Centers for Medicare & Medicaid Services
Hospital Value-Based Purchasing
National Provider Conference Call
Moderator: Geanelle Herring
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Contents

Operator: At this time, I'd 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 Griffith Herring: Thank you, Holley. Hello, everyone, and welcome to the CMS National Provider Call on the Hospital Value-Based Purchasing Program. My name is Geanelle Griffith Herring and I will serve as your moderator for today.

This National Provider Call is an opportunity for CMS to discuss the proposed Fiscal Year 2014 Hospital Value-Based Purchasing Program and help set the framework for fundamentally changing the way hospitals are paid for their services to Medicare beneficiaries.

I would like to remind everyone that the slide presentation we will be using for today's discussion is posted on cms.gov/hospital-value-based-purchasing in the Download section. In addition, at 12:46 p.m. Eastern time, a link to this presentation and any other call materials were emailed to all registrants. If you did not receive this email, please check your spam or junk mail folders for an email from the CMS National Provider Call Resource Box.

This call is being recorded and transcribed. The audio recording and written transcript will be posted to the Hospital Value-Based Purchasing and National Provider Calls Event web pages on the CMS website.

I'd like to thank those of you who submitted questions when you registered for today's call. Your questions were shared with the speakers and this will help them prepare for future calls and the development of frequently asked questions.

After the formal presentation, we will open the lines up for a Q&A session. This will allow you the opportunity to ask questions of subject-matter experts to seek clarification about the program.

It is my pleasure to introduce you to our first presenter, Mrs. Jean Moody-Williams. She will provide you with opening remark and give you an overview of the Hospital VBP Program. I will now turn the call over to Mrs. Moody-Williams.

Overview

Jean Moody-Williams: Thank you so much and good afternoon everyone. This is Jean Moody-Williams. I am the Group Director for the Quality Improvement Group in the Office of Clinical Standards and Quality. I, too, would like to add my thanks to you for joining our call today. This is a National Provider Call. It's specifically developed for those hospitals that will be included in the Hospital Value-Based Purchasing Program.

As was mentioned, Hospital Value-Based Purchasing really is our first National Inpatient Pay for Performance Program, and it will serve as an important driver in revamping how CMS pays for care and services. I think what's more important is that this program is one that you are all well vested in and you're working hard in ensuring that it really becomes a meaningful driver of quality. As I travel around the country and I speak with you and hear about the things that you're doing, I really find it remarkable and we hope that ultimately it evolves into a program that you are proud to speak about to your stakeholders, to your customers, and to the communities that you serve.

I just wanted to take a moment to thank you for helping to shape the program in so many ways. There are many ways in which you participate, whether that's working on the consensus measures that we use, or commenting on rules, or even your participation in calls such as this. I understand we have a near record number of attendees across the country that have joined this call.

You're probably aware that your diligence is remarked upon globally as this is an effort that is studied by many countries. We have international visitors that

come in to look to see the work that's being done, and they too are attempting to drive quality across the world.

So I say all of that really just to say that we know your time is valuable, and so we hope that you'll find today's time well spent and, really, that it leads to better understanding and ultimately, to really improving the care that we provide to those throughout the country.

Our goal today is to provide you really with the deeper understanding of the Hospital Value-Based Purchasing Program, how it's supposed to be implemented for FY 2014, and how it will impact hospitals.

This call was designed to delve into how we're going to evaluate the various domains of care, total performance scores, how it's calculated, how it impacts payments – all those things that are very important to how a program operates.

As was mentioned, we'll do a brief presentation on the program, and then after that, what we really want to do is get to your questions. We ask that you hold them to the end but I think we've allowed ample opportunity to be able to get your input in the conversation.

In addition to CMS presenters, I'd like to acknowledge our partners at the MITRE Corporation, and they are a federally funded research and development center, and they may assist in answering some of the questions that come up.

I'd like to acknowledge my CMS colleagues and team members that have really worked throughout the entire agency to come up with a program that, we hope, is somewhat seamless.

So now, I'd like to turn this over to our next presenter, Don Howard, from the Office of Clinical Standards and Quality who will walk you through the rest of this afternoon.

Presentation

Donald Howard: Thank you, Jean.

Good afternoon everyone. My name is Don Howard from the Office of Clinical Standards and Quality and I am the project lead for the Hospital Value-Based Purchasing Program.

Today, we'll define what the Hospital VBP Program is, what the program is for Fiscal Year 2014, and how hospitals will be evaluated during the Fiscal Year 2014 program.

After the presentation, we'll have time for questions and answers.

We'll go to slide 2, please, Introduction to the Hospital VBP Program. The Hospital VBP Program is required by Congress under Section 1886(0) of the Social Security Act as added by the Patient Protection Affordable Care Act.

The Hospital VBP Program is designed to transform the payment of care from assistance-based on the volume of patient visits and procedures performed to one based on the quality of care provided to Medicare beneficiaries.

The Hospital VBP Program pays for care that rewards better value, patient outcomes, and innovations instead of just volume of services. Hospital VBP is built on the hospital inpatient quality reporting measures infrastructure; however, the Hospital VBP section of the Patient Protection Affordable Care Act strives to change that dynamic and reward the hospitals for providing high-quality care to patients at lower cost.

We view value-based purchasing as an important driver of change, moving towards rewarding better value, innovations, and outcomes, which in turn will lead to better care and healthier patients.

The Fiscal Year 2014 Hospital VBP Program is funded through a 1.25 percent reduction from participating hospitals, diagnosis-related group, 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 actual amount earned by hospitals will depend on the actual range and distribution of all total performance scores.

Slide three please, Hospital Eligibility. Not every hospital is eligible for the Hospital VBP Program; however, more than 3,000 hospitals nationwide will qualify. The program applies to Subsection D hospitals located in the 50 states and the District of Columbia, including acute care hospitals in Maryland.

Slide four, Excluded Hospitals. The Hospital VBP Program does not apply to hospitals and hospital units excluded from the Inpatient Perspective Payment System, or IPPS, such as psychiatric rehabilitation, long-term care, children's, and cancer hospitals.

Hospitals that are excluded from the Hospital VBP Program are hospitals that are subject to payment reductions under the Hospital Inpatient Quality Reporting Program; hospitals cited by the Secretary of the Department of Health and Human Services for deficiencies during the Performance Period that pose an immediate jeopardy to patient's health or safety; and also hospitals that do not meet the minimum number of cases, measures, or surveys required for the program.

It is important to note that excluded hospitals will not have the 1.25 percent withheld from their DRG payments for the Hospital VBP Program for the applicable Fiscal Year.

Slide five, Eligibility Requirements and Measures. As required by the act, CMS established minimum numbers of cases and measures for hospitals to participate in the Hospital VBP Program based on an independent analysis. Hospitals that do not meet criteria could have skewed results that would affect scoring. Based on an independent analysis, CMS has established minimum reporting requirements as stated in the Hospital VBP Program Final Rule 76 FR 26502, setting the number of measures and cases as low as reasonable will enable the largest number of hospitals to participate in this program.

This slide illustrates the eligibility requirements for the minimum number of cases and measures for the clinical process of care domain. A minimum of 10 cases per measure and at least four applicable measures is required to receive a Clinical Process of Care Domain Score.

In the example you see, clinical process measures 1, 2, and 3 and 13 have at least 10 cases, indicated by the small black figures. However, clinical process measure 11 does not have 10 cases, so this measure would be excluded from the hospital score for Hospital VBP.

In this example, even without clinical process measure 11, these hospitals meet the minimum number of 10 cases per measure for at least four measures. And we'll therefore receive a clinical process of care score. To receive a Patient Experience of Care Score, hospitals must have at least 100 completed Hospital Consumer Assessment of Health Care Providers and Systems, or HCAHPs, surveys during the performance period.

Slide six, Eligibility Requirements and Outcome Measure. This slide illustrates the eligibility requirements for the minimum number of measures for the Outcome Domain score. A minimum of 10 cases for two of the three outcome measures during the performance period is needed to receive an Outcome Domain score.

In this example, outcome measures 1 and 2 have at least 10 cases, indicated by the small black figures; however, outcome measure 3 does not have 10 cases. So this measure would be excluded from the hospital's Outcome Domain score. In this case, this hospital meets the minimum number of 10 cases per measure for at least two out of the three measures, and will, therefore, receive an Outcome Domain score.

Slide seven, Fiscal Year 2014 Baseline and Performance Periods. This slide shows the baseline and performance periods for the Fiscal Year 2014 Hospital VBP Program. Please note that the performance period for the Outcome Domain has already ended. The other two domains, the Clinical Process of Care and the Patient Experience of Care domains, will conclude on December 31, 2012. During these performance periods, we will be looking at how hospitals perform on measures and dimensions included in these three domains, which are all listed on the next slide.

Slide eight, Finalized 2014 Domains Measures and Dimensions. The blue box outlines the 13 Clinical Process of Care Measures that will be used for the

Fiscal Year 2014 program. These 13 measures will contribute 45 percent of the hospital's total performance score. These measures are considered industry best practices. The hospitals continue to follow the simple guidelines that can set patients on a solid track for recovery, which will result in reduction in health care associated infections, improvement in patients' overall health, shortened recovery times, and improvement in the likelihood of long-term positive outcomes.

The yellow box on the bottom right contains three mortality measures included in the new Outcome Domain for the Fiscal Year 2014 Program. The Outcome Domain will contribute 25 percent of the hospital's total performance score. The remaining 30 percent of hospital score is based on the Patient Experience of Care domain, which uses the HCAHP Survey.

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. In subsequent years, we plan to add additional domains and measures to provide a broader snapshot of quality improvement and efficient delivery of care.

Slide nine, Fiscal Year 2014 Domains and Measures/Dimensions, Clinical Process of Care Measure. As mentioned earlier, 13 Clinical Process of Care measures will be used for the Fiscal Year 2014 Program. This includes one new measure added to the Fiscal Year 2013 Program, which is the SCIP Infection 9: urinary catheter removed on postoperative day one or postoperative day two.

Next slide, slide 10, Fiscal Year 2014 Domains and Measure and Dimensions, Patient Experience of Care Dimensions. For the Fiscal Year 2014 Program, the same eight Patient Experience of Care domain dimensions will be used that were part of the Fiscal Year 2013 Program.

Next slide, slide 11, Fiscal Year 2014 Domains and Measure/Dimension, Outcome Measures. The slide shows three measures within the new Outcome Domain for Fiscal Year 2014 Program. These measures captured the risk

adjusted 30-day mortality rate for patients admitted for AMI, heart failure, and pneumonia.

Next slide, slide 12, Fiscal Year 2014 Program Summary. In the Fiscal Year 2014 Program, hospitals will be evaluated against three domains. Again, the Clinical Process of Care Domain, which consists of 13 measures; Patient Experience of Care domain, which consist of eight HCAHPS dimensions; and the Outcome Domain, which consists of three mortality measures. Hospitals will be awarded points for achievement and improvement for each measure or dimension with a greater of the improvement or achievement points used.

Points are added across all measures to reach the Clinical Process of Care and Outcome Domain scores. Points are added across all dimensions and are added to the consistency points to reach the Patient Experience of Care domain score.

Slide 13, Achievement versus Improvement Points. Achievement points are awarded by comparing a hospital's rate during the performance period with all hospital rates for the baseline period. A rate at or above the benchmark will receive 10 points. A rate less than the achievement threshold will receive zero points. A rate equal to or greater than the achievement threshold and less than the benchmark will receive between 1 and 10 points.

Improvement points compare an individual hospital's performance during the performance period with that same hospital's performance during the baseline period. If a hospital performs at or above the benchmark, they will be awarded nine improvement points. If a hospital performance below its performance during the baseline period, it will receive zero improvement points. If a hospital performance equal to or greater than its performance during the baseline period below the benchmark, they'll receive between one and nine improvement points.

Slide 14, Baseline Period Data. This slide is a graphical representation of the baseline period data. The curve you see represents all hospitals' data for an example measure in the baseline period. Represented on the curve are three points. First, the floor, which is defined as the zero percentile or the worst

performing hospital; two, the achievement threshold, which is defined as the 50th percentile or the point in which half the hospitals had baseline period rates lower and half the hospitals had baseline period rates higher; and the third one, the benchmark defined as the mean of the top decile, or the top 10 percent of hospitals.

While the floor is only used in the Patient Experience of Care domain to calculate consistency points, the threshold and benchmark are used for the clinical process of care and Patient Experience of Care and the Outcome Domains. If a hospital's performance on a certain measure or dimension is equal to or exceeds the achievement threshold, then the hospital will receive achievement points for that measure or dimension. This will be described more in detail in some of the subsequent slides.

The Outcome Domains baseline period is July 1, 2009 through June 30, 2010. Both the Clinical Process of Care and Patient Experience of Care domains' baseline periods are April 1, 2010 through December 31, 2010.

Slide 15, Total Performance Score. The total performance score comprises the Clinical Process of Care domain, which again accounts for 45 percent of the total performance score; the Patient Experience of Care domain, which accounts for 30 percent of the total performance score; and the Outcome Domain, which accounts for the remaining 25 percent of the total performance score.

Slide 16, TPS, the Outcome Domain. We'll now discuss the last and newest of the three domains that comprise the total performance score. Again, the Outcome Domain is new for the Fiscal Year 2014 program.

Slide 17, Outcome Domain Example. Here we show the same graphical representation of the baseline data that was displayed earlier. The curve represents all the hospitals' performance data for the AMI 30-day mortality measure. The floor is not displayed here as it only applies to the calculation of consistency points with the Patient Experience of Care domain. Represented on the curve are two points – the achievement threshold and the benchmark.

Achievement threshold is defined as the 50th percentile or the point in 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 is 84.77 percent, which is the median for hospitals with AMI 30-day mortality – that is, half of the hospitals had survivability rates less than 84.77 percent of eligible patients and half of the hospitals had survivability rates more than the 84.77 percent of eligible patients. If a hospital's performance on this measure is equal to or exceeds the achievement threshold, then that hospital receives achievement points for that measure.

The benchmark is defined as the mean of the top decile or again, the top 10 percent of hospitals. For this measure, the benchmark is 86.73 percent. If a hospital's performance on this measure is equal to or exceeds the benchmark, then that hospital receives the maximum achievement points for this measure. This will be described in detail on some of the subsequent slides.

Slide 18, Outcome Domain. Mortality is defined as death from any cause within 30 days after the admission date. For purposes of the Hospital VBP Program, the mortality rate is converted to a survivability rate by subtracting the hospital's mortality rate from 100 percent. This ensures that the higher rates are better, making these measures consistent with other Hospital VBP Program measures and dimensions. Therefore, this scale represents the percent of eligible patients who survived for at least 31 days after a hospital admission since mortality is determined within 30 days.

Next slide, slide 19, Achievement Ranges for Outcome Measures. This slide shows all the three measures within the Outcome Domain and their associated thresholds and benchmarks. Recall that the range between the achievement threshold benchmark represents a distance between the 50th percentile and the mean of the top decile of the hospital's performance during the baseline period. If a hospital performance on any measure is equal to or greater than the achievement threshold, then the hospital receives achievement point for that measure.

As an example, we will use the first measure on this slide, mortality 30-day AMI, to demonstrate how a hospital scored in the Outcome Domain. This

measure represents 30-day mortality rate for patients with acute myocardial infarction converted into a survivability rate for purposes of the Hospital VBP Program.

Next slide, slide 20, Outcome Domain Example, Mortality 30-day AMI. Here, we are showing the first of eight slides highlighting the 30-day mortality example. The slide displays the achievement range for this measure, which is defined in the final rule, again 76 FR 26514 as the scale between the achievement threshold, the minimum level of hospital performance required to receive achievement points, and the benchmark or the mean of the top decile hospital performance during the baseline period.

In other words, the achievement range is where a hospital's performance must fall in order to receive achievement points. For this measure, the achievement range is noted on the slide. The achievement threshold represented by the square, 84.77 percent and the benchmark represented by the diamond is 86.73 percent. As stated before, these numbers reflect survivability rates, not mortality rates. Therefore, the achievement threshold of 84.77 percent is a survivability rate calculated from a 30-day mortality rate of 15.23 percent. That is 100 percent minus the 15.23 percent 30-day mortality rate equals the 84.77 survivability rate.

As mentioned previously, achievement points for this measure are calculated as follows. If a hospital's performance on this measure during a performance period is greater than or equal to the benchmark, the hospital receives a maximum 10 achievement points. If the hospital's performance on this measure during the performance period is less than the achievement threshold, that hospital receives zero points for achievement.

If a hospital's performance on this measure during the performance period is equal or greater than the achievement threshold but still below the benchmark, that hospital receives between one and nine points, depending on where the hospital performance rate falls on the achievement range.

Slide 21, Outcome Domain Example. This slide displays an example of a hospital's performance of 86 percent during the performance period. A

performance rate of 86 percent means that 86 percent of this hospital's eligible AMI patients survive for at least 31 days after the hospital's admission during the performance period. Since the performance rate of 86 percent is higher than the achievement threshold rate of 84.77 percent, the hospital receives achievement points. However, the actual number of points is determined based on a formula included in the Hospital VBP Program Final Rule, again 76 FR 26518, which is displayed on the next few slides.

Slide 22, again, Outcome Domain Example. This slide presents the formula from the Hospital VBP Program Final Rule – again 76 FR 26518 – 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 86 percent during the performance period between the threshold and benchmark for this measure. It is important to note that in this formula, the word score actually refers to the hospital's performance rate. This formula calculates the hospital's achievement points for this measure.

Slide 23, here, we are showing how the hospital's performance rate, threshold, and benchmark are used to calculate the achievement points for this measure. Please take a second and look at this particular slide. So in this example, the number of achievement points equals 6.15, which is rounded to the nearest whole number, 6.

Slide 24, we also must calculate the hospital's improvement points for this measure. The improvement rate is defined as, again, a scale between the hospital's prior performance rate on the measure during the baseline period and the benchmark.

In the example, this hospital has a performance rate of 80 percent during the baseline period. This performance rate defines this hospital's starting point or improvement point. Recall that this hospital's performance during the performance period is 86 percent, which is also used to determine this hospital's improvement points. The actual number of improvement points, however, is determined from a formula in the Hospital VBP Program Final Rule, 76 FR 265919, which is displayed on the next few slides.

Slide 25, this slide presents the formula for the Hospital VBP Program Final Rule, again, 76 FR 26519, that must be used to calculate the improvement points for this measure. The formula calculates the relative position of hospital's performance rate of 86 percent during the performance period between the hospital's baseline rate and benchmark for this measure. It's important to note that in this formula, the score actually refers to the hospital's performance rate. This formula calculates the hospital's improvement points for this measure.

Slide 26, here we show how the hospital's performance rate and benchmark for this measure are used to calculate the improvement points for this measure. Again, take a second and review the slide. Again, in this example, the number of improvement points awarded equals 8.42, which again is going to be rounded to the nearest whole number of 8.

Slide 27, this slide displays both the achievement and improvement range for this hospital for this measure. The greater of the achievement or improvement points is used to determine the hospital's points for this measure. In this example, the 8 improvement points are greater than 6 achievement points. Therefore, 8 points are awarded to this hospital for the mortality 30-day AMI measure.

Slide 28, this slide shows the score for the Outcome Domain. The higher of the achievement or improvement points for each measure comprise the domain score; that is 8 points for AMI and 2 points for heart failure. This equals 10 points. In this example, this hospital did have the minimum number of cases required for pneumonia mortality measure, which is represented by the X. Correction, did not have the minimum number. As mentioned previously, this hospital will still receive an Outcome Domain score since it meets the minimum cases for at least two of the three mortality measures.

Slide 29, this slide displays how we will normalize a hospital's Outcome Domain score. The Outcome Domain score is based only on the measures for which the hospital has 10 or more eligible cases and again, a minimum of two measures during the performance period. As shown at the bottom of the slide,

this hospital's domain score of 10 is normalized by dividing 10 as the total possible points this hospital can achieve.

The hospital has sufficient data for two of the three measures. So, multiplying the maximum 10 points for each measure by the two possible measures results in 20 possible points for this hospital. After multiplying by 100, the result is a normalized score of 50 for this hospital. Thus, the un-weighted Outcome Domain score for this hospital is 50. Normalization is used to avoid penalizing a hospital that for whatever reason does not have the minimum number of 10 cases that is required for each of the three outcome domain measures.

Slide 30, this slide represents the components of the total performance score. Each domain's un-weighted score is reflected in this yellow circle. The scores for the Clinical Process and Patient Experience domains were presented in a previous National Provider Call and are used here so we can be consistent with that particular presentation.

Slide 31, this slide converts the un-weighted Clinical Process Care domain score into a weighted score by multiplying the score of 43.6 times the 45 percent weighting. This results in a weighted clinical process of care domain score of 19.6, which is in the indicated red box.

Slide 32. This slide converts the un-weighted patient experience of care domain score into a weighted score by multiplying the score of 38 times the 30 percent weighting for this domain. This results in a weighted patient experience of care domain score of 11.4, which is indicated by the green box.

Slide 33. This slide converts the un-weighted outcome domain score into its weighted score by multiplying the score of 50 times gets 25 percent weighting. This results in a weighted outcome domain score of 12.5 as indicated by the purple box.

Slide 34. This slide shows how the total performance score is calculated by adding each domains weighted score. This hospital's total performance score of 43.5 will be translated into its incentive payment by the use of a linear exchange function.

Slide 35. The law requires that the total amount of the value-based incentive payment that CMS may distribute across all hospitals must be equal to the amount of the base operating DRG reduction which is 1.25 percent for the Fiscal Year 2014 program. The law requires CMS redistribute that available amount across all participating hospitals based on their performance scores. The exchange function is the relationship between a hospital's total performance score and the amount of money that hospital will get as a value-based incentive payment.

Slide 36. CMS will use a linear exchange function to distribute the available amount of value-based incentive payments to hospitals, based on a hospital's total performance score. Each hospital's value-based incentive payment amount for a Fiscal Year will depend on the range and distribution of all hospital scores for that Fiscal Year's performance period on the amount of money available for redistribution and on the amount of its base operating DRG payments. The value-based incentive payment amount for each hospital will be applied as an adjustment to the base operating DRG amount for discharges.

Slide 37. Linear exchange function. This slide shows a graphical depiction of the linear exchange function which will convert each hospital's total performance score along the X axis into its value-based incentive percent – payment percentage on the Y axis. The exact slope of the linear exchange function will be determined after the performance period and will depend on a hospital's total performance scores and the total base operating DRG amount withheld.

Slide 38. Upcoming events. So, let's take a look at some of the things that will be coming your way for the Fiscal Year 2013 program. By August 1st, you will be receiving your estimated – again, estimated percentage payment summary report for the Fiscal Year 2013 program year. The performance period used for the estimated report is not the actual performance period used for the Fiscal Year 2013 program. It will be used – it will use a different performance period than what was published in the Hospital VBP final rule to compute hospital scores.

Hospitals will see their own discharge-level data for a second quarter to the fourth quarter of calendar year 2011. So, specifically, we're talking about April 1, 2011 through December 31, 2011 for this estimated percentage payment summary report. The estimated report performance periods differ because the data from the entire Fiscal Year 2013 performance period will not be available at the time of the estimated reports creation due to the time frame for the data submission.

Accompanying these estimated percentage payment summary reports, we will be providing a fact sheet and a How-To Read Your Report reference guide to help hospitals interpret their reports. While your estimated percentage payment summary report will be an early indicator of your hospital's performance in the Fiscal Year 2013 VBP program, it is not a final report. So, again, to repeat, it is not a final report for your hospital. Your actual percentage payment summary report which will summarize your hospital's performance for the Fiscal Year 2013 program will be made available on or before November 1st of 2012.

Again, CMS is currently targeting the release of this actual percentage payment summary report in October of 2012. These reports will provide your hospitals with its actual total performance score incentive adjustment performance on all Hospital VBP program measures and dimensions from the baseline and performance periods and the Hospital VBP calculated points for your hospital's performance on the measures and dimensions.

CMS will conduct a National Provider Call prior to the release of these actual reports to help educate hospitals on their actual reports. In addition, the National Provider Call will provide operational details for the Fiscal Year 2013 program. An example would be, once the actual reports are made available to the hospitals' QualityNet account, hospitals may review their Hospital VBP data and submit any necessary corrections to CMS. A corrected report will be made available to hospitals and QIOs in the December 2012 time frame.

For further reconsideration of denied corrections requests, hospitals may submit an appeal once they receive CMS evaluation of their corrections

request. Details on the reviewing corrections process along with the appeals process will be made available in the Fiscal Year 2013 IPPS final rule and discussed at the National Provider Call for the Fiscal Year 2013 actual percentage payment reports.

Slide 39. So at this time, we'd like to stop and take an opportunity to take some questions for the Fiscal Year 2014 Hospital VBP Program and to allow everyone opportunity to ask their question. Please limit yourself to one question.

Geanelle?

Polling

Geanelle Griffith Herring: Thank you, Don. At this time, we will pause for a few moments 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 may be moments of silence while we tabulate the result. Holley, we're ready to start 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. 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 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.

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

Geanelle Griffith Herring: While we're holding, let me take this time to remind everyone that this call is being recorded and transcribed. So, before asking your question, please state your name and the organization which you represent. And again, in an effort to get as many of your questions asked and answered as possible, we ask you to limit yourself to just one question.

Holley, when ready, we're ready for questions.

Question and Answer Session

Operator: Thank you for your participation. We'll now move in to the Q&A session for this call. To ask a question, please 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.

Please hold while we compile the Q&A roster.

And your first question does come from the line of Marina Fowlds.

Lisa Klein: This is Lisa Klein from the Department of Health Services, Los Angeles County. I just would like to confirm that the payments that patients included in the HCAHP's domain and payment system are only those covered by Medicare. Is that correct?

James Poyer: This is Jim Poyer, director of Division of Value Incentives and Quality Reporting in the Office of Clinical Standards and Quality. It's Medicare and non-Medicare patients, acute care hospital inpatient stays, and we sample – it's a – it's a random sample of all paid inpatient stays both Medicare and non-Medicare to assess in terms of the quality of care of Medicare and non-Medicare patients are used in terms of – to be able to asses how the relative quality of care is provided to Medicare patients.

Thank you.

Operator: And your next question comes from the line of Sandra Noble.

Sandra Noble: Yes, we would like – Sandra Noble with North Cypress Medical Center in Harris County, and we would just like to know who – if the hospital receives the report – the actual report and the preliminary report that you'll be sending out.

James Poyer: This is Jim Poyer again. It is your QualityNet contact in the hospital inpatient quality reporting program in which you submit data, as well as data from your quality measures for the inpatient hospital setting or personal hospital compare. There should be a security administrator, that's one of the requirements for participating and submitting quality data, and there should be a contact in each hospital if they are participating in that program. It will be the same contact that receives preview information for hospital compare.

Geanelle Griffith Herring: Thank you for the question, Sandra.

James Poyer: Thank you.

Operator: Your next question comes from the line of Tom Carlin.

Tom Carlin: Yes, hello. In the proposed inpatient rule for 2013, there was a table with a value-based purchasing adjustment factor, and I'm wondering if that adjustment factor is the percent that a hospital will receive back from the value-based purchasing program. So, for example, if the factor is a 1.0, the hospital will receive exactly the amount that was withheld to fund the program from the hospital. Thank you.

James Poyer: Hi. This is Jim Poyer, again. That amount cannot be determined at this time as we have not collected all the data yet for the FY '13 performance period. In the upcoming events slide that Don Howard talked about. Essentially, that actual percentage payment report that will be – our target date for release in October 2013, we must collect all the data; determine who isn't a current hospital inpatient quality reporting program; did they meet all the requirements; did they have any immediate jeopardy citation?

Essentially, we have to determine the pool hospitals and then see what the estimated payments are before calculating the actual slope that Don walked

through in another slide for the incentive payment. So, we don't know in terms of what's your actual percentage payment in the – and what the score would be until after those data are available, and we won't know that until the target date in October of 2012 when those reports – the actual percentage payment report would be disseminated to hospitals. Thank you.

Tom Carlin: Thank you.

Operator: Your next question comes from the line of Linda Bush.

(Jenny Mossey): Hi. This is (Jenny Mossey), Columbus Regional. For the value-based purchasing outcome domain, are there any exclusions such as comfort measures or patients who are transferred to another acute care facility?

James Poyer: This is Jim Poyer, again. I believe that there are palliative care measures. I would refer you to the www.qualitynet – Q-U-A-L-I-T-Y N-E-T – dot org and they – and under the hospital inpatient button on the top left part of your screen. This is the same website which hospitals go to submit process of care measures. There are measures specifications that outline in great detail all of the exclusions and who's included in terms of the – in acute care inpatient stays or the acute myocardial infarction – the three measures – acute myocardial infarction, heart failure and pneumonia, but in terms of – as a vague understanding from the distant past palliative care, you mentioned comfort care measures, I believe they are excluded but please refer to the measure specifications for the exact information on how they're calculated and who's excluded. Thank you.

Operator: And your next question comes from the line of Sandra Johnson.

Geanelle Griffith Herring: Ms. Johnson?

Operator: OK, that question has been withdrawn. Your next question comes from the line of Carol Miller.

Carol Miller: Hi. This is Carol Miller from Pittsburgh. I just had a question. We have a new – we're a new facility. We just opened and we just opened on July 2nd. So, we won't have any baseline data, but we will be open for part of the

performance period. So, can you tell me what our scoring would be like? Thank you.

Geanelle Griffith Herring: Hold while we compile support for you.

Donald Howard: Yes. This is Don Howard. You know, as long as you all are able to achieve the minimum number of cases for – or during that period of time, you know, you would – you potentially would qualify for achievement scores.

Carol Miller: OK, so I would only be – it would only be achievement scores that I would be …

Donald Howard: Yes.

Carol Miller: OK.

Donald Howard: There will be on baseline in which for us to do an improvement score.

Carol Miller: Right. OK. So, I only have – I'll have performance for clinical process and for patient experience, but we weren't open during the outcome domain. So, I would just be evaluated on those two?

Geanelle Griffith Herring: Give us a second.

Donald Howard: Yes. Based on what you are describing – this is Don Howard, again – you wouldn't be able to participate in the Fiscal Year 2014 if you didn't have any outcomes…

Carol Miller: OK.

Donald Howard: … data.

Carol Miller: OK. Thank you.

Donald Howard: Thank you.

Operator: And your next question comes from the line of Kathy Doty.

Kathy Doty: Hi. I am calling from West Calcasieu Cameron Hospital in Louisiana, and my question has to do with the mortality rates. I just pulled down our hospital compare data that is for the third quarter of 2008 through second quarter of 2011 discharges, and I realized that our baseline data for our mortality measures is that – is not the same time frame. But looking at this hospital compare report, it gives us a percentage for each of these mortality measure sets, and then a lower limit, and then upper limit. That percentage that they gave us, is that the actual mortality rate, or is this a risk-adjusted somehow rate?

James Poyer: It is a – this is Jim Poyer. It is a risk-adjusted rate and the central, there are three – the~~that~~ way you described, there are three pieces of information. A lower limit of a confidence interval that incorporates the sampling error from, you know, due to risk-adjustment code because of differences in case mix that attempt to adjust for those differences.

And then our best estimate on the mortality of the patients relative to an expected volume from it and then an upper limit and what we intend to use essentially and was communicated in the slide is the – what might be deemed as the complement. I mean, if you had for example a 10 percent mortality rate, we would use one minus 10 percent or 90 percent for survival rate to be able to – just to see in terms of what you're seeing on hospital compare right now and what we intend to do in the program.

It's essentially the same information but the complement, in math terms, that we would use to estimate a survival rate and it is risk adjusted and, as you pointed out, and what you see on your hospital compare preview reports includes a confidence interval. What we intend to use for the Hospital Value-Based Purchasing Program and was finalized through rulemaking is our best estimate that central piece of information, not the lower or the upper limit.

Kathy Doty: OK, and is there any way for us to go back and find our baseline data?

James Poyer: As I understand it, we intend to send out a separate report that includes baseline information including the outcomes domain in the coming months to – we don't have an exact time. We'll let you know a more complete timeline

in terms of estimated delivery date at or near the actual – when we held the national – next National Provider Call at or near October. We'll give you more information on that with respect to a base – essentially the FY '14 baseline report that includes the actual baseline period. That includes that – those three mortality measures.

Kathy Doty: OK, thank you.

James Poyer: Thank you.

Operator: Your next question comes from the line of Diane Davis.

Diane Davis: This is Diane Davis in Fort Dodge, Iowa, and I was wondering how does the VBP Program apply to hospitals involved as an ACO?

James Poyer: As an Accountable Care – I'm sorry; this is Jim Poyer, again. As an Accountable Care Organization, essentially this program would apply if you are meeting the criteria as Don had alluded to in one of the slides as paid under the inpatient prospective payment system. If you're also participating as an ACO that those requirements or whatever the criteria are, are separate and distinct from Hospital Value-Based Purchasing.

This program was – is a part and was mandated by Affordable Care Act to be a part of the inpatient prospective payment system that is used to pay all Medicare accredited hospitals for fee-for-service inpatient stays. So, it's a separate and distinct statutorily mandated program, and its closest link to Hospital Value-Based Purchasing is in the inpatient prospective payment system.

So, critical access hospitals and other hospitals that are excluded for – from the hospital inpatient quality reporting program are excluded except for Maryland hospitals in which there's an exemption this year, but essentially it's a separate and distinct program from the ACO program. Thank you.

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

Operator: Your next question comes from the line of (Wendy Coffin).

(Wendy), your line is open. That question has been withdrawn. Your next question comes from the line of Tim Teyner.

Tim Teyner: Tim Teyner of Blanchard Valley Health System, Findlay, Ohio. Can you tell me if the linear exchange function value will be part of the value-based purchasing report?

James Poyer: On the corrected actual percentage payment report, essentially what we need – the report that's supposed to go out – this is Jim Poyer, again – in October would have the score and what we intend to do on the – that would translate to a percentage payment is to include that in the corrected report and that's essentially target for December of 2012. That is our target date.

Tim Teyner: So, we have a note that that percentage is 2.34, something like that?

James Poyer: It would have an estimated applicable percentage payment on their – on your Medicare payment for FY '13.

Tim Teyner: OK, thank you.

Operator: Your next question comes from the line of Rochelle Roberts.

Rochelle Roberts: Yes this is Loma Linda University Medical Center, and we'd like some clarification on the outcome domain and when the 30-day period starts. Is it with the admission date or the discharge date?

Geanelle Griffith Herring: Give us a moment while we compile your answer.

Donald Howard: Just to confirm, you'll probably want to refer to the measure specification but yes, we're seeing it as from the date of admission.

Rochelle Roberts: Thank you.

Donald Howard: Slide 11 – I think slide 11 indicates that.
Rochelle Roberts: OK, thank you.

Donald Howard: Sure.

Operator: Your next question comes from the line of (Rich Rothenberg).

(Rich Rothenberg): Hi. My name is (Rich Rothenberg) from the Deborah Heart and Lung Center in New Jersey. I have a question related to how we're going to calculate the base rate. Our base rate is made up of labor portion and a non-labor portion and, potentially, we have an adjustment for readmissions and now the value-based purchasing adjustment. Are you – is CMS going to recalculate what our base payment is going to be when we get our reports for all these factors? Or how is that going to – what type of reports are we going to get so can calculate what our base rate is supposed to be?

James Poyer: This is Jim Poyer, again. I believe you're referring to the base operating DRG payment from which …

(Rich Rothenberg): Right.

James Poyer: … in terms of how – where are the 1 percent comes from? One percent of what I believe is what I'm trying to rephrase what you're asking for. I would advise you essentially, we are – we had proposed in terms of how we intend to clarify that base operating DRG in the – in this year's inpatient prospective payment system rule and we – and we have many comments about that. We have to respond to it.

Please review that final rule when we – I mean, and we hope to provide further information with respect to how we articulated in terms of that finalized policy in the next National Provider Call, but essentially a lot of that is still under, you know, essentially how we interpret the statute, and we have a lot of comments with that. We can't really answer that at this time. OK. Thank you.

Geanelle Griffith Herring: Thank you for the question, (Rich). Next question, Holley.

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

John Michael: Hi, hello. This is John Michael from Parma Hospital, and my question has to do with the outcome domain, and what is currently public is a three-year period and the actual baseline and performance periods are one year. Is there

any way we can go see those results? Or if they're going to be provided, will both periods be provided?

James Poyer: This is Jim Poyer. We will provide that as we talked about to a previous call. We will provide baseline information as to the exact delivery date on the FY '14 baseline information that includes the 12-month mortality measure rate baseline. We'll provide more details into a delivery date. You know, we intend to do it at the next National Provider Call.

Thank you.

Geanelle Griffith Herring: Thanks.

Operator: That question has been withdrawn. And your next question comes from the line of John Kane.

(Renee Hathaway): Hi. This is (Renee Hathaway) with Catholic Health in Buffalo. Just real quick for the example equations, I wasn't sure I understood why for the achievement calculation why we were multiplying by nine when the available point zero through 10, and then for improvements, the scale is zero to nine but we're multiplying these by 10.

Geanelle Griffith Herring: Give us a moment while we compile your answer, (Renee).

(Michael Lee): Hi. This is (Michael Lee) of MITRE Corporation. The different numbers in the formulas reflect a policy decision by CMS to provide at least one point for achievement to hospitals that meet the achievement threshold. Whereas a hospital may not receive one point for improvement by improving a small amount scale, and two different numbers reflect that difference on – and that's the different number of subintervals that are captured on the range – the two different ranges the achievement range and the improvement range. Thank you.

(Renee Hathaway): So, with where – you can't – you won't get zero on achievement …
(Michael Lee): Yes.

(Renee Hathaway): … I think you'll be given at least one if you're at threshold.

(Michael Lee): That's right. CMS' finalized policy is any hospital that reaches at least the achievement threshold will receive one point for achievement and that was the decision that was made in last year's rulemaking.

(Renee Hathaway): OK. If we have further questions, do we go out to QNet into their question sets?

James Poyer: Actually, what we're going to do as far as further questions beyond the call today is you can submit those to hospitalvbp@cms.hhs.gov. We'll try to get back to you as soon as we can on those.

(Renee Hathaway): Thank you.

Operator: And your next question comes from the line of Glenn Sommerfeld.

Glenn Sommerfeld: Hi. Glenn Sommerfeld from Yampa Valley Medical Center in Steamboat Springs, Colorado. We're only qualified for one of the outcome of measure scores that disqualify us from the total Fiscal Year 2014 Program or just from the outcome measure set?

James Poyer: Hi. This is Jim Poyer. If you don't have at least two measures with the minimum number of cases then you won't have a domain score; and therefore, you won't have a total performance score. In the FY '14 Program, you must have a score with the – in it – in all three domains in order to get a total performance score. So, based on what you described, if you don't have the minimum number of cases for at least two measures in a performance for outcome measures then you won't get a total performance score because you don't have a score in the outcome domain.

Glenn Sommerfeld: OK.

James Poyer: Thank you.

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

Operator: And your next question comes from the line of Cheryl Czech.

Cheryl Czech: Hi. This is Cheryl Czech from Bellin Hospital. I have a question regarding when the thresholds and base – or the thresholds and – the achievement thresholds and benchmarks are going to be posted.

Geanelle Griffith Herring: Give us a moment while we compile your answer, Cheryl.

Donald Howard: Yes. Cheryl, this is Don Howard. Are you talking about Fiscal Year ’14 or ’15?

Cheryl Czech: Fiscal Year ’14.

Donald Howard: Those were already published in the final rule.

James Poyer: And that – this is Jim Poyer – I’m sorry – that is in the outpatient prospective payment system rule that was published in the Federal register November 30, 2011.

Donald Howard: Thank you.

Cheryl Czech: Thank you.

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

Timothy McClung: Hi. This is Tim McClung from Norwalk Hospital in Connecticut. Question for you referring to slide seven, just curious if the performance period that’s listed will become the baseline period for 2015 – or 2016, I guess. Thank you.

Geanelle Griffith Herring: Give us a moment while we compile your answer, Tim.

James Poyer: We – yes, I would refer – this is Jim Poyer. I would refer you to the – this year’s – the FY 2013 Inpatient Prospective Payment System Proposed Rule where we did proposed performance periods for the out – the three mortality measure and the AHRQ composite measure that we – that we proposed. We – I can’t give you a definitive answer because it’s still proposed policy.
So, please stay – essentially read the final rule that we intend to publish in the coming weeks where we would finalize that policy for FY ’15 and ’16 that is our intent that is subject to comment. Thank you.

Geanelle Griffith Herring: Thank you for the question, Tim. Holley, how many questions do we have left in queue?

Operator: Currently, we have 20 questions in queue.

Geanelle Griffith Herring: All right. Next question please, Holley.

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

Tami Lewis: Hi. This is Tami Lewis with Robinson Memorial Hospital in Ohio. The consistency points – are consistency points with clinical process, patient experience domains, and the new outcome domain, or is it just with clinical and the patient experience?

Geanelle Griffith Herring: Give us a moment, Tami, while we compile your answer.

Donald Howard: Yes. This is Don. Tami, that is just for the HCAHPS domain as we have it set for the Fiscal Year 2013 program at this time.

Tamil Lewis: And those consistency points on – they're based on the floor threshold? Is that why?

Geanelle Griffith Herring: Give us a moment.

Donald Howard: I'm sorry. Yes, it's for the floor as this is calculated for each HCAHPS dimension.

Tami Lewis: OK.

Donald Howard: Thank you.

Tami Lewis: Thank you.

Operator: Your next question comes from the line of Kamaljit Sethi.

Kamaljit Sethi: Well, I'm at Providence Hospital in Washington, D.C. My question really is, one that's related to the performance periods for the three areas – the clinical process, patient experience, and outcome. Is there going to be an attempt to synchronize all of them because the first two are nine months into this year

and, of course, the outcome is a 12-month period. And initially, I know that the value-based purchasing was supposed to be a 12-month cycle, but it did get abbreviated to nine. Now, is there any reason why the two are different?

Geanelle Griffith Herring: Give us a moment while we compile your answer.

James Poyer: Yes, we were striving as much as possible to synchronize the performance period so that it helps in quality improvement efforts. That said, as we had proposed and looked at comments and finalized the outcome domain, we recognize in terms of the data lag, claims take more time in terms of process, as well as to get the information we have to risk adjust those measures.

So, it takes essentially more time to generate claims-based data relative to process of care and HCAHPS. Also, we – as we signaled in last year's final rule, we recognized reliability concern. So, we weighed those factors, and in terms of finalize the policy with respect to performance period. I would also refer you to this year's proposed rule with respect to – we recognize the reliability concerns of outcomes, measures, and want to include as many hospitals as possible.

And so, yes, we're trying to synchronize as much as possible, but we also recognize – we want to address with respect to – concerns about reliability of these measures. So, we're trying to weigh both of those into consideration that's why you don't see in terms of it perfectly synchronized, essentially across domains. So, thank you.

Kamaljit Sethi: I'm sorry. My question also is, why are the clinical process and the patient experience limited to nine months? Why shouldn't they'd be a year as well? That could…

James Poyer: We did finalize or excuse me – we did propose our intent for – starting in Fiscal Year 2015, and we're responding to comments now. We signaled through that proposal to use a 12-month performance period. The reason it's nine for both Fiscal Year 2013 and '14, nine we had to start-up the program and get payments as quickly to – as possible to hospitals, and we signaled in that upcoming event slide in this presentation.

They get in terms of that corrective report to hospitals by December. If we use 12 months worth data, we'd be delaying payments to hospitals by three months further, and essentially that nine-month performance period for Fiscal Year 2014 is our best attempt to be able to align with the start of the Fiscal Year so that we have a score to hospital, and we're trying our best to be able to get that score to hospital and to be able to apply the first claim that gets in the first check that gets cut for hospitals on – for October 1, 2013 discharges.

So, we're trying to catch up essentially and these nine months performance periods active rotation reflection of that. So that's why in terms also with the policy to go to 12 months – yes, we want to go to a 12-month performance period with reliability of data but these nine-month performance periods are a reflection of essentially that we're trying to get payments linked to quality in hospitals but essentially we are several months into a payment year.

Thank you.

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

Operator: Your next question comes from the line of (Donna Clark).

Geanelle Griffith Herring: (Ms. Clark)?

(Donna Clark): Hi, yes. This is Pleasant Valley Hospital in Point Pleasant and I have a question if the 1.25 percent was withheld, say, a $100,000 and the average of scores are finalized and we were to get $120,000. Can you clarify how we get that $120,000 back? Can you clarify that?

Geanelle Griffith Herring: Give us a moment (Ms. Clark) to clarify – to compile your answer.

James Poyer: Hi. This is Jim Poyer. I want to try and paraphrase what I – what we understand in terms of your question. You're looking in terms of as, I believe, how the hospitals are going to get compensated, to that percentage payment that $120,000 is going to get applied to whether be a lump sum…

(Donna Clark): Yes.

James Poyer: … or a per-claim basis…

(Donna Clark): Yes.

James Poyer: … and when you would receive it. And if that's our understanding, essentially in FY '13, the first year of the program, as I've described in a previous question, where we had proposed policy for – in this year's Fiscal Year rule to pay essentially and adjust on a – for the three months of claims or four months or so of claims that had not been billed yet and to be able to – once we catch up with respect to those claims to pay on a per-claim basis, what that percentage payment would be.

Now, for Fiscal Year 2014, it is our intent and as much as possible be able to catch up and to apply that percentage payment to each claim that is paid to hospitals. So, translating that to your $120,000 if your hospital had billed 1,200 for example or an average of $100, you might get an average of $100 per claim to reflect to your incentive payment. But it might vary by in terms of, let's say, your DRG grouping in terms of what you get per claim. So, a little – some claims might be more, some claims might be less.

So, the average overall would add up to the overall $120,000 that you described in your example, but it would be applied to each claim on the Fiscal Year 2014 Program.

(Donna Clark): What if volumes go down?

James Poyer: It is a percentage and essentially that is why we are focusing on a percentage payment if the – and if the volume goes down, then it's still a percentage of your payment and essentially this is a pool – estimated pool to determine at the beginning of the year based on past volume. And so, as you point out, current volume might not reflect past volume and so it's – because it's on a per-claim basis, it's going to – and a prospective payment system, it's an estimate of what payment is associated with the quality and let's say – and that's – that is specified by statutes.

So, essentially we're trying to apply this system to a prospective payment system the estimates in terms of what the payment would be.

Thank you.

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

Operator: Your next question comes from the line of Jill Staiger.

Jill Staiger: Hi. This is Jill Staiger from the Crystal Clinic Orthopedic Center. And I was just clarifying because we are a specialty hospital, we do not have any of the mortality measures, our case rates would all be zero; therefore, we would not have the outcome domain, and so, I just wanted to clarify that, at that point in time, our hospital would actually be excluded from value-based purchasing.

James Poyer: This is Jim Poyer. If you don't have – let's say, you don't bill any acute myocardial infarction or heart failure patients, you might only have surgical specialty. You might only do orthopedic surgeries for example. I'm just guessing but you wouldn't have any enough patients for at least two of the measures. So you wouldn't – yes, that's my understanding. No outcomes domain if you don't have at least two measures – outcome base measures and if no outcomes domain, then you wouldn't receive a score, and you wouldn't have any payment withheld or receive an incentive payment for 2014.

Jill Staiger: OK, thank you very much.

James Poyer: Yes.

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

Operator: Your next question comes from the line of Chuck Laurenson.

Chuck Laurenson: Yes, thank you. This is Chuck Laurenson from Providence Medford Medical Center. The question is on the patient experience domain score, the example you ran through the slide 32, 33, and 34, that patient experience domain score is also adjusted, is it not by patient risk factors? And if so, when would those risk measures be available for us to be able to apply?

James Poyer: This is Jim Poyer. As I understand the measure specification, I would refer to the QualityNet website and also HCAHPS online, www.hcahpsonline.org. I believe that – but essentially as I understand it, the adjustment factors are data collection mode and patient mix.

Chuck Laurenson: Right.

James Poyer: So, it's a data collection mode because research – previous research is found in terms of that – patients might respond slightly differently to a telephone base data collection versus a paper-based survey.

Chuck Laurenson: Yes.

James Poyer: And in terms of patient mix as well, there may – but I would refer you on that – we're not HCAHPS experts, and I would refer you to that website, and there's also essentially a website or e-mail address that you can send questions to for more details on that – those adjustment factors, but it's patient mix and mode as I understand it.

Chuck Laurenson: Thank you.

James Poyer: Thank you.

Operator: And your next question comes from the line of Suzanne Hess.

Suzanne Hess: This is Suzanne Hess at Berger Health System and actually our question has been answered. Thank you.

Geanelle Griffith Herring: Thank you. Next question, Holley.

Operator: Your next question comes from the line of Bob Hussey.

Bob Hussey: Thank you for taking my question. In the final rule for the HVBP Program for 2014, under the outcome measures, there was included patient safety and hospital-acquired condition measures, and I apologize if I may have missed the subsequent communication from CMS. But is there a plan to put those

measures back in the program in 2015 because I'm not seeing them on this day?

James Poyer: Yes, these measures were originally included in the program and we're subsequently in a – subsequent rulemaking were suspended based on several comments – many comments that we received, and we effectively weighted those measures at zero. So, they – technically, they are included in the program, but were suspended for Fiscal Year 2014 and weighted at zero. For Fiscal Year 2015, we did not propose them for inclusion in the program.

Bob Hussey: Thanks.

James Poyer: Sure.

Geanelle Griffith Herring: Thank you. Next question.

Operator: Your next question comes from the line of Maryanne Gordon.

(Joanne Lawton): Yes, we have a question. This is (Joanne Lawton) from Mather Hospital in Fort Jefferson. We have a question on the outcome domain. According to slide 11, it says that the 30-day mortality measure is based on 30 days after admission which is also post-discharge. How were the patients that are sent home capture into this, or they're not captured into this?

Geanelle Griffith Herring: Give us a moment while we compile your answer.

James Poyer: I would refer you to the measure specification – this is Jim Poyer again – for further detail, but as I understand it from the measure specification, you're correct. It's 30 days following admission to inpatient status whether the patient expired during the inpatient stay or was subsequently discharged to whether it be a Skilled Nursing Facility or discharged to home and regardless of the reason for the patient expiring. It's simply a measure in terms of whether the patient – the caseload whether they had – there was a – what the mortality rate was affect adjusting for certain for the risk factors. But yes, it includes patients discharged to home as well.

(Joanne Lawton): How do you know they died if they're home?

Female: Yes.

(Joanne Lawton): That was the question.

James Poyer: As I understand it, it looks back to death certificates and that is reported back to Medicare.

(Joanne Lawton): All right. OK, thank you.

James Poyer: I would refer you to measure – thank you.

(Joanne Lawton): All right …

Geanelle Griffith Herring: Thanks for the question. Holley, we have time for just one more question.

Operator: OK, your final question comes from the line of Diane Moore.

Diane Moore: Hi. This is Diane Moore from Beaver Dam Community Hospital in Wisconsin. We've had a couple of questions about whether CMS is going to provide data on the outcome measures. But it hasn't really been answered directly as far as the performance period score. I've heard that we're going to get baseline period scores, but the performance period has ended June 30th, and I'm curious to know if there is a plan to provide the actual performance period score prior to the end of program of this December 31st and this is for the outcome measures? Thank you.

James Poyer: Hi. This is Jim Poyer. We intend to provide it as expeditiously as we possibly can, but just recognizing that following June 30th discharges you've got a 30-day – if the patient was admitted and discharged, you know, approximately the same day, you get a 30-day lag to measure the mortality, as well as four months, approximately, to allow hospitals to file sufficient volume of claims, as well as the appropriate risk-adjustment data.

So, we intend to provide that as soon as we can in 2013 calendar year, but just recognizing all those moving parts that are taking place. It's highly likely that,

you know, 99.9 percent likelihood, it would be after the end of the December 31st, 2012 performance period that we would get the mortality outcome measured data to hospitals. We recognize you want the data.

I would refer you, you know, it's not the best proxy in the world but the baseline data in the hospital compared data just to get an assessment in terms of how your hospital is doing on mortality.

Diane Moore: And with those be QNet download, or QualityNet, downloads again?

James Poyer: Those are – yes, those are available to every hospitals on QualityNet. Yes.

Diane Moore: OK. Thank you.

James Poyer: For their preview. Thank you.

Additional Information

Geanelle Griffith Herring: Thank you for the question. Unfortunately this is all the time we have for today's call. If you were unable to ask a question of the CMS subject matter experts gathered here today, please feel free to send your question in the form of an e-mail to hospitalvbp@cms.hhs.gov, and we will respond to your question once it's received.

I would like to thank you for attending our National Provider Call. We hope that this has given you a better understanding of the goals, procedures, and performance standards for the Hospital Value-Based Purchasing Program. The impetus behind the Hospital VBP Program is better care, better outcome for patients, and transforming the health care system to a payment system that recognizes and rewards quality.

For additional resources, please visit the Hospital VBP website which is www.cms.gov/hospital-value-based-purchasing. The post-call materials for this call will be posted within three weeks on the National Provider Call events page which is located at www.cms.gov/outreach-and-education/outreach/npc/national-provider-callandevent.html in the download section.

Lastly, to ensure that the National Provider Call Program continues to be responsive to your needs, we are providing you an opportunity to evaluate your experience with us here today. Evaluations are totally anonymous and strictly voluntary. To complete the evaluation, please visit http://npc.blhtech.com and select today's title from the menu dropdown. All registrants will also receive a reminder e-mail within two business days of today's call. Please disregard this e-mail if you've already completed the evaluation.

Again, this is Geanelle Griffith Herring and thank you for joining us today and thank – excuse me – Don Howard and Jean Moody-Williams for your participation in the formal presentation and opening remarks. And Jim Poyer and everyone else gathered for the question and answer session. Have a great day, everyone.

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

END