

**Centers for Medicare & Medicaid Services
Special Open Door Forum:
Hospital Inpatient Value-Based Purchasing Program
Fiscal Year 2013: Proposed Rule Overview
Thursday, February 10, 2011
1:30 – 3:30PM ET
Conference Call Only**

The Centers for Medicare & Medicaid Services (CMS) will hold a Special Open Door Forum (ODF) to discuss the proposed rule for the Hospital Inpatient Value-Based Purchasing (VBP) Program that will go into effect October 1, 2012 (for Fiscal Year 2013).

This Special ODF is designed specifically for hospitals and hospital quality experts, Medicare beneficiaries, their families, and advocates in an effort to increase awareness and understanding of the proposed rule.

The proposed rule was published in the Federal Register on January 13, 2011, and can be read online at <http://www.gpo.gov/fdsys/pkg/FR-2011-01-13/pdf/2011-454.pdf>.

The rule was designed to implement section 3001 of the Affordable Care Act, which requires CMS to establish a new Hospital VBP Program that rewards hospitals for providing high quality, safe care to patients. Under the FY 2013 Hospital VBP Program, hospitals that perform well on quality measures relating both to clinical process of care and to patient experience of care, or those making improvements in their performance on those measures, would receive higher payments.

During this ODF, CMS staff will highlight the key features of the proposed Hospital VBP Program for fiscal year 2013, including but not limited to:

- Brief overview of the Program and its provisions under Section 3001 of the Affordable Care Act;
- Proposals for the performance period, quality measures, and performance standards;
- Proposed scoring and incentive payment calculation methodology;
- Proposed hospital notification and review processes; and
- Transparency of quality measure performance as part of the Hospital VBP Program framework.

After CMS' presentation, participants will have an opportunity to ask questions. Because CMS is in formal rulemaking, we will not be able to respond to questions beyond the scope of the proposed rule. We will be in "listen-only" mode for clarifying questions or comments related to proposals that are not already stated within our proposal.

All participants are strongly encouraged to submit comments through the formal rulemaking process. Instructions on how to submit comments for the rule are included at the beginning of the Federal Register document, linked above.

Discussion materials for this Special ODF will be available to download at <http://www.cms.gov/hospitalqualityinits> by February 3, 2011.

We look forward to your participation.

Special Open Door Forum Participation Instructions:

Dial: 1-800-837-1935 (toll free)

Reference Conference ID#: 39100886

Note: TTY Communications Relay Services are available for the Hearing Impaired.

For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

An audio recording and transcript of this Special Open Door Forum will be posted to the Special Open Door Forum website: http://www.cms.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning on or around March 10, 2011 and will be available for 30 days.

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

Thank you for your interest in CMS Open Door Forums.

Transcript & Audio File -

<http://media.cms.hhs.gov/audio/HospitalValueBasedPurchasing021011.mp3>

CENTER FOR MEDICARE & MEDICAID SERVICES

**Moderator: Barbara Cebuhar
February 10, 2011
1:30 p.m. ET**

Operator: Good afternoon, my name is (Alicia) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services, "Hospital Value Based Purchasing Special ODF, Open Door Forum". All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a comments session. If you would like to voice a comment during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your comment, please press the pound key. Thank you.

Ms. Barbara Cebuhar, you may begin your conference.

Barbara Cebuhar: Good afternoon, everyone and thank you for attending this open door forum regarding our efforts in the Hospital Value-Based Purchasing program. In case you are in front of your computer monitor, I thought you might want to follow along by dialing or raising our slides that were distributed with the invitation. But just in case you don't have that address, it's www.cms.gov/hospitalqualityinits/downloads/o210_slides.pdf. So go to the www.cms.gov/hospitalqualityinits and look in the downloads section and you'll find the slides for today's program.

Our agenda for this call is as follows; we have several presenters that we will introduce during the presentation. We'll discuss the various provisions of the proposed rule and then have some time for comments. I now have the pleasure of introducing our first presenter, Jean Moody-Williams, who is the Director of the Quality Improvement Group in the Office of Clinical Standards and Quality at CMS, who will provide opening remarks and begin our presentation on the Hospital Value-Based Purchasing proposed rule. Just in case people need to get an encore presentation of this program, starting at 7:30 tonight, you can dial 1-800-642-1687 and use the same pass code, which is 31900886. It will be available for two business days until February the 14th.

Jean, do you mind starting?

Jean Moody-Williams: Thank you so much and I'll be happy to start. We are very happy that you've joined us. We have large numbers on the phone today and we

view that as a very good signal for the interest in the program and also our opportunity to hear your thoughts and comments.

This special open door forum was developed specifically for providers and beneficiaries, their families and advocates in an effort to increase awareness and understanding of the proposed regulation. Most importantly, this forum provides us with the opportunity to engage you in the forum highlighting changes that can be anticipated as the result of this new legislation. We will begin today's forum with a brief presentation, but we want to make sure and save time so that you have the opportunity to ask questions and to provide us with comments.

Before we get into the presentation, I would like to point out that we are in a proposed stage of rule making and we're unable to talk about the specifics of the final Hospital Value-Based Purchasing policy or payment implementation. So we won't be able to speak to topics that fall beyond the Hospital Value-Based Purchasing (inaudible) proposed rule making either. As a result though, we will allow questions or comments at the end of this presentation and we will only be listening however, we will be in a listening only mode and we won't respond to any questions or comments on this call.

I'd like to acknowledge the fact that you and I know you have good ideas about how we can implement the program and we really want your feedback and your comments, so I'm asking that you please submit those ideas in the forms of formal comments and response to the Hospital VBP notice of proposed rule making, which was recently published. You will receive instructions on how to submit those formal comments before the end of the presentation, but again, even though you make a comment today, we really do encourage you to submit them for official recognition through the process that we'll describe.

So why don't we move to slide three and we'll jump right into our presentation. The Hospital Value-Based Purchasing program was required by congress in section 1886(o) of the Social Security Act and it will apply to discharges beginning in FY 2013. The program is being launched by CMS as a part of our continuing effort to promote higher quality care for Medicare

beneficiaries. We really view value based purchasing as an important driver of revamping how we pay for healthcare services and really moving us toward rewarding better value, innovations and outcomes. We should note that the details we are presenting here today are proposals. They are subject to change after we get all of the comments in, we review them and analyze them and they will be published, our final determinations will be published in a final rule. So again the whole purposes is to solicit those comments prior to that time.

If we go to slide four, just like to quickly review the legislative requirements. The Hospital VBP legislation imposes multiple requirements on CMS that really necessitate quick action from the agency to get this program implemented in a timely manner. The program applies to discharges beginning in FY 2013 or that's October 1st, 2012. In order to implement the measures selected for the program must have been specified under the Hospital Inpatient Quality Reporting program and posted on Hospital Compare for at least one year. So that was one of the things we had to observe.

The legislation requires that the Secretary establish and announce the applicable performance standards no later than 60 days prior to the beginning of the performance period for our fiscal year. So another important date and timeframe we had to keep in mind. As we'll describe later, CMS proposed a nine month performance period beginning July 1st of 2011. We anticipate using – issuing the final rule as soon as possible after the close of the comment period so that we will have sufficient time to calculate the performance score, the incentive payment and all of the other components of the program.

If we could move to slide five, we begin a discussion of who's eligible to participate in this program. The Hospital Value-Based Purchasing program applies to subsection (d) hospitals located in the 50 states and the District of Columbia. The program does not apply to hospitals and hospital units excluded from the IPPS such as psychiatric, rehabilitation, long term care, children's and cancer hospitals. The Hospital VBP program will apply to acute care hospitals in Maryland as Maryland hospitals continue to meet the

definition of a subsection (d) hospital, unless the Secretary exercises discretion to exclude these hospitals from the program under section 1886.

Continuing on on eligibility for the program, if you could go to slide six please. Some hospitals will be statutorily excluded from participating in the program and that – those would be hospitals subject to the payment reduction under the Hospital Inpatient Quality Reporting program for the fiscal year, hospitals cited by the Secretary for deficiencies during this performance period for those that pose immediate jeopardy to patient’ health or safety and CMS is proposing to interpret that requirement as applying to any hospital cited through the Medicare state survey and certification process. In addition to meeting the definition of a hospital, we will be proposing that hospitals must meet a minimum number of cases and measures to receive a total performance score and I’m going to describe that in the next slide.

If you could move to slide seven, this slide illustrates the eligibility requirements for the minimum number of cases and measures. A minimum of 10 cases per measure and at least four measures are required to receive a total performance score. So we have a visual example and in this example, the hospital has more than 10 cases in measures one, three, four and 17, as we’ve indicated by the number of people presented under each measures. Measure two is excluded as it includes less than 10 cases. I just want to remind you though that although not really illustrated on this slide, we have proposed that hospitals must submit at least 100 HCAHPS surveys during the performance period to receive a patient experience of care score.

If we could move to slide eight, so this slide depicts the two domains and the percentage of the total performance score and detailed measures and dimensions of each of those domains. Both the 17 clinical process of care measures and the eight patient experience of care dimensions can be found in the notice of proposed rule making. These measures meet the requirement outlined in the statute, of course that’s very important, in that they be specified under the Hospital IQR program and be posted on Hospital Compare for at least one year prior to the performance period. So they should look very familiar to you. For the patient experience of care domain, CMS will score

eight dimensions of HCAHPS surveys compared to the scores that are now publicly reported for HCAHPS.

There are two differences; the overall rating dimension is included instead of the would you recommend dimension, since they conceptually really measure the same thing and CMS did not want to double count the patient's overall evaluation of the hospital. Secondly, CMS designed the cleanliness and the quietness dimension. As some of you may remember, these two items were included as one composite measuring two aspects of the hospital environment when HCAHPS was first developed. We later broke these items out into two separate measures since it really made more sense to consumers to show these as distinct environmental factors. But for Hospital Value-Based purchasing, we've combined the cleanliness and the quietness into one dimension so as not to put increased weight on these two aspects of the hospital environment.

We're going to go to slide nine now and here, we begin to look in the next series of slides at the proposed measures for 2014. We can see on slide nine that these measures – this slide represents the proposed Hospital Acquired Condition measures. If we move to slide 10, this slide presents the proposed (AHRQ) Patient Safety Indicators and the Inpatient Quality Indicators and Composite measures for FY 2014. And then lastly, on slide 11, this presents the proposed Mortality measures for FY 2014.

OK. Now let's move on to slide 12. We have proposed a sub-regulatory process for adding or retiring measures beginning in FY 2013. We made this proposal really to expedite the timeline for adding measures to the Hospital Value-Based Purchasing program and under the proposal; CMS could add measures to Hospital Value-Based Purchasing once they've been specified under Hospital Inpatient Quality Reporting and posted on Hospital Compare for at least one year. We are also proposing that the performance period for any added measures begin exactly one year after their posting date on Hospital Compare and this process would not entirely replace rule making as CMS proposed to post performance periods, end dates and measure retirement confirmation in rule making. Other details on this proposal are included in the rule and again, just as all of the slides that I just went through; we really encourage your comments on these matters.

Slide 13 goes into our performance period. We're proposing a nine month performance period for the FY 2013 program, which would run from July 1st, 2011 to March 31st, 2012. For the FY 2014 program, we're proposing three mortality measures using an 18 month performance period and that would begin on July 1st, 2011 and then run through December 31st, 2012.

So with that, I'm going to turn to Barb.

Barbara Cebuhar: Thank you, Jean. Now we will begin the section of the presentation describing how hospitals are evaluated in the hospital value based purchasing program. Jim Poyer, Director of the Quality Improvement Group's Division of Quality Improvement Policy for Acute Care, will review several of CMS's proposals on hospital evaluation. Jim, go ahead, please.

Jim Poyer: Thanks, Barb. First, I want to thank Allison Lee our – excuse me – program lead for Hospital Value-Based Purchasing who would be presenting many of these slides, but was unable to attend today. I'm going to walk through slide 14, how will hospitals be evaluated under the Hospital VBP program and this is a high level summary of the program with further details to follow throughout the presentation.

Under the fiscal year 2013 proposed value methodology for calculating the total performance score, hospitals will be scored on two domains, clinical process of care, which includes 17 measures and patient experience of care, which uses eight of the 10 HCAHPS survey dimensions. Hospitals will receive two scores for each measure, one for achievement and one for improvement. Domain scores will be calculated using the higher of the two scores for each measure. Measured improvement scores means that all hospitals have an opportunity to benefit from hospital value based purchasing, not just the best performing hospitals. Any hospital can benefit by showing improvement from its baseline performance. Seventy percent of a hospital's total performance score would be based on our proposed rule on the clinical process of care domain and 30 percent on the patient experience of care domain.

And moving on to slide 15, this slide is a visual representation of the proposed fiscal year 2013 hospital VBP scoring methodology. Total performance scores will be calculated from two domains, clinical process of care and patient experience of care. The clinical process of care domain is composed of 17 measures represented below the red box. While the patient experience of care domain is composed of eight dimensions of the HCAHPS survey represented below the green box, plus HCAHPS consistency points. Beneath the representation of the measures and dimensions, one clinical process of care measure and one patient experience of care dimension are illustrated. Finally, each measure or dimension is scored on achievement and improvement based on the depiction across the bottom of the slide understanding that this is an example and therefore, represents – presents representative thresholds, benchmarks and improvement in achievement ranges.

And then moving on to slide 16, improvement versus achievement. For improvement, hospitals will be measured based on how much their current performance changes from their own baseline period performance. Points are then awarded based on how much of the distance they cover between that baseline and the benchmark score. For achievement, hospitals will be measured based on how much their current performance differs from all other hospital's baseline period performance. Points are then awarded based on the hospital's performance compared to the thresholds and benchmark scores for all hospitals.

And then moving on to slide 17. Improvement points are awarded by comparing a hospital's scores during the performance period to that same hospital scores from the baseline period. The number of improvement points awarded depends on how much a hospital's measure or dimension score change from it's own score during the baseline period. We've proposed to define the achievement threshold in both domains as the median hospital performance during the baseline period. We've proposed to define the benchmark for the clinical process of care domain as the mean of the top decile of hospital performance during the baseline period.

For the patient experience of care domain, CMS proposes to define the benchmark as the 95 percentile during the baseline period. Improvement scores are calculated as follows; if a hospital's measure or dimension score is greater than or equal to the benchmark, that hospital will receive the maximum 10 achievement points and there is no need to calculate the hospital's improvement score. If a hospital's measure or dimension score is less than or equal to its baseline score, that hospital will receive zero points for improvement.

If a hospital's measure or dimension score is between the baseline score and the benchmark, that hospital will receive zero to nine points based on its unique improvement range, which runs from its baseline score to the benchmark. A unique improvement range would be established for each hospital based on its unique baseline period (inaudible) score and the specific number of improvement points awarded would depend on how much the hospital's performance improved in the performance period from its performance in the baseline period.

We will go into more detail shortly, but an example at the bottom of the slide, the hospital improved their score from 0.21 in the baseline period to 0.70 in the performance period and would therefore receive seven improvement points based on where the performance score of 0.70 aligns with the improvement range. As we have stated, the higher of achievement or improvement scores is used in the scoring calculations.

Moving on to slide 18. The achievement points are awarded by comparing an individual hospital's scores during the performance period with all hospital scores from the baseline period. As we stated earlier, we've proposed to define the achievement threshold in both domains as the median hospital performance during the baseline period. We've performed to define the benchmark for clinical process measures as the mean of the top decile of hospital performance during the baseline period. For the experience of care domain, we've proposed to define the benchmark as the 95 percentile for each dimension during the baseline period. Achievement scores are calculated as the following; if a hospital's measure or dimension score is greater than or equal to the benchmark, that hospital will receive the maximum 10

achievement points. If a hospital's measure or dimension score is less than the threshold, that hospital will receive zero points for achievement. If a hospital's measure or dimension score is equal to or greater than the threshold, but below the benchmark, that hospital will receive a score of one to nine depending on where the hospital's score falls between the threshold and the benchmark.

We will go into more detail shortly, but in the example at the bottom of this slide, the hospital performance (period) score was 0.70 and therefore would receive six achievement points based on where its performance period score of 0.70 aligns with the achievement range.

Moving on to slide 19. Here are the formulas for clinical process of care formulas for determining the improvement and achievement scores for this domain, assuming that the hospital's scores fall between the achievement threshold and the benchmark. As we mentioned on the previous slide, if a hospital's score meets or exceeds the benchmarks, it will receive the maximum 10 points. If a hospital's score falls below the achievement threshold, then it will receive no points. Finally, another key point is that hospitals must score higher than their baseline score in order to receive improvement points.

Moving on to slide 20. How will CMS calculate the clinical process of merit domain score? Because some hospitals will be evaluated on more measures than others, CMS will normalize the domain scores clinical process of care. CMS will do this by converting points earned to a percentage of total points. This makes it easier to compare hospitals with different numbers of applicable measures. Each measure in the clinical process domain is worth 10 points. The highest possible score for this domain is found by multiplying the number of measures that apply to the hospital by 10.

The clinical process of care domain score is computed by dividing the points scored by the total possible points and then multiplying this quotient by 100 percent. As the table on the bottom shows, if hospital one has five applicable measures and scores a nine on each of the five measures, their score would be a 45 reached by multiplying five measures by a score of nine on each

measure. If hospital two has 11 applicable measures and also scores a nine on each of those 11 measures, their score would be a 99 reached by multiplying 11 measures by a score of nine on each measure.

However since both hospitals scored nine out of a possible 10 on all the measures applicable to each hospital, they should both receive the same domain score regardless of how many measures are applicable to them. Therefore, each hospital's score is normalized by multiplying their scored points divided by possible points by 100. This results in a clinical process score for both hospitals of 90, that is 45 divided by 50 multiplied by 100 equals 90 and 99 divided by 110 for the second hospital multiplied by 100 equals 90.

Moving on to slide 21. In this example, the hospital's performance on this clinical process measures exceeded the benchmark level, so it would receive 10 achievement points on this measure.

Moving on to slide 22. In the second clinical process scoring example for hospital L. In this example the hospital's performance on the measure is worse than the baseline period score and falls below the achievement threshold. Therefore, this hospital would receive no points for achievement or improvement on this measure.

Moving on to slide 23. The third clinical process scoring example for hospital I. In this example the hospital improved their score from the baseline period from 0.21 to 0.70. Based on this performance period score, the hospital would receive six point for achievement or seven points for improvement. Picking the higher of these two scores for this measure; the hospital would receive seven improvement points.

Barb(Inaudible), I'm going to turn it over to you.

Barbara Cebuhar: Actually, Jim, I think that you need to go ahead to slide 24.

Jim Poyer: OK. I'm going to turn it over then to Liz Goldstein, who is the Director of the Division of Consumer Assessment and Plan Performance and the Centers for Medicare and Medicaid in the patient experience of care evaluation. Liz?

(Liz Goldstein): Thank you. I'm going to be going over on slide 24 how to calculate your patient experience of care score. The patient experience of care score is based on the sum of the higher of each of the eight HCAHPS dimensions achievement and improvement scores plus the consistency score. By using the consistency score, we're hoping to reward hospitals based on consistent performance across all eight HCAHPS dimensions. Hospitals will be awarded up to 20 consistency points proportionally based on the single lowest of hospital's eight HCAHPS dimension scores during the performance period compared to the median baseline performance score for that specific HCAHPS dimension.

Hospitals will receive the full 20 consistency points if they perform at or better than the 50th percentile baseline score for each dimension. If a hospital scores below the 50th percentile on any dimension, consistency points will be given in proportion to their percentile rank on the lowest scoring dimension. So the total patient experience of care score is the sum of the HCAHPS base and consistency scores. And I just wanted to review the base score is the sum across all HCAHPS dimensions of the higher of the achievement or improvement scores. The patient experience of care score is slightly different than the clinical process of care score in that it takes consistency into account. As I said before, we want to create incentives so that a hospital performs consistently across all of the patient experience dimensions that make up the HCAHPS measure.

Going to the next slide, slide 25, I'm going to go over how a hospital will be evaluated in terms of the formulas for the patient experience of care measure. So on this slide are the formulas for determining the improvement in achievement scores for HCAHPS assuming the hospital's scores fall between the achievement threshold and the benchmarks. As was mentioned on an earlier slide, if a hospital score exceeds a benchmark score, it will receive the maximum of 10 achievement points and if the hospital's score falls below the achievement threshold, then it will receive no achievement points, but may receive improvement points. Finally another key point that I'd like to make is that hospitals must score higher than their baseline score in order to receive improvement points.

On slide 26, it gives a little bit more information about the consistency scores and how they are calculated. If any of a hospital's HCAHPS dimension scores are equal to or lower than the worst performing hospital during a baseline period, that hospital will receive zero consistency points. If a hospital scores at or above the achievement threshold of hospital performance in the baseline period for all eight HCAHPS dimensions, it will receive all 20 consistency points. If any of a hospital's dimension scores are below the achievement threshold, but above the worst performing hospital's score during the baseline period consistency points will be awarded based on the percentile score of the lowest scoring dimension. I have on this slide the formula and the results of the calculation will be rounded to the nearest whole number with a minimum of zero and a maximum of 20 consistency points.

Slide 27 gives an example of scoring for this domain. In this case, the hospital's dimension score exceeded the benchmarks and they will receive 10 achievement points on this dimension. In the next example, this is on slide 28, the hospital's score declined since the (inaudible) baseline period and is still below the achievement threshold. The hospital will receive no points for achievement or improvement on this dimension. The next example, which is on slide 29, the hospital's score improved from the baseline period. Based on this score between the achievement threshold and the benchmark, the hospital will receive three points for achievement or four points for improvement. Taking the higher of the two scores, the hospital receives four points on this dimension.

I'm going to now turn it back over to Jim Poyer to continue the presentation.

Jim Poyer:

Thank you, Liz. Moving to slide 30, how will the hospitals be evaluated in terms of the total performance score? As you will recall, the measure scores are sum within each domain. The domain scores is then weighted and added together to calculate the total performance score. For fiscal year 2013, we propose a 70 percent weight for the clinical process of care domain and a 30 percent for the patient experience of care domain. The proposed weighting is the result of consideration of many factors and analysis including the number and reliability of measures in each domain, Department of Health and Human

Services quality priorities and the effects of alternate weighting schemes on hospitals according to their location and characteristics.

We propose to calculate a hospital's total performance score by multiplying its performance on each domain by the proposed weight for that domain and then adding the weighted scores together and I would refer readers to – it is not included in slide 30, but table six in the proposed rule on – in Volume 76 of the Federal Register Number 9, page 2479, table six that basically walks through how the weights are applied using four clinical process of care measures where the combined score for the four measures is 27 points divided by a total possible number of points 40, divide 27 divided by 40, that means a domain score of 67.5 and then you would multiply that domain score times the weight, 70 percent to come up with 47.25.

The same for HCAHPS in terms of there is a base score of 60 points in table six and then nine points for a consistency score, add those two together, it's 69 points, multiply that by the HCAHPS weight, that is 30 percent and that comes up with 20.70 and then the total performance score that's listed in table six is simply the weighted domain score of 47.25, the 67.5 times the 70 percent clinical process of care weight plus the 20.70 which is simply the 69 times the 30 percent HCAHPS weight and you add those two together and it's .6795. And this score will be translated into incentive payment and now – I will now review in terms of the exchange function – in terms of – excuse me. And we also mentioned for fiscal year 2014 and beyond, new domains could be added and any effect on the overall domain weighting will be established in future rule making and then I'm go on to slide 31.

And in the exchange function, the 2007 report to congress introduced the exchange function as a tool to translate total performance score into value based incentive payment. Payments for hospitals with scores above zero will be set so that the total incentive payment meets the program's statutory budget neutrality requirement and the total amount of value based incentive payments in aggregate are equal to the amount available for value based purchasing incentive payments as estimated by the Secretary. And we proposed a linear function for the fiscal year 2013 Hospital VBP program and I'd like to now introduce Ernessa) Brawley, one of our subject matter experts in CMS for the

Hospital Value-Based Purchasing programs to present the remainder of the presentation slides related to validation, notification and other proposal.

Ernessa?

Ernessa):

Good afternoon. If you will turn to slide 32, it talks about the Hospital Value-Based Purchasing fiscal year 2013 validation requirements. CMS will use the validation process as described in the fiscal year 2011 IPPS final rule for the fiscal year 2013 Hospital Inpatient Quality Reporting program. The benefits both hospitals and CMS in that hospitals can use the same data for both the Hospital Inpatient Quality Reporting program and the Hospital Value-Based Purchasing program. Hospitals will not be required to return requested medical records for the Hospital Value-Based Purchasing program separately. We believe this will also help to ensure the accuracy of the Hospital Value-Based Purchasing program measure data.

Slide 33 addresses the proposed notification and review procedures for the Value-Based Purchasing program. Hospitals will be notified of the 1 percent reduction to the fiscal year 2013 base operating DRG payments in the fiscal year 2013 IPPS rule. Each hospital will be given an estimate of its value based incentive payment for fiscal year 2013 at least 60 days prior to the October 1st, 2012 through its quality net account. The exact amount of the value based purchasing incentive payment adjustment for fiscal year 2013 is scheduled to be given to hospitals on November 1st, 2012. The adjustment will be incorporated into the claims processing system for January 2013.

Slide 34 also discusses additional proposed notification and review procedures. As required by section 1886(o)(10)(i), the Hospital Value-Based Purchasing program includes standards for reporting hospital performance information to the public. So for every hospital, the following scores will be made public through the Hospital Compare Website, each hospital's measure score, condition specific score, domain specific score and total performance score will be posted on Hospital Compare. Hospitals will have 30 calendar days prior to posting to review and submit corrections for this information. CMS will discuss this process further in future rule making.

Slide 35 discusses the proposed appeals process for hospital value based purchasing. CMS will propose an appeals process in future rule making. However, we'd like to point that by statute the following are not subject to administrative or judicial reviews; these include the methods used to determine the amount of the value based incentive payment and the determination of the amount, the determination of the amount of funding available for the value based incentive payments and payment reductions, establishment of the performance standards and the performance periods, the measures specified in the Hospital Inpatient Quality Reporting program or included in the Hospital Value-Based Purchasing program, the methods and calculations that are used to calculate hospital performance scores and the validation methodology used in the Hospital Inpatient Quality Reporting program.

Now CMS welcomes comments on the appropriate process to manage the appeals in a reasonable timeline for resolving these appeals under the Hospital Value-Based Purchasing program. For more information about the appeals process, we would invite you to look at section 1886(o)(11) .

Slide 36 discusses additional information that's included in the proposed rule. Monitoring and evaluation efforts will be part of CMS's oversight of the Hospital Value Based-Purchasing program. Some areas that CMS intends to monitor specifically include access to and quality of care, patterns of care suggesting particular effects on the percentage of patients receiving appropriate care for conditions covered by the measures, the rate of a hospital acquired conditions, best practices of high performing hospitals and trends in care delivery, access and quality.

At this time, I'd like to introduce Tom Kessler, who is one of our subject matter experts from the Quality Improvement Group's Division of Quality Improvement Policy for Acute Care, to discuss proposed changes to the QIO data confidentiality requirements. Tom?

(Tom Kessler): Thank you. The hospital value based purchasing program necessitates CMS access to quality data and brings to the forefront some historical constraints on accessing quality improvement organization or QIO data. As such, CMS has

proposed changes to the QIO data and confidentiality regulations located at 42 CFR part 480. These regulations restrict access to and disclosures of QIO data and information not only for the general public, but for CMS as well. While we believe that most of the regulatory restrictions remain necessary, some of the regulations have created unnecessary problems in managing the QIO program, particularly in light of the significant technological changes that have occurred since these regs were first written over 25 years ago.

To account for these issues, we have proposed changes that will increase CMS's access to data, specifically confidential data. While there are several changes proposed, the key change is the elimination of the restriction that CMS can only access QIO data onsite at the QIO's facilities. This will allow us to better utilize today's technology and thus improve our ongoing oversight of QIO responsibilities. We have also asked for comments on eliminating the onsite restriction placed on the access to QIO data for entities other than CMS, including federal and state agencies who use QIO data for licensing, accreditation, certification and fraud and abuse purposes.

CMS also seeks public comment on the disclosure of QIO data to researchers, since our regulations currently prohibit these types of disclosures. We ask for public comment on the following; first, should researchers have access to confidential information, including access to quality review study information? Second, what process should be used to evaluate these requests? As an example, CMS already has an existing privacy board that could be utilized. Lastly, what criteria should be used in evaluating these requests from researchers?

And with that, I turn it back over to Ernessa).

Ernessa): I'm now on slide 37 of the presentation and slide 37 discusses ways that you may access the rule for further reading and additional information about the rule. If you'd like to read the rule and see the official language we have discussed today and a description of the Value-Based Purchasing program, you can access and comment on that document at regulations.gov by searching for the document numbers CMS-3239-P. You may also find the

rule on the Federal Register or at CMS.gov under the Hospital Quality Initiative tab.

Slide 38 discusses how to comment on the rule. CMS welcomes public comments on all aspects of the proposed rule, including the topics below as specifically listed.

Now slide 39 discusses how you can comment on the rule. There are four methods to describe – to comment on the rule, including hand delivery of the comments as listed in the rule itself. You can also send your comments via mail at the addresses listed in the notice of proposed rule making. You can also submit your comments electronically via regulations.gov by clicking on submit comments near the regulation number. We would like to emphasize, however, any comments made on the call today do not supplement your need to submit formal comments for this rule and you may follow that process by – following the process described in the rules text. The comment period closes on March 8th, 2011 at five pm as provided in the rule language.

Jim Poyer: Thank you, Erenessa). This concludes our presentation on the Hospital Value-Based Purchasing proposed rule. We will open up the line for questions or comments, but as we indicated at the start of this special open door forum, we are in the proposed stage of the rule making cycle and are unable to talk about the specifics of the final hospital value based purchasing policy or payment implementation. As a result, we will allow questions or comments at this time, but CMS will be in listening mode only and will not respond to any questions or comments on this call. We request submission of any comments, questions, ideas or any other feedback through the formal comment process that was reviewed.

Barbara Cebuhar: Thank you, Jim. I am grateful for everybody's thoughts and I hope that, (Alicia), we can open up the line for comments.

Operator: Absolutely. At this time, I would like to remind participants in order to make a comment, please press star and the number one on your telephone keypad. We'll pause for just a moment to compile the comment roster. And our first

comment comes from the line of (Michelle Evans) with Ascension Health.
Your line is open.

(Michelle Evans): I apologize. I no longer have a question.

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

Joanna Kim: Hi. Thanks. This is Joanna Kim from the American Hospital Association and I just wanted to mention that we thought that this was very a well done rule. We thought that the proposals CMS set forth were, for the most part, very well thought out and really take a great step forward at moving us into the pay for performance program. That said, of course, we have a few concerns. I did just want to mention our big ones. Our main concern with this rule is the proposed inclusion of the hospital acquired conditions in the value based purchasing program in 2014 and beyond.

As you know, there is a separate hospital acquired condition policy set forth in the health reform law to begin in 2015 that will penalize hospitals with the highest rates of hospital acquired conditions. So we feel like having that policy, as well as including that HCAHPS and the VBP policy really subjects hospitals to double jeopardy and is inappropriate. So we would urge CMS to drop the hospital acquired conditions from the VBP program.

We also did have a concern about the minimum number of cases as proposed for the clinical process measures. CMS has proposed that to be eligible for a clinical process measure a hospital would have to have at least 10 cases. This is inconsistent with helping with how things are reported on hospital compare right now. As you know, hospitals there must have at least 25 cases to have their data displayed. Obviously, the Medicare program was already complex. I think it's become a lot more complex once healthcare reform passed, particularly the inpatient PPS. So we feel like consistency here is really paramount in getting to a workable program that hospitals and consumers alike can understand. So we would urge CMS there to increase the minimum to 25 in order to be consistent with hospital compare.

On the HCAHPS side, I just wanted to quickly comment on the weighting of the HCAHPS domain. CMS had proposed it at 30 percent, but we do have some concerns there. There is some emerging evidence about some systematic – I don't know if biases is the right word, but with the data where, for example hospitals that serve the more severely ill patients systematically have lower HCAHPS scores. We think that those issues need to be more – explored more further and more research there needs to be done looking at the survey methodology and risk adjusters. So in the interim, we would urge CMS to lower the HCAHPS domain weight from 30 percent to a lower percent.

OK. Thank you very much.

Barbara Cebuhar: Thank you for those comments. I think we would just, of course, (inaudible) is aware we would ask that you be sure that you submit those as part of our formal comment making process so that we can be sure they are considered as we draft the final rule. Operator, I think we're ready for the next question.

Operator: Our next comment comes from the line of (Melanie Graham) with the Healthcare Association. Your line is open.

Female: Hi. A couple of questions, not sure if you can answer them here from (inaudible). Obviously, we're an advocacy association and one of the things we want to be able to do is help our hospitals understand the impacts and implications as the rule is developed and then as fiscal 2013 approaches. If you are going to wait until 60 days prior and I understand you know the timeframe is tight to post for hospitals what their expected estimated incentive payments only out on quality net, will there be an impact file or some sort of a national file that will provided so that advocacy groups, et cetera, can review and audit the impacts and do the type of work that our members pay us to do? So that was question number one. I've already lost track of question number two. What was question number, (Melanie)?

(Melanie Graham): Oh, it was about incentive payments. We were wondering how – I know – we need CMS to clarify how they're going to actually pay hospitals for these incentive payments. Will it be done through the rates? Are you thinking

lump sum? Like we weren't really sure and if you are doing it through the rates, will you be including that in the final IPPS (inaudible) fiscal year 2013 rule so that you know when that comes out in August of 2012 we would be able – you know hospital associations, advocacy groups would have that information by hospital?

That's – is that everything?

Barbara Cebuhar: Thank you for your comments.

Female: OK.

Kelly Anderson: :Yes. We will have to address the logistics and mechanics of payment in future rule making, so please look forward to that. Regarding your first observation, we do thank you for that comment. We would, again, encourage you to submit that through the formal comments making process so that we can consider that formally as we draft the final rule.

Barbara Cebuhar: (Alicia), we have about an hour left, so if you could please get our next comment.

Operator: Absolutely. Our next comment comes from the line of (Kaitlyn Merins) with CFC. Your line is open.

(Kaitlyn Marins): Hi. Thank you so much for this great overview, it's been really helpful. I just had one clarification question that you may or may no be able to answer and really it relates more to the IQR program than specifically the value based purchasing program. I wondered what patient populations are the measures based on. In particular, which measure is focused exclusively on Medicare patients?

Jim Poyer: We would welcome you to submit your comments and also refer the reader to previous rule making for the (inaudible) formally known (inaudible) in the IQR program. That may shed some light on that.

Barbara Cebuhar: Thank you, Jim. (Alicia), our next comment please?

Operator: Our next comment comes from the line of Beth Feldpush with American Hospital. Your line is open.

Beth Feldpush: Hi. Thank you all. I just wanted to add a few more technical comments and questions to my colleague, (Joanna's), comments and that is that when doing the quality measures that we've selected for the program, we strongly feel that those measures should always be added to the rule making process and not through the sub regulatory process. I know that that had been proposed – excuse me – in previous years for the inpatient quality reporting program and then CMS did not finalize those proposals, but instead does add all measures of reporting to the rule making process. And then we would then therefore strongly urge to do the same for value based purchasing.

And I also just wanted to add a few more comments about HCAHPS . In general, you know we all recognize that the value based purchasing program is complex and that probably is the way it does have to be. But it does seem that the HCAHPS component sort of adds several more layers of complexity to the system that we're wondering perhaps could be simplified. For example, our reading of the rule and from what was shared today is that hospitals will be scored on their HCAHPS scores based on the percentile that they fall into in their performance, whereas for the clinical process measures, they will be scored directly on their actual scores for the measures. And we were a little confused as to why CMS is choosing to recommend percentiles for HCAHPS scores, so any (clarity) (inaudible) provide in the final rule and your insight on that, that would be great and I think we would suggest that for simplicity, actual scores might be easier.

Again, also with the consistency score for HCAHPS, you know we questioned why that was added for HCAHPS but not for the clinical practice measures. And it seems that you know while understandably valuable perhaps could be stripped out of the HCAHPS calculations for simplicity again. And then my last comment on HCAHPS is that the achievement score for HCAHPS appears to be a different formula or at least looks like a different framework than the calculations for the clinical process measures for achievement improvement and for HCAHPS improvement. So we question and we wonder why that formula looks different.

And that's all. Thank you very much.

Barbara Cebuhar: Thank you, Beth. (Alicia), our next comment please?

Operator: Our next comment comes from the line of Teri Newsome with Habersham Medical Center. Your line is open.

Teri Newsome: Yes, I'd like for you all to get our QIOs to post how we can listen to this again and I'm asking if you could extend the time period further than just February the 14th since we can comment up until the March the 8th.

Barbara Cebuhar: Teri, there will be a recording and a transcript available starting March the 10th for 30 days. So you can listen to it again then. I just wanted folks to know there was going to be an encore performance. So you can listen to it again by dialing 800-642-1687 and the pass code is 31900886. But starting March the 10th, there will be a recording and a transcript available at the special open door forum Website.

Kelly Anderson: And I just want to add, we will, of course, be sure that QIOs are made aware of any public announcements we have about the call or any other opportunities for additional information about the programs. So we'll be sure that we share that with them as a source of information as well.

Barbara Cebuhar: (Alicia), our next comment please?

Operator: Our next comment comes from the line of (Larry Remumo) with NHCQF. Your line is open.

(Larry Remumo): This is actually following up on the HCAHPS comment. The – at least in our multiple reading of rule, there appears to be some consistency about the use of the word score particularly with the HCAHPS domain. It appears as though sometimes you're referring to the word score and you imply the percentage performance of an institution and a couple of the diagrams may or may not be referring to the institution's performance period percentile score. So that would need to be clarified. If it turns out that you're referring to a percentile score, the obvious implication of that is, is that, as was already noted once, for

the clinical measures you're using an absolute performance scale, but for the HCAHPS score you're using a relative performance scale, which makes methodologically combining them inappropriate, by most standards.

Secondly, you're automatically defining that half of the performance scale – performance period hospitals will not score – not achieve a score on any single element of the HCAHPS method every time if you're using their percentile score as opposed to their percent score.

Barbara Cebuhar: (Larry), we look forward to your written comments. Thank you very much. (Alicia), our next question please?

Operator: Our next question comes from the line of Craig Jefferies with AORN. Your line is open.

Craig Jefferies: Thank you. AORN is the Association of Perioperative Registered Nurses. We are very supportive of the direction of this proposed rule and specifically the identification of clinical process measures for the operating room. We would encourage CMS to look at how nurse sensitive measures or other measures that address the role of the nurse could be integrated into this value based purchasing program. Like being addressing areas of teamwork, implementation of safety or a nurse sensitive measure for example on pressure ulcers in the operating room. We feel that the role of the nurse probably needs to be highlighted and would ask that CMS address this strategy for achieving this, if you can, in the final rule making and if not, in subsequent rule making. And we'll be pleased to address these issues in more detail with our written comments. Thank you.

Barbara Cebuhar: Thank you, Craig. (Alicia), our next comment please?

Operator: Our next comment comes from the line of Lara Wellborn with Vanguard Health Systems. Your line is open.

Lara Wellborn: Hello. Thank you. My question is very specific to the inclusion measures proposed for fiscal year 2014 and my concern is over the suggested inclusion of the complication/patient safety for selected indicators composite given that some of the other patient safety indicators of which that composite is

comprised are already listed in that same – (inaudible) on slide 10 here, some of the items above that are PSIs are in that same composite. So to me, I'm worried about I guess double counting of the same measures and wondered if you had any thoughts or rationale that you could help me understand why it was set up that way.

Female: That's definitely something we would want to be sure we receive in writing. So, if you could, please, submit that for us. (Unfortunately), that's something we can comment on today during today's call, as you can imagine.

We can't expand on what's already been written. But it's something that we could address in the final rule, if you could provide it to us in writing.

Female: (Alicia), our next comment, please.

Operator: Our next comment comes from the line of Tom Jendro with Illinois Hospital Association.

Tom Jendro: Thank you, and good afternoon, and thank you, again, for everyone from CMS for putting on this call. It was very informative.

My question slash comment has to do with the fact in the proposed rule, there are a couple of references to estimates that are going to be used in the payment calculations.

For example, hospitals will be notified as to their estimated 1 percent contribution to the pool, based on DRG payments. Then they will get an estimated 2013 incentive payment score by November 1.

Our concern comment is what happens if hospitals successfully challenge either or both of those two calculations? How will CMS address recalculating or redistributing the dollars in some way?

Will there be a reserve set up at some point? Will they have to be deferred into 2013? What would happen if there are any kind of changes or corrections to those estimates?

Female: Thank you for the question. We actually did address that in the proposed rule. If you're looking at the federal – oh, I'm sorry.

But we did address the – that fact in the proposed rule, though we didn't propose a solution.

On page 2483 of the Federal Register Notice, we did note that we expect to propose to incorporate the reduction into our claims processing system in January 2013.

And that will allow the 1 percent reduction to be applied to the FY13 discharges, including those that began in October 1st.

Because there are some operational aspects of the reduction that we do need to work out, we will address that in future rulemaking.

And we do make a commitment here in the rule that that would be the FY2013 inpatient prospective payment system. That comes out later this year.

Female: Thank you very much, Tom.

(Alicia), we're ready for the next comment.

Operator: Our next comment comes from the line of (Paul Strange) with Franciscan Alliance.

(Paul Strange): Thank you. I have just a question for clarification. Did I understand that both comments and questions about the proposed rule will be accepted via the process outlined at the end of the presentation?

Female: That is correct, yes.

(Paul Strange): Thank you. That's it.

Female: (Alicia), our next comment?

Operator: Our next comment comes from the line of (Aaron Reich) with Port Hospital of Lafayette. (Aaron Reich) from Port Hospital of Lafayette.

Our next comment comes from the line Edward Coyle with Catholic Health East.

Edward Coyle: Hello – excuse me – I just had some questions about monitoring or performance, once you get started, with these scores.

And the scores that we're checking against the (achievement) thresholds and the benchmark of the improvement, one is the percentiles against the rest of the country, I take it.

So how is a hospital supposed to monitor their progress of their position during the course of the year?

Female: Again, that would be something that we'd be certainly willing to look at and we would ask that you submit a written comment so that we can look at that in the final rule.

Female: (Alicia), our next comment, please.

Operator: Our next comment comes from the line of (Melanie Clan) with the Healthcare Academy of New York State.

(Melanie Clan): Hi, follow-up question slash comment, from Beth – to Beth Feldpush, as she was talking about the issues with HCAHPS and using the percentiles.

I'm wondering if you can provide clarification or just verification with a yes or no, it seems as though as perhaps unintended, that the – by using the percentiles, the achievement score, which is a hospital's percentile, was being compared to an absolute number, 95 and 50, which is not really base period performance, but an absolute percentile performance, which is why I believe you're getting the (inaudible) of the methodology is inconsistent with the methodology on the – on the process score side.

I mean – oh, are – it – was that your intent? Or is – or is that an unintended result of making the transformation to percentiles?

Female: Yes, they – just as a clarification, the percentiles are based off of that base period of performance. So that's what you're comparing to (inaudible) performance period.

Those scores are (tracked to) that base period. And, certainly, you know, further questions about that can be ...

(Melanie Clan): So ...

Female: ... (inaudible) comments.

(Melanie Clan): So, in other words, if you have a ...

Male: (inaudible)

(Melanie Clan): ... if you have a score in the performance year, you have an HCAHPS dimension score of 75 percent. You don't assign it to the percentile that it would fall into during the performance year?

You would assign it to the percentile it would have fallen into in the base year?

Female: Correct, because you're comparing everything to that base period.

Female: (Melanie), we really would appreciate your written comments. So thank you very much for your insights.

Female: And just to clarify, I said earlier that the FY2013 (ITTS) will be out later this year. I have my years wrong. It will be out next year. So I just want to clarify that (inaudible).

We are aware of our schedule. Thank you.

Female: (Alicia), our next comment, please.

Our next comment comes from the line of (Jan Orton) with Interment – Intermounted Health.

(Jan Orton): Thank you very much.

I have been running just the numbers that are in the hospital or in the value base purchasing program and am finding consistently using the numbers where a hospital could be a high performing hospital, meaning they're 96 percent or 97 percent, and yet they fall just slightly under the median.

And in the – in this case, sometimes they – their baseline and their median or their performance time, they show no (in performance), and hence they receive 0 points.

It would be my recommendation and that CMS address this type of scenario, either graphically as to why they would choose not to provide a consistency score for clinical improved – or for clinical – the clinical side or higher – I – or more likely, I would recommend that you provide a clinical consistency score, similar to the HCAHPS , so that organizations that are almost to the median, but not quite, don't receive 0 points for both improvement and for – and performance.

Thank you.

Female: Thank you, (Jan). (Alicia), our next comment, please?

Operator: Our next comment comes from the line of (Maureen Diontary) with Marshall Medical Center.

(Maureen Diontary): Hello. Thank you. My comment – can you hear me?

Female: Yes.

(Maureen Diontary): OK. My comment was related to the imperfection of the clinical quality process measures. I have been on many phone calls with (Dr. Dale Braxler), one of the lead (QIO) physicians for these measures.

And he has indicated, over and over, that the intent of those measures was never to be perfect. They're not perfect and, therefore, the achievement of 100 percent as the benchmark was never the goal.

So that, for me, suggests that having the 100 percent – yes, people have achieved it in the top 10 percent, is not the intent of those measures.

For example, as a small hospital, we can be at 99 percent and still not achieve full credit. And that, to me, just seems inappropriate.

And I would like to ask for consideration that California, for example, the (chart) project has adopted a 98 kind of percent as indicating full achievement and benchmarking.

And I think that that would benefit us all to not have 99 percent not be recognized as excellent performance.

Female: Thank you, (Maureen). We really do appreciate your written comments on that front.

(Alicia), our next comment, please.

Operator: our next comment comes from the line of (Betty Janes) with South Fulton Medical.

(Betty Janes): Good afternoon. I had a question concerning the part of the presentation where you said there is an achievement threshold.

And I didn't – maybe I missed it, but I didn't hear how you're determining what that threshold is.

Hello?

Female: Hi, (inaudible), we're formulating a response.

(Betty Janes): OK.

Female: One second please.

(Betty Janes): Sounds great.

Male: We would refer readers to page 2464 in the Federal Register as to example achievement performance standards for FY13 and the process.

And base – if you could base your comment, we welcome your comments on that information on 2464.

Female: So that's 2464.

You can get a copy of that Federal Register document, as we stated earlier in the presentation, either through that regulation.gov address, or it is on our website where you got those slides today. Thank you.

Female: (Alicia), our next comment, please.

Operator: our next comment comes from the line of (Helen McVie) with Memorial Health.

(Helen McVie): Thank you. Good afternoon. I have several comments, so I'll just go through them, one by one. And we will submit comments, of course.

The first one is I can't quite find it clarified, the 1 percent that we're talking about here versus the annual payment update or clinical market basket. Are they – do they overlap?

Or are they independent, in terms of the dollars that we're talking about? If you can clarify that or we'll also submit that question.

The second question, I think it – or comment relates to some of the prior thoughts on this is, in looking at the measures and what's out on (hospitalcompare.org) today, for the most recent 12 months that are available, at least five of the measures are up in the 95 percent-100 percent, 13 are up above 90 percent, just at the current average.

I don't know if that would be the median you would calculate. But it – that's posted as average.

So for smaller hospitals, where there are a lower number of patients, the ability to even meet the threshold, you could have one patient fall (down) and be completely out of the entire, you know, calculation for that measure.

So there seems to be compression, which leads to my third question or thought. A lot of these measures, I like what you mentioned about going forward.

There would be a fairly short time period from the (longitudinal) measure to when it would enter a value-based purchasing.

However, on some of the current measures that have been proposed, they've been, obviously, around for quite a long time, so five to six years. So the comment by (Janet, intermittent) health care, I totally agree with that.

I've run some numbers and if a hospital has worked, you know, very, very hard at increasing their scores and has been consistent over the last two to three years at a relatively high rate of performance, you know, 93 percent-97 percent, they actually, you know, could be out of this value-based purchasing compared to another hospital, perhaps, who might currently be sitting at, you know, who knows what, 65 percent, quickly fix something and they will get a lot of improvement points.

But those other – the other – the first example will not get anything. So I think that does need to be looked at. I like the idea of a consistency score.

One more question about a decimal point it goes out to. A lot of people are spending time kind of crunching the numbers right now.

And when you're talking about the difference between 98 and a hundred, how many decimal points you go out to matters. So I think that could be clarified.

And then, finally, on the HCAHPS piece, agree with some of the prior thoughts about the – you know, there's some risk adjusting concerns and, you know, it's a perceptual survey.

So it is impacted by the kind of community you're in, urban versus rural, the number of hospitals in the area. There's many factors that go into that. And I know a lot of our hospitals are in California, or all of ours.

California as a state performs lower than the nation. How will CMS respond to those kinds of regional differences?

Female: Those are all great points, and we look forward to reading about them. Thank you.

Female: (Alicia), our next comment, please.

Operator: our next comment comes from the line of Tina Schwein with Qualis Health.

Tina Schwein: Hi, thank you, again, for this call today.

Many folks have addressed some of my other comments and concerns about the HCAHPS.

But I guess I would follow-up with this, if the plan is to move forward with HCAHPS dimension scores translated into percentiles, will those percentile scores also be posted on Hospital Compare? Currently it's just the percent.

And, I guess, if those additional items are posted on Hospital Compare, will that be confusing for the consumer?

Female: Thank you, Tina. We look forward to your comments.

Next question or comment, (Alicia).

Operator: Our next comment comes from the line of (Cynthia Satterfield) with Wheaton Franciscan Healthcare.

(Cynthia Satterfield): Hi. Some of my questions have to do with the specifics. I'm not as (higher in abstract), and, of course, will be submitting these questions.

But it has to do with the specifics of the calculation and the use of the methodologies.

We've been required to provide our leadership with sort of a snapshot of where we are and what we can anticipate.

And via the description of the methodologies in the proposed rule, there are terms like the benchmark of the 95th percentile.

And we're looking to find where we would find that, because on Hospital Compare, the benchmark set for the nation is at the top 90th, and equally with regard to the average of the mean or average of the median.

So we're interested in knowing where we can find the benchmarkable data available to us so that we can plot that in.

And then there's another question, and that is will CMS be providing hospitals with any kind of tool they can use to monitor their progress, as it relates to the value-based purchasing scores along the way, such as monitoring where they are every quarter?

We've been provided with tools in the past, but I did not find on (qnet), such as the cart too or something that we can look at.

And I believe that's all of the – well, to reiterate, again, the last comment about how far out the decimal points go, we're finding them – we're plotting that into some of our statistical packages, it does make a difference.

Female: Thank you.

Female: Thanks.

Jim Poyer has a little bit more detail (inaudible) about that.

Jim Poyer: Yes.

What I can do is refer you, if you don't know that already, there is a downloadable database of using the – with Hospital Compare – I believe it's in Access format – so the – so that users can perform their own analyses.

It has the hospital's first – what their measure rate is on each measure, on Hospital Compare. And we'd refer readers to that. And that is on the Hospital Compare website.

(Cynthia Satterfield): I have a follow-up question regarding that. Am I still open?

Female: Yes, you are.

(Cynthia Satterfield): OK. I know what our measure rates are. Are you saying that this database, this downloadable database, also provides us with a benchmarkable?

Jim Poyer: No, it provides all the hospital's measure rates that are posted on Hospital Compare.

(Cynthia Satterfield): Oh, OK. Thank you.

Female: Thank you, (Cynthia). (Alicia), our next comment, please?

Operator: Our next question comes from the line of (Tom Alt) with Health Policy Alternative.

(Tom Alt): Yes, thank you. I actually tried to withdraw my question that – I had a question on the HCAHPS percentile scoring, and it's been asked multiple times. Thank you.

Female: Thank you, (Tom).

(Alicia), our next question or comment, please.

Operator: Our next question or comment comes from the line of Josh Boswell with the Society of Hospitals.

Female: Josh, are you there?

Operator: Josh Boswell your line is open.

Josh Boswell: This is Josh Boswell from the society of Hospital Medicine We would like to just echo what the AHA mentioned about the HAC measures, but would like

to also add that, despite the best care that you can possibly give, these measures aren't always preventable.

And, depending on these patient populations within a – within the various institutions, just these measures can vary greatly.

So we'd like to suggest that these measures be given some kind of different weighting methodology or at least given a – an extremely low value in comparison to the other domains.

We'd also like to suggest that, in regard to the one-year period, where measures have to be posted on Hospital Compare prior to being implemented in the Hospital Value-Based Purchasing program, we – SHM feels that a two-year timeframe would better allow for organizations to prepare and make appropriate corrections before being subject to possible financial consequences with value-based purchasing programs.

We have – we plan on submitting further detail on these comments in writing. Thank you.

Female: Thank you, Josh.

(Alicia), our next comment, please.

Operator: Our next comment comes from the line of Dale Bratzler with the Oklahoma Foundation for Medical Quality.

Dale Bratzler: Thank you. And I've enjoyed the presentations today.

So somebody quoted me earlier and I wanted to reiterate a couple of points about calculation of the benchmark. And if I understood correctly, the calculation of the benchmark is the median performance of the top decile.

And so I'm sure many of you know that the top decile performance, the median rate's going to be 100 percent for at least a lot of the current core process measures that are already listed.

And if you do happen to be a small volume hospital, particularly if the small volume happened to be ten patients, and you had one of those clinical cases that can't possibly pass the performance measure for appropriate clinical reasons, that would put your rate at 90 percent.

And you would clearly be well below the benchmark.

So then my question – and I will be posting written comments – would be, will the appeal process allow a hospital that has one of these clinical cases that appropriately fails the measure, will they have the option of appealing their score, based on a clinical performance measure, because as someone quoted earlier, the target on these performance measures is very high, but they're not perfect and they don't exclude all patients that have appropriate clinical reasons to fail performance measures.

My other comment is one that I haven't heard mentioned, and that's about the patient level data that CMS would have access to. And, again, I understand CMS's issues and desire to have access to the (QIO) clinical data.

But my only – I just wanted to make two comments. One, the first is to make sure everybody understands that this is patient level data.

And, second, to remember the intent of the Social Security Act when the law was passed 25 years ago, as Tom pointed out, that the data in this program, in the (QIO) program, is protected from discovery in any civil or administrative action.

And so I would simply urge caution that, if this process moves forward, if there are – if the rules are changed such that CMS and then potentially CMS could give out the data to other researchers, that we are very, very careful that we don't remove one of the things that it's been the most useful to the (QIO) program, to work with clinical providers, and that is that confidentiality protection that's been tested in federal courts several times, that protects any of this data from discovery in civil and administrative actions.

Thanks.

Female: Thank you, Dale. We look forward to your comments.

(Alicia), our next comment, please.

Operator: Our next comment comes from the line of (Marty Hingam) with Dekalb Medical. Your line is open.

Ellen Hargett: Yes, actually, this is Ellen Hargett from Dekalb Medical, sitting in with (Marty). I have a question to pose in terms of establishing the baseline period, which I haven't yet seen defined anywhere.

I want to be sure that everyone is aware of the precipitous improvement nationwide in all of the quality indicators that occurred beginning quarter one of 2010, when CMS stopped doing (interrater) reliability across the country.

And I'm concerned that with those rates of performance and national averages jumping in a statistically questionable way, in such a short period of time, that this is going to raise the bar so high that most organizations are not going to be able to meet this value-based purchasing incentive.

Thank you.

Female: Thank you for that comment. We did, in fact, articulate in the proposed rule (inaudible) period. And we're looking now for that reference...

Jim Poyer: For – and we refer readers to page 2464.

We also proposed (to set the) improvement threshold for each proposed measure at each specific hospital performance on the measure during the baseline period of July 1st, 2009, through March 31st, 2010.

Female: (Inaudible). And was that everything, Jim?

Jim Poyer: Yes.

Female: OK. Thank you.

Jim Poyer: (I believe so.)

Female: Thank you for your comment, (Marty).

(Alicia), our next comment, please.

Operator: Our next comment comes from the line of (Lucy Luckoff) with The University of Massachusetts Memorial.

(Lucy Luckoff): Hi, thank you. I really echo what has been said previously on the call, particularly about the level of the achievement threshold being so – set too high.

So I just agree that we need to either lower the bar to a more reasonable or statistically significant number that would show that there's a difference between the actual performance and the achievement threshold.

Also, just wanted to know what the support will be. Currently we have for the IQR support from the (QIO). But, recently, our – we've found out that the (QIO) in Massachusetts doesn't support the (BBP).

So what organization will be kind of supporting us along the way?

Female: Thanks. That's a really great comment, and I thank you for highlighting the importance of the (QIO) programming quality initiative to date.

That is something at this time that we're not yet prepared to make an announcement on. But we will be sure that as soon as we are able, we will be sure that hospitals are aware of that resource.

Female: Thank you, (Lucille).

(Alicia), our next comment, please.

Operator: Our next comment comes from the line of (Arlene Osiland)with St. Barnabas Hospital

(Arlene Osiland): Good afternoon, and thank you for taking my comment.

I want to point out – this is a comment on the status of safety net hospitals and in New York state in particular.

We're looking at a hospital that has been struggling, an all-facility hospital that has been struggling with antiquated buildings and renovation and capital projects, with the market crash that we experienced and really a heavy emphasis on patient-centered care.

And now with the Affordable Care Act leading to other reductions in reimbursements and the disproportionate share in the hospital payment systems, I'm just concerned that when we look at our performance to date and how we have consistently pushed ourselves, how we will be able to continue to maintain that performance and, in fact, achieve greater quality, given the circumstances that we are faced with.

And I'm sure that this is not just St. Barnabas in The Bronx, but as a recent study showed, a Robert Wood Johnson study showed last year, The Bronx is the poorest county in New York state.

So I'm hoping I speak for the poorest counties in each of the states. Thank you.

Female: Thank you, (Arlene). We do appreciate your comments. And we look forward to you written comments.

(Alicia), our next comment, please.

Operator: Our next comment comes from the line of (Katherine Gillian) with (Quwashee) Community.

(Katherine Gillian): Yes. I was wondering if you would repeat the information about the encore call. That will come up before the March 10th, correct?

Female: Surely. The encore call can be accessed by dialing tonight at 7:30, 800-642-1687 and by entering in the passcode 31900886. That'll be available for two business days, so it will come down on the 14th of February.

(Katherine Gillian): OK. Thank you very much.

Female: Barbara, would you just clarify for us what time on Monday it goes down?

Barbara Cebuhar: It goes down at midnight, I believe.

Female: OK, great. Thank you.

Female: (Alicia), our next comment please.

Operator: Our next comment comes from the line of Lara Welborn wit Vanguard Health Systems.

Lara Welborn: Hi, thank you. I consider myself lucky here. I'm getting to make a second comment.

Earlier I heard a woman from Intermountain Health recommend that there be consideration given to a consistency component for the clinical process measures.

And I was very glad to hear that suggested, because that's exactly what I had been sitting here thinking, although I also was thinking that, you know, we've heard and we all know that this is kind of a complicated process.

So I was thinking, ooh, do we really want to introduce another level of complexity.

But given what she said about running the numbers and seeing that there were some hospitals that were, you know, very close to achieving points but they – but they didn't, you know, I can see where the value of where – of a consistency measure on the clinical process side is, I think, a pretty good idea.

And that sort of leads me into my second comment or question, which is I'm hearing people talking about running the numbers and crunching the numbers and I can tell you from, you know, in my world, this has been – this has been a very hot topic over the last month here.

So I'm also seeing state or hospital associations come out with some mockups of how they think the number's going to look for the hospitals and their states.

And so there's this flurry of activity around trying to figure out, you know, how are we going to do? How are we going to look if this is what ultimately gets accepted or, you know, into the – into the federal regs?

And so I wonder if there is anywhere that you all can recommend – if there's a place where you have sent folks to obtain any type of modeling or any type of tool that allows people to what if their numbers.

What if we are able to get a 100 percent on this measure, what would that mean for our payout? Any type of software or tool like that that you're aware of? And, if not, would you consider providing one like that?

Female: Thanks. That's a great comment. We are currently working on our outreach and support strategies. And we will definitely take that suggestion under advisement (inaudible) develop that further. So thank you.

Female: Thank you, (Laura).

(Alicia), our next comment, please.

Operator: Our next comment comes from the line of (Chervy Sorials) with Mississippi State.

(Chervy Sorials): Yes, thanks for the presentation today. I keep hearing reference to performance period. And on slide 13, that it should be July 1st, 2011 through March 31st, 2012. What is the baseline period? Are we in it?

Jim Poyer: As we mentioned in pages 2464 as well as 2457 in the proposed rules, we proposed a three quarter baseline period from July 1st, 2009 through March 31st, 2010 I believe. I mean, I would refer you to ...

(Chervy Sorials): I've read it. I've read it.

Male: Yes, OK, thanks.

(Chervy Sorials): Thank you.

Female: Thank you, (Teresa), our next comment, (Alisha).

Operator: Our next comment comes from the line of (Gary Berger) with Bayonne Medical Center. Your line is open.

(Gary Berger): Yes, hi. I'm not sure if I missed it, or if it wasn't discussed. What is the reimbursement penalties for this?

Jim Poyer: It – I would refer the reader to page 2457 basically in the proposal. These incentive payments will be funded for FY13 through reduction of the fiscal year 2013 base operating diagnoses resource group or DRG payments for each discharge of 1 percent as required. That's the fund basically from which, in terms of the payments for the performance scores so – and further – if you want further clarification I would request that you submit a formal comment or a question and we can follow up through the formal – through the formal process.

(Gary Berger): OK.

Jim Poyer: Thank you.

(Gary Berger): Thank you very much.

Female: (Alisha), our next comment please.

Operator: Our next comment comes from the line of (Esther Burlingham) with Kaiser. Your line is open. (Esther Burlingham) with Kaiser, your line is open.

(Esther Burlingham): Thank you so much. I have a question here. You mentioned that we can do the download of the database of hospital care, which we've done. However that's – for the baseline period does not have the nine months, it has the full year.

Also for the service measures when we've done that we've taken a look and realized that those are all at whole numbers. So with service you have everything going to percentiles so there can be quite a range in those percentiles. So we're just wondering if there's going to be additional guidance of what we do when there is range since a score of (audio gap) can

fall in the range from anywhere from the 40th to the 47th percentile. Which based on the way you've indicated will have an impact.

I also wanted to verify that what you are saying now is that that percentile that we'll be using the percentiles for the performance period, the baseline percentiles? Can you just clarify that from what (Elsa Dahl) said earlier? And then reading the (audio gap) ...

Female: OK, all right. Well, it definitely sounds like we're getting quite a bit of feedback today about being sure that we're transparent about the percentiles and the rates here. So we would ask that, you know, for those of you who could put that in writing so we can make sure that we consider that as part of the final rule we'd appreciate it. Thank you.

Female: (Alisha), our next comment please.

Operator: Our next comment comes from the line of (Alyssa Keith) with the California Hospital. Your line is open.

(Alyssa Keith): Thank you. I appreciate you all taking so much time this afternoon to address so many of the questions and comments that have been raised.

And again, I would echo many of the association – hospital association comments. But specifically two issues that I don't believe have come up yet, and was hopeful that you all will address them either in the final rule or in the upcoming IPPS rule. Specifically the interaction of the payment reductions for (VVP) with the current inpatient quality reporting program, there is no mention of it. I think it's caused some confusion. But just clearly spelling out what the interactions will be or what you foresee them to be?

And then second on somewhat of an unrelated note, one of the exclusions is legislated in the ACA is that hospitals cited for deficiencies in performance that pose immediate jeopardy would be excluded. In your impact analysis you note that there are about 385 or so hospitals that were excluded, but you don't note for what reasons they were excluded. We'd be appreciative if you would include in the final rule how many hospitals were excluded for the various

reasons. Whether they be volume or immediate jeopardy so we have a sense of size and magnitude of that.

And then also discuss in your final rule, if you could, the ways in which you would notify hospitals that would be included – excluded from such for an immediate jeopardy. I know that the timing is very short in trying to get all of these – this data pulled together and scores calculated et cetera. However the delay in citations for immediate jeopardy is also a concern. And I think it would be really important if you could discuss in the final rule kind of how you would operationalize and notification of that to hospitals moving forward. Thank you.

Female: Thank you, (Alisha). (Alyssa), could we get our next comment please?

Operator: Our next comment comes from the line of Jacqueline Mathews with Cleveland Clinic. Your line is open.

Jacqueline Mathews: Thank you. It's been a very interesting call and I think the comments have been phenomenal.

I want to talk quickly and make a few comments about the 2014, hack and PSI I think society – Hospital Society of Medicine did talk about this. We are concerned about the lack of risk assessment around those measures, and the transparency still around those measures. Hospitals have no sense right now probably of their performance and the measurement around the hack. The PSI are transparent but kind of hidden within the CMS website and we're concerned that those need to get out on hospital compare for appropriate understanding by organizations also. I would like to echo the hospital medicine group to say it should be at least a two year wait before we have those included in value based purchasing.

Another issue that is very concerning to us is the performance; the achievement thresholds are very, very high. We've been running the model working with (Haney's) and Ohio Hospital Association. And so we can see that the thresholds are very tight, and I think hospitals who are – have been achieving a consistent 93, 95 percent are going to be subject to potentially no points. And to really bottom line as we look at this, people are only going to

be able to score on the achievement points unless they've been very low performers, and the achievement points that you've got to be at the 97, 98, 99th percentile. So it's going to be a rate. So it's going to be a very tough road for some hospitals who have very complex ill patients.

The other thing is wondering on the final rule what would be the public reporting of this information. How will that become transparent across hospital compare or the CMS website? And I think that – and also QIO. We do have concerns as Dr. (Bresler) brought up. We supply a lot of protected information to our QIO and it's – we've always, you know, felt it's not discoverable and protected under the law so very concerned about now suddenly submitting our – from our physicians and from hospitals concerns/comments around quality concerns that our pros or our QIOs bring up to us. So that is of concern also.

Female: Thank you, Jacqueline. (audio gap) those bring up to us. So that is of concern also.

Female: Thank you,(Jacqueline we do appreciate your written comments. So (Alisha), next comment, please.

Operator: Our next comment comes from the line of Dee Rogers with Magnolia Regional Memorial. Your line is open.

Dee Rogers: I appreciate all the comments today. We are a small facility, 49 beds (inaudible). And we have those issues where we have very small population. So, I'm concerned about those because looking at the proposals I only see two measures where we have a large enough population. My fear in that is I've already had a physician comment that we need to focus more on those patients than the ones that we don't have the population in effect to where it's going to be. I think it's going to draw away from appropriate efficacious care and move more towards, are we going to get paid or not? And I'm going – I plan to input those comments.

The other question is, I agree with the person on the validation issue. You know, we don't have of your hospitals validating your scores. And all of a sudden we see this huge dump in the scores. How valid is that on the next go

around? I don't think that the current validation is going to help anybody in the long run. And those are my comments.

Female: Thank you, Dee. (Alisha), next comment, please.

Operator: Your next comment comes from the line of Jackie Birmingham with Curaspan Health. Your line is open.

Jackie Birmingham: Well, thank you very much for a very informative afternoon. I'd like clarification on the encore access code. I think some of the numbers are transposed. The number on the posting was 39100886. I'm going to find everybody to listen to this. I just want to verify the correct access reference.

Female: I am so sorry. It is 39100886. The encore number is 800-642-1687. I do apologize.

Jackie Birmingham: Thank you so much.

Female: I think we have time for maybe one or two more questions.

Operator: Our next comment comes from the line of (Erin Reale) with (Port Hospital of Lafayette). Your line is open. (Erin Reale) with (Port Hospital of Lafayette), your line is open.

Karen Wyble: Hi, this is Karen Wyble, I don't know why it keeps coming up under that name, my apologies. My question is I didn't hear that it was referenced here in the presentation today but under the proposed domains and the measures dimensions when you look at the measures here, (AMIHS) skip. We've seen some additions and changes with these measures over the years. And I understand with the DBT that we're going to be looking at a 90 day performance period that we're going to start with. But if we have any new measures or domains that are going to be into – the clinical process care measures. Will we be given a performance period for us to identify a baseline in determining those baseline initiatives? Will we have another performance period for any new identified measures in the future?

- Male: We did provide for fiscal year '13 proposed baselines for all performance periods in page 2457. I refer to it in previous questions and would have to, for example, for proposed measures for FY14 proposed for future rule making any performance period.
- Karen Wyble: So any addition, just for clarity, any additional measures that we would have after those time periods that we would also get some performance measures so that we can – so we can – prior to scoring those?
- Male: Please submit your comments and we will address through the formal comment process, so.
- Female: Thank you for your comment. I think we've got time for two more questions and then our parting comments. So, I appreciate (Alisha), the next comment.
- Operator: Our next comment comes from the line of Darryl Webb with Cooper Green Mercy. Your line is open.
- Darryl Webb: I'm sorry I believe the question has been answered. I wanted to get the encore information and that was repeated. So, I want to be sure I have the correct information. The encore number is the 1-800-642-1687?
- Female: Correct.
- Darryl Webb: And the reference ID is 39100886?
- Female: Yes.
- Darryl Webb: OK, thank you.
- Female: Thank you. One more comment please.
- Operator: Our final comment comes from the line of Travis Stegeman with Total Benchmark. Your line is open.
- Travis Stegeman: Yes, just wanted to comment again about if you guys will be using the nine month rolling period for (VVP) that it would be good if that data was actually

available by the nine month as opposed to the 12 month rolling that you guys currently provide us with?

Female: OK, thank you. Colleagues we are so grateful for all of your help today. I just want to make sure that I repeat, even though it's been repeated several times, the encore number for – starting at 7:30 tonight, Eastern time, is 800-642-1687 and the pass code is 39100886. It will be available until February the 14th and I wanted to make sure that folks knew that at the special open door website we will have the recording and the transcript. And it will be available starting March the 10th for 30 days.

Thank you very much for your participation today. We are very grateful for your insights and look forward to getting your written comments.

(Alisha), this does conclude the call.

Operator: This concludes today's conference call you may now disconnect your lines.

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