

**CENTERS FOR MEDICARE & MEDICAID SERVICES  
SPECIAL FORUM ON  
MEDICARE HOSPITAL  
VALUE-BASED PURCHASING (VBP) PROGRAM**

**Moderator: Barbara Cebuhar  
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Operator: Good afternoon. My name is Andrea and I will be your conference operator today. At this time, I would like to welcome everyone to the hospital value-based purchasing program special forum conference call. All lines have been placed on mute to prevent any background noise. If you should need assistance during the call, please press star then zero and an operator will come back online to assist you. Thank you. I would now like to turn the call over to our host, Ms. Barbara Cebuhar. You may begin your conference.

Barbara Cebuhar: Good afternoon, everyone. Welcome to the CMS hospital value based purchasing special forum. We are pleased that you could join us for this special forum where CMS will have an opportunity to pose a number of questions and get the benefit of your experience and insights into our hospital value-based purchasing effort. My name is Barbara Cebuhar and I work in the Office of External Affairs and Beneficiary Services here at CMS.

Today, I will be working with Allison Lee who is the project lead for the hospital value-based purchasing program development and implementation and the Hospital Inpatient Quality Reporting program, formerly known as RHQDAPU program. She will help facilitate this call and will be asking the questions. We are hopeful that you can help inform our deliberative process by sharing your insights on what makes sense in the design and implementation of a hospital value-based purchasing program. Before we get

started, I'd like to introduce Dr. Barry Straube, who is CMS Chief Medical Officer and Director of the Office of Clinical Standards and Quality, to offer a few remarks.

Barry Straube: Thank you, Barb. Good afternoon, everyone, and I'd also like to welcome you to this call along with the entire team here at CMS. About three months ago, Dr. Donald Berwick was appointed Administrator of CMS and he's been working busily with all of us in senior leadership and will be talking to an all-staff meeting later today with a proposed vision for CMS, which is to recognize CMS as a major force and a trustworthy partner for the continual improvement of health and healthcare for all Americans. Dr. Berwick is articulating something that he calls, and we are now using in all of our programs, called the "triple aim". The aim for CMS going forward will be to achieve three aims. One, better care for individuals, two, better health for populations, and three, lower costs in healthcare through improvement.

The Affordable Care Act was passed in March of this year and signed by the president and I believe is an excellent opportunity, giving CMS all types of authority and assignments to try to achieve this "triple aim" of better care for individuals, better health for populations and lower costs for improvement. Section 3001, which we'll be talking about today, focuses specifically on the hospital setting and we're going to be welcoming your comments and your thoughts as we devise this very important program.

I'd like to turn things over now to Jean Moody-Williams, who is the Director of the Quality Improvement Group within the Office of Clinical Standards and Quality here. She will tell you a little bit more about this afternoon's proceedings. Jean?

Jean Moody-Williams: Thank you, Barry, and I too welcome you and we're very excited to have this opportunity to get your comments on Section 3001 of the Affordable Care Act, which really authorizes the establishment of a quality incentive program for inpatient prospective payment system, subsection (d) hospitals. This is effective with the FY2013 payment determinations for Medicare discharges occurring on or after October 1, 2012. The hospital value-based purchasing program, and we'll probably refer to it as well as

hospital VBP, is really designed to link payment to quality processes and outcomes to transform CMS from a passive payer of claims to an active purchaser of care.

The hospital VBP program moves really from providing an incentive to the nation's acute care hospitals for reporting measures, which you've been doing for a number of years now, to paying for quality performance. Under the hospital VBP program, payment to high performing hospitals will be larger than to those lower performing hospitals, using the IPPS to provide financial incentives to drive improvement and clinical quality, patient centeredness and efficiency. We want to make sure that we do that in a very constructive and deliberate manner and today gives us an opportunity to hear from you. So again, thank you and welcome and I will turn it back over to Barb.

Barbara Cebuhar: Thank you very much, Jean and Barry. During the forum, CMS is asking for input from attendees on all aspects of the hospital value-based purchasing program development and implementation. Because CMS is in the process of rulemaking, we are unable to answer questions during the forum and will be in a listening only mode. We are going to try to get to everyone's answers, but if we don't, please take down this e-mail box number.

We are accepting your ideas up until November 5. If you would like to have a comment registered, please write us at [hospitalvbp@cms.hhs.gov](mailto:hospitalvbp@cms.hhs.gov), that's [hospitalvbp@cms.hhs.gov](mailto:hospitalvbp@cms.hhs.gov). I also wanted you to know that today's call is being recorded and will be posted on the following website for those that want to listen to it later. You need to go to [www.cms.hhs.gov/hospitalqualityinits](http://www.cms.hhs.gov/hospitalqualityinits), that's [www.cms.gov/hospitalqualityinits](http://www.cms.gov/hospitalqualityinits). Now, I'd like to turn it over to Allison who will walk you through the questions.

Allison Lee: Thank you, Barb. I just want to check with the operator. Am I OK to go with the questions?

Operator: Go ahead, please.

Allison Lee: OK, thank you. So, in terms of the hospital value-based purchasing program implementation and development, we again thank you for your participation and the first question that we'd like your input on is what is an acceptable

performance period to determine performance scoring and payment calculations for the hospital value-based purchasing program? Thank you.

Operator: So if you would like to answer that question, please press star then the number one on your telephone keypad. We'll pause to compile the results.

Your first question comes from the line of somebody that we not have yet obtained their name. If your call is with 704 area code, your line is open.

Christine Van Dusen: Yes, this is Christine Van Dusen from the Premier Healthcare Alliance and I want to thank CMS for offering this opportunity to speak back, to provide these comments. We're going to go ahead and offer some recommendations here. Because the VBP program will begin to affect inpatient hospital payments in fiscal year 2013, we realize that this will pose some challenges for you and that, for example, it is possible that the performance period will need to end by December 31, 2011 to allow time for hospital reporting, validation and notification of VBP scores and appeals prior to October 1, 2012.

As part of that, so in view of the short implementation timeframe, the requirement of notice and comment will make and the requirement for 60 days advance notice, the initial performance period may need to be less than a full year in duration. We believe the initial performance period should not be less than six months' duration. Considering seasonal variation, performance measures should compare performance levels for comparable time periods in the current and prior years.

Premier understands the 60 day notice requirement can mean that hospitals will know all of the standards on which their performance will be assessed before the performance period begins. They will know the performance score they must achieve to earn back their full VBP set aside and they will know their VBP incentive will be calculated from their performance score. These standards and methodologies are fixed before the performance period begins so that the hospitals know exactly what is at stake and have a fair chance to earn back their VBP set aside. Thank you.

Operator: Your next comment comes from the line of somebody from an 870 area code. Please give your name and your organization. Your line is open.

Again, you're from an 870 area code, your line is open.

Dee Rogers: This is Dee with Magnolia Regional Medical Center. We are a 49 bed licensed PPS hospital and I agree totally with Premier's comment on the timeframe. You need comparable data, you need that 60 day notice to know what you're having measured and I think you need to figure out what your measures are going to be before you determine your timeframes as well because with hospital acquired conditions, we haven't had just barely two years' worth of data on that reimbursement issue if you look at those. If you look at the core measures, are you going to go towards appropriate care versus the individual measures? Thank you.

Operator: Your next question comes from somebody – your line is open. Speak up.

Allison Lee: Operator, if I could just jump in here, is it possible that we ask all of the participants to identify themselves and their organization when they get into queue.

Operator: Yes, most lines will be transcribed and I will introduce them.

Allison Lee: Thank you.

Operator: Your next caller is coming from a 513 area code, please identify your name and your organization, your line is open.

(Dan Kincaid): Hi, this is (Dan Kincaid), I'm with Technology Medical Partners. I just wanted to reiterate the need for year-over-year reporting to adjust for seasonalities. Also, with respect to new measures, particularly for using core measures, obviously there needs to be a built-in lead time to measure the baseline period for that particular core measure and then implementation of that core measure's performance rating the following year, so that each facility has a unique score from which to start with to measure improvement. Thank you.

Operator: Your next question or comment comes from the line of somebody from the 660 area code, please identify your name and your organization, your line is open.

Again, you're from a 660 area code, your line is open.

(Jackie Christensen): Hello?

Operator: We can hear you.

(Jackie Christensen): OK, I'm sorry, this is (Jackie Christensen) from Western Missouri Medical Center and so far every one of my ideas have already been spoken. We just can't stress enough that hospitals need to have a good lead time in order to get their own, improve their processes going before any kind of reporting goes on. That's it, thank you.

Allison Lee: Operator, can we also ask everyone to be sure that their phones are on mute because we're getting so much background noise?

Operator: Yes, definitely. Your next question comes from the line of (Linda Sweeney) with Massachusetts General Hospital. Your line is open.

(Linda Sweeney): Thank you. I would just like to reiterate that I agree with the previous speakers that I think we need annual time periods for scoring.

Operator: Your next question comes from the line of Linda Brazell with Ferrell Hospital. Your line is open.

Linda Brazell: Yes, I'm Linda Brazell. I'm the Vice President of Nursing and Quality at a critical access hospital in southern Illinois. Our biggest concern on that would be how is that going to compare with the electronic health record with all the improvements that we'll be doing as well coming up in the next few years, the comparable time periods to report such as maybe six months as opposed to a whole year of information, maybe for the first six months instead of the whole year, so I would also want to know how we're going to try to tie that in with our quality that we do internally as well as was mentioned earlier, the quality of core measures as well. Thank you.

Operator: Your next question comes from the line of Jessica Walker with Gallup organization, your line is open.

Jessica Walker: Great, thank you very much. Just also operator, if we could have the instructions to withdraw a question if need be as well afterwards, that'd be great. My comment would be that we would endorse based on industry standards and performance feedback that we use with clients to at least, as other callers mentioned, have an appropriate baseline period of one year as well as an established period of reporting for a minimum of a year.

Therefore, we would endorse a measure that would allow facilities to have a full year of reporting whether it be for clinicals and/or HCAHPS items, that they would have a baseline period that they can prepare against another year performance. Therefore, having enough time to adjust performance and measure improvement over time so truly a baseline of a year and a performance period of a year. Thank you.

Operator: Your next question comes from a participant from a 520 area code, please give your first and last name and your organization and if you would like to withdraw your question at any time, please press the pound key. Your line is open.

Kathy Goff: Hello, my name is Kathy Goff, I am the Director for Quality and Outcomes Management at University Medical Center. We would just like to add to what has been said already that we support, that we would also like something within the guidelines that if you fall out on, for a period of time that there is something within that that allows you to correct, to make an action plan and correct it prior to being penalized. So that we need something that, when we know that we've been a high quality performing hospital and we are meeting the pay for performance expectations that if you fall out for a short period of time, that you have an opportunity to correct that and bring it up without being penalized. Thank you.

Operator: Your next question comes from the line of a caller from an 803 area code, please advise your name and your organization. Your line is open.

Barney Osborne: This is Barney Osborne with South Carolina Hospital Association. Can you hear me, just to make sure?

Operator: Yes we can.

Barney Osborne: Oh, OK, thank you very much. We would, again, like to agree with most of the speakers that the acceptable time period is not what's proposed right now with the baseline and the measurement data beginning April 1, 2010. Obviously it's too late to make any adjustments to that. We would also like to reiterate the fact that there needs to be a time period to allow hospitals, and states for that matter, to accumulate comparative data before there is real enforcement.

For example, the new measurements added would be 2011 IPPS proposed rule. We are trying to provide information and comparative data to our members while none of this data has been accumulated to date. If indeed the measurements and adjustments had started with the 2011 cost report period, we would really have no information to compare to until after the fact, which we, comparing and real-time adjustment is vitally important. We put together worksheets for our members and are sharing with members from some other states that attempt to compare real-time data while the data is still actionable for the hospital so number one, we know what to expect, whether we will keep our one, two percent coming into the cost report period for obvious budgeting and costing purposes. Also for productivity measurement, improvement measurement, all around quality action measurements on this data and we would ask CMS to consider some beta groups where you would provide that information on a test basis, real-time or perhaps quarterly, with hospitals' signed releases. Thanks.

Operator: So, again, if you would like to make a comment or ask a question, please press star then the number one on your telephone keypad. If you would like to withdraw that comment, please press the pound key.

Your next question comes from the line of Beth Feldpush with American Health. Your line is open.



Beth Feldpush: Hi, this is Beth Feldpush with the American Hospital Association. In addition to agreeing with most of the comments that have been said already, I just also wanted to note that should CMS decide or be under time constraints so that the only option for time periods would have the baseline period already starting at this point, or starting before a rule comes out, we would just ask that for any hospitals that do not have data in the baseline period because they were not already participating in the hospital inpatient quality reporting program, that those hospitals be simply omitted from the value-based purchasing program in the first year.

No money would be withheld for those hospitals because they wouldn't be able to earn any money back since they didn't have baseline scores so we would hope that no hospitals would be doubly penalized for not participating in the pay for reporting program and then therefore not having data to be able to participate in VBP. So just exclude those hospitals for the first year. Thank you.

Operator: There are no further questions in the queue at this time. Please continue with your next question.

Barbara Cebuhar: Allison?

Allison Lee: Yes, I'm sorry.

Barbara Cebuhar: Your next question?

Allison Lee: Oh, OK, thank you. The next question is what type of performance scoring methodology should CMS implement to have an immediate and significant impact on hospital performance that improves quality of care received by patients and how should the performance score determine the payment incentive? Thank you.

Operator: If you would like to have your line open, please press star then the number one on your telephone keypad. Again, if you would like to withdraw your question, press the pound key. We'll pause for a moment to compile the roster.

Your first and only question comes from the line from an 803 area code.  
Please state your name and your organization. Your line is open.

Barney Osborne: Hi, this is Barney Osborne again from South Carolina Hospital Association. Our suggestion regarding immediate impact would be to allow hospitals, again, to plan for changes, but in doing so, we would ask that CMS release, as soon as possible, information on potential gains from the program based on the, both the Senate and the CMS version, of the proposal. The information stops with gaining back 100 percent of your set aside amount. We would be interested in knowing if there are indeed increases above the 100 percent in the form of bonuses to hospitals that report superior quality results. Thank you.

Operator: Again, if you would like to make a comment, please press star then the number one on your telephone keypad.

Your next question comes from a 253 area code. Please state your name as well as your organization. Your line is open.

Tony Haftel: This is Dr. Tony Haftel, Associate Chief Medical Officer for Franciscan Health System. If CMS is serious about true process improvement in inpatient hospital units, the proposal of formulas for scoring against median and top percentiles for the country, this is essentially marking on the curve and it guarantees that even if everyone improves significantly, there will be winners and losers. If absolute targets are the key and not percentile based, true improvement would be rewarded. Otherwise, the cynical response will inevitably be that this is a takeaway program masquerading as a quality initiative.

Operator: Your next question comes from the line of Christine with Premier Health Alliance. Your line is open.

Christine with Premier Healthcare Alliance, your line is open.

Christine Van Dusen: I'm sorry, I had my phone on mute. This is Christine Van Dusen with Premier Healthcare Alliance and in regards to the performance scoring methodology, we have noted that the ACA requires that hospital's

performance be assessed based on a single composite measure and to implement this requirement, we recommend that CMS calculate a separate composite score for each specific patient condition such as the heart attack, heart failure, pneumonia or the surgical infection care improvement measure and that these separate condition scores be combined into an overall composite score based on a case weighted average using the number of cases in each condition. Also, the ACA requires that both performance and attainment be considered in determining a hospital's performance score. We recommend that each hospital's performance score be determined by whichever yields the higher value whether it be the performance or the attainment. Thank you.

Operator: Your next question or comment comes from the line of (inaudible) with Good Samaritan Hospital. Your line is open.

Female: Yes, I was wondering if the CMS person could repeat the question please because it was in two parts and it's difficult to capture all that at once.

Allison Lee: Yes, I'd be happy to do that. What type of performance scoring methodology should CMS implement to have an immediate and significant impact on hospital performance that improves quality of care received by patients and then the second part is how should the performance score determine the payment incentive? Additionally, these questions are included in the invitation that was sent out. Thank you.

Operator: Again, if you'd like to make a comment, please press star then the number one on your telephone keypad and if you would like to withdraw that, please press the pound key.

Your next question comes from the line of (Lucy Luckoff) with University of Massachusetts. Your line is open.

(Luck Luckoff): Hi, this is (Lucy). I have two points to make on that question. There was actually a (inaudible) health initiative that took into consideration both the performance score and an improvement score that might make sense if you want to actually reward improvement. So if there's a baseline established in

one, the first year, then the second year based on the amount of improvement that was done, you get a certain number of points for that. That's an idea.

You either get a certain maximum point score for performance or improvement, one or the other. The other question was if the scoring is all relative and there will be, have to be losers, is there's a measure where we're all performing at 99 percent and then there's a group that's at 100, doesn't it make sense that even the 99 percent performance deserves some sort of reward? It seems like not everybody can score 100 percent all the time and if you're that little under the highest possible score, you should still get some sort of reward.

Operator: Your next question comes from the line of (Maria Grey) with (inaudible) Healthcare Systems. Your line is open.

(Maria Grey): Thank you, this is (Maria). Actually, I concur with what (Lucy) said from UMass. Seeing as we're from Massachusetts, we're both used to the Medicaid program and it is to establish two sets of criterion for meeting the threshold. One is based on achieving score as it relates to benchmark, but the other is performance involved so that actually we'd have to wait two years to do that but for the second year, for those hospitals who actually improve, they could also have an attainment score so that they could get incentive money.

My other concern is regarding threshold of cases in order to meet criteria for incentive payment. Some organizations will have cases as low as 20 or 30, some will have over 100. That really needs to be risk adjusted so that all organizations have opportunity to make these incentive payments. Thank you.

Operator: Your next question comes from the line of Larry Mandelkehr of the University of North Carolina Hospital. Your line is open.

Larry Mandelkehr: Thank you. I just wanted to agree and add on to a couple of the previous callers regarding having both relative and absolute scores. I agree that those hospitals that score better should be in a situation to receive more of their money back. I would recommend that we establish targets or minimum attainable values such that any hospital that reaches a particular level of performance should not be penalized irregardless of where they fall on a

relative basis and conversely in a situation where fewer than the desired number of hospitals meet that target then there is money left over. That provides an opportunity for everyone to win and not be penalized even if those hospitals do very well. Thank you.

Operator: Your next question or comment comes from the line of Martha Radford with NYU Langone Medical Center. Your line is open.

Martha Radford: Thank you. I just want to support the comment earlier about 99 percent versus 100 percent in that the people that are at 99 percent often are uncovering problems with the measures more than they are problems with the quality so I think it's important to acknowledge that the measures themselves are not perfect and therefore attainment of 100 percent may or may not be advisable. Thank you.

Operator: Your next question comes from the line of Dee Rogers, I'm sorry with (Jeremy Springsteen) with Denver Health. Your line is open.

(Jeremy Springsteen): Yes, I'd just like to reiterate what was said earlier regarding risk adjusted measures need to be used so that hospital, trauma hospitals that kind of take the worst of the worst cases aren't penalized for caring for the worst cases. Thank you.

Operator: Your next question or comment comes from the line of Dee Rogers with Magnolia Regional Medical Center. Your line is open.

Dee Rogers: I wanted to agree with the UMass group. We, in Arkansas, are also participating in the Medicaid incentive program and if you list the baseline, for instance ours was the state 75th percentile or 35 percent reduction in failure rate compared to what your previous performance was, then you are in the green for your incentive payment. I also agree with the weighted or risk adjusted because of the small facility, I mainly have one surgical case per quarter so zero out of one is zero percent and I would appreciate the recognition of risk adjustment. Thank you.

Operator: Your next question comes from the line of (Carol Mullin) with Virtuous Health. Your line is open.

(Carol Mullin): Thank you. We'd also concur with the comments from University of Massachusetts about absolute and improvement goals. I think we, when CMS finalizes which goals to select, you have to go back to that triple aim and pick a quality goal, pick a population goal and then a cost goal. Our concern about using the core measures, and I think one of the other commenters mentioned it, pretty much on most of those metrics, there are many people very close to 99 and 100 percent and I think it's going to be hard for CMS to differentiate for value-based payment on those. However, the benefit is there is a validation process, although not statistically valid, there is a validation process for that. If we look at something like surgical site infection, now that everybody's going to have to report through NHSN, there is no validation process for that data input and we would have concern about that. For population goal, we might, and this is a core measure goal, looking at pneumonia and flu vaccination rates, that would be one goal you can look at as truly elevating health, population health in an area. I think that's it, but thank you very much for the opportunity to comment and to send e-mails after this conference call.

Operator: Your next question comes from the line of Pam Nickolenko with Orlando Health. Your line is open.

Pam Nickolenko: Thank you for this opportunity. I also ask that you please go ahead and consider an adjustment based hospital size because currently the way the information has been published, the smaller, less than 100 bed hospitals are the ones that are performing better, but when you compare to other hospitals of equal size, you see that it, right now it's skewed toward the little hospitals, but larger hospitals actually perform very similarly so in addition to an adjustment for trauma centers, also consider an adjustment for size of hospitals. Thank you.

Operator: Your next comment comes from the line of Michael Nix with Fletcher Allen. Your line is open.

Michael Nix: Good afternoon. We'd like to support the comments made by UMass and UNC about the absolutes and relative movement characteristics of the

measure and we'd also like to strongly support the positions taken by Denver Health and some of the other medical centers about the critical nature of risk adjustment being built in so that the (inaudible) and (inaudible) care settings would have a mechanism to respond to differing patient levels and populations and the third point is the point made by NYU Medical Center about at high levels of performance, often times the issues do center around specific aspects of the measures themselves and problems with the measures so Dr. Radford's point is very well taken. Once you reach very close to 100 percent, often times the issues are the measures themselves, not the performance. Thank you.

Operator: Your next comment or question comes from the line of Mark Currier with Curbside Hospitality. Your line is open.

Mark Currier: Hi, my name is Mark Currier with Curbside Hospitality. In these measures, I was looking to see if there would be any differentiation between clinical outcomes and non-clinical outcomes, the impact of customer service and ancillary services in those metrics. I think that's very important in the end. Thank you.

Operator: Your next comment comes from the line of Barney Osborne with South Carolina Hospital. Your line is open.

Barney Osborne: Thank you very much. Another comment if I may, we would request that the new model be released prior to its inclusion in the IPPS proposed rule to allow hospitals, again, more adequate time to review the necessary calculations and what will be necessary for the hospitals' part, rather than the short period from the IPPS comment period. We'd also like to ask that you include American Hospital Association and perhaps selected hospitals in the development of the plan and the development of the calculations.

We would like to support the concept that has been mentioned a couple of times that there be baseline goals applied with no penalties once you reach those goals, particularly since we have not been privy to what will be some of the new measures. We will be targeting ourselves against history that some of us may not even be aware of. We would particularly like information for the

small hospitals and, in particular, critical access hospitals, most of which have never been required to report before and we would like new measures allowed to them, at least one year prior to their inception and the program to allow them to accumulate their own data and compare to themselves. Thank you.

Barbara Cebuhar: (Andrea), if we could take the next question from Allison, that would be very helpful. Thank you.

Operator: Yes, I will clear the queue.

Allison Lee: OK, thank you and I think that several commenters have addressed this question related to measures. However, the question is, what measures from the current hospital inpatient quality reporting program, which was formally known as the RHQDAPU program measure set, and measures are required to come from this measure set, which measures should be selected for the hospital VBP program to drive quality improvement and why?

Secondly, which measures are most important and how should they be weighted?

Operator: If you would like to make a question, make a comment or have a question, please press star then the number one on your telephone keypad and if you would like to withdraw your question, please press the pound key.

Your first question comes from a caller from area code 520. Please state your name and your organization. Your line is open.

Vicky Mahn-DiNicola: Hi, my name is Vicky Mahn-DiNicola and I'm from ACS MIDAS+. I believe that the individual measures that are used to compile the more global composite scores should be based on those measures that are in alignment with the joint commission concept of accountability of care and where there's a very strong evidence based link that has been established between process and outcome. Additionally, the measures that are currently compiled by CMS from Medicare claims data such as the hospital acquired complications or the AHRQ measures, I would recommend that they should not be used for value-based purchasing because these measures don't appear



to be reliably recalculated or replicated or even validated by the hospitals themselves, particularly since very often the technical specifications, particularly for AHRQ measures, are quite complex and the exact process for how CMS calculates these measures tends to be somewhat obscure. Thank you.

Operator: Your next question comes from the line of Donald Casey with Atlantic Health in Morristown, New Jersey. Your line is open.

Donald Casey: Good afternoon, can you hear me OK?

Operator: Yes.

Donald Casey: Good. So I wanted to, before I get to my comment, say that I totally agree with Vicky Mahn, the previous speaker and agree with that. Let me set forward four points about this bullet. The first is that because of the burden of data collection, I believe that the measures that either are within the current meaningful use criteria or lend themselves to rapid implementation in that iteration or the next iteration of meaningful use would be a very important criterion for this measure set to reduce dramatically, hopefully, the burden of data collection on the hospitals of which we spend a lot of time, effort and money.

The second is that I think we should look at the few measures within the larger measure set that have the largest gap on a national basis in terms of performance, not just those that are at a high level between, as the previous speakers' discussed the 95 to 100 percent range. The third is that there needs to be a clear set of evidence based interventions that are available to all as to how to improve and improve rapidly. While I think that sometimes we talk about process interventions, I don't think we talk about outcome intervention.

Then the fourth, which I think is the most important is that I don't think CMS has actually formally evaluated the quality of evidence related to the specific impact of individual measures. There's been a lot published on them and as you can recall the data on the evidence in terms of impact is highly variable within the existing measure set and within existing composites. There has been no formalized evaluation process of the quality of evidence vis-à-vis

what the Institute of Medicine will look at next year. I believe that we ought to have an explicit evaluation showing those measures that have the highest quality of evidence impact and then focus on them. Thank you.

Operator: Your next question or comment comes from the line of (Steve) (inaudible) with Catholic Health. Your line is open.

(Steve): Yes, I'd actually like to concur with the comment that Dr. Casey made regarding meaningful use. Value-based purchasing, as it's shaping out, looks like it's going to be a manual data extraction paper chase and the cost of that just doesn't justify the impact it's going to have on improving the health of people in our communities. It'd really be nice if value-based purchasing, as opposed to CMS, would walk across the hall and (inaudible).

I do want to question, disagree with one of the commenters who disparaged the administrative data that is currently being used. In the absence of better data, I believe that the administrative data piece that CMS receives to capture hospital acquired conditions and other measures of patient harm are acceptable. I think it's the burden of the hospital to insure that they're accurate and I believe that the office of inspector general can handle failures accurately or fraudulently report data and those are my two comments. Thank you.

Operator: Your next question or comment comes from the line of (Becky Christensen) with Western Missouri Medical Center. Your line is open.

(Becky Christensen): Hello again. My comment kind of pales, I think, in comparison to these others, but I'm reading this literally and it's asking what measures should be selected. I'm asking though that one measure in particular not be selected and that would be the heart failure discharge teaching. As it's written right now, it's very cumbersome and it's very hard to get all of the medication in the way that the spec manual wants it to be done and again, like the caller said before, it's a paper chase and it's very hard to, if you miss one medicine, then the whole sets gone and that accounts for a quarter of your scoring so I would respectfully ask that that be either completely retooled or thrown out

altogether for this value-based purchasing. It does not really show a whole lot to me of quality of care. Thank you.

Operator: Your next question or comment comes from the line of Jessica Walker with the Gallup Organization. Your line is open.

Jessica Walker: Great, thank you very much. Beyond the clinical measures, we would endorse the inclusion of the HCAHPS measures and also when we talk about it from a perspective of weighting, we would ask that CMS examine the weights applied to the individual domains within the HCAHPS measures for the scoring model specifically looking at measures such as cleanliness of hospital environment, quietness of hospital environment and discharge information. They should be weighted down to their overall impact as it relates to the quality performance of the service performance. CMS could examine the correlations related to outcome as expected by the patient experience. So the domains included, however, some weighting applied as it relates to correlation. Thank you.

Operator: Your next question or comment comes from the line of Michael Nix with Fletcher Allen. Your line is open.

Michael Nix: Yes, Fletcher Allen would like to strongly suggest that there is a need to align the various measures between the value-based program and meaningful use and our suggestion is specifically that CMS align uniformly all of the various measures in these reporting programs that are currently now being done somewhat independently and particularly in terms of this program aligning it with meaningful use of the, at the onset. Thank you.

Operator: Your next question or comment comes from the line of Tanya Alteras with National Partnership of Women and Families. Your line is open.

Tanya Alteras: I agree with the two previous callers including HCAHPS in the set of measures and also aligning the measures in this program with meaningful use as well as across other hospital pay for reporting programs. In addition, we feel that for AMI, heart failure and pneumonia, we think CMS should choose outcome measures related to mortality, hospital acquired conditions, surgical and medical healthcare acquired conditions, IC mortality and readmissions

rather than focusing on process measures that provide incomplete and less than meaningful information on the overall quality of care provided.

That information is just not as meaningful to consumers as (inaudible). We also would like to see some time in the future measures on costs and resource use, overuse and we think that the measures should address the entire population and be populated with all of the (inaudible) data rather than just Medicare data. We think that the alignment of incentives to provide high quality care across the public and private sector pairs should be very deeply ingrained in this program. Thank you.

Operator: Your next question or comment comes from the line of Dr. Glenn Mitchell with Sisters of Mercy Healthcare Systems. Your line is open.

Glenn Mitchell: Good afternoon. I'd like to agree and then build on the comments of those who have preceded me in terms of talking about the alignment of the metrics we're using. I would like to suggest that Dr. Berwick and CMS take this opportunity for leadership to host a collaborative effort to align measures across federal and perhaps even state metrics to include the operational definitions of those metrics as much as possible and to work towards measures that can be directly extracted from EHRs as they proliferate across our system. We cannot continue to manually collect so many metrics with varying definitions and still realistically try to significantly reduce our healthcare costs across the country. Thank you again for the opportunity to comment.

Operator: Your last question in queue at this time comes from the line of Beth Feldpush with American Health. Your line is open.

Beth Feldpush: Thank you, this is Beth Feldpush with the American Hospital Association. In looking at which measures to include, we would suggest that CMS consider a framework for really assessing the quality of quality measures that has been put forward by the joint commission recently. The joint commission refers to this framework as accountability measures and they are measures that really look at a tight link to outcomes, a real captioning of evidence based care processes and measures that have a lack of unintended consequences by

providers following them. We suggest that that framework might be a good one to look at.

Typically we talk about topped out measures and measures that have very high scores and there is often a discussion that those types of measures should be excluded from the value-based purchasing program. In thinking more about the quality of the quality measures, I don't think that necessarily topped out measures should be excluded. Measures should be evaluated based on their merits of quality measure rather than necessarily on provider scores. as opposed to the, in reference to the weighting, we think that measures assessing the process of care should be weighted more highly than patient experience with care measures or outcome measures, particularly for the outcome measures. I think there are outstanding questions now on the measure methodology with regards to the measures ability to accurately assess differences among hospitals by thoroughly risk adjusting for different patient populations.

Finally, the last thing to note is that we know from, particularly the process measures that reaching 100 percent of performance probably isn't appropriate for many of these measures. It just wouldn't (inaudible) all patients for that population so as CMS is developing the curve in the performance attribution model, we would suggest that that curve should be flatter near the top and that perhaps there should be some benchmark at some high level of performance but not 100 percent above which any hospital would be able to get the full amount of VBP points for that measure. Thank you.

Operator: Your next question or comment comes from the 253 area code. Please state your name and your organization. Your line is open.

Tony Haftel: This is Dr. Haftel again from Franciscan Health Systems. I'd like to differ on the opinion that HPACPS should be included in the calculation for value-based purchasing in that patient satisfaction scores are extremely subjective and have, carry a large degree of bias generally due to cultural, socioeconomic, age, geographical acuity issues and also hospitals pay the price already for poor satisfaction when patients walk away. I don't think it needs to be included in value-based purchasing.

Barbara Cebuhar: (Andrea), we probably need to get to the next question. Thank you.

Operator: You're welcome.

Allison Lee: OK, thank you. The next questions is the legislation requires the inclusion of a Medicare spending per beneficiary efficiency measure adjusted for age, sex, race, severity of illness and other factors. How should this be measured and how should risk adjustment be applied within efficiency measure?

Operator: If you'd like to make a comment, please press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. We'll pause for a moment to compile the results.

Your first question comes from the line of (Mary Locke) from St. Mary's. Your line is open.

(Sherry Locke): Yes, my name is (Sherry Locke). I'm from a critical access hospital in Nebraska. Related to all of the conversations, I have concerns about the small rural critical access hospital and the, in the ability for them to be able to be successful and once this is rolled out, how many of those will potentially close and what will that do to access of care issues for rural people and what kind of burden will that place on the tertiary hospitals at that point. Thank you.

Operator: Again, if you'd like to make a comment, please press star then the number one on your telephone keypad.

No one else is queued up for this question.

I'm sorry, there is one more question from the line of Michael Nix with Fletcher Allen. Your line is open.

Michael Nix: Yes, we'd like to recommend that as a minimum, not necessarily the ideal, but as a minimum, that there be a factor of using the relative resource consumption, relative weights applied to any of these efficiency measures associated with spending, particularly in terms of tertiary care and more complex settings, but we would also like to see on top of the basic weighting

factor, risk adjustment due to variability of outcomes also be examined.  
Thank you.

Operator: There are no further comments or questions at this time.

Allison Lee: OK, the next question is the legislation calls for the secretary to use the Hospital Compare website to include information that is useful to consumers and providers. What information should be included on the website that's not currently and what performance data will be most useful to consumers and providers? Additionally, are there improvements that should be made to the website to improve its usability?

Operator: If you would like to ask a question or make a comment, please press star then the number one on your telephone keypad and if you would like to withdraw your question, press the pound key.

Your first question comes from the line of somebody from a 202 area code.  
Please state your name and your organization. Your line is open.

Leah Binder: This is Leah Binder from the Leapfrog Group. we would recommend that the Hospital Compare website show more variation among hospitals in their performance and include much more robust information about cost effectiveness and efficiency data as well as certainly outcome measures, which we think need to be far more well represented on the site. We represent purchasers of healthcare and they are very, hold as a very high priority outcome measures and efficiency measures and want their employees to use that information to make good decisions about their healthcare. That's a very high priority and as we consider value-based purchasing, I think it is essential that CMS is aligned with what the private sector is already doing with value-based purchasing. I think that will not only make it a more effective program overall, but also assure that employers are fully engaged in the healthcare system, which is going to be essential to the future of the reform effort.  
Thank you.

Operator: Your next question or comment comes from the line of Tanya Alteras from National Partnership for Women and Families. Your line is open.

Tanya Alteras: Thank you. We support the current efforts of CMS to improve data display of measures that are part of what was formerly known as RHQDAPU and the pay for reporting in the outpatient setting, the (inaudible) program, and we'd like to see these types of activities be ongoing and applied to measures that are used in the hospital VBP program as well. We think that hospital ratings for public reporting displays should be determined separately from how the scoring is developed for performance based payment since payment is intended to affect provider behavior and not consumer behavior and requires more precise estimates of performance and we feel the consumers have a higher tolerance for uncertainty in provider ratings and they don't want to see hospitals labeled as superior or good.

They need more variation as the previous caller Leah just mentioned. We'd like to see more distinction in how hospitals are, how their ratings are displayed. We would like to see hospital performance be reported by individual hospitals and we understand this is an issue when multiple hospitals in a community have a common ownership and operate under a single license and report to Medicare as a single entity. We understand the data collection issues inherent in that, but we still think it's important for consumers to be able to see data and be able to view information on individual hospitals.

We think the display of outcome measures that utilize risk adjustment methods should be presented in a way that shows meaningful differences in provider performance, again echoing Leah Binder's comment on variation rather than putting almost all the providers in the no different from national average category. Finally, we are very supportive of the language in the Affordable Care Act that would allow for Hospital Compare to report not only performance data, but also an aggregate of which hospitals receive payments for high performance or for attainment and which hospitals lost payment for poor performance. We think that that would be very meaningful for consumers to have that information. Thank you.

Operator: Your next question or comment comes from the line of Jessica Walker with the Gallup Organization. Your line is open.



Jessica Walker: Thank you very much. I don't know if it's me or if it's all of us, but I'm hearing a beeping in the background during the speakers. I don't know if it has something to do with the operator line or what not, just a comment. Based on this issue, based on consumer feedback and public response, we would endorse the inclusion of a single measure or single rating that allows consumers to more easily note performance of hospitals. We've heard from consumers that there is a great deal of confusion around what measures they look at.

The clinical process of care measures don't mean as much to them and they may not understand how it all rolls up to some sort of a single measure of performance and/or including a national ranking of some sort is something that consumers respond to. They want to know how does their local facility compare to others within the state, but more importantly, even nationally. So we'd also like to echo the comment of the ability to show linkages of what physical locations roll up to public reporting. We realize again, as the previous caller mentioned, the challenge of that is a critical feedback item for the public to understand where the data comes from. Thank you.

Operator: Your next question or comment comes from the line of (Maureen Velasquez). Please state your organization. Your line is open.

(Maureen Velasquez): Hi, this is to echo similarly Jessica Walker's comment previously, but here in North Carolina, we have data feedback from the North Carolina Hospital Association and then per measure, we have an optimal care score and so it creates a composite for the entire measure in a single number and kind of according to Jessica's point, it would be more revealing to have a single number per measure population versus individual measure scores on Hospital Compare site. My other comment is it'd be helpful to know how many years an organization has participated in the quality measurement. As you mentioned across the comments, some hospitals will just begin to be reporting in this effort and so that may give some insight into whether they're performing well or poorly if they're publicly reported before they have a chance to begin to bring scores up to expected levels. That's my comment, thank you very much.

Operator: Your next question or comment comes from the line of Dee Rogers with Magnolia Regional Medical Center. Your line is open.

Dee Rogers: I agree with the previous commentators about the scoring system and actually I'm kind of looking toward the joint commission's quality check performance scores where when you look on that and when I present it to the public in a board meeting, they see that gold star, that check, or they see that MIDAS mark, it makes them look a little closer. It gives them a little bit more meaningful information. Similar to how some of the nursing home facilities are scoring as a five star or two star rating so this might be a little bit easier for the general public to understand.

I also agree with the comments about the time of reporting and whether a hospital has been required to report prior to that as a basis as well. Hospital Compare is kind of difficult to navigate if you're not used to it. To be honest with you, when I say Hospital Compare, a lot of my consumers in this small rural area don't even know what Hospital Compare is. If the general public were more aware of what it is, they might be utilizing it more to choose their service areas and where they want to have their care. Thank you.

Operator: Your next comment or question comes from the line of Larry Mandelkehr with University of North Carolina Hospital. Your line is open.

Larry Mandelkehr: Thank you again for the opportunity to provide comment. I wanted to echo the comments from our colleagues from Duke. The North Carolina Public Safety and Quality website, in addition to having the single rate, also has individual dashboard for each hospital and it's a very easy way to quickly see all of the measures, both in aggregate as well as individually for a hospital. It'd be a great feature to add. I'd also recommend just from a usability perspective, if you'll go out and take a look at a lot of the other folks that are kind of pre-chewing and redisplaying data, folks like USA Today and others who have made very intuitive, easy to navigate websites and make it easy to come in and either start searching by hospital and then take a particular diagnosis or measure or come in and take a measurement and then take the hospitals you're looking at, but see what others have done. There's a lot of

good designs out there and I think having an easier to use website will provoke the use of it and folks will get a lot more value from it. Thank you.

Operator: Your next comment or question comes from the line of Barney Osborne with South Carolina Hospital Association. Your line is open.

Barney Osborne: Thank you again. I'd like to comment on the Medicare payment and volume data page on Hospital Compare. First of all, the comparative data is, primarily revolves on standardized volumes, wage index items like that that really do not mean that much to the patient directly. We would like to see the amounts included on this page targeted more so to the patient responsibility portion, a number they can actually use and understand versus the BRG reimbursement, which most people are not familiar with at all and we would like to see better explanation and better highlights that this is indeed Medicare payment versus hospital gross charges with the understanding that frequently this information is used more from the commercial and self-pay market than the actual Medicare patients themselves.

It makes it very difficult for the hospitals to explain that their charges may not be equal to the amounts that are displayed on [hospitalcompare.gov](http://hospitalcompare.gov). Obviously, with a contractual adjustment, the actual charges that the patient will receive on an invoice will be much higher frequently than the amount showed as the medium Medicare payment and it's very hard for the individual to understand that they are not being overcharged because the information they are comparing to on your website is not gross charges. Thank you very much.

Operator: Your next question in queue comes from the line of a caller from a 973 area code. Please state your name and your organization. Your line is open.

Don Casey: It might be me, can you hear me?

Operator: Yes sir.

Don Casey: It's Don Casey again, I apologize, I got disconnected before. My comment, and I have two comments, one is that I don't think looking at it right now in front of me, that it's as clear to the users about the timeframe of the results

vis-à-vis for example the HCAHPS data, which I think is one important factor here that needs to be addressed because of the time lag. The second thing is again related to my comment about the value-based purchasing program vis-à-vis making it clear, in a clearly understandable way, the quality of evidence behind some of the measures or all of the measures vis-à-vis their ability to have impact on mortality. There's a lot of variation between measures and as I said before, CMS has not done an evaluation of this nor have they tested consumers' ability to learn more about how to evaluate evidence behind measures. I just think that letting people know that certain measures have stronger evidence behind them in terms of impacting care would be a helpful improvement.

Operator: There are no further questions in queue at this time.

Allison Lee: The next question addresses unintended consequences. What are some of the unintended consequences that might result from implementing this hospital pay for performance program and how should CMS monitor the impact of the program on beneficiaries and the healthcare system?

Operator: If you would like to ask a question or make a comment, please press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key.

Your first question comes from the line of (Lori Baker) with Brookdale Medical Center. Your line is open.

(Lori Baker): Thank you, I wasn't answering correctly so I have one comment on the previous two questions. I believe that the outcome measures would be something the patients are more interested in as was mentioned before as far as on Hospital Compare. The problem with the outcome measure is that they have not really been validated yet and they're shown to be inaccurate in terms of what's actually found by chart review. It would be very helpful if reports could be prepared that gave us patient level information in our preview report so we could actually go in and look at these cases.

Also, if the formulas, whether it's the, even the SQL queries or whatever formulas would be used that we could get to our information system to get

these reports of these administrative outcome measures for ourselves so we could be proactive in seeing how our results are coming concurrently with what is going to be in the future outcome report. I'm talking about all the reports that are based on administrative data. So those were my previous comments. Thank you.

Operator: So again, if you'd like to make a question or have a comment, please press star then the number one on your telephone keypad.

Your next question comes from a 202 area code. Please state your name and your organization. Your line is open.

Leah Binder: Hi, this is Leah Binder from the Leapfrog Group. You asked about unintended consequences. I think one unintended consequence would come if CMS shies away from introducing outcome measures as core principals in their value-based purchasing program. One reason that there might be some shyness is that there are no perfect outcome measures that absolutely everyone agrees are 100 percent indicative of the actual performance of a provider. If we let the perfect substitute for the good, I think we will in fact not create a value-based purchasing program that in itself has enough teeth to make a real difference either for providers or for consumers.

Consumers will not get the information they need to be more active consumers of healthcare, which is really critical. We will not see the bending of the cost curve over time that is so important to sustaining our healthcare system overall. I think that the, CMS' ability to use a, to be forthright in advancing outcome measures even if they're imperfect, not saying that they should be extremely imperfect, but imperfect, but good enough outcome measures that enable consumers and purchasers to work alongside CMS to create an improved performance and cost effectiveness of our system. That's important and the unintended consequence would be, could be potentially quite dire if we actually don't do this the way it needs to be done. Thank you.

Operator: Your next question or comment comes from a 253 area code. Please state your name and your organization. Your line is open.

Tony Haftel: This is Dr. Haftel again from Franciscan Health System. This actually is an unintended consequence that I've been concerned about ever since we started tracking the kind of four major (inaudible) for clinical outcome measurements. That is we dedicate an awful lot of resource in terms of time, personnel, projects. We have teams all over the place looking at heart failure or heart attack, pneumonia, (inaudible) et cetera and at the same time, I think there's an inevitable walk away from things such as sepsis, COPD, CVA, blood utilization, other major surgical endeavors that, and with the lack of really hard core evidence based improvements in, across the board, even in the ones that we work on right now, it just makes you wonder if we have, if we're targeting correctly. I would say, I would like to see some more endeavors and projects, as a director, at those other major clinical entities.

Operator: Your next question comes from the line of Larry Mandelkehr with University of North Carolina Hospital. Your line is open.

Larry Mandelkehr: Thank you, just to build on the comments of the previous speaker. There is going to be an unintended consequence of folks basically chasing the money. Depending on wherever you put the focus, look for as much as possible with the evidence more broad-based metrics and/or those serving larger patient populations, it also provides the opportunity for us to engage more people in the process of improving care and seeing our successes publicly reported. The more patient populations that are represented, the more that we'll be able to engage physicians, all caregivers and all other staff. Thank you.

Operator: Your next question or comment comes from the line of (Steven) (inaudible) with Catholic Health Partners. Your line is open.

Mr. (inaudible), your line is open.

(Steven): Hi, it's (Steven) (inaudible) from Catholic Health Partners. I think in reviewing the potential unintended consequences of value-based purchasing, I think there's a couple of things that should ...

Barbara Cebuhar: I think he must have dropped off.

Operator: He's still in queue, are you still there Mr. (inaudible)?

No, he dropped out of the call.

Your next question comes from the line of a 973 area code. Please state your name and your organization. Your line is open.

Don Casey: Hi, this is Don Casey, it might be me again, I think. The, I think there are two major unintended consequences that I worry about. The first is that we're measuring care in an episode generally, generally for hospitalization and my concern is that now we're creating silos across which we're measuring at a patient level that may not have as the most important episode of care the hospitalization. For example, I believe that there are a large number of infections that are present on admission at the time of hospitalization that don't get looked at and that we need to figure out a way to evaluate and work together with, for example, long-term care facilities on preventing.

This notion of partitioning episodes of care across different sort of domains of healthcare is going to create this continued partition of worrying about patient level problems that I think are across multiple organizations. Another example is patients transferred from one hospital to another with ST elevation MI and this business of attribution and who's responsible, I think that the measurement at a hospital level again creates this consequence of people not necessarily being accountable to the patient as opposed to the organization. I think that on the other side of what the first speaker mentioned, one of the unintended consequence is to give people the false impression that some of these measures that have poor quality of evidence actually can discriminate quality. I think we just have to be continuously mindful of that issue too. Thanks.

Operator: Your next comment or question comes from the line of Jessica Walker with the Gallup Organization. Your line is open.

Jessica Walker: Great, thank you very much. Two comments of just intended consequences, first I'd like to urge CMS as much as possible to release to facilities in advance. I know the proposal is 60 days in advance. Facilities would receive a notification of potential losses based on performance. We would argue that

even prior to that, if there could be some sort of advance warning system or other ongoing tracking on QNET or other forms that give administrators of hospitals heads up as far as what current performance means as far as subsequent losses. The unintended consequences of waiting until 60 days that could create kneejerk reactions based on losses or again, not giving enough financial planning for the organizations that may suffer the most severe losses. We would urge as much as possible advance reporting, heads up, however you may call that to prevent those unintended consequences.

Secondly, the other item just to mention is that CMS may need to look at ongoing patient treatment based on payer and if there are differences between how, based on the payer mix or the payer type that the patient presents with. As many of these measures are Medicare specific patient measures, we'd encourage as much as possible to continue the inclusion of all patient populations or other examinations that there is not differentiation between types of payer even on patient experience for their age cat. Thank you.

Operator: Your next question or comment comes from the line of (Steven) (inaudible) with Catholic Health Partners. Your line is open.

(Steven): Yes, I wanted to say that reacting to unintended consequences, Medicare will need to be very nimble, much more nimble than has been the case during the public reporting initiative of polling measures out of the mix when the evidence based becomes unstable or starts to shift and we can look at the examples like timing of pneumonia antibiotics, (inaudible) as examples of where we have really allowed unintended consequences to continue when the evidence suggests that measures were potentially causing some harm because of attempts to drive towards 100 percent whenever possible.

The flipside is I think we have to balance unintended consequences of value-based purchasing against the unintended consequences of a procedure based pay for procedure reward system that we currently have and I think we should give CMS a tremendous amount of latitude to get this, to work on this, develop this because the current process has its own unintended consequences which are far worse than anything we've seen with public reporting on the value-based purchasing pilot. Thank you.



Operator: Your next question comes from the line of (Jeremy Springsteen) with Denver Health. Your line is open.

(Jeremy Springsteen): Hi, we just wanted to comment on one potential unintended consequence and that's that hospitals might be negatively impacted based on factors that are out of their control. Factors that are patient responsibilities like for example if your hospital sees a high volume of homeless patients, a hospital's performance scoring may be negatively impacted based on patients not taking their medication, not getting appropriate follow-up care and things of that nature. Thank you.

Operator: There are no further questioners in the queue at this time.

Allison Lee: Thank you. The next question is what validation processes should be included in the hospital value-based purchasing program and I know there have been several comments made alluding to this.

Operator: If you would like to ask a question or make a comment, please press star then the number one on your telephone keypad and again, press the pound key if you would like to withdraw your question. We'll pause for a moment to compile the roster.

Your first question comes from the line of Michael Nix with Fletcher Allen Healthcare (inaudible) Virginia. Your line is open.

Michael Nix: Good afternoon. By the way, it's Vermont. The validation requirements, we are proposing that CMS look at a periodic feedback mechanism for all of the selected measures similar to what is done currently on QNET where each quarter we get both a summary of the results as well as the ability to download case level detail, particularly in a standard data transfer format, not PDF files, but in electronic form for combination in with other data for validation. We'd also like to propose that as an integral part of this periodic feedback mechanism, that there be streamlined mechanisms for essentially updates and error corrections through the CMS data sources prior to the finalization of data for reporting and we would recommend localized entities like the QIOs as opposed to a national entity for compilation of data.

The data could be compiled nationally, but the servicing should be more local like at the QIO level. We'd also like to recommend that prior to final publication or release of the data that the aggregate results be released to the hospital a minimum of 60 days prior to, to allow for validation and any correction updates that occurred periodically have actually flowed. This has been a problem in the past with CMS data warehouses not being updated so we'd like that 60 day final review process. As an overriding characteristic, we're recommending that data quality be a core requirement in terms of the whole design of the validation and appeals process, which is the next question. Be focused on data quality to improve the validity both in terms of interpretation and presentation to the public. Thank you.

Operator: Your next question or comment comes from the line of Vicky Mahn. Please state your organization. Your line is open.

Vicky Mahn: Hi, I'm from ACS MIDAS+. I think validation is a significant concern of hospitals as well as vendors and my concern is that as we move towards meaningful use and as it very likely will be transitioning from the very labor intensive manually collected core measures toward the more automated collection of quality measures in meaningful use and that those programs will eventually, and probably rapidly, start to converge, that we recognize that first of all, these measures are being selected by CMR vendors using clinical point of care documentation and those systems currently have not lived in the world of quality performance of measurement and often times, or at least right now, perhaps lag the rigors that are required in the calculation of these very complex algorithms and (inaudible) statements that are inherent in the specification and more importantly, the meaningful use certification process for vendors that are going to be reporting the clinical quality measures currently lack a validation process that the software is actually compiling the results accurately.

For example, there's not a test file that vendors must test to similar to the way that we currently test with the joint commission or its validation process. So that we can insure that our, all of our software across multiple systems are computing accurate results, I believe without this, there could be significant

unintended, negative consequences on the whole value-based purchasing program unless a strong validation component is built into that process. While I believe it's an ideal vision, and is very much needed goal to get to automated reporting of quality measurement, I think we have to recognize and acknowledge there's a lot of learning ahead of us as a whole nation about the data flow between the clinical documentation systems and the whole world of quality measurement.

I would urge CMS to transition cautiously to the world of e-measures in their program for value-based purchasing until we fully understand this new world. Finally, I think that the measures that we use today, which are calculated from Medicare claims data, while they are theoretically non-biased, they can be problem prone because they, again, can't easily be validated by hospitals. We've seen this recently in the most recent round of data that was compiled by CMS for the AHRT measures where they suppressed the reporting of these due to probably several things, but one of them was a very simple technical problem where the ICD-9 present and absent on admission flag was incorrectly attributed to the ICD-9 diagnosis in the file.

As a result, CMS delayed the reporting of the AHRT measures and understandably so, but I want to echo (Steve) (inaudible) comment that CMS really, for this to be successful, needs to be more nimble. Beyond that, there's also issues of variation in coding defs and precision of the definition of what constitutes an inpatient population or even something as basic as elective admission status. Those kinds of inclusion criteria need to be well thought out and very explicit before we move into using these stats to value-based purchasing, I believe. Thank you.

Operator: There are no further questions on this comment in queue at this time.

Allison Lee: OK, and as the previous caller indicates, the next question relates to appeals. What appeals process should be included in the hospital value-based purchasing program? Thank you.

Operator: Again, if you would like to make a comment or ask a question, please press star then the number one on your telephone keypad. If you would like to

withdraw your question, press the pound key. We'll pause for a moment to compile the results.

Your first question comes from the line of Joanna Kim with American Hospital Association. Your line is open.

Joanna Kim: Hi, we think that it's vital to the VBP program that there be a well-run appeals process. We think that it should have clear and consistent processes with well communicated guidance as is the case now with the inpatient quality reporting program. Thanks.

Operator: So again, if you would like to make a comment or ask a question, please press star then the number one on your telephone keypad.

Your next question comes from the line of James Cole from the Virginia Hospital Center. Your line is open.

You may begin, your line is open.

Geri Bishop: Hi, I'm Geri Bishop. I'm the Associate Vice President for Quality Resource Management here at Virginia Hospital Center. I just wanted to confirm what other people have said both about the validation and the appeals process. I think with the new, looking at the new EMRs like the one caller spoke about, it is going to be a very different process for many of us to be able to collect much of this data and be able to look at this data and to validate it. I think with us going and losing to an electronic medical record that that needs to be taken into consideration in the future for reporting and as far as the appeals process. Thank you.

Operator: Your next question or comment comes from the line of Barney Osborne from South Carolina Hospital Center. Your line is open.

Barney Osborne: Thank you once again. We would request that you consider not publishing results under appeal until those appeals have been resolved and perhaps allowing hospitals a chance to comment or even protest if you do decide to publicly publish before the issues are resolved. We'd also like to request that when published, particularly for hospitals with insufficient data such as

smaller rules of critical access hospitals that you recognize that it is due to insufficient data versus the lack on the hospital's part to report the data. Thank you very much.

Operator: Your next question or comment comes from the line of Karen Zoeller with Louisiana Hospital Association. Your line is open.

Karen Zoeller: This is Karen Zoeller from the Hospital Association. We thoroughly agree with South Carolina. We would ask that if you do not publish while there is appeal in process that at least on the website you make note that there is an appeal in process so that any consumers who are looking at that website thoroughly understand that the data is under appeal and perhaps would eventually be corrected. Thank you.

Operator: Again, if you'd like to make a question, ask a question or make a comment, please press star than the number one on your telephone keypad.

No one else is queued up for this question.

Allison Lee: OK, thank you. The next question is what are important elements of a hospital value-based purchasing program demonstration program to test innovative methods of measuring and rewarding quality and efficiency in critical access hospitals and those hospitals with an insufficient number of cases or measures. There have been many comments related to concerns around this and we'd like your input on the key components of demonstration programs as we develop those.

Operator: If you would like to ask a question or make a comment, please press star then the number one on your telephone keypad. Again, if you would like to withdraw your question, press the pound key. We'll pause for a moment to compile the results.

Your first question comes from the 973 area code. Please state your name and your association. Your line is open.

Don Casey: Don Casey from Atlantic Health in Morristown, New Jersey. Knowing that critical access hospitals rely very much on their relationship with the hospitals

to which they transfer, I think that, again, measuring the accountability at the patient level in this process so it's not just within the critical access hospital would be a useful enhancement in terms of rewarding their ability to not only treat their own patients but also effectively and in a timely way triage their challenging patients to the referral centers.

Operator: Your next question or comment comes from the line of Joanna Kim with American Hospital Association. Your line is open.

Joanna Kim: Hi, we think the key to a successful demonstration program for the cause in the small hospitals is a lot of flexibility. They're not going to have the numbers for a lot of the measures that are currently in the RHQDAPU program so we would urge CMS to look at possibly different measures for them such as on transfers and stabilization. We also think that in this case it may be warranted to aggregate several years of data for these hospitals so that that can get their number of cases up and they can have larger numbers for some of the measures. Finally, we ask that CMS be as inclusive as possible and try and get as many hospitals as possible into these demonstrations. We know that these hospitals are really interested in joining the program in some capacity and would love that opportunity. Thanks.

Operator: Again, if you would like to make a comment, please press star then the number one on your telephone keypad.

There are no further comments at this time.

Allison Lee: OK, the final question for the forum is what other considerations are essential to address in the development and implementation of CMS' hospital value-based purchasing program. Thank you.

Operator: Again, if you'd like to ask a question or make a comment, please press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

Your next question comes from a 973 area code. Please state your name and your organization. Your line is open.

Don Casey: Don Casey again, Atlantic Health in Morristown, New Jersey. We're actually participating in the CMS physician hospital gain sharing program and achieving quite a bit of success and I think that one big disconnect is between measurements that are currently going on at the hospital level and measurements at the physician level. I think we need to find a way to align those and also to ramp them up so that physicians understand the impact of their performance, not just on their own practice, but within the hospital as well.

So getting that alignment in the physician based value-based purchasing initiative that I believe is coming forward would be a big help. It's easy to measure costs and I mean that relative to quality. It's very difficult to measure costs, but it's even more difficult to align the quality measurement aspects of this so I'm hoping that in this future state that soon we'll have better alignment.

Operator: Again, if you'd like to ask a question or make a comment, please press star then the number one on your telephone keypad.

Your next question comes from the line of Joanna Kim with American Hospital Association. Your line is open.

Joanna Kim: Hi, this goes back to one of the earlier questions, but we would urge CMS to consider when you're making the value-based purchasing payment to consider making it in the form of a lump sum payment, for example, 80 percent of the hospital's estimated amount at the very beginning of the fiscal year. Then at the end of the fiscal year when the actual discharges are known, CMS could settle that amount. We think that having a dedicated lump sum received by the hospital will help motivate them to improve their quality a little bit more.

We also think that having that dedicated sum will help them funnel it towards quality improvement in a more efficient manner as opposed to tacking on a much smaller dollar amount to every discharge during the year. I think that goes back to the question where it says how can CMS have an immediate and significant impact on hospital performance. I think giving hospitals that very

visible, that sum at the beginning of the year can really have an impact there and have one quickly. Thanks.

Operator: Again, if you'd like to ask a question or make a comment, please press star then the number one on your telephone keypad.

Your next question comes from the line of 202 area code. Please state your name and your organization. Your line is open.

Leah Binder: This is Leah Binder from the Leapfrog Group. It would be good if CMS made public the payments that are made to hospitals or not made to hospitals and/or others under the value-based purchasing arrangement so that communities can become engaged and insure that purchasers as well are aligned in their value-based purchasing efforts. Thank you.

Operator: Your next question or comment comes from the line of Karen Zoeller with Louisiana Hospital Association. Your line is open.

Karen Zoeller: Thank you. I would just like to urge CMS to provide us as soon as possible any kind of guidance or thinking on their part that they possibly have regarding this program. Everything that's coming down in the health reform act, which we have now read in detail, there's so much that's going to have to be implemented over the next couple of years that for us to adequately and accurately work with our hospitals, we need information as soon as possible so we can get it out and inform the hospitals. This is especially true of our smaller critical access hospitals that don't have the staff that some of our larger hospitals so as soon as you can include us in your thinking, your thoughts, your preliminary work, we would very much appreciate that.

Operator: There are no further questions or comments in the queue at this time.

Barbara Cebuhar: Thank you very much (Andrea). It's Barb Cebuhar again. I just want to make sure that everyone has a sense of how you can reach us. We are accepting your ideas up until November 5th so please write us at [hospitalvbp@cms.hhs.gov](mailto:hospitalvbp@cms.hhs.gov). Also, we just want to make sure that everyone remembers if you've got colleagues that didn't participate in the call who want



to listen, the call is being recorded and will be posted on the website at [www.cms.hhs.gov/hospitalqualityinits](http://www.cms.hhs.gov/hospitalqualityinits).

Thank you very much for everyone's help today. We are very grateful for your insight and your information. We will take it and process it over the next couple of days and we do appreciate all your time. Thank you very much for coming today.

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

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