Centers for Medicare & Medicaid Services
Special Open Door Forum:
Nursing Home Value-Based Purchasing Demonstration

Monday, April 6, 2009
2:00 PM - 4:00 PM, Eastern Time
Conference Call Only

The Centers for Medicare & Medicaid Services (CMS) will hold a Special Open Door Forum (ODF) to present an overview of the Nursing Home Value-Based Purchasing (NHVBP) demonstration. The primary audience for this call is Medicare certified nursing homes from the States that have been selected to host the demonstration: Arizona, Mississippi, New York and Wisconsin.

The NHVBP demonstration is a CMS initiative to improve the quality and efficiency of care furnished to Medicare beneficiaries residing in nursing homes. Under the demonstration, nursing homes will be eligible to receive performance payments if they achieve the highest performance levels or the most significant quality improvements based on four domains: nurse staffing, avoidable hospitalizations, minimum data set (MDS) outcomes and survey deficiencies. The availability of performance payments will depend on whether the demonstration produces savings to the Medicare program.

The implementation phase of this demonstration is scheduled for July 1, 2009 through June 30, 2012. CMS is currently accepting applications from nursing homes in the above States through May 1, 2009. All applicants will be required to submit payroll and census data for the first quarter of calendar year 2009. During the pre-implementation period, nursing homes that volunteer to participate in the demonstration will be stratified and randomly assigned either to the demonstration, to a comparison group, or to neither group. Nursing homes assigned to the demonstration group will be required to submit payroll and census data every quarter throughout the demonstration.

During this Forum, CMS will explain in greater detail: (1) the application process and next steps for nursing homes interested in participating in the demonstration, and (2) an overview of the final demonstration design. A question and answer session will follow the presentation but due to the limited time available, questions from those eligible to participate will be answered first.

We look forward to your participation

Special ODF participation Instructions:
Dial: 1-800-837-1935 & Reference Conference ID: 87622411
Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880 and for Internet Relay services click here http://www.consumer.att.com/relay/which/index.html. A Relay Communications Assistant will help.

An audio recording of this Special Forum will be posted to the Special Open Door Forum website at http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning April 14, 2009.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at http://www.cms.hhs.gov/opendoorforums/

Thank you for your interest in CMS Open Door Forums.

Audio File of this transcript: http://media.cms.hhs.gov/audio/SpecODF_NursingHVBP.mp3

Centers for Medicare & Medicaid Services
Special Open Door Forum:
Nursing Home Value Based Purchasing
Moderator: Natalie Highsmith
April 6, 2009
2:00 pm ET

Operator: Good afternoon my name is (Tim). And I'll be your conference facilitator today. At this time I would like to welcome everyone to the Center for Medicare and Medicaid Services Nursing Home Value Based Purchasing Demonstration Special Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks there'll be a question and answer session. If you'd 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, press the pound key. Thank you. Miss Natalie Highsmith, you may begin your conference.

Natalie Highsmith: Thank you (Tim) and good day to everyone and thank you for joining us for this special open door forum on nursing home value based purchasing demonstration. The primary audience for this call is Medicare certified nursing homes from the states that have been selected to host the demonstration which is Arizona, Mississippi, New York, and Wisconsin.

This demonstration is a CMS initiative to improve the quality and efficiency of care furnished to Medicare beneficiaries residing in nursing homes. Implementation phase of this demonstration is scheduled for July 1, 2009 through June 30, 2012.

CMS is currently accepting applications from nursing homes in the referenced states through May 1, 2009. Today CMS will explain the application process and next steps for nursing homes interested in participating in the demonstration and give an overview of the final demonstration design.

As always a question and answer session will follow the presentation. Questions from those eligible to participate in the demonstration will be answered first.

The slides for today are posted on the skilled nursing facility walk through care open door forum web page under the download section. And you will be able to access them there. I will now turn the call over to (Ron Lambert) who is a private officer for this demonstration. (Ron).

(Ron Lambert): Thanks. Welcome to this presentation of the Nursing Home Value Based Purchasing Demonstration. As Natalie said I'm (Ron Lambert) the CMS Project Officer for the demonstration and I'll be presenting a little later today on the application process.

With me today is (Alan White) of Abt Associates who'll be presenting the demonstration design and (Murray Cote) of the University of Colorado who'll present the payroll data submission requirements. Then we'll have a Q&A session following the presentation. At this point I'd like to turn it over to (Alan).

(Alan White): Thanks (Ron). For those that were able to download the slides I'm on Slide 2. The big picture objective of nursing home value based purchasing demonstration or NHVBP as I'll refer to it during this

presentation is pretty straightforward to improve the quality of care furnished to all Medicare beneficiaries in nursing homes.

This demonstration offers the opportunity to test whether a performance based reimbursement system can improve the quality of nursing home care while not increasing overall Medicare expenditures. Now the general goal is to align payment incentives with quality improvement and allow providers to share in the benefits of their quality improvement.

The demonstration is intended to build in stronger incentives for quality enhancement and it is a response to a recommendation from the Institute of Medicine to identify, test, and evaluate options for aligning payment methods with quality improvement.

It's also part of CMS' broader long term care quality initiatives. I'll be talking on the slides that follow about the methods and the approach for the demonstration at a real high level and kind of break it down into 3 Steps. Step 1 is assess nursing home performance based on selected performance measures.

Step 2 is make annual payment awards for those nursing homes that achieve the best performance or the most improvement based on the measures. Step 3 is determine the payment pool for each state which is going to be determined based on Medicare savings that result primarily from reductions in hospitalization.

It's based on the reduction of Medicare expenditures. Moving on to Slide 3 framework for the demonstration as Natalie mentioned this is a three year demonstration. We anticipate that it will begin on July 1 of this year.

There are four states that are in the demonstration Arizona, Mississippi, New York, and Wisconsin. Nursing homes within these states are being solicited to participate in the demonstration. The nursing homes that are on the phone should have already received information on the demonstration and an application package in the mail.

If you haven't you can go to the CMS web page for the demonstration which you can get to through www.nhvpb.com. You can also email a request for application materials to the email address we set up for the demonstration nhvpb@cms.gov and we'll get that right out to you.

Participation in the demonstration is voluntary. We welcome and encourage all nursing homes in the four demonstration states to participate but the decision is really up to you to decide whether this is something you want to do or not.

In order to participate you must submit an application. The application collects basic information on the nursing home from contact information and base line period data for staffing performance measure and a couple of other essential performance measures.

As I mentioned the application kits are available on line at www.nhvpb.com. Nursing homes that apply for the demonstration will be randomly assigned either to the demonstration or to a comparison group after stratifying nursing homes based on certain characteristics like bed size, urban rural status, hospital based or free standing status things like that.

The reason for that is twofold. One is to permit a valid evaluation of the demonstration the second is to permit valid calculation of the Medicare savings for the demonstration. Moving on to Slide 4 a few significant features of the demonstration that I just wanted to highlight briefly.

The demonstration includes all Medicare beneficiaries residing in nursing homes including long stay residents not just Medicare - not just beneficiaries in Medicare care covered nursing home stays. this is because our goal is to promote quality of care provided to all Medicare beneficiaries in nursing homes.

Both free standing and hospital based nursing homes are eligible and encouraged to participate in the demonstration. The demonstration will reward both levels of performance and improvement in performance over time so that all participating nursing homes in a state may qualify since we qualified for a payment award regardless of their initial performance level.

This is because the demonstration is intended to both reward and to recognize nursing homes that have high performance levels but also to encourage improvement for nursing homes that may not have such good quality initially but make efforts to improve during the course of the demonstration.

And also the demonstration is designed to be budget neutral. This was a requirement of getting approval from the Office of Management and Budget to operate the demonstration. that's similar to other CMS pay for performance programs.

A little bit more on budget neutrality moving on to Slide 5 as I mentioned the demonstration will be budget neutral within each state. a pool of Medicare savings must be generated before payments can be made. As I mentioned in each state CMS will randomly assign nursing homes that apply to either the demonstration group or to a comparison group.

We're anticipating about 50 nursing homes of each state will be assigned to each group, that's 50 in a demonstration group, 50 in the comparison group. The size of the payment pool in each state will be determined based on estimated Medicare program savings achieved by demonstration homes in each state.

The higher quality of care that results from the demonstrations should result in fewer avoidable hospitalizations thus yielding savings to Medicare. We have more details on this the methodology for calculating these Medicare savings a little bit later in the presentation.

Moving on now to Slide 6 each year of the demonstration CMS will calculate a performance score for each nursing home based on performance on four domains nurse staffing, rate of potentially avoidable hospitalizations, outcome on selected MDS based quality measures, and results from state survey inspections.

We'll be talking more about those in the slides that follow. There's also a couple of additional performance measures that we're considering but that will not be included in the first year of the demonstration because of the need for some additional development work.

Talk about staffing performance measures. First there's a considerable body of literature that suggests that low staffing levels and high nursing staff turnover compromise the quality of care of nursing home residents. Staffing performance measures are an important part of nursing home value based purchasing.

They're of relative importance and our weights reflects findings in the literature regarding the importance of these nurse staffing measures. And we've got four staffing measures that will be used in the demonstration. Three of them are based on staffing levels; one of them is based on turnover.

The staffing level measures are registered nurse/director of nursing hours per resident day. This includes both nurses that are providing patient care and DONs and assistant directors of nursing. Also have a measure for total license nursing hours. This includes your RNs and also your LVN again per resident day.

We've also got a measure for your nurse aide hours per resident day. And we've got a measure of overall nursing staff turnover. The staffing measures will be adjusted for case mix differences. The weights for the case mix adjustment will be based on the new CMS staff time measurement study the strive study.

The data from the strive study are not available yet thus the final case mix weights and everything isn't yet available but it will be available in plenty of time for us to use it for the first year of the demonstration. We're also considering some potential additional risk adjusters such as the percent of nursing home resident on a Medicare Part A stay.

The reason for this is to address the large staffing differences that we observe between hospital based and freestanding nursing home even after adjusting for street case mix. The staffing measures will be calculated from payroll data submitted by nursing homes.

This data will be submitted quarterly and the use of payroll data reflects some of the limitations in the existing Oscar staffing data particularly the two week time period that it covered. We want to have a more comprehensive view of staffing to use for NHVPB and also Oscar does not collect any information on turnover levels.

The use of payroll data will ensure that accurate staffing data are used for the demonstration and all participating nursing homes will be required to submit extracts of this payroll information for their nursing staff and their resident census. We'll have a little bit more detail on that a little bit later in the presentation.

The second performance measure category and I'm on Slide 8 is potentially avoidable hospitalization. There's a body of literature out there that suggests that careful management of certain kinds of conditions may reduce hospitalization of nursing home residents and that a substantial portion of hospital admissions of nursing home residents are potentially avoidable.

So our intent in having performance measures based on potentially avoidable hospitalization is to give nursing homes a direct incentive to reduce or maintain a low rate of potentially avoidable hospitalizations for their residents. We define potentially avoidable hospitalizations as being those that have any one of these diagnoses.

Congestive heart failure, expiatory infection, electrolyte imbalance, sepsis, or urinary tract infection. additionally for long stay residents we consider anemia hospitalizations to be potentially avoidable. In the demonstration we're going to have separate measures of hospitalization for short stay residents and for long stay residents.

Some of the data that we've looked at suggests that the hospitalization rates for short stay residents is much, much higher than the hospitalization rate for long stay residents suggesting that it's appropriate to have this separate specification.

The relative weight of our short and long stay hospitalization rates will depend on the facilities specific mix of short and long stay residents. The hospitalization measure will include both transfers directly from the nursing home to the hospital and admissions to the hospital within three days after nursing home discharge.

But it will not include hospitalizations that occur within 24 hours of hospital discharge what we refer to as bounce back hospitalizations. Concern is the hospitalizations like that that occur so soon after nursing home admission may not be at all related to the quality of care provided by the nursing home but rather may reflect a premature discharge from the hospital.

And the hospital measure will be risk adjusted based on data available from Medicare claims data and the MDS minimum data set. The third category of performance measure that we're going to use is a set of MDS based quality measures and I'm on Slide 9. The use of MDS based quality measures aligns payment incentives with achievements that are out them.

And we're going to use a subset of already developed and validated MDS based measures that cover a broad range of functional and health status measures, health status scenarios. We selected these measures based on several factors: reliability, the extent to which the measure is considered to be under the facility's control, the statistical performance of the measure that means variation in the rate across nursing homes, and policy considerations.

Now as you know the demonstration is going to be going on right as we transition from MDS 2.0 to MDS 3.0. When MDS 3.0 is implemented CMS is going to review this domain and it may be appropriate to make some revisions to the measures and point allocation that are used.

So this that we're talking about now is the MDS 2.0 version of the MDS measures. And depending on whether you are a nursing home that has just long stay residents or just short stay residents or both types of residents there may be different weighting for the MDS measures.

There are five chronic care or long stay measures that we're going to use in NHVPB. Those of you that are familiar with the measures on nursing home compare should be familiar with these measures because they're all posted on nursing home compare now.

That's percent of residents who's need for help with daily activities is increased; percent of residents who's ability to move in and around their room got worse, percent of high risk residents who have pressure ulcers, percent of residents who have got a catheter left in their bladder, and percent of residents who are physically restrained.

And for each of these measures the exclusion criteria, the minimum required sample size, and the risk adjustment methodology is the same as that used in nursing home compare. The three short stay or post acute measures that we're using are not on nursing home compare but they have been validated in earlier CMS studies.

These three measures are percent of residents with improving level of activities of daily living/functioning, percent of residents who improve status on mid life ADL functioning, and percent of residents experiencing failure to improve bladder incontinence. So we've got a total of eight MDS based performance measures that we'll be using in the demonstration.

The final category of performance measures that we'll use is results from state survey inspections. I'm sure almost all of you know nursing homes must be certified as meeting certain federal requirements. This certification is achieved through nursing home surveys which occur on a regular basis every 9 to 15 months.

Health inspection surveys provide a broad perspective on the quality of care furnished by nursing homes. On site independent observation of nursing home quality we think that's important. None of the other categories that we've talked about involve any type of on site independent observation but the state survey inspections do.

And we're going to use results from survey inspections in two ways in the demonstration. One is as a performance measure the second is as a screening measure. The screening measure is that facilities that have a sub standard quality of care deficiency will not be eligible for an incentive payment in that year.

Now this is intended to address concerns that nursing homes that otherwise have good performance would receive a performance payment even though surveyors identified serious quality of care issues as part of the inspections. It's important to keep in mind here that this applies only to the demonstration year.

So if you're a nursing home that got a sub standard quality of care deficiency on your survey this year that doesn't necessarily - it shouldn't necessarily have any bearing on your decision about whether you want to participate in this or not because that won't be held against you when we look at your performance for next year.

But it'll be your survey that occurs, you know, during the demonstration year between July 1 of this year and June 30 of next year that we'll be looking at for that screening measure. Survey inspection will also be used as a performance measure.

Each deficiency will be assigned a value, a point value based on the scope and severity. These range from 0 points for A, B, and C level deficiencies to 4 points for D level deficiencies, 20 points for G level deficiencies all the way on up to 50 points for J level and 150 points for L level deficiency.

You may notice on this one more points is bad. You want to get a zero if you can on this one. The system also considers the number of revisits required to correct deficiencies. The first revisit no additional points. Second revisit 50 extra points on up to the fourth revisit 100 additional points.

And this is very similar to the system used in the CMS five star rating system which many of you may be familiar with. The main difference

is that for value based purchasing we're only going to use the most recent survey the survey that occurs during each year of the demonstration.

Our five star system takes a little bit broader look and considers the last three years of the survey but other than that the scoring rules and everything are the same. We spent a long time looking at different performance measures and considering what might be appropriate measure to include in the demonstration.

And there were a number of promising performance measures that made sense to us conceptually that we might like to include in the demonstration but we didn't feel they were quite ready now. We felt like they needed further development work.

They may be added in the second year of the demonstration and if you noted - if you looked at the application materials you may notice that it collects some information on some of these measures that's part of the data that we collect. It's going to help us kind of assess the feasibility and the suitability of these measures.

These are what we call developmental measures. There's a couple of them that we're looking at one is use of resident experience with care surveys. A second relates to staff influenza immunization rates. And a third that's not actually on the slide but it's under consideration is a measure of community discharge for short stay residents.

So CMS plans to continue conducting research on these and other measures for possible future applications. So I've quickly gone through all the performance measures and I'm on Slide 13. I'm going

to just briefly talk about the scoring rules that we're going to use for the demonstration.

Basically each performance measure in each category is given a certain number of points and these at least in the first year without any developmental measures add up to 100 so every nursing home will get a score hopefully above 0.

Theoretically it could be 0 all the way up to 100 and the weights for the different categories are 30 points or 30% of the weight for the staffing measures, 30 points or 30% of the weight for potentially avoidable hospitalizations, 20 points or 20% of the weight for survey deficiencies, and 20 points or 20% of the weight for the MDS based measures.

Within the staffing category the RN staffing level measure counts for 10 points. The license staffing and the CNA staffing each count five points. The turnover measure counts ten points. Within the potentially avoidable hospitalization measure the 30 points are allocated between a short and long stay measure depending on the short and long stay residents.

With respect to the MDS measures the 20 points are basically allocated equally to all the measures that we can calculate. So if you've got both short and long stay residents so we can calculate all eight measures, they're 2.5 points each.

The scoring system that we're going to use in the demonstration is a continuous scoring system with points based on facility relative performance within each state basically based on facility percentile.

Let me just walk through an example that might illustrate what we mean by that.

Let's look at the RN staffing measure which I said was 10 points. Let's say we have 50 nursing homes in a state. The nursing home that has the highest level of RN staffing is going to get 10 points on that measure. The one with the second highest is going to get 9.8 points all the way down to the 49th one who's going to get 0.2 points and the 50th one is going to get 0 points.

So it's a continuous scoring system there's no cliffs or thresholds in here that's because we thought that was the fairest system rather than have a system where you have if you had a threshold and you have a point where there was a big difference in points associated with a very small difference in staffing.

We felt this was the fairer system. The one exception to that rule is with the hospitalization measure. We were concerned that while we wanted nursing homes to reduce their rate of potentially go to the hospitalization we didn't want them to reduce it too much.

Because we recognize that even some hospitalizations that our system classifies as potentially avoidable really aren't. So for the hospitalization measure there's no additional points above the 75th percentile so that is the 25% of nursing homes in the state with the best hospitalization rate, the lowest hospitalization rate will get the maximum number of points for the measure.

Let's go to Slide 14 measuring Medicare savings. As I mentioned earlier the size of performance payments depends on the Medicare savings generated by demonstration participants in each state. We're

doing the calculation at the state level rather than at the level of the individual nursing home simply because we can't generate stable Medicare savings estimates for individual nursing homes.

The samples are just simply not big enough. So CMS anticipates that certain hospitalizations specifically these potentially avoidable hospitalizations may be reduced as a result of the improvement in quality of care that result from the demonstration.

If this happens there's going to be a pool of savings to the Medicare program that can be used to fund performance payments and the approach that we're using in NHVPB is very similar to the approach used in the CMS physician group practice demonstration and also the home health pay for performance demonstration.

So there's some precedent out there and some indication that this approach can be successful. The Medicare savings will be calculated based on the difference and the change in Medicare expenditures between demonstration and comparison groups.

It seems like a wordy slide but there's some kind of subtle but important messages in there. One thing is we're not saying expenditures for demonstration homes, Medicare expenditures for demonstration nursing homes have to decrease.

We're just saying they have to increase at a slower rate than the increase for our comparison group nursing homes in the state. We use the comparison group to get us kind of our best guess of what the experience of the demonstration group would have been in the absence of a demonstration.

Now just to give you a real simple example including risk adjustment models and all that stuff. Let's say in a state our comparison group expenditures went up by 5% but our demonstration group expenditures only went up by 1%. Well 5 minus 1 equals 4% savings would be what our estimate of Medicare savings would be for a demonstration State.

So with our method under that scenario we would estimate that the demonstration homes achieved a 4% savings. And we would use that 4% savings to fund performance payments for nursing homes in this state. And similar to the physician group practice model we have a shared savings approach for the estimated Medicare savings.

There's a threshold so the amount that exceeds 2.3% of total Medicare expenditures is considered Medicare savings. How we come up with 2.3% well this was based on some statistical analysis and it was really intended to avoid paying for relatively small differences in the growth of Medicare expenditures that would more likely be due to chance rather than any real savings achieved by demonstration participants.

Savings amount above the threshold are divided with 80% used to fund performance payments and 20% retained by CMS. The size of the performance pool in any state cannot exceed 5% of total Medicare expenditures. Any savings above this cap will be retained by CMS.

If there's no Medicare program savings generated within a state then no incident payments would be made to any facility in that state regardless of their performance so that's kind of a down side because you go into the demonstration with some uncertainty about the size of the payment pool.

I think the real up side of this approach is that the methodology ensures that no nursing home faces payment reductions as a result of participating in the demonstration. So this method is a way we can potentially increase payments, increase reimbursement to nursing homes in the demonstration state the participating nursing homes without putting anybody at risk of having their payment rate reduced to fund those performance.

We thought that was an important feature to maintain. We know folks may have questions about the expected size of the performance pool. We really don't know. I mean this is a demonstration so we're wanting to learn and see how it really depends on how nursing homes respond to the incentives and the demonstration.

We did lots of simulation analyses during the design phase in the process of getting R&D approval for the demonstration. And if you go to the design report at the web site for the demonstration you can see some of those numbers. I'm not going to say what they are but you can look at them for yourself if you're interested.

I'm moving on to Slide 16 eligibility for performance payments. Performance payments will be based on overall performance across all the measures that we talked about rather than scores on individual performance measures or categories of measures.

This means we're going to calculate an overall performance score for all the nursing homes. And the reason for this specification is that it reflects the intent of the demonstration to reward nursing homes that provide overall high quality care rather than rewarding nursing homes for high performance on individual measures or categories of measures.

This specification should minimize the possibility that a nursing home with very, very low performance on any one dimension would qualify for an incentive payment. So in terms of eligibility for incentive payments facilities in the top 20% in terms of overall performance across all measures qualify for an incentive payment as do those in the top 20% in terms of improvement relative to the baseline period.

As I mentioned it's important to us that we reward both the high performers and the ones that are showing significant improvement so the top 20% in terms of level and the top 20% in terms of improvement both qualify for an incentive payment.

However if you're an improver and we realize that some of the improvers may be starting from a really, really, really low baseline level and while we want to recognize that we didn't want to make performance payments to anybody that who's overall performance is still really low.

So your overall performance must still be in the 40th percentile within your state to be eligible. Since really no performance payments are made to nursing homes with overall poor performance. For three years though you may make a lot of improvement in the first year, not quite get to that 40th percentile.

Keep making improvement in the second year and get over that 40th percentile then you'd be eligible. So there's incentive to keep trying to improve performance. Nursing homes with hospitalization rates that are above the comparison group median or significantly higher than the base year rate will be ineligible for performance payment.

This is really to try to minimize what you might think of as a free rider problem of nursing homes that aren't really contributing to the savings pool in their state and not achieving reductions in hospitalizations or have a high rate of potentially go to the hospitalization.

We want to make sure that everyone that qualifies for an incentive payment is contributing to the savings pool in this state. In terms of the allocation of performance payments and this is on Slide 17. While the top 20% in terms of performance or improvement will be eligible. The top 10% will get a bigger payment than the next 10%.

It will be 1.2 times higher than the next 10%. The payment pool will be equally allocated between top performers and improvers. Payments will be weighted based on nursing home size so two nursing homes with identical performance would get the same. If one had 100 beds and one had 50 beds the one with 100 beds would get a performance payment that's twice as high as the one with 50 beds.

You can't get an incentive payment for both performance level and improvement. You can get one or the other but not both that's to try to kind of spread the performance payments out a little bit more broadly rather than having them concentrated in a smaller number of nursing homes that might be both high performers and high improvers. I'm going to turn it back to (Ron Lambert) who's going to talk about the application process.

(Ron Lambert): Thanks (Alan). As (Alan) mentioned recently application kits were mailed to all nursing home administrators in the four host states and to repeat if you didn't receive the kit it's posted at www.nhvpb.com under demonstration application and data specifications.

You just click on that and you'll get it. The application kit consists of instructions, a one page cover sheet, and a data collection form. The cover sheet asks for facility identification information. It should be signed by an authorized official and mailed to the address shown in the instructions.

The data form consists of seven sections labeled A through F. Section A is facility identification. Sections B through E are resident census, payroll, and agency staff information for the period January 1 through March 31, 2009. These data will be used to determine the baseline staffing level that is the performance of nursing homes in the period prior to the demonstration.

Sections E and F are staff immunization and how nursing homes use resident care experience surveys and as (Alan) mentioned these are quality of care measures that could be included in year two of the demonstration. An Excel version of payables A through F can be downloaded from the CMS web site.

The Excel spreadsheets should be emailed or a CD should be mailed to Abt at the address in the instructions. The next slide talks about time frame. To be considered timely the above information must be sent that is mailed and emailed by May 1. If you need help please email us at nhvpb@cms.hhs.gov and we'd be happy to provide technical assistance.

If you still have problems filling out certain sections as the deadline approaches I would urge you to go ahead and submit whatever you have by the deadline. We anticipate that the selection of the demonstration nursing homes will be completed by the beginning of June.

CMS will send award letters to the selectees and acceptance letters must be sent to CMS within 30 days. Now I'll turn it over to (Murray Cote). He'll talk about the payroll data.

(Murray Cote): Good afternoon everyone. My name is (Murray Cote). I want to talk to you very briefly about the data submission requirements with respect to payroll data. As (Alan) had alluded to in this demonstration project we - one of the important pieces is the ability to collect on an ongoing basis accurate staffing data.

And the way to collect the accurate staffing data in this demonstration is to ask you to provide your staffing data as it is represented within your payroll system. The payroll data we're going to be treating it as the source for nursing home staffing and turnover measures.

So with respect to those quality measures that's where the payroll data will come in. It is in our mind more complete, more accurate than what is currently reported within the Oscar data set. The - for the application part as (Ron) alluded to we will require one quarter of data from you.

The first quarter, first calendar quarter of 2009 from January 1 through the end of March 2009 and then at an ongoing basis we will select or we will collect quarterly payroll data from you. And as, you know, the last part on Slide 20 is the staffing measures collected from the payroll data we're going to use them because of their accuracy and their potential to be audited in the sense of making sure that things look like the way they're supposed to look with respect to those performance measures.

On Slide 21 in our payroll data element this is actually a fairly important part of the application procedure so we'd want to spend a little bit of time going over these data elements. The first is your Medicare, your individual facility Medicare provider number which will be unique from facility to facility.

The second is for each employee that you have at your facility we require an employee identification number. It's unique to the employee at the facility but it should not be their social security number or any other personal identifiable piece of information in this.

It's important that we don't receive that kind of information from you or that kind of data from you. If the employee is promoted or changes positions within your facility it is our expectation that that employee I.D. number should not change if the employee changes his or her position within the facility.

But if the employee leaves the facility and returns at some later date we understand that a new employee I.D. may be assigned to that individual. There will be an employee start date that we'll require from you for each employee. And this employee start date will be the date that the employee started employment with the facility in his or her most current position.

So for example if an employee had been with your facility for five years and within the last six months he or she was promoted to a new position it would be the start date from that new position that he or she entered into that last six months would represent the start date.

The employee job category we recognize that all of the facilities that will participate in this demonstration will not necessarily have used or

use the same job categories as each other and so we have distilled those job categories into one of those four job categories.

And so it will be the responsibility of the facility with help from us if required to take their job categories and fit them into one of director of nursing, registered nurse, licensed practical nurse, or certified nurse aide as appropriate.

Now one comment on the payroll data elements we're going to require a payroll record for each payroll for each employee within both the application package then if you're selected for the ongoing demonstration then to do this quarterly. So for example if you had ten employees and you paid everybody once monthly we would have ten employees times three pay periods in the demonstration or in the application piece.

So there would be 30 employee/payroll records that we would have that you would be submitting on behalf of your facility. On page 22 some important additional pieces of information is that we also need to know when your pay period begins and when your pay period ends. And so we need a start date. We need an end date.

We expect that pay periods could be 7 days, 14 days, bi-monthly or monthly in length and that consecutive pay periods should not over lap. We also realize that, you know, in the application piece we require January 1, 2009 until the end of March.

If these are in between pay periods we were asking you to start your pay period ahead of that so it includes January 1 or if it includes the end of March that you would include the pay period up to and

including the end of March for that particular piece of the data requirement.

For employee hours reported we will require from you the number of hours actually worked at the facility and this will be in hours plus some fraction of hours if they work a quarter of an hour, a half of hour, three quarters of an hour or however your time keeping record keeps track of those hours.

And also the non productive hours with it that may be allocated to an employee for a given pay period that would represent things like the employee being sick, the employee on vacation or on holidays, disability, or administrative leave or anything else that qualifies for non productive hours.

And again these can be any number including fraction of hours and we have the templates and the data specifications available on our web site for that. And that's with respect to the pay period or the payroll data elements. I'm going to turn it over to (Ron) to provide the concluding remarks on our presentation.

(Ron Lambert): Okay in conclusion the NHVPB demonstration has several noteworthy features. It includes all Medicare beneficiaries not just those in a Part A nursing home stay. Also the performance measures reflect various dimensions of quality care and by rewarding both the level of performance and improvement all demonstration nursing homes can potentially qualify for performance award.

Again for more information you can go to www.nhvpb.com. One thing I wanted to mention (Alan) alluded to a refinements report that is

supposed to be on the web. We were hoping it would be there today. I think it's going to be there tomorrow instead.

I would urge everyone if they wanted to review the details of the demonstration design to go to the design refinements report that's going to be posted on the web a little later this week. And that sums up our presentation. We're now ready for questions Natalie.

Natalie Highsmith: Okay (Tim) if you can just remind everyone on how to enter the queue to ask a question and everyone please remember when it is your turn to restate your name, what state you are calling from, what provider or organization you're representing, and also that we are accepting questions - the primary questions should be coming from Arizona, Mississippi, New York, and Wisconsin nursing homes that are affected by this demonstration.

And please keep your questions to just one. If you have another question or comment we ask that you get back into the queue to ask your second question or state your follow up comment because we have such a large number of participants on the phone line. (Tim).

Operator: At this time if you'd like to ask a question please press star then the number one on your telephone keypad. We'll pause for a moment to compile the roster. And your first question comes from (Richard Mallet).

(Richard Mollot): Yes my name is (Richard Mollot). I'm from New York. I'm with the Long Term Care Community Coalition. You had mentioned that there would be no nursing homes would be facing payment deductions as a result of participating in the demo program. I was wondering if you could just speak a little bit about why the decision was made and if this

program is ever extended beyond a demo program if that would possibly change. Thanks.

(Ron Lambert): Well we didn't think it would be fair to penalize nursing homes. And we thought it actually might discourage some from participating if they felt as though they might be penalized so this is something that this is part of the design that was built into ensure that nursing homes would want to participate.

Particularly in light of the fact that we don't have a sour payment pool so at the least there won't be any disadvantage or it won't be a discouraging element to participating. In terms of what we're going to do - what we would do under a national program.

I think we pretty much - we haven't made decisions about what is going to happen under a potential national program and that will come out - those decisions will be made as we go along and depending on the results of the evaluation.

I think that if this demonstration shows that it saves money to Medicare that would be something that would be taken into consideration. But beyond that I don't know.

In fact if it saves money maybe there's some sentiment towards not generating the pool of money based on reductions in payment but generating it from the savings that are anticipated under a national program. But I can't really speak for sure about that. It's just my own thoughts.

(Richard Mollot): Thank you.

Operator: And your next question comes from (Rhonda Sanders).

(Rhonda Sanders): Yes in regards to Slide 15 where it says the threshold the amount that exceeds 2.3% of total Medicare expenditures is considered Medicare savings. Could you please just explain what the Medicare expenditures could include? Would that be just SNF or hospitals? What all that would include. Thank you.

(Alan White): You've almost answered your question. It includes Part A SNF, Part A hospital, Part B physician and outpatient. It does not include DME or home health so it's much broader than just your Medicare Part A expenditures.

(Ron Lambert): Also for those who are in short stays, short nursing home stays it includes hospitalizations that occur within three days of discharge from the nursing home to the community. So if hospitalization occurs within that three day window that's also included.

Natalie Highsmith: Okay next question please.

Operator: Okay your next question comes from (Dennis Conway).

(Dennis Conway): Yes I wondered whether any hypothetical model has been drawn on this to help us understand just under certain circumstances how much would a nursing home actually gain financially from this.

(Ron Lambert): In fact we have done some modeling and in the report that I think will be posted tomorrow we do give an example. So the information's going to be out there soon. But just to give you an idea.

In our simulations and I won't go through the whole technical details about how they were put together but we did a simulation where we found that for a reduction in hospitalizations of 6.6% the average pay out to a nursing home that was a winner, an average sized nursing home and on the average the pay out would be about $115,000.

So that sort of gives you an idea of if hospitalizations are reduced on average about how much on average a nursing home might be able to get at least based on our simulations.

(Alan White): We think that type of impact is very achievable if you look at like the Ever Care model for example. They achieved a reduction of close to 50%. Now they had some features of that program that we don't have in this demonstration. But I think there's considerable room for hospitalization to be decreased.

(Dennis Conway): Okay thank you.

Operator: And your next question comes from (JoAnn Newcomb).

(JoAnn Newcomb): Good afternoon. I was curious to know if a nursing home was in the control group would they still be eligible for increased funding.

(Alan White): Not through this demonstration. I mean basically control group they're not required to submit any data or do anything just kind of through luck of the draw didn't get to become a demonstration participant. But you won't be eligible for any of the performance payments that we talked about.

(Jo Ann Newcomb): Okay thank you.

(Alan White): Sure.

Operator: And your next question comes from (Mark Greene).

(Mark Greene): Yes based on my experience it would appear that this is some what biased against your high Medicaid provider. Is there going to be an adjustment factor that takes into consideration those providers who are very high Medicaid mix as well as a larger Medicare provider?

(Alan White): Overall of the performance measures have a case mix adjustment that we think will help address that. But I mentioned talked a little bit about the staffing case mix adjuster. Our data showed that staffing is pretty highly correlated with your percent of Part A plus acute residences. Control for that in the staffing model.

The hospitalization rate measure I mentioned we have a separate rate for short stay residents and for long stay residents that's because our data show that the rate is much, much higher. Short stay residents and we didn't think we'd be able to adequately adjust for that through our other risk adjustment model.

So that should hopefully level the playing field with respect to the hospitalization measure. Also a number of the NDS case measures have risk adjustment and if you're a place that only treats short stay residents then you're only going to be rated on your performance eon those short stay measures.

So the other questions that might have different levels of performance on the long stay NDS measures that won't be relevant for you. So we've tried as best we can to have a level playing field between the hospital base and the free standing.

We considered whether we should do some sort of stratification where we had a separate group of hospital based and a separate group of non hospital based facilities. But our approach turned out not to really be feasible given that we're only expecting about 50 participants in each state. It just wasn't going to work out.

(Mark Greene): I don't think you've quite understood my question. I was asking free standing non hospital based, non governmental facilities that are high Medicaid providers given the parity between Medicaid payments and cost. Would it not disadvantage the high Medicaid provider who is a healthy Medicare participant as well simply because there's no adjustment to take into consideration weak Medicaid payment?

(Ron Lambert): You mean disadvantage in terms of how the performance is measured or…

(Mark Greene): Well and how they are able to staff.

(Alan White): Well I think that my answer even though I've made it with reference to the high Medicare places and it's real adjusting and kind of on setting a higher bar for staff and for places that have more a higher proportion of Medicare patients that it's kind of in effect setting a lower bar for the places you're talking about that have a lot of Medicaid people if I understand correctly what you're saying. Is that what you're getting at?

(Mark Greene): Yes and I could give you an example where we run maybe 40% Medicare and maybe 50% Medicaid. You have some unique situations out there where you don't have a broad general mix of patients. It creates a very complex set of payment factors.

(Mark Wynn): Let me just add one other point here and that is this is really designed - this project is designed to take into account the large number of residents in many nursing homes who are dually eligible for Medicaid and Medicare. So in fact if you have a large number of people who are on Medicaid and for their Medicare they're only Part B eligible.

They're not on skilled nursing care. You won't be compared with other nursing homes in the same state who are under similar types of payment rules. And we think that although we can't solve all the Medicaid payment issues you all at least be fairly comparing you with other nursing homes in that same state.

Natalie Highsmith: Okay next question please.

Operator: Your next question comes from (Ena Eng).

(Ena Eng): Will all residents enrolled in Medicare Advantage institutional special needs plan be included in the data performance?

(Ron Lambert): In terms of the performance in general let me give you just a general answer. The general answer is yes. In terms of the cost savings calculations the general answer is no. And...

(Alan White): And no for the hospitalization.

(Ron Lambert): No for the hospitalization rate. Yes there are exceptions but...

(Alan White): And that's simply because the claims data are not available for those residents...

(Ena Eng): So if the nursing home has high penetration rate of Medicare Advantage enrollees it would not benefit the nursing home to participate. Is that correct?

(Ron Lambert): I don't know if it would. I don't think you can say that because what it does is it makes the sample size smaller for things like the hospitalization rate measure and for the cost calculations. But just to get a little bit into the details and not get too much in the nitty gritty:

We - when we do the cost comparison between the demonstration group and the control group we do it on a cost per resident day or cost per stay basis and then we so we compare apples to apples. So it gets it down to the basic unit and then we inflate it up.

And when we inflate it up to dollars overall dollars we include every Medicare eligible whether they're a managed care or not. So although the sample size is smaller I don't know they're necessarily disadvantages nursing homes with higher Medicare enrollment, Medicare managed care enrollment.

(Eng Eng): So just so I can understand. You're going to use the cost per resident day based on the non managed care residents times the total number of residents regardless of whether they're managed care residents or not.

(Ron Lambert): Right. It's a complex calculation. And if I had laid it all out I could show you but the basic idea is we're looking for differences between the demonstration and control group and the cost.

And it's actually a difference in differences model where we're looking at the difference in growth rate for the comparison group and then applying that to the demonstration group. We basically set a

target for the demonstration group, an expenditure target based on the growth rate for the comparison group.

And the extent to which the demonstration group on a per day or per stay basis falls short of that target that constitutes the difference and actually creates the savings if that makes any sense.

(Eng Eng): Think so.

(Ron Lambert): Okay. It's explained in the design refinements report in a little more detail so that's really the place to go to for a better explanation.

(Eng Eng): Okay thank you.

Operator: And your next question comes from (Colleen Michaels-Walsh).

(Colleen Michaels-Walsh): Hi this is (Colleen). I'm calling in from Boston, Massachusetts. I'm calling in from (Tuftf) Health Plan. And I did hear in the call previous that some Medicare Advantage members may be involved if they're in the special needs plan.

But I'm trying to - I didn't hear if there's going to be any impact on such as like PQRI Medicare Advantage plan to take some of that claims data in. Do the - trying to find out if Medicare Advantage plans on the whole will be involved with providing any bonus to these providers?

(Ron Lambert): I don't think so. I think that's a separate thing from this demonstration.

(Colleen Michaels-Walsh): Okay great. Thank you for your help. I appreciate that. Have a nice day.

(Ron Lambert): Thank you.

Operator: And your next question comes from (Tammy Carlisle).

(Tammy Carlisle): The questions already been answered. Thanks.

Operator: And your next question comes from (Tony Lewis).

(Tony Lewis): Yes hi. This is Dr. (Tony Lewis), (Cobble Hill) Health Center, Brooklyn, New York. I certainly do applaud your effort at reducing unnecessary or inappropriate hospitalization. I'm just curious about your categories for deciding, you know, what are deemed inappropriate hospitalizations?

I think certainly CHS, electrolyte imbalance, UTI and anemia make a lot of sense from a patient care and outcome perspective. I'm kind of perplexed that you've included sepsis on that. Does that mean that if a nursing home keeps a patient till they go into septic shock?

Then that's correct and appropriate? Where as if a patient sends - if a nursing home sends a patient who's septic and perhaps the hospital can prevent them going into septic shock then that's deemed according to you all as an inappropriate hospital admission.

(Ron Lambert): I guess I should clarify that these are potentially avoidable and we've used the term inappropriate at some point. It's only inappropriate if it can be avoided. So the two terms aren't really interchangeable but what we're really trying to capture is those hospitalizations that could potentially have been avoided with better care in the nursing home or could have been prevented.

(Alan White): The selection of the specific types of hospitalizations that we're using was guided by some previous CMS research specifically the CMS staffing study. And these were all types of hospitalizations that had a reasonably high prevalence in the nursing home population and that we found were sensitive to other measures of the quality of nursing home care specifically staffing measures.

(Mark Wynn): Let me just add to it that point here and that is of course we're not saying that somebody who needs to go to the hospital should be kept in the nursing home. We're just saying that if the margin is possible both to prevent some of those needs for hospitalizations in some cases it's possible to care for that patient in the nursing home.

But of course there are many examples where people for example with as you just pointed out of course somebody who needs to go to the hospital will be admitted to the hospital. And it's just overall the total number of patients during the year we're hoping to see a reduction in hospitalizations would contribute to savings.

(Tony Lewis): Thank you.

Operator: And your next question comes from (Saunders Preiss).

(Saunders Preiss): Hi good afternoon. At the present time we admit many people with the pressure ulcers. And on the QI we put we are rated as a very - an institution with a high percentile. How will you be handling that?

(Ron Lambert): Well we'll be using the measures as they are posted currently on nursing home compare. I think your question is, given that you have a higher admission is there any way we're adjusting for it. Initially since

we're using the MDS 2.0 based measures we'll use whatever adjustments are included for those measures. And I don't think that necessarily addresses your question or satisfies your concern.

(Saunders Preiss): No it doesn't because the QI report really doesn't tell the truth about facilities. We admit into our sub acutes daily people with stage fours and stage threes and yet on the report, we come out very, very high. And it doesn't account that we're admitting these people.

(Ron Lambert): Right and I think that's what the impetus was for MDS 3.0 which we're going to switch to as soon as possible. Because we recognize that these measures need to be improved but right now those measures aren't available so initially, we're basically starting with what is there.

(Saunders Preiss): Okay thank you.

Operator: And your next question comes from (Susan Hoskins).

(Susan Hoskins): Yes hello. I'm calling from Kendall Ithaca, New York State. And we just wanted to - it sounds like the payroll data that's going to be requested each quarter is that going to be the same detail as the data requested for the application?

(Murray Cote): Yes it is.

(Susan Hoskins): Okay so that part of the - that report will probably the same each quarter the same information will be requested.

(Murray Cote): Right.

(Susan Hoskins): Okay.

(Murray Cote): Right.

(Susan Hoskins): Okay thank you.

(Murray Cote): You're welcome.

Operator: And your next question comes from (Paul Listro).

(Paul Listro): Hi this is (Paul Listro) from Arbors in Connecticut. You talked about risk adjustment on page seven for staffing measures. And also on page eight can you talk about a little about them elaborate how you're going to risk adjust?

(Ron Lambert): Well I guess I turn it over to (Alan) in a second because he could speak in more detail than I. But initially at a minimum we're considering the risk adjustment approach as using what's being used for five star. And we're looking at ways that we might be able to progress and do a little better. But I think our starting point is the five star risk adjustment approach. And I don't know if (Alan) would add to that.

(Alan White): The five star risk adjustment approach is to adjust based on the RUG system. At a minimum we want to enhance that by using data based on the new staff time measurement study. As I mentioned we're also likely to include an additional adjuster in the staffing case mix model that's based on a percent of Part A nursing home residents and the nursing home. We just feel that results in a fair risk adjustment model.

Now with respect to that risk adjustment model for potentially avoidable hospitalization it's going to be based on past Medicare

claims data and the MDS. For long term residents we're likely to use the HCC institutional model which is a risk adjustment model that's already out there.

And it's been developed and it's appropriate for this population. We're still developing the risk adjustment model for the short stay residents because that particular model doesn't really work so well for the short stay resident.

(Paul Listro): Thank you very much. Have a good day.

(Alan White): Sure thanks.

Operator: And your next question is from (Roxanne Tenelson).

(Roxanne Tenanelson): Hi this is (Roxanne). Just wondering how the demonstration would work for nursing homes that are serving specialty populations such as ventilator dependent, HIV AIDS nursing homes or event units they would seem to be able to apply. But what types of risk adjustment methods were taken into consideration for these kinds of specialty organizations?

And will there be any assurance that in the - once the homes are selected to be part of the demonstration and they're split into control and demonstration will they there be any thought to the types or organizations that are in the control group and the types of organizations that are in the demonstration group?

(Ron Lambert): I think that we - currently we don't have anything in the design that adjusts for HIV or ventilator. We do have a requirement that nursing homes in order to be - in order to participate they have to have at least

50% Medicare population but that wouldn't necessarily address those issues.

And consequently a nursing home that serves mostly a pediatric population wouldn't be eligible to participate. But regarding special populations we don't have any specific adjusters for those kinds of populations in the design. I don't know how many of them there are out there. But to the extent that they're - they would be disadvantaged because of their special populations we don't have a specific adjuster for that.

(Alan White): Some of these ventilator patients for example are part of the large system that will get you into the expensive care group which has a much higher case mix weight than many of the other groups. So it's probably not a perfect adjustment but it's a partial adjustment for those types of special patient populations.

(Roxanne Tenanelson): And is that going to be taken into account as to who's going to be in the control and who's going to be in the demonstration for organizations that have let's say, what would the case be if, - one of the reasons why New York was very interested in getting involved in the demonstration is so that it's this type of value based purchasing situation.

We could better learn about how it would work for a complex, very complex population being served. So I'm concerned as sort of that type of population wasn't really sort of that much considered in terms of the demonstration but correct me if I'm wrong.

(Alan White): So we have some flexibility with respect to the exact stratefiers we're going to use for assigning nursing homes to the demonstration group

or the comparison group. And if we find in New York that we're getting a good number of participants with these special patient populations we may want to ensure that we kind of have some balance.

So they don't all wind up in the comparison group or all wind up in the demonstration group and cause some problems in terms of being able to get reliable estimates of savings and reliable estimates of affects from the evaluation of the demonstration.

(Roxanne Tenanelson): Okay. Thank you.

Operator: And your next question comes from (David Weinstein).

(David Weinstein): Hi good afternoon. A question about the survey deficiencies that you mentioned earlier. You gave a weighted score for depending on A, B, C, D, etc. Are those specific to clinical outcomes? Or are they potential to have non clinical outcomes such as expired medication? Is that going to weight against someone in your survey in this analysis?

(Alan White): It's all the health inspection related F tags. It doesn't include the life safety violations. I don't think I mentioned it but deficiencies that are related to sub standard quality of care receive more points so you're more heavily penalized for those than for other types of deficiencies.

(David Weinstein): And can a facility pull out at any time during the three years if they're selected?

(Ron Lambert): Well we're going to have certain conditions for participation that we're going to disseminate at a certain point before the demonstration begins. This will specify the conditions under which a facility can pull out. Let me just - this is sort of a draft language.

But it's expected that nursing homes will commit to participating for the full duration of the demonstration. Any nursing home that terminates this participation of the demonstration before the end of the demonstration will not be eligible to receive any performance payments for any year during which they did not fully participate or for which they did not - do not comply with all the demonstration requirements. Any nursing home that intends to terminate it's participation in the demonstration shall provide at least 30 days advanced written notice to CMS.

(David Weinstein): Thank you.

Operator: And your next question comes from (John Linda).

(John Linda): This is (John Linda) from Arizona. As I read page 16 the top 20% overall and then the top 20% improving performers that 40% I would assume is of the 50 so does that mean that only 20 facilities of the 50 in the demonstration group would be eligible for payment each year?

(Ron Lambert): Yes.

(John Linda): So less than half.

(Ron Lambert): Correct. If we made it too many we would split up the pool. In other words, you have a pizza and how many slices do you want 8 or 16? Well if you have 16 slices they're half as big so it's sort of a trade off.

(John Linda): I understand thanks.

Operator: And your next question comes from (Carol Carter).

(Carol Carter): Hi can you hear me?

(Ron Lambert): Yes.

(Carol Carter): Okay. I was wondering - I'm from Med Pac. I was wondering if you're going to change the reporting requirements for the MDS. I'm concerned about for the short stay measures. Almost half of patients don't stay for a second assessment so there's a systematic bias of the patient for the short stay measures.

(Ron Lambert): Yes that I think and I'm not - I can't speak fully on the MDS 3.0 design. But there was some thought given at some point to try and address that as part of MDS 3.0. I don't know for sure what those design elements are. But initially we don't have a way of addressing that issue under MDS 2.0. So we're aware of the issue it's just that initially we don't have a way to deal with it.

(Alan White): And that is the fact that we lose almost half the short stay people because they don't have the 14 day assessment. This is one reason why we're considering the community discharge measure for short stay residents.

Because that is a problem. We need to use incidents measures for the short stay people so it can better adjust for case mix differences and that kind of stuff. But the down side is you do lose a lot of the people because they're not around for 14 days.

(Carol Carter): Thank you.

Operator: And your next question comes from (Kris Krentz).

(Kris Krentz): Hi I have a question on turnover rate and how you're going to measure that. I've looked in the Abt study on page 18. And I can't make sense out of that calculation. It says it's 100 times and in parenthesis number of nurse staff employees at the nursing home during the period divided by the average number of nursing staff employees minus 100.

We're in (Bethelhome) in Wisconsin. So with regards to nurse staffing what's the calculation? And then uniformity are you going to build into it so that if one facility has employees leave and they count them as a termination where as some other facility make just put them into an on call status and not count them as the termination.

(Alan White): Well one thing that we're going to do to try to ensure consistency across nursing homes and how that's calculated is we're going to calculate turnover ourselves based on the payroll extracts that nursing homes submit as part of the demo.

So we won't really depend on whether the nursing home is classifying someone as active or inactive. It's going to depend on whether that person is working during a certain period or not working during that period. In terms of the exact measure the formula is kind of complicated.

I think that's from the old design report. But it's going to be just a measure of staff stability. And I think the key thing that we're still trying to finalize is the weight that the categories, the three nursing categories, RN, LPN and nurse aide are going to have in that calculation of the composite turnover measure.

(Ron Lambert): We'll be coming up with more information on that later with the exact formula.

Natalie Highsmith: Okay next question please.

Operator: Your next question is from Dr. (Jonathan Mawere).

(Jonathan Mawere): My question is, you know, there are two questions. I am from the Queens Boulevard Extended Care facility in Woodside, New York. The first question is you mentioned something that the benchmark for you to save to participate in the program is they have to have Medicare residents of about 50% is that correct?

(Ron Lambert): Right. Medicare eligible – 50 percent of them have to be Medicare eligible.

(Jonathan Mawere): Oh okay. Okay that's makes sense. And then the other thing is you characterized earlier - you characterized the payment provision for this using one parameter to give an example. And you say that the facility could be paid for reducing hospitalization rate by a total of $115.

And I was just wondering what that would be the only thing or that $115 become a part of the other parameters of assessment that would include issues like say the results and other parameters of assessment that you talked about.

(Ron Lambert): Well let me explain there's an annual payment. At the end of every year we'll do the reconciliation. And it'll take some time after the end of the year to do it because we have to gather all the claims data and all the other information and put it together and analyze it. So it'll be a

one time payment each y ear and it was $115,000 for an average sized nursing home on average.

(Jonathan Mawere): Okay and that just in one parameter of assessment or it's all allowed for all parameters of assessment? Do you think there's an overall score for that particular facility?

(Ron Lambert): Right the winners will be determined based on the top 20% of performers on the overall quality score. And the top 20% of improvers on the overall quality score will be winners.

(Jonathan Mawere): Okay. And that - and so I'm just trying to figure out how you arrived at $115,000. Is that just for one particular area of scoring or the overall score?

(Ron Lambert): No that is - it's all part of the one simulation and it's actually based on - it's related to in our simulations an average 6.6% reduction in overall hospitalizations. And this is for groups of nursing homes of 50 so there's some random variation in our estimates.

The actual calculation was some what complex and we could probably spend the rest of the hour going through the details of it. And we simulated this because it wasn't based on a single simulation. We did 100 simulations and took averages across all 100.

But this is just to get an approximate benchmark. So the way to think of it is if you performed well such that you are a winner and you also reduced hospitalizations by 6.6% then according to the simulations the average pay out to you would be $115,000 if you were a winner.

(Jonathan Mawere): And you compared - when you say you reduce hospitalization you are compared to just the control group. Is it just the control group or is there some benchmark of what are considered low hospitalization rates? Or that is being proved in our years of studies of what's customary or is this just something that's going to come out of this control group? Or the samples that you're going to be working with?

(Ron Lambert): Well we spread - we took random samples of nursing homes and split them. We basically compared a group of 50 nursing homes to a comparison group is essentially what we did. And on average those groups on average across all 100 simulations they had a 6.6% less of a hospitalization rate than the comparison groups in our simulations.

(Jonathan Mawere): Okay thank you very much then.

Operator: And your next question comes from (Ann Petock).

(Ann Petock): Hi I was - I had another question about submission of payroll data. On the examples that you show it's listed by employee for their entire quarterly payroll amounts. Would it be possible to submit summaries including all employees by payroll so that your - you can generate a report each time you do a payroll. And it wouldn't be one report just for one employee that makes sense.

(Ron Lambert): (Murray) do you...

(Murray Cote): Yes I'm not - well I think it kind of makes sense if you could sort of restate what would be in the report that you were thinking of.

(Ann Petock): Well we could provide all of the information you need. But instead of showing (Joe Smith) and the corresponding pay periods for him we

would instead have a summary for pay period number one listing all the employees. Then another report with pay period number two, etc.

(Murray Cote): That would work. The only thing again to keep in mind on that is there's a couple more data elements that we'd require. One would be modifying your report to make sure that you give the correct employee job category per the four job classifications that we've defined.

The idea of being able also to disseminate between productive and non productive hours for this and then just - yes those should be - it should be sufficient. Would that be possible within your payroll system?

(Ann Petock): Well that's what we're going to determine. But I think...

(Murray Cote): Okay.

(Ann Petock): It's our thought that we would be able to provide all the elements that you're looking for.

(Murray Cote): Okay. (Alan) or (Ron), did I miss anything in there?

(Alan White): Well we would need to make sure we had adequate information so that the turnover rates could be calculated. And I guess as a big picture I mean we recognize that nursing homes are going to have some differences in their payroll systems and how that information is captured.

And we encourage again just nursing homes to ask us ways that they may be able to provide the information in a way that lets us calculate what we need to calculate but minimizes the burden to them. So we encourage folks to contact us with those types of questions. We

recognize there's going to be a lot of nursing home specific steps so we don't want to get into it too much on this call. But we're eager and happy to provide that assistance.

(Murray Cote): Right and following on (Alan's) comment. It really is in I think on both parties best interest to make sure that we do capture all of the data elements as defined. So it may require a little bit of burden within whatever existing payroll system you have to make sure that you keep track of the employees starting date for his or her most current position that he or she is in. Their job category and then the distinction between productive and non productive hours. Does that help?

(Ann Petock): Yes thank you very much.

(Murray Cote): You're welcome.

Operator: And your next question comes from (Mark Olsen).

(Mark Olsen): The question was answered earlier. But we may have a follow up question.

Man: Yes I was just one other question. I don't know if you can hear me. If you are assigned to the comparison group and you have excellent performance you're not eligible for any awards is that correct?

(Ron Lambert): That's right.

Man: Okay. A real incentive there is you get assigned just by the luck of the draw to the comparison group.

(Ron Lambert): Well the idea is we want the comparison group to perform as it would have whether the demonstration happens or not.

Man: And the demonstration group there's really nothing that they're going to do differently except that they have the financial incentive to perform better.

(Alan White): What we hope that financial incentive will encourage them to make improvements in this types of measures that we've been talking about. But comparison group you're right, you know, hopefully you don't have incentive to change your behavior as a result of being in the comparison group. You're not eligible for any rewards. You're also not required or even asked to submit any data or any type of information like that. It's just going back to...

Man: I didn't catch that last part. You're not required to do what.

(Alan White): You're not asked to or expected to submit any data or do anything. You're just kind how you were before you applied for the demo.

Man: Okay thank you.

(Alan White): Sure.

Operator: And your next question comes from (Gary Eye).

(Gary Eye): Can you join after May 1 or get in after the demo starts?

(Ron Lambert): Well we want everyone to submit their applications by May 1. And if you're having difficulty particularly with for instance the payroll data we would like you to give it your best shot. Do what you can on it. If

you can't handle certain fields try to get that assistance but wherever you are send it in by May 1. Because otherwise we won't make our deadlines. We have to cut them off somewhere.

(Alan White): Well we at least need to know that you have the intent to apply.

(Gary Eye): So you can't join after May 1.

(Ron Lambert): If you don't submit it - if you don't send your information by May 1 we won't consider you.

(Gary Eye): And whether your - which group you're in is strictly a matter of luck.

(Ron Lambert): Yes.

(Gary Eye): Okay thanks.

Operator: And your next question comes from (Robert Hurlbut).

(Robert Hurlbut): Hi this is (Bob Hurlbut). And I'm from - an operator from New York State. And one of my concerns is with the staffing that in New York I don't know if you're familiar with the Medicaid system and the Medicaid rate itself.

There's a thing called Schedule 8 which gives you the staffing by RN, LPN, and nurse's aide by your case mix index that you have. Have you looked at that at all?

(Ron Lambert): I don't think we were aware of the Schedule 8 at least I'm not aware of it.

(Alan White): From the cost reports I take it.

(Robert Hurlbut): No it's - your actual Medicaid rate there's a Schedule 8 in there and that tells you what the state is willing to pay you for RNs, LPN and nurse's aide as far as hours. And I think that that has a direct correlation with Medicare and Medicaid because the homes that have the higher Medicaid utilization and it was pointed out earlier by a gentleman that we're not necessarily getting our costs now.

A lot of nursing homes use that as a benchmark at least I do for the 12 nursing homes I've got as a benchmark to staffing for my facilities. And Medicare really doesn't - we have a high utilization for Medicare. But I don't change my staffing because of it. And I think that that needs to be taken into consideration.

(Ron Lambert): We'll have to look into this a little more to see if we can get some information on this.

(Robert Hurlbut): Well it's a huge - it's huge for New York State nursing homes especially up state well actually all over the state in deciding whether they're going to do it because staffing, you know, certainly more numbers there that doesn't mean that the quality of care is going to be any better.

(Ron Lambert): Okay so I guess we just need to look into this and get more information is all I can say at this point.

(Robert Hurlbut): Well okay.

Operator: And your next question comes from (John Binderup).

(John Binderup): Yes this is (John Binderup) with Life Care Centers. Besides the payroll data that will be submitted each quarter is there any other significant data submissions that are required by the facilities?

(Alan White): On the initial application we do ask for some information on a couple of developmental measures that I talked about the staff immunizations and a few questions on whether your nursing home uses care experience surveys those are pretty minor.

(John Binderup): But on a continuing basis.

(Alan White): On a continuing basis no unless we decide that those measures should be added to the demonstration beginning in year two. And if they are then, you know, you'd be asked to submit those.

(John Binderup): And then just a short question will the ABT be providing any interim data to the facilities that are selected in the sample group to show how they are ranking in comparison to the other facilities?

(Alan White): You mean interim - the ones we've talked about any more frequently than annually. Some of the measures like the hospitalization rate measure we continue to allow that length of time in order to have kind of a stable measure.

But it will take quite a bit of time from when the demonstration year ends to when we can calculate as far as performance pool. So you have to wait a while for the claims data to come in. And I think our plan is to provide nursing homes as quickly as we can information on their performance for the first year of the demo.

(John Binderup): Very good thank you.

(Ron Lambert): I think, just to add, I think to report some of these measures during the year on an interim basis may be misleading because things change. And particularly anything that's claims based you're really not going to be able to get a good handle on that until after the demonstration year is over and then some. So I think that's why we're doing this annually.

(John Binderup): Thank you.

Operator: And your next question is from (Dennis Conway).

(Dennis Conway): Yes I just wanted to clarify something. The only way a facility might financially benefit from participating in this am I correct to say that they have to fall within the top 20% of the 50 or so that are participating in which case they'd have to be in the top 10 within their state?

(Alan White): Top 20% in terms of either performance level or improvement so if there are 50 in a state they'd have to be in the top 10 in terms of level or in the top in terms of improvement. And then if you have a couple of nursing homes that were in the top 10 on both it might be that you take the 11th or 12th in terms of one of those categories.

(Dennis Conway): So you say improvement relative to the baseline period. The baseline period being I'm sorry when is that?

(Alan White): Baseline - well for the staffing it's for the first three months of this year so for the others it's going to be for the year prior to when the demonstration starts.

(Dennis Conway): And that's an aggregate baseline period or an individual facility baseline period?

(Alan White): That's for the individual facility.

(Dennis Conway): The individual facility so if the individual facility should improve by 20% it can receive some financial benefit.

(Alan White): Assuming that puts them in the top 20% in their state yes.

(Dennis Conway): Right okay thanks.

(Ron Lambert): It's a relative ranking approach so they would have to get into the top 20% compared to other nursing homes in the state.

(Dennis Conway): Well that's a big challenge. There are going to be quite a few of the 50 that are left out.

(Ron Lambert): Yes there's also an opportunity to get in the top 20% in terms of improvement so if you miss on one you have a chance on the other. You see you have two shots at this.

(Alan White): You got two shots and then you got three years so we expect...

(Dennis Conway): Three years okay what's the demo should be...

(Alan White): Expect well more than 40% will qualify in at least one of the years that's what we hope.

(Dennis Conway): It's an annual measurement. Okay thank you.

Operator: And your next question comes from (Amy Yamriska).

(Amy Yamriska): Hi we're calling from Columbia Healthcare Center in Wyacina, Wisconsin. And our question is under the agency staffing my concern is there are a lot of facilities who utilize large numbers of agencies and that agency staff is coming in on a daily basis may not be consistent. So in essence you're having the same issue as far as quality of care.

But if they're just throwing a blanket number in there how does that qualify versus a facility that is hiring people, screening them well, and within the first 30 or 45 days says this really isn't a match and that person's position is terminated.

(Alan White): We have some of the same concerns that you just articulated with respect to agency staffing. And our response to that is to include agency staff in the staffing level calculations but only include them at 80% of the rate of regular staff employees.

Kind of a recognition that we view the agency staff is certainly preferable to being under staffed but because of issues around continuity of care and things like that we didn't want to count them quite as heavily as full staff so that was our response to the agency staff issue.

(Amy Yamriska): Thank you.

Operator: And your next question comes from (Sandy Bestic).

(Sandy Bestic): Hi there. I have a question regarding the demonstration and the comparison group. When - if you get selected into the project are you notified which group that you are put into?

(Ron Lambert): Yes you will know when it starts whether you're in the demonstration or comparison group.

(Sandy Bestic): And then will the other facilities in your state know which facility is participating and what group they ended up in?

(Ron Lambert): You mean will everyone know what everyone else - where everyone else is?

(Sandy Bestic): Yes.

(Ron Lambert): I don't know if we - I guess we never actually thought that was an issue. But, you know, we'll consider the question.

(Sandy Bestic): Okay and then my next question is if you are in the comparison group you - if I understood you correctly you said that you submit your data once and then you don't have to submit it again.

(Alan White): If you're in the demonstration group you need to submit payroll data on a quarterly basis.

(Sandy Bestic): No but if you're in the comparison group.

(Alan White): The comparison group - well you're filling out the application and that's it. You're not asked if you get put in the comparison group.

(Sandy Bestic): But things change in the comparison group how can you compare the demonstration group to the comparison group when you only have one set of data from the comparison group?

(Alan White): Well we have a lot of the data we need for the comparison group. We can calculate, we have the Medicare claims data - and that's the main thing we need it for measuring the Medicare savings. The organization that is doing the evaluation of the demonstration they'll be able to look at MDS based outcomes for the comparison group and for the demonstration group.

They'll be able to look at the hospitalization measures for both groups. We didn't want to impose any data collection burden on the comparison group and that's why we're not expecting them to submit payroll data or any other types of data.

(Sandy Bestic): Okay thank you.

(Alan White): Thank you.

Operator: And your next question comes from (Louis Harris).

(Louis Harris): Our question was previously answered. Thank you very much.

Operator: And your next question comes from (Elizabeth Kaneb).

(Elizabeth Kaneb): Hi. I'm calling from New York State. My question concerns maybe I'm not understanding exactly how you're determining your cost savings. It won't be a cost savings if you're simply shifting the cost of care to the nursing homes from the hospital.

So how exactly - you haven't mentioned cost reports being submitted from nursing homes showing the increased costs of staffing to try and decrease hospitalizations. And you haven't said how you're going to cost out the hospital savings if you don't know the hospital costs. Do

you understand where I'm coming from? Like how are you going to determine a savings if you've merely shifted the cost to the nursing home?

(Ron Lambert): Well first of all we're measuring savings to Medicare and to do that we're using Medicare claims data. So that's really - it's really the only costs we're looking at for our purposes. And the best way to illustrate is to give you an example.

It's complex. But the best way to illustrate it is to give you an example of two residents of two different nursing homes. Mr. (Jones) and Mrs. (Smith) and Mr. (Jones) is - they're both long stayers, long term residents of their nursing homes.

Mr. (Jones) is - Medicaid is paying for his stay. He's getting Part B services during his stay in the nursing home. And because his nursing home avoids the hospitalization he doesn't go in to the hospital during the year.

Mrs. (Smith) however does go into the hospital which increases the cost to Medicare in that now Medicare has to pay for a hospital stay and in some cases the subsequent SNF stay.

So not only are the Part B costs incurred to Medicare but the cost of the hospitalization and in some cases the Part A SNF stay that follows it will be incurred by Medicare. So that results in a cost savings to Medicare for the nursing home that avoided the hospitalization.

(Elizabeth Kaneb): Not really because you don't - you seem to have forgotten that the Feds pay for half of what you're paying for Medicaid. So if you're going to be increasing the costs to the nursing homes - that nursing

home that doesn't have the person going to the hospital added a nurse practitioner to their staff.

So they're now - you've turned them into like many hospitals so you really - how have you saved if you're increasing costs overall? Because you're saying okay well it's not a Medicare A stay. But you're going to be increasing the cost of that facility to both the state and to yourselves long term.

So there really isn't a cost savings if you do the calculations out. So that's what I'm asking. How in depth have you done these calculations? Because like nursing homes right now are under a burden of everybody's looking at us as being a very expensive place to put people because you keep pushing us and pushing us as to who we have to have on staff. So that really isn't a pure cost savings to Medicare under those terms.

(Ron Lambert): Well to Medicare it is. You made reference to costs to Medicaid, to costs to the nursing home but to Medicare it is a pure cost savings. Now we have looked at the impact on costs to Medicaid.

You're right there's a potential impact on cost to Medicaid. If the person stays in the nursing home Medicaid's still paying for the stay instead of Medicare. But the costs to Medicare are much higher for a hospitalization and subsequent sit stays than the cost to Medicaid if they stay in the nursing home.

So it's - overall, from the perspective of the federal government they're actually saving money even with potentially higher costs to Medicaid. Regarding the costs to the nursing home for hiring more staff, that's a decision the nursing home has to make.

They have to decide how they're going to achieve these quality goals and that's one possible way. And they have to weigh the potential pay off against the potential costs. That's sort of their decision.

(Elizabeth Kaneb): But then long term those costs come back to Medicare because on the - when we submit a Part A bill you itemize what you're doing and if those costs are more expensive that leads to the changes in our Medicare rate. So the savings to Medicare is only if you never change our rate.

And how can that happen? I mean yes I suppose it could happen on a Medicare level if you decide that you're just going to stop giving us any increases. But I don't see how long term it's going to save Medicare money because that will be showing up on the bills we submit to Part A.

(Mark Wynn): Well you're absolutely correct and all of these things are part of the sort of total economic evaluation. It will be a careful evaluation of this to find out how we're really not just for Medicare but for the entire system including the nursing homes.

We're hoping however that we can improve the quality of care and the cost of efficiency to Medicare while at the same time preserving the financial health of the nursing homes. But that's why at the demonstration we want to find out what happens.

(Elizabeth Kaneb): Thank you.

Operator: And your next question comes from (Eileen Tocco).

(Eileen Tocco): Yes hi. I believe my question has already been answered about the assignments to the groups the demonstration/comparison or neither. And if I understand correctly if we get selected to the demonstration group we would have to submit data quarterly otherwise we do not. Is that correct?

(Alan White): Correct.

(Eileen Tocco): Okay thank you.

Operator: And your next question is from (Maureen Cerniglia).

(Maureen Cerniglia): Hi yes my questions been answered also. Thank you.

Operator: And your next question is from (Bonnie Zabel).

(Bonnie Zabel): Hi my question is related to staff stability and turnover. And I'm calling from Markwood in Wisconsin. And how will that data if you're just looking at the staffing data, how will you account for someone who is still an employee but they're on a leave of absence, family medical leave, medical leave or someone who's a college student who works periodically throughout the year but not every pay period? They're still our employee so how will you be certain that you don't count them as terminated?

(Alan White): What we're going to be looking for is significant gaps in a person's employment history that suggests that they're terminated if they're gone. I mean one of the things that we want to try to do here is have a consistent definition of turnover.

Where it's calculated the same way across nursing homes there may be cases of college students that work in the summer and then go away when school starts back up that we would look at in the payroll data. It looks like that person's gone and we count them in our turnover measure.

I think that's just part of having a consistent database method of calculating turnover. Otherwise, you know, we'd just be having to take nursing homes at their word that I don't know if that person's coming back in six months don't worry about it. And we just wanted to try to get away from some of that inconsistency.

(Bonnie Zabel): So what's a reasonable time? Like someone is allowed to have their 13 week medical, family medical leave would they like wise be considered not an employee?

(Alan White): (Murray) do you remember the exact time interval that we looked at?

(Murray Cote): I believe for the sake of turnover we're looking at two quarters of data. So that we would have, you know, there would be no record of this individual for six months in the payroll record.

(Bonnie Zabel): Okay that's reasonable. Thank you.

(Murray Cote): Yes because we wouldn't, you know, again as following on (Alan's) comment. We don't want to bias the measures one way or the other. But we also want to make sure that we don't drop someone out when in fact they are still a legitimate employee.

I mean the down side of this is that the summer work that you may get from a university student will not show, you know, will show up as

kind of we hired and then we fired. We hired and then we fired over the summer period because, you know, the nine months had lapsed in between summers. But for someone who's on family medical leave that 13 weeks we'll be able to pick that up and easily recognize that person still remains an employee of the facility.

(Bonnie Zabel): Typically the students also come back for breaks and holidays so I think that they would meet the same criteria.

(Murray Cote): Good but - and as long as they're for the purposes of consistency in the payroll data. As long as that person's employee I.D. hasn't changed we'll be able to keep track of those time periods when they're there versus when they're not there.

(Bonnie Zabel): Okay.

(Murray Cote): Okay.

(Bonnie Zabel): Thank you.

(Murray Cote): You're welcome.

Operator: And your next question comes from (Carmen Halsey).

(Carmen Halsey): Hi there. Three questions related to the avoidable hospitalization. If I'm understanding that you're going to get your data from submitted claims am I correct in thinking that you will not take into consideration ER visits or observation stays to the hospital?

(Alan White): ER visits would only be counted if they resulted in an admission to the hospital and that would show up in the hospital claims data.

(Carmen Halsey): But then what about the observation stay up to 72 hours.

(Bill Buczko): That would be a Part B - paid under Part B and not considered a hospital stay.

(Carmen Halsey): Okay thank you.

Operator: And your next question comes from (Kathleen Pagels).

(Kathleen Pagels): Thank you. This is (Kathleen Pagels) from Arizona. I just want to say that there's some concern in Arizona as we learn more about the details of this project that the savings pool would be quite small given the fact that we have 136 nursing homes in the state and a very high penetration of managed care on the sub acute side.

As some estimates two thirds so that is a concern I just wanted to make that point. I also related to that have some concern about sample size. If you were not to get 100 facilities and 100 would be the vast majority of our state's facilities. Would you reduce the sample size dependent upon the number of facilities who applied?

(Ron Lambert): I think we can accept less than 100 nursing homes. I can't say what the number would be but I mean certainly 99 or 98 or anything close to 100 will be acceptable. At some point though it causes the estimates to be so random if the sample size is too small that we simply can't accommodate it. So the answer is generally yes we can accept less than 100 but not many less.

(Kathleen Pagels): Well then if I may ask let's say you got 50 to apply. Could you use those 50 for the demonstration project and then randomly select another 50 that hadn't applied for the comparison group?

(Ron Lambert): Well I don't think we're going to do that because there may be something systematically different between those that apply and those that don't. And we don't think it will be a fair comparison.

Also I think if you had any information you said that two thirds of the Medicare eligible population was enrolled in managed care. If you do have any information on the percentage of nursing home residents that's enrolled in managed care we'd be interested in that. I don't know if you have that available.

(Kathleen Pagels): Ours is antidotal at the association level. There may be other sources that would be more concrete.

(Ron Lambert): Okay.

(Kathleen Pagels): Thank you.

Operator: And your next question comes from (Valerie Deetz).

(Valerie Deetz): The question relates to why you are looking at turnover if you're counting anybody who is off payroll for a while but then comes back on payroll if you're not counting that person as someone who's gone. And if that person's absent isn't contributing to turnover why are you looking at turnover in the first place?

I mean I assume that you are looking at turnover because it's related to resident outcomes. Because when staff are familiar with the residents

that they care for they provide better care. So it would seem to me that it doesn't make any difference whether it's poor facility management and supervision or whether it's out of their control if the person leaves and is gone for two or three months and a stranger is brought into care for that resident that's going to affect resident care as in outcomes.

(Alan White): I think it was kind of a fairness question for the nursing home. We didn't want to punish a nursing home because they had an employee that went out on maternity leave and was gone for a few months or those situations. We wanted to try to measure situations where the person made a clean break and just wasn't working there any more and count that in our turnover measure.

I expect that the correlation between a turnover measure that had a shorter than two quarter period like (Murray) talked about and had a much - looked for a much shorter break in employment would be pretty high. It probably get a pretty similar measure no matter which specification you used. But I think it was that fairness consideration that got us to that level that we selected.

Natalie Highsmith: Okay next question please.

Operator: And your next question is from (Randy Muenzner).

(Randy Muenzner): In terms of our HMO patients I think all the measures will be on Medicare A eligible is that not correct?

(Alan White): The MDS measures will be everybody. Hospitalization measure will be - well I guess hospitalization measure will not include your HMO patients because there's no claims data there. And then the staffing and

the survey measures are just facility level measures so they don't relate to individual patients.

(Randy Muenzner): So the hospitalization rates are on Medicare A eligibles only and there was a minimum requirement if I heard you correctly of 50% of our total patient population.

(Ron Lambert): To be Medicare eligible.

(Randy Muenzner): To be Medicare eligible. Now in the event of let's just say year two you fell below the 50% mark what happens?

(Ron Lambert): Well I don't know how many nursing homes around that border that seems to be - it would be an odd place to be. I think they're probably well above or well below it.

(Alan White): I don't think we had any provisions for reselecting that information.

(Ron Lambert): Right I think that if you apply and you meet the requirements then you are - we're not going to take another look at that and kick you out.

(Randy Muenzner): Okay good that's good. Okay thank you.

Operator: And your next question comes from (Roxanne Nelson).

(Roxanne Tenanelson): Hi. My question is how is CMS going to ensure that this demonstration - the demonstration states do not get hurt once the value based purchasing program may eventually go nationwide? Because over three years it might be expected that in the - at least in the demo states there will be adjustments made and during the demo, you know, improvements in hospitalization rates and other areas see improve

which is probably what you're looking to do and hopefully that will be a result.

But when it transitions into the nationwide program has there been any consideration as to making sure that the states who have invited CMS to come in to be - to demonstrate in those states don't get hurt once it's goes national.

Because my understanding is when New York offered to be a demonstration state for the Rug system there was some implications to when the PBS assumed that nationwide. So if you've thought about it that's great I'd love to hear some of your thoughts at this point. And if not if we could just make that that's factored into all of the activities over the next three year demonstration period.

(Ron Lambert): Well we'll certainly take it into account. I'm trying to imagine how the states would get hurt. You know, maybe you could provide us with some examples of what you're thinking.

(Roxanne Tenanelson): Even just sort of the concept that the states - the first states that are taking part in this demonstration spend the next three years doing a really phenomenal job of reducing hospitalizations in those states. And so that they're at the level where the hospitalization rates are pretty reasonably low in comparison maybe to other states.

And so they've done a really good job doing a lot of hard work to get there and even I think one of the comments I don't know if it was (Alan White) or another person saying that there are just some situations where you absolutely do need to hospitalize an individual when it's necessary. So, you know, you're never going to get to zero

because of we're talking about a very frail elderly and disabled population.

So your states who are doing really well on for example the hospitalization rate at the end of three years and it's not likely that you're going to get it to do any better because of the population we're taking care of. So that's just sort of a conceptual idea to this kind of thing.

(Mark Wynn): Well thanks for that comment. The folks - some of the folks in this room will certainly be involved if we do get to that place of developing a national program and taking the evaluation of the demonstration into account. And we would certainly not want to in any way give participating states some how a disadvantage. So I think that's an important point that I think our focus would be on how do we improve the entire set of nursing homes nationwide.

(Bill Buczko): Yes we're a bit far away from that and we'd - it appears from what you're saying that we'd have to factor past experience into whatever type of risk strategy we'd come up with. But then that is right now far in the future for us depending on the experience that we get in the demonstration.

(Roxanne Nelson): Right. Okay thank you. I appreciate you listening and that you think about it and that we think about it early on. Thank you.

Natalie Highsmith: Okay (Tim). We have reached our 4:00 hour here on the East Coast. I will turn it over to (Ron Lambert) for any closing remarks.

(Ron Lambert): Well thank you all for participating. We appreciate your enthusiasm and all the questions and clearly there's a lot of interest out there

which is a good thing. If you have any further questions please email them in that's probably the best way to get them answered at nhvpb@cms.hhs.gov . So we look forward to your participation thank you very much.

Natalie Highsmith: Okay thank you all again for joining us. (Tim) can you tell us how many people joined us on the phone lines?

Operator: Looks like it was around - just a second I wrote it down 580.

Natalie Highsmith: Five eighty wonderful. Please remember the email address is nhvpb short for nursing home value based purchasing at cms.hhs.gov. Thank you and have a wonderful day.

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

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