

**Centers for Medicare & Medicaid Services  
Hospital Value-Based Purchasing  
National Provider Call  
Moderator: Geanelle G. Herring  
February 28, 2012  
1:30 p.m. ET**

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Operator: At this time, I would like to welcome everyone to the Hospital Value-Based Purchasing National Provider Conference Call.

All lines will remain in a listen only mode until the question-and-answer session. This call is being recorded and transcribed, if anyone has any objections, you may disconnect at this time. Thank you for your participation in today's call.

I will now turn the call over to Geanelle Herring. Thank you, ma'am, you may begin.

## **Introduction**

Geanelle Herring: Hello, everyone, and welcome to CMS' National Provider Call on the Hospital Value-Based Purchasing Program dry run. My name is Geanelle Griffith Herring and I will serve as your moderator during today's call.

This National Provider Call is an opportunity for CMS to discuss the dry run simulation for the Hospital Value-Based Purchasing or Hospital VBP Program. This dry run is designed to help hospitals anticipate how the Hospital VBP Program will affect their hospital payments in Fiscal Year 2013 by providing simulated reports that employ hospital data from prior years to construct the baseline period and performance period scores. I'd like to advise everyone that the slides we will be using for today's discussion are posted at [www.cms.gov/hospital-value-based-purchasing](http://www.cms.gov/hospital-value-based-purchasing) in the download section on the CMS website. Should you like to follow along with us, please take the time now to download those slides.

After the presentation, we will open a line to answer questions about the program. And we would encourage you to use this opportunity to seek clarification about the program. The presenter today is Mr. Donald Howard, Project Lead for the Office of Clinical Standards and Quality. Mr. Howard, I will now turn the call over to you.

## Presentation

Donald Howard: Thank you, Geanelle. Slide one, the agenda, today we'll present an overview of the Hospital VBP program, discuss how hospitals will be evaluated for the Fiscal Year 2013, and describe the purpose of the dry run for the Fiscal Year 2013 program. There will be a sample simulated hospital report, discuss where to go for questions related to the report, and close with what to expect in the next 12 months for the Hospital VBP program. We will conclude our presentation with the questions and answers.

I'd like to thank everyone for joining us for today's call. The National Provider Call was designed to help hospitals learn more about the Hospital VBP program for Fiscal Year 2013.

As you may recall from the Open Door Forum in July 2011, Hospital VBP is the nation's first national pay for performance program, and it will serve as an important driver in revamping how CMS pays for care and services. It is CMS' goal that the Hospital Value-Based Purchasing program will link payment to quality outcomes and transform CMS from a passive payer of claims to an active purchaser of high quality material.

Our goal today is to refresh our understanding of the Hospital VBP program and provide you with an overview of the dry run process for the Hospital VBP program. As part of the dry run, CMS will create simulated hospital specific Hospital VBP performance reports for each hospital review over the next month.

During this call we will review a sample simulated report in detail and address any questions you may have about the Hospital VBP program or report. We will also review the critical timelines for the next year. After this presentation we'll provide you with an opportunity to ask questions, so please hold your questions until the end.

In addition to myself today, I'd like to acknowledge our partners at the MITRE Corporation, which is a Federally-funded research and development center; and Brandeis University, who may assist with responding to some of the questions today.

Without further ado, I'd like to begin. Next slide, please.

Slide two, introduction to Hospital VBP. Overview, the Hospital VBP program is required by Congress under Section 1886 of the Social Security Act as added by the Patient Protection and Affordable Care Act. Hospital VBP is designed to transform the payment of care from a system based on volume of patient visits and procedures performed to one based on quality of care provided to Medicare beneficiaries.

Hospital VBP is a quality incentive program built on the hospital and inpatient quality reporting, or what's called hospital IQR, measure reporting infrastructure. It is considered the next step in promoting higher quality care for Medicare beneficiaries. The Hospital VBP section of the Patient Protection Affordable Care Act strives to reward a hospital for providing high quality care to patients at a lower cost.

Review value-based purchasing is an important driver of change moving toward rewarding better value and outcomes, which in turn will lead to better care and healthier patients.

Hospital VBP will be funded through a 1 percent withholding from participating hospitals' Diagnosis-Related Group, or DRG, payments in Fiscal Year 2013. That percentage withheld rises to 2 percent by Fiscal Year 2017.

The money that is withheld will be redistributed to hospitals based on their Total Performance Scores, or TPS, as required by statute. And the amount earned by the hospitals will depend on the actual range and distribution of all TPS scores.

Hospital VBP can only use measures that have been in the Hospital IQR program and results published on hospital compare for at least one year. There is no additional data submission required for this program.

Next slide, slide three, Hospital Eligibility. The Hospital VBP program defines hospitals by statutory definition as Subsection D hospitals located in the 50 states and the District of Columbia, including acute care hospitals in

Maryland. Not every hospital is eligible for the Hospital VBP program, however more than 3,000 hospitals nationwide will be eligible for the Fiscal Year 2013 Hospital VBP program.

Next slide, slide four, Excluded Hospitals. The following two slides list the categories of hospital exclusions for the Fiscal Year 2013 Hospital VBP program. First, Hospital VBP does not apply to hospitals subject to payment reductions because they do not meet the requirements for the Hospital IQR program for the applicable year. Second, Hospital VBP does not apply to hospitals and hospital units excluded from the Inpatient Prospective Payment System, IPPS, such as psychiatric, rehabilitation, long-term care, children's, and cancer hospitals. There is a limited number of IPPS-exempt cancer hospitals.

Slide five, Excluded Hospitals continued. Hospital VBP does not apply to hospitals that have received an exemption from the Secretary of the Department of Health and Human Services after an exemption request by their state. States must submit a report that describes how a similar program in the state or a participating hospital or hospitals achieve or surpass the measured results of the Hospital VBP program in terms of patient health outcomes and cost savings.

Maryland hospitals were approved for a waiver from the Fiscal Year 2013 Hospital VBP program through this process, though we note that states must re-submit their exemption request annually.

Other exclusions from Hospital VBP include hospitals that do not meet the minimum number of cases, measures, or completed surveys. We will discuss this in more detail in the next slide.

Finally, Hospital VBP does not apply to hospitals cited by the Secretary for deficiencies during the performance period that pose an immediate jeopardy to the patients' health or safety of patients. It is important to note that excluded hospitals will not have one percent withheld from their DRG payments for the Hospital VBP program for the Fiscal Year 2013 program.

Next slide, eligibility requirements for measures as required by the Act and based on independent analysis. CMS established minimum numbers of cases and measures for hospitals to participate in the Hospital VBP program. Hospitals do not meet minimum numbers of cases and measures which skew results that would affect scoring. As a result, these hospitals are excluded from the Fiscal Year 2013 program.

This slide illustrates eligibility requirement for the minimum number of cases and measures. A minimum of 10 cases per measure, at least four applicable measures, are required to receive a clinical process of care domain score.

An example shown here at this hospital had at least 10 cases or clinical process measures one, two, three, and 12, indicated by the small black figures with a green checkmark. However, for this hospital clinical process, measure 11 does not have 10 cases, as indicated by the red X. This measure will be excluded from this hospital's domain score for Hospital VBP. In this example even without clinical measure 11, this hospital meets the minimum number of 10 cases for measure or at least four measures and would therefore receive a clinical process of care domain score.

To receive a patient experience of domain score, hospitals must have at least 100 completed HCAHPS surveys during the performance period. We will go into more detail later on domain scoring and determining your TPS score. For now you must have a score for both the clinical process of care and the patient experience of care domains to be eligible in the actual reports for the Fiscal Year 2013. The dry run will provide participating hospitals with more information for educational reasons.

Next slide, Critical Dates and Milestones. This slide presents the critical dates, as indicated by the triangles and milestones for the Fiscal Year 2013 Hospital VBP program. The baseline period, July 2009 through March 2010, indicated by the green bar, is the starting point for all comparisons.

Hospital VBP scoring will be based on comparisons to performance during the baseline period. As you can see we are now in the performance period.

That started on July 1st, 2011 and will end March 31st, 2012, indicated by the orange bar, for the Fiscal Year 2013 program.

In August 2012, hospitals will be notified of their estimated Fiscal 2013 value-based incentive payment. By November 1st, 2012, CMS will notify hospitals of the exact amount of their Fiscal Year 2013 value-based incentive payment. Finally we expect to have incorporated the adjustments into our claims processing system by January 2013. We will provide further details on the payment details of the Fiscal Year 2013 program in the Fiscal Year 2013 IPPS rule.

Next slide, slide eight, Fiscal Year 2013 Hospital VBP Domains. This graphic depicts an overview of the 12 clinical processes of care measures that will be used for Fiscal Year 2013 program in the blue box. These 12 measures will contribute 70 percent of the hospital's total performance score. These measures represent consensus-based practices and we believe tracking quality with these measures and to the patients on a solid track for recovery, improve patients' overall health, and shorten recovery times, thereby improving a likelihood of long-term positive outcomes.

The remaining 30 percent of the hospital score is based on the patient experience of care domain, which is of the age gap survey. Hospital VBP places a strong emphasis on the patients' perception of care, which is covered by the eight dimensions listed in the red box.

Please note that the dry run has used the Fiscal Year 2013 VBP domains. In subsequent years, the Hospital VBP program plans to add additional domains and measures to provide a broader snapshot of quality of improvement in efficient delivery of care.

Next slide, Fiscal Year 2013 Program Summary. There are two domains for the Fiscal Year 2013 program, a clinical process to care domain with 12 measures and a patient experience of care domain with eight HCAHPS dimensions.

Hospitals will receive two scores on each measure and dimension, one for achievement and one for improvement. The two scores measure how the hospital performed compared to other hospitals and how much a hospital has improved compared to its own performance. We will use the greater of the two scores on each measure and dimension to calculate the hospital's overall performance.

For Fiscal Year 2013, 70 percent of the hospital's total performance score was based on clinical process of care measures, and 30 percent of hospital's total performance score will be based on patient experience of care dimensions.

Next slide, slide 10, baseline performance data. The slide is a graphic representation of the baseline performance data for a select period. The bell-shaped curve represents all the hospital performance data for sample measure or dimension in the baseline period. Represented on the curve are three points.

The first point is the floor, which is defined as a zero percentile or the lowest performing hospital. The second point, the achievement threshold, which is defined as the 50th percentile for the point at which half of the hospital performance rates lower and half of the hospital performance rates higher. And on the third mark, the benchmark, which is defined as the mean of the top decile or top 10 percent of the hospitals.

The floor is only used in the patient experience of care domain to calculate consistency points. The threshold and benchmark are used in both clinical process of care or patient experience of care domains. If a hospital's performance on a certain measure of dimension is equal to or exceeds the achievement threshold, then that hospital will receive achievement points for that measure or dimension.

Next slide please, Achievement. The achievement score means, "How did my hospital perform in the performance period compared to all eligible hospitals performance during the baseline period?"

Next slide, Improvement. An improvement score means, “How did my hospital improved in the performance period compared to my performance in the baseline period?”

Next slide, Achievement Points. As discussed previously, we will award achievement points based on an individual hospital’s performance during the performance period compared to all hospitals’ performance during the baseline period. If a hospital performs at or above the benchmark, it will be awarded the maximum 10 achievement points. If a hospital performs below the threshold, that will receive zero points. If a hospital performs equal to or greater than the achievement threshold but below the benchmark, it will receive between one and nine achievement points.

Achievement points are awarded according to a formula finalized in rule making. In the example at the bottom of the slide, this hospital’s performance rate was 0.70, or one measure or dimension, and it would therefore received achievement points based on where its performance rate of 0.70 falls on the achievement range.

Next slide, Improvement Points. Improvement points compare individual hospital’s performances during the performance period with the hospital’s performance during the baseline period. If a hospital performs at or above the benchmark it will be awarded the maximum of nine improvement points. If a hospital’s performance is less than or equal to its performance during the baseline period, it will receive zero improvement points. If a hospital performs between its performance in the baseline period and the benchmark, it will receive between zero and nine improvement points.

From a rounding perspective, the hospital may improve its performance by a small amount. For example, the hospital can improve by 0.08 and still receive zero improvement points. Improvement points are awarded according to another formula finalized in rule making.

In the example at the bottom of the slide, the hospital improved their measure rate from 0.21 in the baseline period to 0.70 in the performance period and will therefore receive improvement points based on the performance rate of

0.70 – falls on the improvement range. As a reminder, the greater of the achievement or improvement points is used for the total performance score.

Next slide, Total Performance Score. The total performance score is comprised of clinical process of care domain, as indicated in the red box, which accounts for 70 percent of the hospital's total performance score. And the patient experience of care domain, which is in the green box, which accounts for 30 percent of a total performance score.

Next slide, Objectives for the Fiscal Year 2013 Program Dry Run. Now that we have discussed how hospitals will be evaluated for the Fiscal Year 2013 program, let's take a look at why CMS is conducting a dry run. The purpose of the dry run is to simulate the Hospital VBP program. By simulating the program we hope that this will provide hospitals with a better understanding of the Hospital VBP program and how their performance will be scored for Fiscal Year 2013.

The dry run will provide a hospital's specific reports that simulate the Hospital VBP programs' calculations. This will show a hospital's computed scores based on the baseline period from April 1st, of 2008 to December 31st, of 2008, in the performance period of April 1st, 2010 to December 31st, 2010. It will inform hospitals of how the reports will be distributed for the Fiscal Year 2013 program.

Hospitals can download their dry run reports through the quality – their QualityNet account. The same process will be used for the Fiscal Year 2013 program reports. It will also provide QIOs with a better understanding of the hospital reports and the types of questions that the hospitals may ask.

Next slide, Accessing Your Hospital Specific Report. As part of the dry run, CMS will create simulated hospital-specific reports for each hospital to review. These reports will be available through your QualityNet account after this call. If your hospital has an inactive QualityNet account, please make sure that you reactivate it by contacting the QualityNet Help Desk at [qnetsupport@sdps.org](mailto:qnetsupport@sdps.org) or call 866-288-8912. The number again is 866-288-8912. Make sure that you can access your simulated hospital specific report.

Next slide, Simulated Hospital Report Overview. The simulated dry report will use a different time period than CMS will use to compute Hospital VBP scores for the Fiscal Year 2013. Instead the simulated report will use a baseline period again of April 1st, 2008 to December 31st, 2008 and a performance period of April 1st, 2010 to December 31st, 2010. CMS will provide complete simulated reports to hospitals eligible for the Fiscal Year 2013 program, based on reporting data from the baseline and performance periods noted above. To be eligible, a hospital must meet the minimum reporting requirements for both domains for the dry run period.

In addition, CMS will provide abbreviated reports to non-eligible hospitals displaying performance and scores for areas where they have met the eligibility requirements in using “N/A” to indicate for program areas that will not be eligible or where insufficient data was available.

Slide 19, Simulated Hospital Report Overview. A few important notes regarding the simulated hospital reports. Actual reports for the Fiscal Year 2013 program used later this year will be different in format and content from this dry run report. CMS has included graphics on the dry run report to help you better understand how scoring will occur for the Fiscal Year 2013.

The dry run report and supporting narrative are provided to help educate hospitals about Hospital VBP and its scoring process. Dry run reports will be sent to all hospitals while the Fiscal Year 2013 reports will only be sent to eligible hospitals. The report does not indicate how a hospital will actually perform in Fiscal Year 2013 or whether your hospital will be eligible for the Fiscal Year 2013 Hospital VBP program. The simulated dry run report has no financial implications. It is merely a tool to help educate you about Hospital VBP.

Slide 20, Simulated Hospital Report Overview. As a reminder, the following comment is noted on each page of the report. The simulated report and supporting narrative are provided to help educate hospitals about the scoring methodology for Fiscal Year 2013 Hospital Value-Based Purchasing program. The simulated report does not indicate how your hospital will actually perform in the Fiscal Year 2013 program or whether your hospital will be

eligible for the Fiscal Year 2013 VBP program. The simulated report has no financial implications and will not be available to the public. Further, the simulated report may not resemble the actual report used in the Fiscal Year 2013 program.

Slide 21, Hospital VBP Simulated Report Content. The simulated hospital report is divided into seven sections. The first section provides hospitals with an overview of the Hospital VBP Program and the purpose of a hospital report. The remaining six sections shown on this slide display hospital specific data for the baseline and performance periods used in the dry run. Each section within the report will be represented by a graphic and a narrative explaining how to interpret the information provided.

In the following slides we will review each of the six sections of a report in detail. For sections five and six, the clinical process of care measures and patient experience of care dimensions. We will review scenarios you may see in your simulated hospital-specific reports. We will not be reviewing the Hospital VBP program background as we've already discussed that in earlier slides.

Slide 22, Estimated TPS Summary. The section shows your hospital's total performance score, TPS, in percentile in relation to other eligible hospitals. The report covers both a baseline and a performance period for comparative purposes to demonstrate how your hospital was performing. The time periods are shown at the top of the page; comparisons of your hospital's TPS score to your state and the national percentile scores are also provided.

As you can see in this example, the hospital has a total performance score of 72.35 out of a total 100 points which is above the state TPS average of 49.15 and above the national TPS average of 46.83. If we look at the graphic, the hospital is at the 97 percentile when compared against all other eligible hospitals, meaning that 97 percent of eligible hospitals had total performance scores less than 72.35. It was important to note the hospital specific reports will have narrative explanations for each of these sections.

Slide 23, Estimated Value-Based Incentive Payment Percent. The slide shows the Estimated Value-Based Incentive Payment Percent section of the report. Its estimated impact summary identifies your hospital's estimated net change in base operating DRG payment and national distribution of net change in base operating DRG payment, which is the horizontal bar graph.

Let's first look at the simulated report impact on the estimated net change in base operating DRG payment for Fiscal Year 2012. This is the percentage amount that your base operating DRG payments would have changed for the Fiscal Year following the simulated performance period due to the Hospital VBP program. A positive number means we estimate that the hospital would have had higher payments because of the HVBP program performance, and that amount of zero means that we estimate that it would have been no change in the hospital's payments as a result of the Hospital VBP program. A negative number means we estimate that the payments would have been lower as a result of the Hospital VBP program.

In this example the estimated incentive payment percentage is a positive 0.119 percent. Please keep in mind that the initial one percent withheld from your estimated DRG payment is the amount used to fund the incentive adjustments.

The horizontal bar illustrates your hospital's net change in base operating DRG payment amount compared to the national distribution. The simulated dry run period of hospitals had a net change in base operating DRG payments ranging from negative 0.78 percent and positive 0.91 percent.

In this example, the hospital's net change is greater than zero which is indicated by the green bar at 0.1189. Please note that the rounding used to generate the 0.119 percent if the net change is less than zero, a red bar would be displayed showing the hospital's payment would be lower.

Next Slide, Slide 24, Measure Performance Summary. The slide shows a performance summary section of the report. The section of the report summarizes your hospital's measure dimension performance with the two domains that contribute to the hospital simulated dry run total performance score, or TPS.

For this example the TPS score is 57.60. The score is comprised of two domains; the total score is computed by multiplying the clinical process domain by 70 percent and the patient experience domain by 30 percent and then summing.

Remember the weighted clinical process domain score accounts for 70 percent and comprises your hospital scores from all 12 clinical process domain measures that your hospital was eligible for during the performance period, while the weighted patient experience domain score accounts for 30 percent of your TPS and comprises your hospital scores from all eight patient experience domain dimensions during the performance period.

Now we'll take a closer look at each of the domain scores.

Slide 25, Unweighted Clinical Process of Care. This slide displays the unweighted clinical process of care section in the report. The unweighted score for the clinical process domain is the sum of your hospital's scores from the 12 individual clinical process measures. The score has been normalized, taking into account only those measures that your hospital was eligible for during the performance period. For example a hospital that scores five out of 10 for four measures would have received the same score as the hospital that scores five out of 10 for 12 measures. Both hospitals will receive 50 out of a 100 possible points. In this example the hospital receives 69 out of a 100 possible points for its performance on 11 of the 12 measures.

The graphic displays the actual clinical process measures that the hospital was eligible for. The blue portion of the columns represent where your hospital scored above the achievement threshold and the gray represents where the hospital scored below the achievement threshold. Measures without a column indicate your hospital did not meet the minimum number of cases required for that measure.

For this example, this hospital scored above the achievement threshold for nine of 12 clinical processes of care measures and below the achievement threshold for the SCIP Card 2 and SCIP VTE-1 clinical process of care

measures. The minimum cases required were not met for one measure, AMI-7a.

Slide 26, Unweighted Patient Experience of Care. This slide represents the unweighted patient experience of care section in the report. The unweighted score for the patient experience domain is the sum of your hospital scores from the eight patient experience dimensions.

In this example, the hospital received 31 out of a 100 possible points for its performance in all eight of the dimensions. The graphic displays the actual patient experience dimensions for this hospital. The blue portion of the column represents where the hospital scored above the achievement threshold and the gray represents the dimensions where the hospital scored below the achievement threshold. For this example, this hospital scored below the achievement threshold for two patient experience dimensions, which are the communication with nurses and responsiveness of staff, and scored over the achievement threshold for the remaining six patient experience dimensions.

Next slide, slide 27, Scenarios You May See in Your Reports. The table shown lists seven scenarios that you may see in your simulated hospital-specific report. The scenarios are based on how hospitals will be scored for the Hospital VBP program for Fiscal Year 2013, as previously discussed. Based on how a hospital performs during the baseline period and performance period, achievement points and improvement points are awarded for each clinical process of care measure and patient experience of care dimension to determine a hospital's total performance score.

In the following slides we'll review each of the seven scenarios listed in the table, as these scenarios apply to both 12 clinical process care of measures and eight patient experience of care dimensions. We will display one example for each scenario from either the clinical process of care measures or patient experience of care dimensions.

Remember, formulas from the final rule are used to determine the exact achievement and improvement points that will be awarded based on a hospital performance during the performance period.

Slide 28, Simulated Hospital Reports; Scenario One. In scenario one, this hospital has a baseline rate, a performance rate, achievement points, and improvements points. The greater of either of the achievement or improvement points are awarded and are used to arrive at the hospital's total performance score.

For this scenario we will look at the clinical process care measure example. For the initial antibiotic measure, this hospital achieved nine achievement points since its performance rate, which are represented by the blue bar was close to the benchmark. This hospital receives seven of nine improvement points since its performance rate improved from its baseline rate which is represented by the gray bar, those scores are displayed. However, the nine achievement points are greater than the seven improvement points and, therefore, nine points are awarded to this hospital for the initial antibiotic measure.

Slide 29, Simulated Hospital Report; Scenario Two. In scenario two, this hospital has a baseline rate and performance rate. The hospital also has achievement points but it has no improvement points. The hospital is awarded the achievement points which are used to arrive at the hospital's total performance score. This slide shows a score for the primary PCI, clinical process of care measure. In this example the hospital received 10 achievement points since its performance rate, represented by the blue bar, exceeded the benchmark. For improvement, this hospital's performance rate is the same as its baseline rate, which is represented by the gray bar.

Therefore no improvement points were earned. It is important to note that even a hospital performance at a 100 percent on a measure or dimension in both the baseline and performance periods is not actually improved. However the hospital received achievement points based on its performance in the performance period.

In this example, the full 10 points for its 100 percent performance in the performance period, the greater of either of the achievement or improvement points is awarded, therefore 10 achievement points are awarded to the hospital for the primary PCI measure.

Slide 30, Simulated Hospital Report; Scenario Three. In scenario three, this hospital has a baseline report and performance rate. The hospital has no achievement points but has improvement points. The hospital is awarded the improvement points which are used to arrive at the hospital's total performance score.

The slide shows the score for the communications with nurses, patient experience of care dimension. In this example this hospital received zero achievement points since its performance rate, which is represented by the blue bar, was below the achievement threshold. For improvement, this hospital performance rate is greater than its baseline rate, which is represented by the gray bar, but below the benchmark. Therefore, four improvement points are awarded to the hospital for the Communication with Nurses dimension.

Next slide, slide 31, Simulated Hospital Report; Scenario Four. In scenario four, this hospital had a baseline rate and performance rate. However the hospital had no achievement points and no improvement points, this hospital is awarded zero points.

The slide shows the scores for the Communication About medicine, patient of experience care dimension. In this example this hospital received zero achievement points since its performance rate, which is again represented by the blue bar, is below the achievement threshold. This hospital also received zero improvement points since its performance rate is lower than its baseline rate, which is represented by the gray bar. Here, no points were awarded to this hospital for the Communication About Medicine dimension.

Slide 32, Simulated Hospital Report; Scenario Five. In scenario five, this hospital has no baseline rate but it has a performance rate. This hospital also has achievement points and no improvement points. The hospital is awarded the achievement points. The slide shows the scores for the Communication with Nurses, patient experience of care dimension.

In this example, this hospital received seven achievement points and since its performance rate, represented by the blue bar, is a little more than halfway

between the achievement threshold and the benchmark. Since this hospital has no baseline rate, improvement points cannot be calculated. It is important to note that the baseline period is only needed for improvement points. So a hospital can still earn achievement points if it does not have performance during the baseline period.

This hospital received no improvement points since it had insufficient data for the baseline period which is represented by the “N/A,” that’s the greater of either of the achievement or improvement points is awarded, this hospital received seven achievement points for the Communication with Nurses dimension.

Next slide, Slide 33, Submitted Hospital Report: Scenario Six. In scenario six, this hospital has a baseline rate but it has no performance rate. The hospital also has no achievement points and no improvement points. This hospital received N/A, or not applicable, for its score on this measure. The slide shows the score for the Primary PCI Clinical process of care measure.

In this example, the hospital has a baseline rate, which is represented by the gray bar, for the baseline period. However there was insufficient data for this hospital during the performance period. It is important to note that the performance period is needed for both improvement and achievement. This hospital received “N/A” for both improvement and achievement points.

Next slide, which is 34, Simulated Hospital Report: Scenario Seven. In scenario seven, this hospital has “N/A” with a baseline rate and performance rate. The hospital also has “N/A” for achievement points and improvement points. The hospital received N/A, or not applicable, for each score on this measure. This slide shows a score for Fibrinolytic Therapy, clinical process of care measure. In this example, the hospital received “N/A” for both improvement and achievement scores since there was insufficient data available for the baseline rate or performance rate.

Next slide, Slide 35, Clarification of Criteria in Clinical Scores in the Dry Run. Let’s clarify what hospitals will see for the clinical scores in the dry run. Where the simulated dry run report hospitals did not report 10 cases for at

least four measures will not be provided a total clinical domain score, a total performance score, or an incentive adjustment. For those measures, hospitals will see their baseline rate and performance rate with “N/A” represented for improvement and achievement points.

In this example, the hospital has a baseline rate of 0.8757 and has a performance rate of 0.9307 from the SCIP VTE-1 measure. However the rates are based on less than 10 cases. Therefore the hospital received “N/A” for both improvement and achievement scores.

Next slide, Slide 36, Patient Experience Domain Score. Now let’s take a closer look at the patient experience domain score. This section report summarizes your hospital’s total patient experience domain score for the eight patient experience of care dimensions used in a simulated Hospital VBP dry run. Two scores based on consistency are calculated for this domain.

Like the clinical process of care domain, the patient experience of care dimensions are scored on the greater of the improvement or achievement points for each of eight dimensions with 80 total points possible. This is called your base score. Hospitals with a 100 completed reported HCAHPS are raised during the performance period, receive a patient experience of care domain score. Again the greater of the achievement for improvement scores for each dimension is used to calculate the patient experience of care domain’s base score.

Next slide, Slide 37, Consistency Point Details Example. In addition to the base score, your hospital can earn between zero and 20 consistency points towards its total patient of experience of care domain score. Consistency points encourage the hospitals to meet or exceed the achievement threshold in all HCAHPS dimensions. The higher your lowest dimension score is relative to other hospitals, the more consistency points are earned. Simply, the higher a hospital’s lowest dimension score is compared to the lowest performing hospital on this dimension, which is shown as the floor in this example, the better your score becomes.

For this example, the responsiveness of staff dimension was the lowest HCAHPS dimensions score for this hospital. The consistency points for this hospital were 17 out of 20 points based on the relative location of this hospital performance rate of 56.07 percent, which is represented by the blue bar, compared to the range from the floor to the threshold. If the blue bar is close to the threshold, the majority of the 20 consistency points are awarded to the hospital. Remember, formulas from the final rule are used to calculate the exact number of consistency points.

Next slide, Slide 38, Non-Eligible Hospitals. Now that we have discussed the simulated hospital report we'd like to take a few minutes to review the types of reports that non-eligible hospitals will see for their dry run. The table shown is a list of categories for exclusions for the Fiscal Year 2013 the Hospital VBP program and the designation of the type of simulated hospital report that hospitals will expect to see after today's call.

As you will see, hospitals are subject to payment reductions under the Hospital Inpatient Quality Reporting, which is the IQR program, we'll get a simulated sample report. Hospitals and hospital units excluded from the IPPS will get their simulated report with TPS and incentive adjustment omitted, if data is available and minimal requirements are met. If data is not available or minimum requirements are not met, these hospitals receive a sample report.

Next slide, Slide 39, Non-Eligible Hospitals. Hospitals that are paid under Section 1814 (b)(3) but have received an exemption from the Secretary of Department of Health and Human Services will receive a similar report with only the incentive adjustments omitted, if data is available and minimum requirements are met. These hospitals will receive a report with both their TPS and incentive adjustments omitted if data is not available or if the minimum requirements are not met.

Hospitals that report fewer than 100 HCAHPS surveys will receive their simulated report showing "N/A" in the patient experience of care domain. "N/A" will also appear in the patient experience of care dimension section of the report. TPS and incentive adjustments are also omitted.

Next slide, Slide 40, Non-Eligible Hospitals. Hospitals without the minimum number of cases and measures will receive their simulated report showing “N/A” in the clinical process of care domain. TPS and incentive adjustment will also be omitted. Sample reports are provided to hospitals if data is not available or minimum requirements are not met for both the patient experience and clinical domains. Hospitals cited for deficiencies during the performance period that pose immediate jeopardy to the health and safety of patients have not been incorporated into the dry run. Immediate jeopardy will be part of the actual reports for Fiscal Year 2013.

Next slide, 41, Questions on Hospital Reports. The table shown is a guide to where to find answers to questions related to the dry run your hospitals report. As discussed in a previous slide, hospitals that have specific reports will be available through your QualityNet account after the call, starting tomorrow February 29th. If you have questions, we suggest you first review the Hospital VBP Frequently Asked Questions, FAQ, located on CMS website <http://www.cms.gov/Hospital-Value-Based-Purchasing/>.

The site will be periodically updated with new questions and answers. If a hospital has a question that is not addressed in the FAQs, hospitals should complete the feedback form available on QualityNet. Our goal is to provide responses to your questions as soon as possible after receiving your completed feedback form. If you have an inactive QualityNet account, we encourage you to contact the QualityNet Help Desk to reactivate your account to ensure you will be able to access your simulated hospital specific report after the call.

Next slide, Feedback Form. This slide shows the feedback form that will be posted on a QualityNet site. On this feedback form, enter your contact information such as your name, position, e-mail address and phone number, CMS certification number, provider number, name of the hospital, and hospital address. Please complete all required information to ensure a timely response to your question.

Next. Enter your questions; one question per line. There will be five lines available to enter your questions in the table. If you have more than five questions, please use another feedback form to enter your remaining

questions. Once completed, submit your questions by clicking the “submit form” button in the upper right hand corner, or you can send your form to the e-mail address [HospitalVBP@cms.hhs.gov](mailto:HospitalVBP@cms.hhs.gov).

Next slide, Slide 43, Critical Dates and Milestones. We want to take this opportunity to also discuss what to expect from the HVBP program in the next 12 months, this includes dates and milestones for the dry run report for Fiscal Year 2013, Fiscal Year 2014, and Fiscal Year 2015 programs. Let’s start by reviewing the key dates for the Fiscal Year 2013 program. As we previously discussed performance periods for the clinical and HCAHPS domains are July 1st, 2011 to March 31st, 2012.

Next slide, Slide 44, Critical Dates and Milestones. After this call, CMS will make available the hospital specific dry run reports through QualityNet. Remember hospitals that are not eligible during the dry run performance period will not receive a hospital specific dry run report for review, but will receive a sample report to assist in their understanding of the Hospital VBP program.

Next slide, Slide 45, Critical Dates and Milestones. For the actual Fiscal Year 2013 program, the focus is on payment. Hospitals will be informed of their estimated incentive adjustment by August 1st, 2012. Please note, the keyword in this portion of the slide is estimated. Estimated reports are provided to hospitals as early as we can possibly generate them. Our intent is to assist hospitals and their planning for the upcoming year. As we all know, estimates are estimates.

Additional time to review the Fiscal Year 2013 data permits CMS to validate information, submit it and allow the actual report in November to be definitive and permit the inclusion of the potential request for review of hospitals’ data.

Slide 46, Critical Dates and Milestones. By November 1st, 2012 the hospitals will be provided their actual incentive adjustment for Fiscal Year 2013. Again CMS is working to provide these reports to QualityNet as soon as possible.

Next slide, slide 47, again Critical Dates and Milestones. Following the release of the actual incentive adjustments for Fiscal Year 2013, hospitals will have 30 days from that date to review and correct their data.

Next slide, slide 48, Critical Dates and Milestones. After the review and corrections period, CMS will make adjustments to the claim systems to accommodate the value-based incentive payments. This will occur in January 2013.

Next slide, Slide 49, Critical Dates and Milestones. For the Fiscal Year 2014 program, the focus is on performance. As shown, the performance periods for the Fiscal Year 2014 clinical and HCAHPS domains for April 1st, 2012 to December 31st, 2012.

Next slide, Slide 50, Critical Dates and Milestones. The performance period for the Fiscal Year 2014 mortality measure is July 1st, 2011 through June 30th, 2012. As you can see, we are eight months into the performance period for the mortality domain, and the performance period for the clinical and HCAHPS domains begin in one month.

Next slide, Slide 51, Critical Dates and Milestones. Finally, for the Fiscal Year 2015 program the focus is on feedback. As shown, the Medicare Spending per Beneficiary preview report for Fiscal Year 2015 was released in February of this year.

Next slide, Slide 52, Critical Dates and Milestones. CMS will take comments on the Medicare Spending per Beneficiary Measure from February 1st, 2012 to March 1st, 2012.

Next slide, Slide 53, Critical Dates and Milestones. The Fiscal Year 2013 IPPS proposed rule is expected to be displayed in the spring. To clarify, we intend to make proposals on the Fiscal Year 2015 Hospital VBP program in that rule.

Next slide, Slide 54, Critical Dates and Milestones. Following the release of the IPPS proposed rule for Fiscal Year 2013, CMS will take comments for up to 60 days.

Next slide, Slide 55, Critical Dates and Milestones. As shown, we expect to publish the IPPS final rule in late summer.

Next slide, Slide 56, Critical Dates and Milestones. As you can see, there are a number of critical dates and milestones for the Fiscal Year 2013, Fiscal Year 2014, and Fiscal Year 2015 Hospital VBP programs in calendar year 2012. We hope this timeline gives you an understanding of what to expect in the next 12 months with a Hospital VBP program.

Next slide, Slide 57, Useful Resources. Listed on this slide are some resources which can provide you with additional information regarding the Hospital VBP program. Please refer to these resources and use the feedback form previously discussed should you have any questions about the Hospital VBP program or the dry run.

I would now like to turn the call over to Ms. Herring.

## **Poll**

Geanelle Herring: Thank you, Mr. Howard. At this time we will now pause for just a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note there will be moments of silence while we tabulate the results. Holley, we're ready to start polling.

Operator: CMS greatly appreciates that many of you minimized the government's teleconference expense by listening to these calls together in your office using only one line. Today we would like to obtain an estimate of the number of participants in attendance to better document how many members of the provider community are receiving this valuable information.

At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the

room, enter one. If there are between two and eight of you in the room listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine.

Again if you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine. Please hold while we complete the polling. Please continue to hold while we complete the polling.

## **Question and Answer Session**

Geanelle Herring: Thank you for your participation in our polling. We are now ready to begin our question and answer session. First I would like to remind everyone that this call has been recorded and transcribed, so please state your name and the organization which you represent. In an effort to get as many questions asked and answered as possible, we ask that you limit the number of questions you ask to just one.

Holley, when ready, we're ready for our first question.

Operator: To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking a question and pick up your handset before asking your question to assure clarity. Please note, your line will remain open during the time you're asking your question so anything you say or any background noise will be heard in the conference.

And your first question comes from the line of Ramona Thompson.

Ramona Thompson: Hi, I'm Ramona Thompson from King's Daughters Medical Center. I'm curious to know where I can find the Medicare Spending per Beneficiary report that was apparently released earlier this month. Is that on QNet?

Donald Howard: Yes, yes, that is on QNet.

Ramona Thompson: Thank you.

Donald Howard: OK, thank you.

Operator: Please hold for your next question. Your next question comes from the line of Lindsay Duckworth.

Lindsay Duckworth: Hi, this is Lindsay Duckworth calling from PeaceHealth Ketchikan Medical Center, and I know that critical access hospitals are not currently included in the Value-Based Purchasing program but I'm wondering if there is a plan to include them in the future, and if so when that may happen?

Michael Lee: Hi, this is Michael Lee from MITRE Corporation. The Hospital Value-Based Purchasing does not currently incorporate critical access hospitals, and CMS is currently considering how to best include critical access hospitals in future program years. There are no plans to include them at this time. And as a reminder there, the critical access hospitals are ineligible for the program pursuant to the statute.

Operator: And your next question comes from the line of Michael Cahill.

Michael Cahill: This is Michael Cahill from Parker Adventist Hospital in Denver. I just have a question. I am looking for the FAQs on the Value-Based Purchasing site and I just – I can't find the general CMS FAQ at the bottom, but I'm looking for the Value-Based Purchasing specific one.

Kelly Anderson: Thanks for the question. This is Kelly Anderson. I am the Communications Manager for the CMS Office of Clinical Standards and Quality. We are currently experiencing a technical issue with our website. You may notice that our website looks a little different than it had in the past. We are having a little bit of a technical issue as we go through the design change, and so we hope that they will be out in the next 24 hours. We will ask our friends in the Listserv area where you may have received notice of this call to let folks know when those FAQs are up. So, thank you for your patience with us.

Michael Cahill: Thanks, I'll cancel my ophthalmology appointment.

Operator: And your next question comes from the line of Jacob Parrish.

Jacob Parrish: Yes, this is Jacob Parrish of Vital Health in North Carolina. I have a question that relates to children's hospital, I see that they're also excluded. How will you treat a children's hospital that is actually a hospital within a hospital?

Jim Poyer: Hi, this is Jim Poyer from Clinical Standards and Quality, Director for Quality Improvement Policy Care Division. If the CMS certification number which the children's hospital excludes that from, by being a specific children's hospital, per that CMS certification number, then they would not be paid under an eligible for the Value-Based Purchasing program. It's only episodes of care for patients under 18 treated by eligible hospitals under the—for eligible hospitals and the inpatient prospective payment system, Subsection D hospital. So if it's the children's hospital that's excluded from the IPPS, it's ineligible for Hospital Value-Based Purchasing.

Jacob Parish: OK, thank you.

Jim Poyer: Thank you.

Operator: Your next question comes from the line of Carol Volk.

Kathy Gough: Hello, this is Kathy Gough. I'm calling from the University of Arizona Medical Center in Tucson, Arizona. I was just wondering, when we started this journey it was originally said that we would – the first performance period would be nine months and then subsequently would be one year and I don't see that as for our next period, it looks like it's nine months again. Is there – what rationale was there for just using nine months, and are we going to continue with just a nine-month performance period? Thank you.

Jim Poyer: You are correct in saying that, observing that the finalized performance period for HCAHPS, that domain as well as clinical process of care, it continues to be nine months. The rationale is, as you might see from the presentation for Fiscal Year 2013, we're paying hospitals in January we are trying to get back to make the initial payment by October of the fiscal year to make – to have it applicable for all 12 months of the payment year so that we're not having to withhold potential payments for several months prior to doing it.

And we thought that and finalized to rule making that an additional year of the nine months performance period for Fiscal Year '14 and getting the payment out to the hospitals in a more timely manner outweighed the need for, you know, the increased reliability for 12 months. Please stay tuned for additional proposals for FY '15. In future years we want to ensure that the data are as reliable as possible while ensuring as much as possible that we want to incentivize hospitals and get the payments out at the start of the fiscal year.

Kathy Gough: All right, then. Just see that you're looking for trends of improvement, you know, just three quarters.

Jim Poyer: I'm sorry, you're talking about Fiscal Year 2014 that these – these proposals were – this is Jim Poyer again – these proposals were proposed and finalized for rule making last year. And we do recognize in terms of that if it is increased reliability for 12 months' data and recognize that. That said, we want to make sure that the hospitals are getting their payments as soon as possible at the start of the Fiscal Year.

Right now for Fiscal Year '13, as Mr. Howard had alluded to in the presentation, we have to withhold the initial incentive payment until at least three months. So we want to get to a point where we're paying hospitals sooner or at the start of the Fiscal Year recognizing cash flow issues and ensuring that the hospitals get the payment that they have earned. Thank you.

Geanelle Herring: Thank you for the question. Next question, Holley?

Operator: Your next question comes from the line of Richard Ketcham.

Richard Ketcham: Hi, this is Rick Ketcham, St. Elizabeth Medical Center in Utica, New York. On slide 23, you talked about the incentive payment percentage. I understand there is a 1 percent withheld but I would like to further understand what the maximum potential incentive could be, or conversely the maximum percentage withheld?

Geanelle Herring: Just a moment while we pull up that slide.

Jim Poyer: This is Jim Poyer again from CMS. In slide 23, the range of payments that ranged from 0.78 to 0.91 positive, are estimated from the dry run data baseline of nine months in 2008, discharges performance period in 2010. That exact amount – percentage amount range might vary slightly with respect to the actual data that is used for an actual baseline and the performance period. And we take in terms of what pool of hospitals are eligible and then determine essentially what is a slope to be able to ensure that the pool of payments is budget neutral per the statute that the amount of what get – goes out to the hospital is the same as what goes in.

I just wanted to emphasize also again that it's going to depend on the actual data for the performance periods so that those amounts – exact amounts and percentages might vary slightly. Thank you.

Geanelle Herring: Thanks for the question. Holley, next question please.

Operator: Your next question comes from the line of Teresa Ryals.

Teresa Ryals: Good afternoon, this is Teresa Ryals from Mississippi State Hospital. I would like to thank you for putting on this afternoon's call, firstly. My question is for smaller hospitals who cannot meet the eligibility requirements. Will there be any payment adjustments for those hospitals, or will they remain as is?

Jim Poyer: They will remain as is. The statute is very explicit with respect to who is an eligible hospital, also that its provision is that we must meet minimum numbers of case thresholds. And we tried when we made the initial proposals for Fiscal Year '13, we ran a lot of analysis to check the reliability relative to the impact on the number of hospitals and wanted to ensure that what has been, first and foremost, be complying with the statute. But second, also that what we're paying out the hospital is reliable and indicative of quality of care and patient experience of care and not, you know, as reliable as possible.

That said, for critical access hospitals statute would have to be modified in order to – in the payment system – to include them and for hospitals with minimum numbers of cases. The Affordable Care Act also did task CMS with conducting study, and we're considering that and more details to come, in

terms of those findings, but in terms of critical access hospitals, Congress and the President would have to modify statute in order to allow critical access hospitals to receive the incentives for quality.

Teresa Ryals: OK, thank you.

Jim Poyer: Thank you.

Geanelle Herring: Thank you for your question. Holley, next question please.

Operator: Your next question comes from the line of Davida Sanders.

Davida Sanders: Yes, this is Davida Sanders from Hamilton Medical Center in Dalton, Georgia. On slide 49, you have the clinical performance period there and the HCAHPS performance period. What is used for the baseline for Fiscal Year 2014? Will it be the performance period for Fiscal Year 2013? Or will it be the previously established baseline?

Geanelle Herring: Give us a moment while we pull up those slides.

Jim Poyer: Hi, this is Jim Poyer from CMS again. We have proposed and finalized through rule making in the last calendar year. For Fiscal Year 2014, the performance period is April 1st through December 31st, 2012. Discharges for the patient experience of care and the clinical process of care domain, and the baseline for HCAHPS as well as clinical process of care is two years prior, April 1st through December 31st, 2010.

Geanelle Herring: Thank you for the question. Holley?

Davida Sanders: OK.

Geanelle Herring: Holley?

Operator: And your next question comes from the line of Joshua Scott.

Joshua Scott: Hi, this is Joshua Scott from Madison Memorial Hospital. I have a question about the baseline period for the Simulated Hospital report. Why are we not using the baseline period that – the actual baseline period for that time period?

Geanelle Herring: Give us a moment while we pull the question to answer that.

Joshua Scott: It's on slide number 18.

Geanelle Herring: Give us a moment while we pull up slide 18.

Jim Poyer: Hi, this is Jim Poyer from CMS. We wanted – we chose to utilize two columns in the eight data because of – to replicate as much as possible the seasonality as well as the lag between the baseline period, which is two years prior to the performance period, just to give a rough estimate as to some of the change in the data that is not due to seasonality, because we did finalize a performance period that's two years following the baseline period. And that would help give a rough estimate to hospitals in terms of what you might see with respect to change over time that might not be associated with, let's say, quality improvement efforts related to, you know, focusing on value-based purchasing what you see in terms of data that were two years prior.

Joshua Scott: OK, thank you.

Jim Poyer: Thank you.

Geanelle Herring: Thank you for the question. Holley, next question please.

Operator: Your next question comes from the line of Amelia Bryant.

Amelia Bryant: Yes, I'm from North Carolina. I would like to go to slide five, please, regarding the I.J. letters. I want to understand clearly if a hospital received an I.J. letter during the performance period but was cleared and never lost their certification, are they excluded just because they received the I.J. letter? Thank you.

Jim Poyer: We are aware of many concerns with respect to how CMS intends to implement the immediate jeopardy language that is in the statute and we intend to provide proposals on how we intend to implement that language on immediate jeopardy deficiencies in future rulemaking, so.

Amelia Bryant: OK, thank you.

Jim Poyer: That's all I have to say at this point, thank you.

Operator: Your next question comes from the line of Cathy Vanrudden.

Cathy Vanrudden: Hi, Cathy Vanrudden from Essentia Health. I also have a question regarding the payment adjustment that will go into effect January 1st of '13. The program is funded by a one percent withhold from all of the participating hospitals. But it's not like we're all going to receive that, it'll depend on our payment adjustment, and there's a maximum negative payment adjustment one percent.

Jim Poyer: This is Jim Poyer. It's going to be dependent on the pool hospitals as in the previous question. And the number of eligible hospitals and the amount that is in the pool and then the statutory requirement after the 1 percent was withheld, is that CMS big budget, budget neutrality which means the pool of money that gets withheld from the hospitals, that entire amount no more, no less gets disseminated to the hospitals. So the actual amount, yes, we have run regulatory impact analysis and published that in the last year's proposal in the standalone rule for Fiscal Year '13. I would refer you to that information for an estimate.

It's going to – you know, the range that we've posted in this presentation is going to slightly vary. So you mention terms of max, one percent. It's going to vary but I would refer you to that regulatory impact analysis for a more detailed discussion on the estimated impact. We don't know because we don't have the actual data and the pool of hospitals that are eligible, and we won't have that information until we have the actual report, so I wish I had better information for you but that's the best I can do for you at this point.  
Thanks.

Cathy Vanrudden: Thank you.

Geanelle Herring: Thank you for your question. Holley, your next question.

Operator: Your next question comes from the line of Adelina Vasilescu.

John Michel: Hi, this is John Michel from Parma Hospital. I would like you to confirm that the floor achievement in benchmark numbers for the purposes of the dry run will come from that baseline period, and are those sets of metrics published anywhere?

Geanelle Herring: Give us a moment to get our question and answer together, please.

Jim Poyer: Hi, this is Jim Poyer from CMS. The National Floor Median and Benchmark, the mean of the 90 top decile is published in the Federal Register. We've proposed and finalized rule making for both Fiscal Year '13 and '14 and have the National Floor Median and Benchmark.

John Michel: Is that for four years for the dry run period?

Phil Beenhouwer: This is Phil Beenhouwer from the MITRE Corporation. For the dry run period you will see the floor, achieving threshold, and the benchmarks used for the dry run in your hospital's specific reports. Jim was responding to the FY '13 and FY '14 programs where those measures are from the baseline period and they are published as part of rulemaking for the FY '13 and FY '14 period.

John Michel: OK, thank you.

Geanelle Herring: Thank you for your question. Holley, next question please.

Operator: Your next question comes from the line of Tami Lewis.

Tami Lewis: Hi, this is Tami Lewis with Robinson Memorial Hospital. You actually answered the question, but if you could just state one more time, what is the baseline going to be for 2014? Was it April 1st to December 31st, 2010?

Jim Poyer: This is Jim Poyer. That is correct. April 1st through December 31st, 2010, discharges for patient experience of care and clinical process of care domains.

Tami Lewis: OK, and was it two – was it a two-year timeframe for our first – our first run here, our first performance and achievement, was that two years because the timetable doesn't look like that one was two years?

Jim Poyer: This is Jim Poyer again. It's a nine-month performance period, the lag between – for the difference between the baseline period.

Tami Lewis: Right.

Jim Poyer: Which is nine months and the performance period is two years between.

Tami Lewis: OK.

Jim Poyer: So, the last nine months of 2008 versus the last nine months of 2010 and the simulated dry run reports.

Tami Lewis: OK, thank you.

Jim Poyer: Sure.

Geanelle Herring: Thank you for your question. Holley, next question please.

Operator: Your next question comes from the line of Charles Phillips. And that question has been withdrawn.

Your next question comes from the line of Paula Parsons.

Tina Swing: Hi, this is Tina Swing from Qualis Health in Seattle. CMS has done a great job of describing point assignment for process and patient experience measures in this call and in previous calls, and I'm wondering when CMS will be providing a description for point assignment for the 30 day mortality measures?

Jim Poyer: Tina, this is Jim Poyer. Thank you for the questions. We'll put it on our list of things to do, and stay tuned for a future call, potentially we'll consider it. And for that we would refer you to the FY '14 final rule and proposed rule that's published in the Federal Register for discussion on the points for mortality measures.

I think we're, you know, paging for additional information. If we have additional information we will also put it on the QualityNet website and let

the folks know we plan to update that website on a CMS website to provide more information, so.

Tina Swing: Thanks so much.

Operator: And your next question comes from the line of Marsha Ford.

Marsha Ford: Hi, this is Marsha Ford with University of Illinois. I am calling more on the finance side of the world. Is CMS considering giving hospital administration some sort of letter or communication for their determination on what the hospital will get for each type of reimbursement? Meaning, for a value-based purchasing you'll get a plus .119 percent. Hospital required condition – you're going to lose your percentage point somehow, so that finance can make sure that the hospital is getting paid what they believed they're getting paid with all the new changes going into effect.

Jim Poyer: This is Jim Poyer, we'll consider it – we recognize that this information is coming from a myriad of sources, and it can be a challenge for hospitals, their financial administration, and C Suite to be able to get all this information from the many sources and integrate it. But we will consider it and will send it throughout CMS and also encourage you when we put our proposals for rule making to submit that, that way CMS must respond to every single comment and it has to be published in the Federal Register, so.

Marsha Ford: OK, thank you very much.

Jim Poyer: Thank you.

Operator: Your next question comes from the line of Kelsey Pence.

Kelsey Pence: This is Kelsey Pence from Summit Medical Center. And you may have answered this question through the slides and I just didn't get it but I was curious, is there a point range that you have to earn to guarantee your hospital of the one percent payment?

Geanelle Herring: Can you give us a moment, please?

Jim Poyer: I'm sorry. We can't give you that exact information because the pool of hospitals, as well as how the hospitals score what their total performance scores are – as I pointed out, it has to be budget neutral and paid out, no more, no less. So what the exact measure, you know, quality performance rates are, we're going to have to run the data and calculate the scores based on that.

So, your score is going to be based on your performance relative to baseline as well as your improvement. And then the pool of money has to be overall budget neutral, so we can't give you an exact. If you get this measure rate, then you get a net positive.

Kelsey Pence: OK, thank you.

Geanelle Herring: Thank you for the question. Holley, next question, please.

Operator: Your next question comes from the line of Peggy Jarrett.

Peggy Jarrett: This is Peggy Jarrett from Platte Valley Medical Center and I have been trying to track down a little bit more specific information related to the consistency score for the HCAHPS. It's on slide 37. You kind of briefly talked about it.

Performance and the improvement scores are very well defined and I totally understand those. The consistency score is, I can't find any place in the register or on CMS that kind of gives an easily understandable, and I don't know if you can explain that a little bit more as to where you come up with those 20 points. Or if there's a place that I can go to kind of read up on that and get a little bit more detail.

Bill Lehrman: Thanks for the question. This is Bill Lehrman from CMS. I work on the HCAHPS survey. We had a more extended discussion about how the consistency points will be scored in our July call and I believe the slides are still available.

Peggy Jarrett: OK.

Bill Lehrman: And just as a brief reminder, consistency points accrued to the lowest score amongst the HCAHPS dimension so we're trying to ...

Peggy Jarrett: Right.

Bill Lehrman: ... incentivize hospitals to raise their lowest score to the achievement threshold. And through testing analysis we did on developing VBP we came up with a number of 20 points. That will be total – 20 points for consistency, if a hospital has every one of its eight dimensions above the threshold.

Peggy Jarrett: OK, that helps. Thank you.

Geanelle Herring: Thank you for the question. Holley, next question, please.

Operator: Your next question comes from the line of Rebecca Thurman.

Rebecca Thurman: Good afternoon and thank you for this teleconference. It's been very informative. My question is – and this is Rebecca Thurman. I'm from Coffey County Hospital in Burlington, Kansas.

My question is in regards to the clinical performance period. I'm very concerned that it goes through March 31st, 2012. As I'm sure you all are aware, the National Abstracting System has been down for the first three months of 2012. How can we submit clinical performance data to you all for this period when we don't have a way of doing it?

Jim Poyer: Thank you for that question, and that affects – first, this is Jim Poyer, I'm sorry. This would potentially affect the – only the first calendar quarter 2010 discharges. It is our strongest intent to have this system, and this is the QIO, Quality Improvement Organization, clinical warehouse that accepts the Hospital IQR data. We intend to have this up within the next several weeks hopefully no later than April 1st and would allow hospitals approximately 4½ months to be able to submit data to CMS by the August 15th, 2012 warehouse deadline.

Now, as I understand it, hospitals can submit the fourth calendar quarter 2011 discharges that are due to CMS by May 15th, 2012, and there's no impact to that submission. What you're talking about, I believe, is affecting only first calendar quarter 2012 discharges. And we're making every effort to get that

released to the hospitals as expeditiously as possible but we want to make sure that it's working correctly and I appreciate that.

Rebecca Thurman: But won't this affect the reports that we'll get November 1st where it says our actual incentive adjustment, if we don't get these first three months in?

Jim Poyer: The requirement is it's a quarterly requirement in the hospital IQR program to submit data prior. And for first calendar quarter discharges that deadline is August 15th, 2012 and we're making every effort to get this warehouse up and running by, within the next several weeks. Hopefully it's March, hopefully it's no later than April 1st, but even with an April 1st release, hospitals and their vendors have April, all of April, May, June, July and half of August to be able to submit their patient level chart extracted data. So we ...

Rebecca Thurman: All right. Thank you.

Jim Poyer: Thank you.

Geanelle Herring: Holley, we have time for just one more question, please.

Operator: Thank you. Your final question comes from the line of Denise Black.

Denise Black: Yes, my question was – this is Denise Black from St. Vincent East in Birmingham, Alabama. I was under the impression that the readmissions were also going to be added to the value-based purchasing measures for Fiscal Year '14 and we've just talked about mortality. Are readmissions playing a role or will they in the future?

Jim Poyer: Statute precludes, we are not allowed to have measures of readmission in the Hospital Value-Based Purchasing. Section 3025 of the Affordable Care Act, which is separate and distinct, has a provision for compensating hospitals for their performance on readmission measures. That is a separate program from the Hospital Value-Based Purchasing program. That's why we only allude to them in the measure set that we finalized for Fiscal Year 2014.

There is – there are three 30-day mortality measures that, in addition to patient experience of care and clinical process of care domains, no readmission

measures for Fiscal Year 2014, and statute prevents us from adding measures on readmission in a Hospital Value-Based Purchasing program. Thank you.

Geanelle Herring: Thank you, Jim. I would like to thank everyone for attending this National Provider Call. We hope that this call has provided you with a better understanding of how the Hospital VBP Program will affect your hospital payments in Fiscal Year 2013, and what to expect when you receive your simulated hospital specific dry run report.

We also hope that this call has given you an understanding of what is ahead in the next 12 months related to Fiscal Year 2013, Fiscal Year 2014, and Fiscal Year 2015 Hospital VBP Programs.

Remember, the impetus behind Hospital VBP is better care, better outcome for patients, and transforming the healthcare system to a payment system that recognizes the reward – excuse me, recognizes reward and quality.

The audio file and transcript of today's call will be made available at <http://www.cms.gov/Hospital-Value-Based-Purchasing/> on the CMS website. If you were unable to ask a question of the CMS subject matter experts gathered here with us today, please feel free to complete the feedback form that will be posted on the QualityNet website at <http://www.qualitynet.org>. Or send an e-mail to [HospitalVBP@cms.hhs.gov](mailto:HospitalVBP@cms.hhs.gov).

To ensure that the National Provider Call program continues to be responsive to your needs, we are providing an opportunity for you to evaluate your experience with us here today. Evaluations are anonymous and strictly voluntary. To complete the evaluation, visit [http://npc.-B as in boy, L as in Larry, H as in Harold – tech.com/](http://npc.-B-as-in-boy,L-as-in-Larry,H-as-in-Harold-tech.com/) and select the title for today's call from the menu.

All registrants will receive a reminder e-mail within two business days of today's call. Please disregard that e-mail if you have already completed the evaluation. We appreciate your feedback and thank you for joining us. Goodbye.

Operator: Thank you for your participation. You may now disconnect. Speakers, please hold the line.

END