the actual non-compliance that occurred. In response to this, here is a recap of the regulation changes.

We finalized the ability for CMS to impose per-instance and per-day CMPs for the same surveys. Additionally, we finalized revisions to allow CMS to impose additional per-instance CMPs for multiple instances of non-compliance that warrant enforcement regardless of the F-tag number the non-compliance was cited at. We believe that these revisions will allow CMS to be more flexible and impose CMPs in a manner that addresses the types of non-compliance and risk to resident health and safety that occur. Lastly, we finalized revisions to allow CMS to impose CMPs for any non-compliance that occurred and was previously cited looking back up to three standard surveys.

So those are the enforcement regulation changes included in this SNF PPS final rule, which will be operationalized March 3, 2025. Thank you, and I will pass it on to Wil Gehne to speak to you about the PDPM Grouper to support XML input.

Wil Gehne: Thanks. Just a quick update about the PDPM Grouper. Currently, the PDPM Grouper processes the MDS assessment in a fixed length format. To allow future flexibility, the FY2025 release of the PDPM Grouper, one that's effective October 1, 2024, will also support MDS assessments in XML format. The XML format will be the same one used for the submission of the assessment to iQIES. That format is defined in the download section of the MDS 3.0 technical information page.

We advise Skilled Nursing Facilities and their software vendors to consider whether this enhancement is beneficial to them. SNFs may continue to use the fixed length string format, or they can convert to using the XML any time after October 1, 2024, if that better serves their business needs.

If you have any questions regarding this change, you can submit those to GrouperBetaTesting@cms.hhs.gov. With that, I will hand it back to Chris Palmer.

Christopher Palmer: Thanks, Wil. I just wanted to remind folks that now that August has rolled around, the FY2025 SNF VBP Program Performance Score Reports are now available for your review in iQIES. These reports contain facility and state-level data and results for the SNF 30-Day All-Cause Readmission Measure for the FY2025 performance period and include the Incentive Payment Multiplier for the SNF VBP program for the FY2025 program year. We

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recommend that all SNFs go and review these new performance score reports as soon as they can. And now I'll pass it on to Heidi for an update on the SNF QRP.

Heidi Magladry: Thanks. I also wanted to provide a quick reminder that on July 3, CMS provided notifications to SNFs and non-critical access swing beds that were out of compliance with the SNF QRP reporting requirements for calendar year 2023, which will affect their fiscal year 2025 annual payment update.

Non-compliance notifications were distributed by the Medicare Administrative Contractors (MACs) and placed into facilities' "My Reports" folders in the iQIES system. I would encourage providers to look at the version within their folder, as it contains more specific information about which SNF QRP requirements the SNF was non-compliant with, whether it be MDS data submission requirements or the NHSN (National Healthcare Safety Network) data submission requirement.

If you received a letter of non-compliance, you may submit a request for reconsideration to CMS via email no later than 11:59 p.m. August 14, 2024. If you received a notice of non-compliance and would like to request a reconsideration, you should see the instructions on your notification—these are also listed on the SNF Quality Reporting Reconsideration and Exception and Extension web page, and the link to that page is listed on the agenda.

Please note, any reconsideration containing protected health information (PHI) will not be processed. All PHI must be removed in order for a reconsideration to be reviewed, and any reconsideration request received after August 14 will not be processed. Providers that do submit a reconsideration request can expect to be notified of the agency's decision on the reconsideration by a letter from the MAC and from CMS in September. And with that, I will pass it back to Jill Darling.

Jill Darling: Thank you, Heidi, and thank you to all of our speakers. We will give it a moment, if anyone has questions, comments, to raise their hand. We can begin our Q&A. We have one hand so far. Joel, you can unmute yourself.

Joel VanEaton: All right. Well, thank you so much. Can you guys hear me?

Jill Darling: Yes.

Joel VanEaton: OK, great. Just a suggestion and then a question related to the final rule and the changes that are coming up in relationship to VBP, QRP, and five-star related to the Discharge Function Score.

My suggestion to CMS is to consider finding a way, perhaps, to include additional information related to the discharge function score in relationship to the expected Discharge Function Score. I've had many questions from facilities that have been frustrated to look at their iQIES reports and other reports that really only indicates residents that trigger for that quality measure, but

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there is no indication for those residents that don't trigger. Why? Certainly not knowing the expected Discharge Function Score in comparison to the reported Discharge Function Score and then, the list of co-variants is extensive. It would be helpful in terms of being able to use that information as actionable data for quality improvement and facilities to have more information about that particular quality measure. And there are others as well that have an expected score I think that would be helpful to have more insight into what the reports are showing and how we can improve. So just a suggestion there, perhaps, for future reporting capacity from CMS.

Then I had a question related to Value-Based Purchasing and the policy that has been finalized now in relationship to the corrections to baseline year data if the technical specifications have been updated in a future performance year. In the final rule, CMS indicated, "We don't believe that it is fair or appropriate to calculate performance period measures resulting using the updated measure specifications and then compare those results to the performance standards and baseline period measure results that were calculated using the previous measure specifications to generate the achievement and improvement score." So, the "apples to apples" comparison is a good thing.

My question is, for the Total Staff Per Resident Per Day quality measure coming up for FY2026, as we know we have a performance year that is 2024 and the staffing numbers with a five-star rating and everything currently, with those updates are acuity adjusted with the PDPM Nursing CMI (Case Mix Index) in the baseline year 2022 for that quality measure they were acuity adjusted with RUG (Resource Utilization Groups) scores and STRIVE (Staff Time and Resource Intensity Verification) data. My question is, will CMS apply this policy to this particular quality measure as it applies to the upcoming 2026 implementation into Value-Based Purchasing? Thank you.

Christopher Palmer: Thank you for that question, Joel. It is a very thoughtful one. I'm not 100% sure if I can respond to that one at the moment. We are trying to maintain an apples to apples comparison. If you can follow up through our mailbox, we should be able to get back to you in the near future.

Joel VanEaton: I did send that to the SNF VBP folks, and they indicated there would be something coming out indicating what CMS' response to this would be. And of course, in the final rule, they indicated it would be in various formats. I guess I'm curious to know where that would be or how we would know what would end up happening in this particular situation.

Christopher Palmer: Yes, I believe I can say keep an eye on your inboxes. We are anticipating having further news on this measure and approach very soon.

Joel VanEaton: Thank you.

Christopher Palmer: Yep.

Marvelyn Davis: Sarah, your line is unmuted.

Sarah Zlotnick: Yes. Hi, good afternoon. This question is for John Kane, relating to PDPM. We wanted to receive some clarification regarding IV antibiotics that are given after a dialysis session when its indication is completely unrelated to End-Stage Renal Diagnosis (ESRD), and if the administration should be coded under 0110-H1 (IV Medications While a Resident). The reason why—It's my understanding that the reason why it is administered after the dialysis has to do with not having additional lines, and according to the ESRD PPS (End-Stage Renal Disease Prospective Payment System) consolidated billing, you know, the SNF is responsible for the cost of these medications, and I wanted to confirm if it could be coded as "IV administered while a resident."

John Kane: Hi. So yeah, so I think we had actually provided a response to this. I'm looking through where you said this in the past. You had emailed this question in. Is that correct?

Sarah Zlotnick: Someone in my organization had sent it in, or something similar. We just wanted to receive you know, just wanted to clarify once more because it kind of had been something that, having done MDS a long time, it was considered that it shouldn't be coded, but then, you know, once taking a deeper dive and reaching out to the end stage team, suggested it seems it really should be coded, and we just wanted to clarify.

John Kane: So, yes. I mean the response we provided is if you have IV medications that are furnished outside of the ESRD treatment and it is something that is not being covered under the ESRD payment, and it is something that is meeting the various criteria that we outline on Page 0-6 of the MDS manual, then that is something that can be captured in the 0110-H1B, I think it is.

Sarah Zlotnick: Right. OK. Thank you for that clarification. Appreciate it.

John Kane: Thank you. Bye.

Marvelyn Davis: Jane, your line is unmuted.

Jane Schoof: Oh, thank you. My question is in regard to the quality measures that will unfreeze come January, and the January report should include Quarter 4 data for the calculation of the four-quarter average. However, the quality measure when we run the reports for Quarter 4 right now just to see the percentages and the patients that are flagging. Because it took two assessments for comparison, many patients didn't have a second assessment until Quarter 1. So, the denominators are very low and potentially nonexistent. I've got facilities that are showing no data or facilities that had one patient in the denominator, and that patient did have a decline, so they are at 100% for decline in ADLs (Activities of Daily Living) or Locomotion.

So, my question is because of the Quarter 4 data not being, in my opinion, usable because of the caveats to those calculations of those ADL quality measures, do you know if you plan to use only a three-quarter average and throw out Quarter 4? Will there be adjustments made for those Quarter 4 data, since the fluctuation of that percentage could be extremely high, low, or no

available data because of the way it calculates? Can you give any insight into what we can expect about when those unfreeze in January based on the Quarter 4 data?

Jill Darling: Hi there. I don't think we have the appropriate person on. If I put the ODF email, could you send it in, please, and we will forward it along.

Jane Schoof: OK, thank you.

Jill Darling: OK, we'll give it just another moment for any raised hands. Jill, your line is open.

Jill Liila: Hi, good afternoon. Thank you. In chapter 6 of the Medicare Processing Manual, it discusses rules related to the VA (Veteran Affairs) Community Nursing Home Fee Schedule as it relates to PDPM billing. We've reached out to all of the resources available on their website for clarifications on some billing questions and have yet to get clarification. Is there someone at your office that we could contact to help us get those answers?

John Kane: Hi, this is John Kane. I'm sorry. Is this a question related to the processing of VA claims?

Jill Liila: Community Nursing Home—the fee schedule, and then they have specific billing requirements allowing us to bill beyond day 100 for the VA. It's a federal...

John Kane: Right. Yeah. You would need to be contacting someone at the VA. We are not able to speak to policies that lie outside of Medicare.

Jill Liila: OK. Thank you.

John Kane: Thank you.

Marvelyn Davis: Jane, your line is unmuted.

Jane Schoof: Thank you. Sorry, you may not be able to answer this, and I may need to send it up with my last question, but it also pertains to the quality measures unfreezing, and will we be able to find out ahead of time what the new cut points will be for the new quality measures? Or will we have to wait until you have made the reports public?

Jill Darling: Jane, if you wouldn't mind sending that in?

Jane Schoof: OK. Thank you.

Marvelyn Davis: Dena, your line is unmuted.

Dena Finestone: Yeah. Hi. Thank you. I have a question about some of the exclusions for the Discharge Function Score Measure, and the discharge, mobility, and self-care. I did submit this to the QRP helpdesk, but I have a follow-up question to it.

So, one of the exclusions is “resident discharge to hospice or received hospice services while resident,” and obviously the way to indicate discharge to hospice is A 2105 discharge status. Unfortunately, a 2105 is not on the NP discharge assessments. So, when I submitted this to the QRP helpdesk, they said that the only way that hospice would be an exclusion is if the patient is physically discharged to the facility from hospice, but 99% of the time when a resident is transferred from Medicare A to hospice, they do remain in the facility. So, my question is, on the NPE (National Provider Enrollment), are we allowed to code 00110K1B, which is “hospice while a resident,” on the NPE if the patient is being discharged to hospice the next day, because that would be the only way to capture the exclusion. Then I have another question as well.

Heidi Magladry: Hi, Dena. This is Heidi with the SNF QRP. I have been in receipt of your question. In response to your first question, if no hospice services were provided during the time 00110K1B is not coded on the NPE. I do have your question, and I will be responding to you in writing on the other ones as well.

Dena Finestone: OK. So, OK. I will leave the others as well. Thank you.

Heidi Magladry: You bet.

Dena Finestone: OK.

Marvelyn Davis: Rhonda, your line is unmuted.

Rhonda Zarkis: Yes, thank you. I'm not sure if this has been answered before, but I just was wondering if there's been any consideration for the QRP data elements when we have an unplanned discharge, PPS discharge. The elements are needed when Part A PPS Discharge A0310H equals 1. However, it doesn't reference anything about that being unplanned, and I know that a lot of our facilities have had issue gathering that data when someone goes out, say in the middle of the night or you know, just unexpectedly during the day if they are acutely needing to be transferred to the hospital. So, is there going to be any consideration of maybe taking those data elements away when there is an unplanned discharge? Or is that going to continue to count against us in the 90% threshold?

Ellen Berry: Can you submit that question to the mailbox that Jill placed into the chat, the SNF_LTCODF-L, please?

Rhonda Zarkis: Sure.

Marvelyn Davis: Joel, your line is unmuted.

Joel VanEaton: Yes. Thank you for taking another question. I just want to make sure I understand the response John gave related to the IV medication question that came up earlier. Maybe I misunderstood the question, but the instructions on page 0-6 indicate do not include IV admissions that were administered during dialysis. Could I get clarification on that? Maybe I misunderstood the question.

John Kane: Right. So, this is not in reference to IV medications provided during dialysis. They are provided after dialysis.

Joel VanEaton: All right, thank you.

Marvelyn Davis: Esther, your line is unmuted.

Esther Olshin: Hi. Thank you for taking my call. So, I need a clarification. We have one of our facilities that low stars related to the schizophrenia audit. I asked multiple questions to the email that CMS provided me. It's been more than a year. We immediately, at the time last year, corrected everything that came up on the report. So, it's now been a full year, and our star report is still showing our QMs (quality measures) that were degraded to a one. I need to get in touch with someone who can look at this. We were told it would be for a year. It's now over a year, our QMs are still a one. I reached out to all of the mailboxes and emails sent to me. I get the same answers. We have to look at it, revise it, and review it, and see if you actually made corrections. This was done already last year. So, who is responsible to look at this and give us back our—we were a five-star facility in QMs, and we now became a one, so we lost two stars. It's hurting us really terribly.

Evan Shulman: Hi. This is Evan Shulman from the Division of Nursing Homes, and I'm going to post a, an email address in the chat that you can send to. I realize that you said you already emailed them. But email again and you can put that you raised this on the SNF Open Door Forum. I'll say that we still do monitor facilities' data after audits, and we will at times do a reaudit to ensure that the facility has corrected what was identified during the audit. I'm not sure the status of your particular facility, but it is not automatically reversed based on a time frame. We monitor the data to make sure that we see the changes that we expect based on the findings from the original audit. So, I pasted the message, the email address in there, and you can email that and mention that you raised this on a SNF Open Door Forum with your facility name, and we'll take a look at it again.

Esther Olshin: Could we send in our correction that we already sent in last year? Because we are just sitting and waiting for this to go back up.

Evan Shulman: Yeah. I don't want to commit to anything.

Esther Olshin: OK.

Evan Shulman: Well, yeah, but email that address and we would be happy to take another look at it.

Marvelyn Davis: Diane, your line is unmuted.

Diane Gaskey: Hey, yes. This is Diane Gaskey with the Parkside Group. I have a question in regards to the staffing star. If we have a facility that we believe the census is in error that calculated our staffing star, how do we go about appealing that? We had a situation where some discharges were completed on the 15th of May—all submitted, all accepted, but the staffing star was calculated with a census that's like 20 more than what was actually there, and 10 more than that, the facility would actually even hold, that has the capacity for.

Evan Shulman: Hi again. This is Evan Shulman, and I am going to post another email address to send this question for. I'll mention that we calculate your census based on the MDS assessments that are submitted, and what we basically do is look for admission assessments and count up everyone that has an admission assessment who does not have a discharge assessment, and we do that for every day, and that then is your daily census. So, the census that we calculate is exclusively based off of adherence to the MDS timelines. If there is something specific or

different that happened in your situation, we would be happy to take a look at it. Email NHStaffing@cms.hhs.gov and you can mention that you brought this up on the SNF ODF.

Diane Gaskey: OK. Thank you.

Marvelyn Davis: S. Levy, your line is unmuted.

Sorah Levy: Hi. This is Sorah Levy from Engage Healthcare. Thank you for taking my question. My question is related to the five-star measures. I want to know if the calculation of overall five stars is a linear or an overall calculation. So, for example, a facility is one star for health inspection and one star for staffing and five star for quality measures. Will that one star for staffing negate the five star for quality measures, or will it make the facility go up to five stars? The same question would be if they are a one-star for health inspection, five-star for staffing, and one-star for quality measures, will it go the other way?

Evan Shulman: I'm going to post a link to the Five-Star Technical Users' Guide which describes the exact methodology used to calculate your star ratings. I going to post the web page, and it is in the download section of this web page. Five star...

Sorah Levy: Thank you, Evan. So, I have it open actually in front of me, and I guess the question is, does the calculation go in order of steps, like how it says step 1, 2, 3, or can that one star make you lose a star impact anywhere along the way?

Evan Shulman: It goes in order of steps. Starts with the inspection rating, then goes to staffing rating and then goes to quality measure rating.

Sorah Levy: Beautiful. Thank you for answering my question.

Marvelyn Davis: Joanne, your line is unmuted.

Joanne Jones: Thank you. I just wanted to clarify something, I think, with Evan concerning the census and when that calculation is done. Is it done by all MDSes as far as discharge MDSes, etc. by the end of the last day of the quarter? Or is it based on the same time frame as when the staffing data is submitted? Since obviously residents could be discharged within the last couple of days of the quarter but the MDSes would not be submitted until completed which could be up to 14 days after the actual discharge date.

Evan Shulman: Thanks for that question. We do use a lag to allow for enough time for the MDS data to be submitted, and it is more than enough time. I believe it is either 120 or 150 days we may use. But the specifications for this are in that same Five-Star Technical Users' Guide. That's the link that's downloadable on the page.

Joanne Jones: Not a problem. I just, I've never seen, I didn't see that it actually specified when you pull it to actually use it but thank you.

Marvelyn Davis: Mary, your line is unmuted.

Mary Gracey-White: Good afternoon. Thank you for the call today, and I appreciate Evan addressing the schizophrenia survey. We do get many questions from facilities in our association regarding the restoration of the stars. And I have emailed a couple of times regarding that question. So, thank you for addressing that.

My other question is regarding penalties and CMS' changes to the, you know, enforcements. I know it was mentioned about the previously cited deficiencies. I am just trying to clarify or expand on previously cited—would that be at harm levels? Is that for any previously cited deficiencies? What would that encompass?

Evan Shulman: Hi, this is Evan Schulman again. It is for deficiencies that still meet the enforcement policies for...that are in Chapter 7 of the State Operations Manual. So, these are

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situations where a deficiency met our enforcement policies but due to the timing of surveys and timings of different surveys, enforcement was not imposed but normally would have been. So, it's the same types of deficiencies that would normally get enforcement but in this case, didn't.

Mary Gracey-White: Thank you very much. I appreciate it.

Marvelyn Davis: Pete, your line is unmuted.

Pete Van Runkle: Yeah, thank you. This is a question relating—I heard all of these things about the schizophrenia audits, and it raised a question that might have come across on that topic. So, the result of the schizophrenia audit if the provider doesn't pass or admits that they were in error is that there is a suppression for a period of time of their quality measure for anti-psychotics, and that was mentioned earlier in terms of when that gets lifted, but my question is different. What I have seen in the CMS data tables, the QM one that is published quarterly, is that once that suppression happens, it goes backward before the audit was conducted for several quarters. I have not figured out exactly how many on average it goes back, but it goes back, and while that may not affect star ratings going forward, we in Ohio—I'm from Ohio—we use the anti-psychotic measure as one of our, one of our quality measures for Medicaid purposes for reimbursement, and that sort of retroactive suppression of data can be, can be very harmful in that context. So, I was just curious why that, why that happens and why the suppression isn't prospective from the time of the audit.

Evan Shulman: Hi. Thanks for that question. I'm going to ask you to also submit that to email and include an example because I'm not sure I fully understand. I don't think we have the capacity to apply a retrospective suppression. When the data comes in, we calculate ratings, we post those ratings, calculate measures, post those measures, calculate the ratings. And then it is at a later—usually at a later point in time when we conduct an audit. The findings of those audits are collected and then the following month that the findings from an audit, from failure or attestation, are applied. So, I would love to see some examples of that and would be happy to take a look at it.

Pete Van Runkle: Sounds good. Will do. Thanks.

Jill Darling: All right, well, we thank you all for joining us, as I don't see any more hands raised. We hope the links and emails were very helpful in the chat and on the screen. Again, email the SNF Long Term Care ODF mailbox for further questions and comments, and thank you for joining us today. This concludes today's call.