

This document has been edited for spelling and grammatical errors.

Centers for Medicare & Medicaid Services
Hospital Value-Based Purchasing Fiscal Year 2015 Overview
National Provider Call
Moderator: Aryeh Langer
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Operator: At this time, we'd like to welcome everyone to today's National Provider 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.

I will now turn the call over to Aryeh Langer. Please go ahead.

Announcements and Introduction

Aryeh Langer: Thank you, Holley. Hello, I'm Aryeh Langer from the Provider Communications Group here at CMS, and I'll serve as your moderator for today's call. I would like to welcome you to the Hospital Value-Based Purchasing Fiscal Year 2015 Overview National Provider Call.

Today's NPC, or National Provider Call, is part of the Medicare Learning Network, your source for official CMS information for Medicare fee-for-service providers. Today we have CMS subject-matter experts here to discuss the design and preview of the FY 2015 Baseline Measures Report in order to help demonstrate how hospitals will be evaluated for each of the FY 2015 domains.

Before we get started, there are few items that I need to cover. Number 1, a reminder e-mail about today's call, including a link to the slide presentation, was e-mailed to all registrants at approximately 12:15 this afternoon. If you did not receive this e-mail, please check your spam or junk mail folders for an e-mail from the CMS National Provider Calls Resource Box.

If you did not get today's presentation, you can go to the National Provider Calls and Events Web page located on the CMS Web site at www.cms.gov/npc, as in National Provider Call, and click on the National Provider Calls and Events link on the left side of the page. You'll then be able to scroll down and click on the link to today's call. I'm just going to repeat that URL for you: www.cms.gov/npc.

The second item is that this call is being recorded and transcribed. An audio recording and written transcript will be posted to the National Provider Calls and Events Web page that I just mentioned within the next 3 weeks. The URL is located on the final slide of today's presentation. A direct link to the page where these materials will be posted is also included in the e-mail that went out to registrants earlier today.

Number 3, I'd like to thank those of you who submitted questions in advance of today's call. Your questions were shared with the speakers to help prepare slides and remarks for today's presentation. They may also be used in the future to help produce outreach products, including frequently asked questions.

At this time I would like to introduce our first speaker for today. We are pleased to have with us Jean Moody-Williams, Director of the Quality Improvement Group of the CMS Office of Clinical Standards and Quality. And now, it is my pleasure to turn the call over to Jean, who will begin our presentation.

Presentation

Introduction and a Word about Carbapenem-Resistant Enterobacteriaceae [CRE]

Jean Moody-Williams: Thank you, and hello everyone. As was mentioned, this is Jean speaking. I'm the Quality Improvement Group Director. And I want to thank you for joining us today, and I also wanted to thank you for the work that you do on a daily basis to provide quality care to patients and to support the families and caregivers that are so dependent on the work that you do.

This call was developed really for hospitals that will be included in the Hospital Value-Based Purchasing Program. I'm sure you are aware if you're on this call that the program is designed to promote better clinical outcomes for hospital patients and to improve the experience of care that patients have as they continue during their hospital stays.

Participating acute care hospitals are awarded incentive payments if they achieve a specific level of the quality of care measures and also meet appropriate patient experience of care levels for the care that's provided to the Medicare beneficiary. This National Provider Call was really designed to give an opportunity to engage you, the hospitals, in a discussion about the FY 2015 Hospital Value-Based Purchasing Program.

After a brief presentation, we're going to give you the opportunity to ask questions and provide feedback, so we're going to ask that you hold your questions until the end. In addition to the CMS presenters that will be speaking with you today, I'd like to take this opportunity to acknowledge our partners—the MITRE Corporation, a Federally funded research and development center; Telligen, our support contractor; Mathematica Policy Research; and the Centers for Disease Control and Prevention—all of whom will help in responding to the questions today.

Before I turn it over, I would like to take a moment for a brief public service announcement. I guess we're going to have a commercial here. But—and it's not really directly related to Hospital Value-Based Purchasing, but it is certainly related to the safety of patients in this country—I just wanted to bring to your attention, and I'm sure you're probably getting this information in multiple sources, but the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services, we're asking your assistance in tackling what may be one of the most pressing patient safety threats of our time. And that is carbapenem-resistant Enterobacteriaceae [CRE].

CDC recently released a report on the presence of, I'll say CRE, in the United States' inpatient medical facilities, demonstrating that action is needed now. Really, it's needed to halt the spread of these deadly bacteria. We are asking for rapid action from healthcare leaders to ensure that infection prevention measures are aggressively implemented in your facilities and in those facilities surrounding you, as this really is pervasive in the community.

Enterobacteriaceae are a family of more than 70 bacteria, including *Klebsiella pneumoniae* and *E. coli*, and it normally lives in the digestive system. But over time,

some of these bacteria have become resistant to the group of antibiotics known as carbapenem, often referred to as the last-resort antibiotic. And during the last decade, CDC has tracked the CRE from a single healthcare facility to at least 42 States. In some healthcare facilities, these bacteria already pose a routine threat to patients, and the CRE results in death in one in two patients who get the bloodstream infection. So—very, very serious.

CDC has released a concise practical prevention toolkit with recommendations for how we can control the transmission. It really follows—and they're looking at long-term care, acute hospitals, nursing homes, health departments, and these recommendations follow the detect-and-prevent strategy. And you're very familiar with that, I'm sure, as things like enforcing the use of infection control precautions; grouping patients together with CRE; dedicating rooms, staff, equipment to the care of patients with CRE whenever possible; having facilities alert each other. As patients move in and about the community, it's really important that we provide the information so that the receiving facility knows about this and can set up the appropriate precautions. And asking the patient—having a conversation with the patient about the—receiving care about what they—to see if they are likely to have this CRE. And then using antibiotics wisely because, obviously, unwise use leads to further resistance.

When fully implemented, CDC recommendations have been proven to work. Medical facilities in several States have reduced CRE infection rates by following these guidelines. And, again, I'll just reiterate that the United States is at a critical point in our ability to stop the spread of CRE, and if we do not act quickly, we will miss our window of opportunity, and it could become more widespread across the country. So I thank you for listening to this message. Anything that you can do to help us slow this down, we do appreciate it.

And I would like to now turn over to our next presenter, Jim Poyer. And we thank you. And, Jim, I'll turn it to you.

Introduction to the Hospital Value-Based Purchasing (VBP) Program

Jim Poyer: Thank you, Jean. Good afternoon, my name is Jim Poyer, and I work at CMS's Center for Clinical Standards and Quality, and I'm the Director for the Division of Value, Incentives, and Quality Reporting, in the CMS Quality Improvement Group that Jean is the Director for.

Today we will provide background on a Hospital VBP program: what the program's requirements will be for fiscal year 2015 payment, and how hospitals will be evaluated under the fiscal year 2015 program. For FY '15, a hospital's Total Performance Score will be based on four domains: clinical process of care, patient experience of care, outcome, and efficiency. We will also go over an example that illustrates the scoring methodology for the FY '15 program, as well as discuss the FY '15 Baseline Measures Report, which will be available to hospitals through QualityNet. After the presentation, we will have time for questions and answers.

Next slide, please. The Hospital VBP program was established by Congress by the Affordable Care Act, which added Section 1886(o) to the Social Security Act. Hospital VBP is a quality incentive program built on the Hospital Inpatient Quality Reporting, or Hospital IQR, measure reporting infrastructure, and it's considered the next step in promoting higher quality care for Medicare beneficiaries.

The program is designed to transform the payment of care from a system based on the volume of patient visits and procedures performed to one on the quality of care provided to Medicare beneficiaries. The Hospital VBP section of the Affordable Care Act strives to change that dynamic and reward hospitals for providing high-quality care to patients at a lower cost. We view Value-Based Purchasing as an important driver of change moving toward rewarding better value and outcomes, which in turn will lead to better care and healthier patients.

The fiscal year 2015 program will be funded through a 1.5-percent reduction from participating hospitals' Diagnosis-Related Group, or DRG, payments. The money that is withheld will be redistributed to eligible hospitals based on their Total Performance Scores, or TPS, as required by statute. The hospitals have the potential to earn more than the 1.50 percent based on their total performance.

Next slide, please. Who is eligible for the program in fiscal year '15? Not every hospital is eligible for the Hospital VBP program. Currently, more than 3,000 hospitals nationwide do qualify for the program. The program applies to subsection (d) hospitals located in the 50 States and District of Columbia, including acute care hospitals.

Next slide, please. Who is excluded from the program? Hospitals excluded from the program are hospitals subject to payment reductions under the Hospital Inpatient Quality Reporting, or IQR, program; hospitals and hospital units excluded from the Inpatient Prospective Payment System, or IPPS (these include psychiatric, rehabilitation, long-term care, children's, and cancer hospitals); hospitals cited by the Secretary of Health and Human Services for deficiencies during the performance period that pose an immediate jeopardy to patients' health or safety; hospitals that do not meet the minimum number of cases, measures, or surveys required; and hospitals that are paid under Section 1814(b)(3) and have received an exemption from the Secretary of Health and Human Services. It is important to note that excluded hospitals will not have the 1.5 percent reduced from their base operating DRG payment amounts for the Hospital VBP program for the applicable fiscal year.

Next slide, please. In slide 7, the blue box outlines the 12 Clinical Process of Care measures that will be used for the fiscal year 2015 program. These 12 measures will contribute to the 20 percent of the hospital's Total Performance Score. The yellow box on the bottom right contains five measures included in the Outcome domain for the fiscal year 2015 program. The Outcome domain will contribute a total of 30 percent to the hospital's Total Performance Score. The Patient Experience of Care Domain, which uses the HCAHPS survey, is represented by the red box on the top right. This will also contribute 30 percent total to the hospital's Total Performance Score.

The Hospital VBP program places a strong emphasis on the patient's perception of care, which is covered by the eight dimensions listed in the red box. The remaining 20 percent of a hospital's score is based on the Efficiency domain, which is new for the fiscal year 2015 program. This domain contains one measure, the Medicare Spending Per Beneficiary measure. In subsequent years, CMS will be exploring the feasibility of excluding other potential domain measures to provide a broader snapshot of quality improvement and efficiency delivery of care.

Next slide, please. As mentioned earlier, the 12 Clinical Process of Care measures will be used for the fiscal year 2015 program. Please note that these 12 measures were also in the fiscal year 2014 program. The only exception is the SCIP Venous Thromboembolism 1, or VTE-1 measure, which was removed from the fiscal year 2015 program.

Next slide, please.

Aryeh Langer: Can I just ask the speakers who have their lines open to please mute them? Thank you.

Jim Poyer: Thank you. In slide 9, the same eight Patient Experience of Care dimensions will be used that were part of the fiscal year 2013 and '14 programs.

Next slide, please. For the fiscal year 2015 program, there are five Outcome measures. Two new measures have been added for fiscal year 2015 program that were not in the fiscal year 2013 and '14 programs. These two measures are the Agency for Healthcare Research and Quality, or AHRQ, Patient Safety Indicator composite, and the code for that is PSI-90. And the Center for Disease Control's Central Line—Associated Bloodstream Infection, or CLABSI measure, which will be described further in the following slides.

Next slide, please. And first we'll be describing the AHRQ Patient Safety Indicator, or PSI-90. It's one of two new measures in the Outcome domain. This measure is the composite of underlying indicators related to patient safety. The PSIs are a set of indicators providing information on potential in-hospital complications and adverse events during hospitalization on or after a surgery or procedure.

Next slide, please. The interpretation of a hospital's PSI composite ratio is complex. Lower ratios indicate better quality. The AHRQ PSI-90 composite is a ratio, but a value of "1" does not mean that the hospital is performing as expected. The best interpretation of a PSI composite ratio is in a comparison. For example, a hospital with a PSI composite ratio of 0.5 represents higher quality than the national median—or a threshold of 0.622879, since 0.5 is lower than 0.622.

Next slide, please. The PSI composite consists of eight PSI rates, as shown on the slide.

Next slide, please. Next, I'll be discussing the CLABSI, or Central Line—Associated Bloodstream Infection measure, on slide 14 on your deck. It's the second new measure in the outcome domain for fiscal year 2015. This is a healthcare-associated infection measure that assesses the rate of laboratory-confirmed cases of bloodstream infection among intensive care unit patients. Adoption of CLABSI is consistent with the intent in the Hospital VBP program's statutory requirements to consider measures of Healthcare-Associated Infection in the program's measure set.

Next slide, please. For the fiscal year 2015 program we've also finalized a new efficiency domain. This domain is comprised of one measure, the Medicare Spending Per Beneficiary measure, or noted on the slide deck as MSPB-1. This domain comprises 20 percent of the hospital's Total Performance Score.

Next slide, please. The Medicare Spending Per Beneficiary measure is a claims-based measure that includes risk-adjusted and price-standardized payments for all Part—Medicare Part A and Part B—services provided from 3 days prior to the hospital admission—and that's index admission—through 30 days after the hospital discharge.

Next slide, please. Next, in slide 17, we'll walk through the fiscal year 2015 baseline and performance periods for the domains. Please note that the performance period for the Clinical Process and Patient Experience of Care domains, as well as performance period for CLABSI and MSPB, or Medicare Spending Per Beneficiary, end on December 31, 2013.

Within the outcome domain, the performance period end date for the Mortality and the AHRQ measures is June 30th, 2013. During these performance periods, we will be looking at how hospitals perform on the measures and dimensions included in these four domains.

How Hospitals Will Be Evaluated

Next slide, please. "How Will Hospitals Be Evaluated? Achievement versus Improvement." Achievement points are awarded by comparing an individual hospital's rates during the performance period with all hospitals' rates from the baseline period, with the exception of the MSPB measure, which we will discuss in a moment. Hospitals with a rate equal to or better than the benchmark will receive 10 points. Hospitals with a rate worse than the achievement threshold will receive zero points. (Excuse me.) A rate equal to or better than the achievement threshold and worse than the benchmark will receive between 1 and 10 points.

It's important to note that unlike the other measures, the MSPB measure compares a hospital's rate during the performance period with all hospitals' rates from the performance period for the purpose of awarding achievement points. A hospital is eligible to receive improvement points if its performance on a measure during the performance period is better than its performance on the measure during the baseline period. Improvement points are calculated by comparing a hospital's performance during

the performance period to their performance during the baseline period and the benchmark.

Hospitals with a rate that is equal to or better than the benchmark and better than the baseline period rate will receive 9 points. (Excuse me.) Hospitals with a rate equal to or worse than their baseline rate will receive zero points. Hospitals with a rate between the baseline period rate and the benchmark will receive between zero and 9 points. It is important to note that when a hospital is not open during the program year's baseline period but is open during the performance period, only points based on achievements for that program year will be rewarded. Improvement points cannot be awarded since there is—as there is no baseline data.

Next slide, please. How will hospitals be evaluated in terms of the baseline data? In slide 19, in the graphic on the top right of slide 19, there are two points represented in the curve: the benchmark, which is defined as the mean of the best decile, and (2) the threshold, which is defined as the 50th percentile of the hospitals. The benchmark is on the right side of this chart to show that a higher rate is better for the measures dimensions listed in the top left of the slide. This holds true for the Clinical Process of Care measures, the Patient Experience of Care dimensions, and the Mortality measures.

In the graphic that is at the bottom right of the slide, the benchmark is on the left of the chart to show that a lower rate is better for the measures listed in the bottom left of the slide. The benchmark is still the mean of the best decile, and the threshold is still the 50th percentile of hospitals. The measures where a lower rate is better are AHRQ PSI-90, CLABSI, and Medicare Spending Per Beneficiary. MSPB, or Medicare Spending Per Beneficiary's benchmark and threshold are based on hospital data from the performance period.

Next slide, please. How will hospitals be evaluated? In the Clinical Process of Care domain, this slide illustrates the requirement for the minimum number of cases and measures in the Clinical Process of Care domain. A minimum of 10 cases for at least 4 applicable measures is required to receive the Clinical Process of Care domain score. In the example shown here, Clinical Process measures 1, 2, 3, through measure 12 on the slide have at least 10 cases, as indicated by small black figures with the green check mark.

However, Clinical Process measure 11 does not have 10 cases, so this measure would be excluded from this hospital's score for Hospital VBP. In this example, even without Clinical Process measure 11, this hospital meets the minimum number of 10 cases per measure for at least 4 measures and would therefore receive a Clinical Process of Care score.

Next slide, please. In the Patient Experience of Care domain, to receive a score—a domain score, hospitals must have completed at least 100 completed Hospital Consumer Assessment of Healthcare Providers and Systems, or HCAHPS surveys during the performance period.

Next slide, please. In slide 22, to receive an Efficiency domain score, hospitals are required to have a minimum of 25 cases for the Medicare Spending Per Beneficiary, or MSPB, measure during the performance period. One case is equivalent to an MSPB episode. Remember, one case is equal to one MSPB episode, which is comprised of all Medicare Part A and Part B services provided from 3 days prior to a hospital admission, or index admission, through 30 days after the hospital discharge.

Next slide, please. And in slide 23, we illustrate the minimum case requirement for the Mortality measures included in the Outcome domain score. These minima include at least 25 cases for the Mortality measures, which is represented with the green check marks over Mortality-30-AMI, or the 30-day AMI Mortality measure, and the Heart Failure 30-day Mortality measures noted on your slide deck as MORT-30-HF. In this example, MORT-30-PN, or the Pneumonia Mortality measure, did not have the 25 cases, so it would not meet a minimum case requirement and has the corresponding red X on the slide.

Next slide, please. Slide 24, on the AHRQ PSI-90 composite measure, it requires at least three cases on at least one underlying indicator. In this example, the first AHRQ PSI Indicator shown meets this criterion for at least three cases. Therefore, this hospital would qualify for the measure.

Next slide, please. How will hospitals be evaluated in terms for the CLABSI measure case minima? The minimum case requirement for CLABSI is one predicted infection. In this example, the hospital did not have one predicted infection and, therefore, meets the criteria as indicated in the green check mark.

Next slide, please. In order for a hospital to receive an Outcome domain score, the – hospitals must meet the applicable case minimum for at least two of the five Outcome measures during the performance period. On this slide, the example hospital will receive an Outcome domain as it has met the case minimum for four out of the five Outcome measures, as denoted by the green checks.

The Total Performance Score and Calculating Domain Scores

Next slide, please. Next we'll describe the Total Performance Score. For the fiscal year 2015 program, this score is comprised of the Clinical Process of Care domain, which accounts for 20 percent of the Total Performance Score; the Patient Experience of Care domain, which accounts for 30 percent; the Outcome domain accounts for 30 percent; and the Efficiency domain, which accounts for the remaining 20 percent. (Excuse me.)

Unlike past program years, hospitals do not need to have a score for all domains to receive a Total Performance Score. Hospitals only need at least two of the four domains to receive a Total Performance Score. For hospitals with at least two domain scores, the excluded domain weights will be proportionately distributed into the included domains to calculate that hospital's Total Performance Score.

Next slide, please. When a hospital meets only the minimum case and measure requirements for two or three domains, the domain weightings will be recalculated to proportionately redistribute the weighting of the excluded domain or domains. Whether a hospital's TPS is comprised of two, three, or four domain scores, the domain weightings must add up to 100 percent. In order to calculate the domain weightings for a hospital with two or three domain scores, the sum of domain weightings of the excluded domain or domains will first be subtracted from 100 percent. The weightings for the remaining domain scores will be divided by the resulting difference. The result is the redistributed domain weighting.

In this scenario, a hospital meets the minimum case measure and survey requirements for the Clinical Process, Patient Experience, and Outcome domains, but it does not meet the minimum requirements for the Efficiency domain. The excluded domain weight will be proportionately redistributed to the remaining score domains to calculate the Total Performance Score. Since the Efficiency domain, which is worth 20 percent of the Total Performance Score, is being excluded, we first subtract its 20 percent from the total 100 percent to get 80 percent. Each score domain weight will be divided by 80 percent to redistribute the Efficiency domain's 20 percent to the scored domains.

In this example, the Clinical Process of Care domain increases from 20 to 25 percent. This is 20 divided 80 multiplied by 100, to come up with 25 percent. And the Patient Experience of Care domain increases from 30 to 37.5 percent, and the Outcome domain increases from 30 to 37.5 percent. And these two—the math is 30 divided 80 and then multiplied by 100 percent.

After reweighting, the remaining domain scores continue to make up the same relative proportions of the Total Performance Score, but they now each account for a higher percentage in order to make the full 100 percent of a hospital's Total Performance Score. This process is intended to preserve the ratio between the domain scores when calculating the TPS, regardless of the number of eligible domains.

Next slide, please. Calculating the domain score: Now that we have discussed what the program's requirements will be for fiscal year 2015 and how hospitals will be evaluated under the fiscal year 2015 program, we will go through a detailed example. In the following slides, we will describe how to calculate the Outcome domain score.

Next slide, please. This slide shows all five Outcome within—all five measures within the Outcome domain and their associated thresholds and benchmarks. As you can see from this slide, each of the measures have different thresholds and benchmarks. As was previously mentioned, lower rates are better for the AHRQ PSI and CLABSI measures. This results in a benchmark to the left of the – of the threshold on the scale shown at the top of the slide. This differs from the three Mortality measures, which the Hospital VBP program has converted to survivability rates, where higher rates are better. As a result, the benchmark is to the right of the threshold.

Next slide, please. This slide depicts a hospital's performance data for the PSI-90 composite. The hospital's—excuse me, the baseline performance rate for the outcome domain was October 15, 2010, through June 30, 2011. Represented on the curve on slide 31 are two points, the achievement threshold and the benchmark.

The achievement threshold is defined as the median, or the point at which half of the hospitals have performance rates lower and half of the hospitals have performance rates higher than this point. For this measure, the achievement threshold or the 50 percentile for hospitals is 0.622879. That means—this means that half of the hospitals have performance rates higher than the 0.622879, and half have performance rates that are lower. If a hospital's performance on this measure is equal to or better, that is lower, than the achievement threshold, then that hospital will receive achievement points for this measure.

The benchmark is defined as the mean of the best decile of hospitals. For PSI-90, the benchmark is 0.451792. If a hospital's performance is equal to or better, that is lower, than the benchmark, then that hospital will receive 10 achievement points for this measure. As you can see on the slide, unlike the measures in the fiscal year 2013 and '14 programs, the benchmark is on the left of the curve for PSI-90, so lower ratios are better. Since this measure evaluates hospital complications and adverse events, the fewer complications and adverse events, the better for both hospitals and patients.

Achievement and Improvement Points: the AHRQ PSI-90 Example

Next slide, please. Over the next 12 slides, we will be using AHRQ PSI-90 as an example of how a hospital earns achievement and improvement points. On this slide, you will see the achievement range for PSI-90. Achievement points are awarded to hospitals by comparing individual hospitals' rates during the performance period against the benchmark and the threshold. For AHRQ PSI-90, the benchmark is 0.451792 and the threshold is 0.622879.

Achievement points for this measure are calculated as follows: Since lower is better for PSI-90, if a hospital's performance on this measure during the performance period is equal to or less than the benchmark, that hospital will receive the maximum 10 achievement points. If a hospital's performance on this measure during the performance period is greater than the achievement threshold, that hospital will receive zero points for achievement. If a hospital's performance on this measure during the performance period is equal to or less than the achievement threshold but greater than the benchmark, that hospital will receive between 1 and 9 points, depending on where the hospital's performance rate falls on the achievement range.

Next slide, please. Slide 33 displays an example of a hospital's performance rate of 0.504370 during the performance period. Since the performance rate of 0.504370 is better than the achievement threshold, the hospital will receive achievement points. However, the actual number of points is determined based on a formula included in the Hospital VBP Final Rule, which is displayed on the next few slides.

Next slide, please. On slide 34, we present the formula from the Hospital VBP Final Rule that must be used to calculate the achievement points for this measure. This formula calculates the relative position of this hospital's performance rate of 0.504370 between the achievement threshold and the benchmark for this measure.

Next slide, please. Here on slide 35 we show how the hospital's performance rate threshold and benchmark are used to calculate the achievement points for this measure. The blue dotted lines on the next few slides represent where each number appears in this formula. On this slide you can see that the benchmark of 0.451792 is represented in the denominator of the equation.

Next slide, please. On slide 36 we see the hospital's performance rate—0.504370—represented in the numerator of the equation.

Next slide, please. In this slide, we see the threshold 0.622879 is in the numerator and denominator of the equation, as indicated by the blue dotted lines. When we calculate the formula, we see that the number of achievement points equals 6.73, which is rounded to the nearest whole number, 7.

Next slide, please. We must also calculate the hospital's improvement points for this measure. Improvement points are awarded to hospitals by comparing a hospital's rate during the performance period to that same hospital's rate from the baseline period. Improvement points are calculated for a hospital as follows: If a hospital's performance period rate is equal to or less than the benchmark, the hospital will receive 9 points. A hospital with a rate equal to or higher than the baseline period rate will receive zero points. A hospital with a rate between the baseline period rate and the benchmark will receive between zero and 9 points.

In this example, this hospital has a performance period rate of 0.504370 and a baseline period rate of 0.550000. This performance rate from the baseline period defines this hospital's starting point for improvement points. The actual number of improvement points is determined from a formula in the Hospital VBP Final Rule, which is displayed on the next few slides.

Next slide, please. On slide 39 we present the formula from the Hospital VBP Final Rule that must be used to calculate the improvement points for this measure. The formula calculates the hospital's improvement points by using the relative position of this hospital's performance period rate of 0.504370 between the hospital's baseline period rate and the benchmark for this measure.

Next slide, please. On slide 40, here we show how the hospital's performance period and baseline period rates and the benchmark for this measure are used to calculate the improvement points for this measure. In this example, we see that the benchmark 0.451792 is represented in the denominator of the equation, as shown by the blue dotted line.

Next slide, please. In slide 41, we see that the hospital's performance period rate 0.504370 is represented in the left of the numerator of the equation, as indicated in the blue dotted line.

Next slide, please. In slide 42, we see that the hospital's baseline rate 0.550000 is represented in both the numerator and the denominator of the equation, as indicated by the dotted blue lines. When we calculate the formula, we see that the number of improvement points equals 4.15, which is rounded down to the nearest whole number, 4.

Next slide, please. In slide 43, we displayed both the achievement and improvement points for this hospital for the AHRG PSI-90 measure. The higher of the achievement or improvement points is used to determine this hospital's points for this measure. In this example, the 7 achievement points are greater than the 4 improvement points. Therefore, 7 points are awarded to this hospital on the PSI-90 measure.

Next slide, please. For purposes of calculating the Outcome domain score for this example, this slide reflects the sample scoring for the CLABSI measure. In this example, on slide 44, the greater of the achievement or improvement points is used to determine this hospital's points for the CLABSI measure. The 7 achievement points are greater than the 6 improvement points. Therefore, the higher of achievement and improvement points is awarded, and in this case, it is 7. Please note, for CLABSI, the baseline rate refers to the baseline standardized infection ratio, or baseline SIR.

Next slide, please. On slide 45, we present the unweighted, unnormalized Outcome domain score for this example. Each of the five measures in the Outcome domain [is] shown with the points reflected for four of the five measures that this hospital met a minimum number of cases for. The fifth measure, MORT-30-PN, the Pneumonia 30-day Mortality measure, is shown with an X through it, as the hospital in this example did not meet the minimum number of cases.

As you can see, the sum of the higher of each measure's improvement and achievement scores equals an unweighted, unnormalized domain score of 24. We arrived at this score by adding 7 for CLABSI plus 7 from the AHRQ PSI-90 plus 8 from each of the two included Mortality measures, AMI and Heart Failure 30-day Mortality.

Next slide, please. Slide 46 displays how we will normalize a hospital's Outcome domain score. Normalization is used to avoid penalizing a hospital that for whatever reason it does not have the minimum number of cases that are required for each of the five Outcome domain measures. As mentioned previously, the five Outcome domain measures have different criteria for minimum case requirements. The three Mortality measures—MORT-30-AMI, MORT-30-HF, and MORT-30-Pneumonia or PN—require at least 25 cases. The AHRQ PSI measure requires at least three cases on any one underlying indicator, and CLABSI requires at least one predicted infection. As shown on the bottom of slide 46, this hospital's unweighted domain score of 24 is normalized by dividing 24 by the total possible points that the hospital can receive. The hospital met the minimum requirements for four of the five measures, so multiplying the

maximum 10 points for each measure by the four possible measures results in a total 40 possible points for this hospital. The hospital's unweighted domain score of 24, divided by the 40 total possible points, divided by 100 results in an unweighted, normalized outcome domain score of 60, or 24 divided by 40 equals 60.

Next slide, please. In slide 47, we show the normalized score of 60 for the Outcome domain from the previous slide, along with the example scores for the Clinical Process of Care and Patient Experience of Care domains. These example domain scores were presented in the fiscal year 2013 and 2014 National Provider Calls and are used as examples only. As you can see on this slide, to calculate the Total Performance Score for the fiscal year 2015 program, we still need to address the Efficiency domain.

Next slide, please. In slide 48, the hospital did not meet the minimum cases, or 25 episodes, required for the MSPB, or Medicare Spending Per Beneficiary measure, and thus does not receive points for either achievement or improvement. This means that this hospital does not receive a score for the Efficiency domain. Therefore, the Efficiency domain will be excluded from the Total Performance Score for this hospital's example.

Please note that for details on how to calculate the MSPB measure scores, please view the February 9, 2012, National Provider Call presentation. The Web site is included on slide 48.

Next slide, please. As mentioned earlier in the presentation, hospitals will need domain scores in at least two of the four domains to receive a Total Performance Score.

As shown in the previous slide, this example hospital did not receive points in the Efficiency domain because the hospital did not meet the minimum number of cases. Therefore, we must redistribute this hospital's Efficiency domain weighting to the other three domains in which CMS was able to compute domain scores. This means that the Clinical Process of Care domain weighting will go from 20 to 25 percent, the Patient Experience of Care domain weighting will go from 30 to 37.5 percent, and the Outcome domain weighting will go from 30 to 37.5 percent. The three domain scores will be multiplied by their respective redistributed domain weightings and will be added together for their hospital's Total Performance Score, even though the hospital had only three of four domain scores. The redistribution of domain weights means that the hospital's maximum Total Performance Score will be 100.

The Total Performance Score and How It Is Converted to a Value-Based Incentive

Next slide, please. Using the example domain scores that were previously discussed, along with the Outcome domain score from this presentation, we can calculate the Total Performance Score in this example. We convert the unweighted Clinical Process of Care Domain into its weighted score by multiplying 43.6 by its redistributed weight of 25 percent. This results in a weighted Clinical Process of Care domain score of 10.9, as shown in the equation in the slide.

Next slide, please. In slide 51, we convert the remaining domain scores into the redistributed scores. The Patient Experience of Care's unweighted domain score of 38 is converted to 14.25 by multiplying the redistributed 37.5 percent. The Outcome domain's unweighted domain score of 60 is converted to 22.5 by multiplying by the redistributed 37.5 percent. Adding the redistributed domain scores for the three domains together results in a Total Performance Score 47.65 in this example.

On the Hospital Value-Based Purchasing Program Percentage Payment Summary Reports, however, the Total Performance Score is reflect- – is represented with 10 decimal places. The Hospital Value-Based Purchasing Total Performance Score is then translated into a value-based incentive payment by the linear exchange function, which is presented on the next few slides.

Next slide, please. (Excuse me.) The law requires that the total amount of the value-based incentive payments that CMS may distribute across all of the – all hospitals must be equal to the amount of the base operating DRG reduction, which is 1.50 percent of the fiscal year 2015 program. Additionally, the law requires that the value-based incentive payments are based on hospitals' performance scores. CMS will use a linear exchange function to distribute the available amount of value-based incentive payments to hospitals based on hospitals' Total Performance Scores on the Hospital VBP measures.

Next slide, please. Each hospital's value-based purchasing – value-based incentive payment amount for a fiscal year will depend on the range and distribution of hospital Total Performance Scores for that fiscal year's performance period and on the amount of hospitals' base operating DRG payment amounts. The value-based incentive payment amount for each hospital will be applied as an adjustment to the base operating DRG amount for each discharge.

Details on how a Total Performance Score is converted into a value-based incentive payment can be found on the CMS Web site. The direct link is found on slide 53.

The Baseline Measures Report

Next slide, please. In the near future, CMS intends to provide hospitals with their Fiscal Year 2015 Baseline Measures Report. The Fiscal Year 2015 Baseline Measures Report will show hospitals' performance during the baseline periods listed on this slide. This includes four domains: Clinical Process of Care, Patient Experience of Care, Outcome, Efficiency.

Next slide, please. In your hospital's report, you will see the 12 Clinical Process of Care measure details, including benchmarks, thresholds, numerators, denominators, and your hospital's baseline rates. You will also see eight Patient Experience of Care dimensions detailed. This includes the floor values, benchmarks, thresholds, a hospital's baseline rate, and number of completed surveys during the baseline period. On this slide, you will see screenshots of a sample hospital baseline report for the Clinical Process of Care and Patient Experience of Care domains.

Next slide, please. On slide 56, the five Outcome measures will also be included in your report. The Mortality measure details, including the number of eligible discharges (that's the denominator for the measure), benchmarks, thresholds, and the hospital's baseline rate, will be shown. For the AHRQ PSI-90 composite measure, details including the index value, achievement threshold, and benchmark will be shown on the report. For the CLABSI measure, details including the number of observed infections (that's the numerator), the number of predicted infections (that's the denominator), the standardized infection ratio, the achievement threshold, and the benchmark will be shown. This slide shows a screenshot of the sample hospital's Outcome measures section of their hospital report, in slide 56.

Next slide, please. In slide 57, we talk about the Medicare Spending Per Beneficiary, or MSPB, part of the Efficiency domain. It will also be included in a hospital's report. Details including the payment-standardized, risk-adjusted MSPB amount (that's the numerator), the median MSPB amount (that's the denominator), the MSPB measure, and the number of episodes will be shown. The hospital on this example does not meet the minimum number of 25 cases and would have a note indicating this – appears at the bottom of this report. The slide shows a screenshot of the sample hospital's Efficiency measure.

Next slide, please. CMS intends to have the Fiscal Year 2015 Baseline Measures Report—we intend to have it available to hospitals in April of 2013. These communications will be sent to hospitals and QIOs when the Fiscal Year 2015 Baseline Measures Report will be available for viewing on the My QualityNet Web site.

Resources

Next slide, please. And we hope this presentation has been useful for you in your understanding of the fiscal year 2015 program. And in this slide, you'll see a number of resources that provide you with more details on the Baseline Measures Report for fiscal year 2015, as well as to help you access your report on the QualityNet Web site should you need assistance.

You can also find frequently asked questions related to the Hospital VBP program by using the Hospital Inpatient Questions and Answers tool on the QualityNet Web site. The direct link can be found on slide 59.

This concludes our presentation. We will now turn it over to the operator for any questions that you might have.

Next slide, please.

Keypad Polling

Operator: CMS greatly appreciates that many of you minimize the Government's teleconference expense by listening to these calls together in your office using only one line. 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 1. If there are

between two and eight of you listening in, enter the corresponding number between 2 and 8. If there are nine or more of you in the room, enter 9. Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number between 2 and 8. If there are nine or more of you in the room, enter 9.

And please hold while we complete the polling.

Again, please continue to hold while we complete the polling.

And this does conclude the polling session of today's call. We'll now move into the Q&A session.

To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Please remember to pick up your handset before asking your question to ensure clarity. And please note, your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

Aryeh Langer: I just want to take this time to remind everyone that the call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. And in an effort to get as many of your questions as possible, we ask that you limit your question to just one. There are many people on the call today so we'd really appreciate if you'd stick to that request.

Question-and-Answer Session

Operator: And your first question comes from the line of Sharon Ellis.

Sharon Ellis: Yes. I was wondering—I have heard from several sources that maybe some of the questions that are considered in the Patient Experience domain will be changing. Is that true? Or are they the same questions that we've been looking at the last couple of years?

William Lehrman: Hi, this is Bill Lehrman from CMS. No, the same dimensions will be in the Patient Experience of Care domain for the fiscal year '15 program. Same ones as in fiscal '13 and '14.

Sharon Ellis: Thank you.

Operator: And your next question comes from the line of Elaine Tsiakopoulos.

Elaine Tsiakopoulos: Yes, hi. I was wondering, when is the preview report available?

Jim Poyer: The Baseline Measures Report for fiscal year '15, we intend to release it in April of 2013. We will send out communications just prior to the date—the release of that to remind you of that. Thank you.

Operator: And your next question comes from the line of Tim Teyner.

Tim Teyner: Hi, this is Tim Teyner from Blanchard Valley Health System in Findlay, Ohio. I've got a question on slide 17. The performance period for the Mortality measure says it's October 1st, '12, through June 30th, '13, and I noticed the 2014 performance period is July 1st, '11, through June 30th, '12. So I'm wondering, is there a time period there where mortalities will not be captured?

Jim Poyer: We would have to—I don't have the 2014 period slides in front of us. We would have to research that and get—and if you could submit that as part of a question on the Web site, we can get back to you.

Tim Teyner: OK, thank you.

Jim Poyer: Thank you.

Operator: And your next question comes from the line of Rex Graff.

Rex Graff: Hi, my name is Rex Graff. I'm calling from Munson Medical Center in Traverse City, Michigan. A question about slide 4: I just wanted to confirm that, let's say, we totally bottom out, the worst that we'll get with is a 1.5 reduction. And the best that we can do is breaking even and earning 1.5 above operating DRG. Is that correct? We couldn't—if we have a stellar year, we couldn't get 1.8 or higher. Is that correct?

Kim Spalding Bush: Hi, this is Kim Spalding Bush from CMS. And CMS does not impose an upper limit on the amount that you could earn back. It depends on the Total Performance Scores that the whole universe of participating hospitals earned, and also on their annual base operating DRG payment amounts, which are subject to that reduction that funds the value-based incentive payments. So it's theoretically possible that you could earn back more than an additional 1.5 percent, but we won't have those numbers until we have everyone's Total Performance Scores and payment factors calculated.

Rex Graff: Thank you.

Operator: And your next question comes from the line of Rebecca Elkin.

Virginia Smith: Hi, I have a question about the time range when fiscal year 2015 payment is issued to hospitals. This is Virginia from Masspro. In other words, we are looking at fiscal year 2015, which has a baseline time period, you know, prior to that. When is payment actually issued for fiscal year 2015?

Jim Poyer: Hi, this is Jim Poyer. It will commence with discharge – inpatient discharges starting with October 1st, 2014, discharges, since this is fiscal year 2015 and a section of the Inpatient Prospective Payment System, and that’s – and that operates on a fiscal year basis. So you should see – our intent is to reflect the incentive payment corresponding to the initial discharges starting with October 1st, 2014, discharge payments and reflected on each claim – Part A claim.

Virginia Smith: OK. But when are those payments issued?

Jim Poyer: When the claim is paid, essentially the hospital would submit the claim to the fiscal intermediary, and the payment would be—there might be a lag of days or a few weeks . . .

Virginia Smith: OK.

Jim Poyer: . . .following that, but essentially it would be paid on a per claim basis. And that . . .

Virginia Smith: OK.

Jim Poyer: . . .same incentive would be reflected in each of the claims.

Virginia Smith: Thank you very much.

Operator: And your next question comes from the line of Nancy Griffith.

Nancy Griffith: Hi, this is Nancy Griffith from Littleton Adventist Hospital in Littleton, Colorado. My question is this: On slide 13, you indicate that central line venous catheter–related bloodstream infections is a part of PSI-90 outcome measure, but you also indicate that it’s another separate Outcome measure. So, will in this—this in fact to be measured twice?

Jim Poyer: It is included in two separate measures, but we believe that healthcare acquired—healthcare-associated infection is a danger to patients, and it is important to measure and reflect in terms of linking payment to quality and safety.

Nancy Griffith: So it will be measured on its own as well as part of PSI-90?

Jim Poyer: Yes. It will be—it’s part of PSI-90. It’s also a separate—one of the five measures in among itself in the Outcomes domain. Yes.

Nancy Griffith: OK, thank you.

Jim Poyer: Thank you.

Operator: And your next question comes from the line of Dan Schulte.

Dan Schulte: Hi, this is Dan Schulte. On slide 30, you indicate that the benchmark is the mean of the best decile, which can be as high as the 99th percentile mathematically, and I don't think that the equation you use after that to do the calculations would support that. Why not use the 90th percentile rather than the mean of the top decile?

Jim Poyer: Hi, this is Jim Poyer. Let me help clarify. It's not the *mean* of the best decile. It is the *median*. So essentially, it's – let's – alright, I apologize. With this domain, we will have to—if you could submit this question, we'll research and get back to you. Thank you.

Dan Schulte: Thanks.

Operator: And your next question comes from the line of Erika Pineda.

Erika Pineda: Hi. My question for you is in regards to slide 13 for the PSI-90. Just to confirm: PSI-3, 6, 7, 8, 12, 13, 14, 15 are the only ones that will be required for this measure, right?

Jim Poyer: That is correct. These PSIs were listed in the *Federal Register* proposed and finalized rulemaking for the fiscal year 2015 program. Yes, these are the only eight measures that would be included in the fiscal year 2015 PSI composite measure, yes.

Erika Pineda: Thank you.

Jim Poyer: Thank you.

Operator: And your next question comes from the line of Gino Conconi.

Gino Conconi: Hi, it's Gino Conconi from St. Joseph Health in Orange, California. My question is in regards to line—slide 14 and the definition for the CLABSI. It does state there that it's for infections among ICU patients. Just wondering if that would also include the neonatal intensive care unit patients.

Kathy Allen-Bridson: Hi, this is Kathy Allen-Bridson from NHSN. Yes, it includes both neonatal ICUs and adult ICUs as well. And pediatric ICUs.

Gino Conconi: Thank—

Kathy Allen-Bridson: So all ICUs.

Gino Conconi: Thank you. OK, thank you.

Operator: And your next question comes from the line of Augusta Agalaba.

Augusta Agalaba: Hi, this is Augusta from Robert Wood Johnson, New Brunswick. Actually someone had already posed my question because I was concerned about the central line–associated infections being measured twice, so hospitals are potentially being penalized twice. So that was my concern.

Jim Poyer: And if they perform very well on it, they also could receive additional payment related to that.

Augusta Agalaba: Thank you.

Operator: And your next question comes from the line of Lorri Cevallos.

Lorri Cevallos: Yes, this is Lorri Cevallos calling from Hendrick Medical Center in Abilene, Texas. And my question relates to slide 17. It indicates on the slide that the performance period for the CLABSI measure is February 1st of 2013 through December 31st, 2013, and the baseline is January through December 2011. Is that a typo?

Jim Poyer: It is not a typo. That is correct information. The baseline is 12 months. The performance period starts on February 1st, 2013, as statute requires that we commence or start a performance period no earlier than 12 months prior than the initial public posting on a Hospital Compare Web site, and these data were initially posted in January of 2012, hence the February 1st, 2013, start date for that particular measure. Thank you.

Lorri Cevallos: OK.

Operator: And your next question comes from the line of Joyce Francis.

(Victor Becca): Hello, this is (Victor Becca) from Lincoln Hospital in the Bronx. How does the payment affect hospitals' prospective payment system, which are not—which are reconciled much later, after the end of the fiscal year?

Jim Poyer: Hi, this is Jim Poyer. Could you repeat the question, please? I ...

(Victor Becca): How does the payment of incentive affect hospitals on prospective payment system?

Kim Spalding Bush: Hi, this is Kim Spalding Bush. So the program is for inpatient PPS hospitals, so it affects them on a prospective basis. So it's—information that we're looking at today is about how we calculate the performance that affects the fiscal year 2015 payments. So we do a claim-by-claim adjustment beginning with discharges, as Jim said, in fiscal year '15, which begins October 1st, 2014.

(Victor Becca): But which means that we'll get the money after reconciliation is done, correct?

Kim Spalding Bush: I'm actually not sure what you mean by reconciliation. Are you not paid under the IPPS?

(Victor Becca): Yes. So, but we reconcile it later on to the actual. Correct?

Kim Spalding Bush: IPPS hospitals are going to be paid on a prospective basis, on a per discharge basis, and these adjustments will be made at the time that the claim is paid.

(Victor Becca): OK, thanks.

Kim Spalding Bush: If you have further—if I'm just not understanding the question, please feel free to submit it to CMS, and if there's something that we can clarify more for you, we'd be happy to do that.

Aryeh Langer: For those folks that were asking to submit questions, the link or the URL is on the bottom of slide 59.

Operator: And your next question comes from the line of Priscilla Flake.

Priscilla Flake: Priscilla Flake from Harker Heights Medical Center. I think I may have got it answered as people have been talking. I got confused about one slide where it looked like you were taking a baseline from 2011. We're a new hospital start-up in June of 2012, and so I just wondered how we're being—going to be affected by that, but it looked like you were taking it from 2012 and 2013. So I think that answered my question.

Jim Poyer: Hi, this is Jim Poyer. If you were open after December 31st of 2011, you wouldn't have submitted any claims or treated any patients, so you wouldn't have any baseline data. So consequently you would only be scored on achievement related to any care quality measures, efficiency measures, safety measures during the performance periods that are listed. So you could only be scored on achievement points, not improvement.

Priscilla Flake: OK, that clarifies it.

Jim Poyer: [inaudible] improvement points, OK? Thank you.

Priscilla Flake: Thank you.

Operator: And your next question comes from the line of E.A. Ritter.

E.A. Ritter: This is E.A. Ritter. I was calling—so is the CLABSI—or is that going to be based off of claims data like the other program, or is it what hospitals are submitting to NHSN?

Jim Poyer: This is Jim Poyer. For the CLABSI measure that's listed separately, that is based off of hospitals' submissions to the Centers for Disease Control's National Health Safety Network.

E.A. Ritter: OK.

Jim Poyer: Both the denominator file as well as the infection events that are submitted to the CDC's National Health Safety Network. Now for the AHRQ PSI-90, because we – you know, one, or at least one questionnaire had mentioned as in terms of the inclusion twice, those infection events, if they are on claims, would also be counted in the PSI-90 measure. If they meet the criteria in terms of the measure specification, they would in fact be included also in the PSI-90 composite, but that of course is claims. The ...

E.A. Ritter: OK.

Jim Poyer: OK?

E.A. Ritter: OK. So CLABSI is what we submit to NHSN. The AHRQ is based off the claims data. I just needed—and so, that's the clarification?

Jim Poyer: That's the clarification, yes.

E.A. Ritter: Perfect. OK, thank you.

Operator: And your next question comes from the line of Joyce Schwarz.

(Joan Bicarri): Yes. Hi, this is (Joan Bicarri) of Robert Wood at Hamilton in Hamilton, New Jersey. Just to clarify on the Mortality measures: Is that an observed over expected rate or a percentage?

Candace Natoli: This is Candace from Mathematica. The Mortality measures are the same measures that are used for the IQR program. They're actually a predicted over expected rate, and it's a risk-adjusted measure.

(Joan Bicarri): OK, thank you.

Operator: And your next question comes from the line of Justin Hunter.

Justin Hunter: Hi, this is Justin Hunter with HealthSouth, and my question relates to the Medicare Spending Per Beneficiary measure. When hospitals are given the amounts of services involved comprising what I'll call the episode for an index admission, presumably those claims, expenditure amounts—what I'll loosely call the total “spend” at various points along the way in the episode—will include the names of the providers along with the amounts of services that were provided for a given beneficiary. My question is, will those providers who are so named in those reports in turn also have access to that data so that they can reconcile those amounts that are being reported to the hospital in question?

Kim Spalding Bush: Hi, Mr. Hunter. This is Kim Spalding Bush. We currently report not every provider. If you look at the QualityNet—and I'm sorry, I don't have the URL in

front of me—but the QualityNet MSPB information: There’s a list of the specific data files that we do provide to hospitals, and it describes which providers would be named in there. And at this time, no, there is no plan to provide that information to those other provider types. So it has no effect on their payment, and it’s never publicly reported. It’s provided so that hospitals have an opportunity to understand what drives their MSPB measure rates, and so that they can work to better coordinate and communicate about the care they provide to beneficiaries.

Justin Hunter: Thank you.

Operator: And your next question comes from the line of Sheree Washington.

Sheree Washington: Hi, this is Sheree Washington from Shands Jacksonville in Florida. I’m referring to slide 18 with my question. As far as the MSPB measure is concerned, I understand that for the achievement points, that we’re going to be using the performance period as compared to the performance period. But will this measure be receiving improvement points at all?

Kim Spalding Bush: Hi, this is Kim Spalding Bush again. Yes, the measure does receive improvement points. And that piece of it is similar to the other measures under the program in that the threshold to qualify to receive improvement points is the hospital’s own performance during the baseline period. And then we compare that performance, and if they improved during the performance period, then they can earn up to 9 points on a scale between their performance during the baseline and the benchmark during the performance period.

Sheree Washington: OK, thank you.

Kim Spalding Bush: Sure.

Operator: And your next question comes from the line of Shanelle Van Dyke.

Shanelle Van Dyke: Hi, this is Shanelle Van Dyke with Mountain–Pacific Quality Health. I just had a question in relation to whether or not there is currently or any thought going forward on having a reconsideration process for hospitals to be able to appeal their TPS and the amount of money that they could potentially be receiving or not receiving, somewhat similar maybe to like that of the Hospital IQR program related to APU?

Jim Poyer: Hi, thanks for the question. This is Jim Poyer. It’s statutorily mandated that we provide a review-and-correction process, that hospitals are allowed to submit on certain types of corrections, whether – it’s calculated – and it’s limited in scope. And we finalized last year in the *Federal Register* what’s in scope in – in primarily data calculation errors to the Total Performance Scores. And since we’re expanding to claims-based measures, that’s the Mortality measures and terms, we would have a process for the hospitals to review and correct their performance period data and submit correction requests. And we would review the request and then notify the hospitals whether we had

granted the correction request. Subsequent to that correction request, if we had denied, they are eligible to appeal. We had finalized that policy in the *Federal Register* in last year's rule as well. And they can appeal our initial decision on that.

So, unlike in the hospital inpatient program where we have various reporting requirements, this, in terms of what is essentially excluded from appeal as well as a review-and-correction process, is specified in the statute. And please refer to last year's IPPS final rule that was posted sometime in August 2012, that lays out some of the operational details of that program. I'll also refer you to the QualityNet Web site, [www.qualitynet](http://www.qualitynet.org) (all one word: Q-U-A-L-I-T-Y-N-E-T) dot org, for additional information on the VBP review-and-correction process and the appeals process. And we have conducted that for the first year, fiscal year 2013, of the program and are reviewing the one hospital that had submitted an appeal request. Thank you.

Shanelle Van Dyke: Thank you.

Operator: And your next question comes from the line of Jane Armstrong.

Aryeh Langer: Hi, your line is open.

Operator: Hi, Jane, your line is open.

Jane Armstrong: Our question has been answered. Thank you.

Operator: And your next question comes from the line of Karen Gavinski.

Karen Gavinski: Hello?

Aryeh Langer: Hello.

Operator: Yes, your line is open.

Karen Gavinski: Hi there. This is Karen Gavinski from ThedaCare in Wisconsin. My question is about the Mortality measures. We are building calculators for every one of these years, and we are a little frustrated. We're trying to get information on those three Mortality measures to even come close to the measurement period for 2014's measurement period. Do you know when Hospital Compare will have more updated numbers?

Candace Natoli: This is Candace Natoli with Mathematica. CMS plans to update the Mortality measure results on Hospital Compare for the IQR program this coming July. But your fiscal year 2014 Mortality measure results for the HVBP program will actually be arriving to you in April. Does that answer your question?

Karen Gavinski: Well, yes and no. So now, for the following year, for 2015, the measurement period is from 10/1 of '12 through 6/30. So we're almost done with this

year. We don't know how we're doing, you know, for any of that measurement period at this time. Is there more recent—you know, because this is a predicted-over-unexpected rate, we can't replicate that number. So we were just wondering if there's something out there that is more up-to-date that we can see how we're doing compared to everybody else.

Candace Natoli: I think the July 2013 results will provide you that most up-to-date information. The data period for the IQR program is different than the fiscal year 2015 program. But you will be able to see the discharges for that time period that overlaps with the fiscal year 2015 program when you receive your results for the IQR program this coming spring. So I'm hoping that will help address your concern.

Aryeh Langer: Thank you for your question. Holley, we have time for one last question, please.

Operator: OK. Your final question will come from the line of Marcy Cameron.

Aryeh Langer: Hi, Marcy.

Marcy Cameron: Thank you. Our question got answered a couple of times already. Thanks. Bye.

Aryeh Langer: Try one more time.

Operator: OK. Your final question will come from the line of Karen Trimberger.

Karen Trimberger: Yes. My question—this is Karen Trimberger from Memorial in Springfield, Illinois—it also relates to the CLABSI data. I understand, and thank you for clarifying, that the Outcome information will come from NHSN submission and that will be calculated on an SIR. I'm looking at the PSI-90, the measure 7. That actually says a rate, so that's going to be claims data, the infections by patient days, calculating a rate?

Alex Bohl: Hi, this is Alex Bohl from Mathematica. Actually, PSI – yes, PSI-7 is a rate but it's not – the denominator is not patient days; it's actually a rate per discharge. So ...

Karen Trimberger: Rate per ...

Alex Bohl: I'm sorry?

Karen Trimberger: I just clarified what you said, rate per discharge.

Alex Bohl: Yes, correct.

Karen Trimberger: OK. Thank you.

Additional Information

Aryeh Langer: And thank you, everybody, for participating and asking some great questions. Unfortunately, this is all the time we have on today's call. If we did not get to your question today, please refer to slide 59. There is a URL at the bottom of that slide where you can submit questions. Please note that while we may not be able to address every question, we will review them to help us develop frequently asked questions, educational products, and future messaging on these programs.

On slide 62 of the presentation, you'll find information and a URL to help evaluate your experience with today's call. Evaluations are anonymous and strictly confidential. I should also point out that all registrants for today's call will receive a reminder e-mail from the CMS National Provider Calls Resource Box within 2 business days regarding the opportunity to evaluate this call. You may disregard this e-mail if you have already completed the evaluation. Please note, evaluations will be available for completion for 5 business days from the date of today's call. We appreciate your feedback.

Again, we'd like to thank you for participating in today's call. As mentioned before, an audio recording and written transcript of the call will be posted to the CMS Web site within 3 weeks. I'd also like to thank our CMS and other subject-matter experts for participating in our call today. Again, my name Aryeh Langer, and it's been a pleasure serving you as your moderator today. Have a great day, everybody.

Operator: Thank you for your participation on today's call. You may now disconnect.

-END-