Blue Cross Blue Shield of Michigan

2022 Hospital Pay-for-Performance Program

Peer Groups 1 through 4

November 2021

VALUE Partnerships

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Program overview

Blue Cross Blue Shield of Michigan's Hospital Pay-for-Performance program recognizes short-term acute-care hospitals in Peer Groups 1 through 4 for achievements and improvements in quality and population-health management. In 2022, the program will pay hospitals, in aggregate, an additional 5% of statewide inpatient and outpatient operating payments — over $200 million statewide.

The P4P program structure and measures are developed with input from hospitals through the P4P Measurement Workgroup. Hospital performance on most program measures is evaluated on a calendar-year basis and the P4P rate a hospital earns, based on its 2022 P4P program performance, will be applied to its inpatient and outpatient operating payments, starting October 1, 2023.

To help hospitals better assess their performance across all program measures throughout the program year, Blue Cross will continue to provide hospitals with quarterly, **informational** P4P performance reports into 2022. P4P participating hospitals also have the opportunity to request patient-level readmissions information to help assist readmission reduction efforts.

What's new in 2022

The 2022 P4P program year will closely follow the structure, performance measurement and incentive framework of the 2021 program year, with one exception:
Claims Pilot Project: If a hospital chooses to participate, 10% of their readmission's measure will be allocated to HIE for participation.

2022 program components and weights	
Prequalifying condition	0%
Collaborative Quality Initiatives	40%
Michigan Value Collaborative	10%
All-cause readmissions domain*	30%
Health information exchange	20%

*Subject to change depending on Claims Pilot Project participation

Payment methodology

The 2022 P4P program maintains that the statewide **aggregate** P4P payout is equal to the full 5% value of the program. Although some hospitals will earn a P4P rate less than 5%, some high-performing hospitals may earn P4P rates greater than 5%.[1]

As introduced with the 2014 program year, the 2022 P4P program will continue to use the performance scoring multiplier concept to redistribute any remaining, unearned incentive dollars differentially within each program component. This allows the program to award a larger portion of unearned incentive to the highest-performing hospitals in each individual program domain.

Introduced in 2020 and continued in the 2022 program, hospitals who participate in all CQIs for which they have been recruited will be eligible for a fixed-dollar bonus paid from the unearned incentive dollars within the CQI component. All other remaining unearned dollars will be paid based on the multiplier concept. The below chart provides the potential bonus by hospital, depending on the number of CQIs in which they participate:

Number of eligible or participating CQIs	Potential unearned dollar fixed bonus
1-4 CQIs	$20,000
5-9 CQIs	$50,000
10 or more CQIs	$75,000

For hospitals to be eligible for any additional P4P multiplier dollars, they must meet **one** of the following criteria:

- CMS hospital star rating of at least 2
- Leapfrog hospital safety grade of at least a C

Appendix A provides a more detailed explanation of this performance scoring multiplier concept and a mock distribution of unearned incentive back to P4P participating hospitals.

[1] If a hospital's reimbursement arrangement doesn't comply with the formula established within Blue Cross' *Participating Hospital Agreement*, its payout is limited to 4% of its inpatient operating payment only. Non-model hospitals will also not be eligible to receive any unearned incentive.

Prequalifying condition

All P4P participating hospitals must first meet a patient-safety prequalifying condition to be eligible to participate and receive incentives for performance within the P4P program. Hospital compliance with this prequalifying condition is determined by CEO attestation due by **March 31, 2023.**

To successfully meet this condition, hospitals must fully comply with the following three requirements:

1. Conduct regular patient Walk Rounds with hospital leadership
2. Assess and improve patient safety performance by fully meeting one of the following options:
    - Complete and submit the National Quality Forum Safe Practices section of the *Leapfrog Hospital Survey* at least once every 18 months
    - Complete the Joint Commission Periodic Performance Review of National Patient Safety Goals at least once every 18 months
        - First established by The Joint Commission in 2002 to help accredited organizations target critical areas where safety can be improved
        - All Joint Commission-accredited health care organizations are surveyed for compliance with the requirements of the goals — or acceptable alternatives — as appropriate to the services the organization provides
        - Goals and requirements are re-evaluated each year and new NPSGs are announced in the year prior to their implementation
        - For more information, visit National Patient Safety Goals*
    - Review compliance with the Agency for Healthcare Research Patient Safety indicators at least once every 18 months
        - Set of indicators providing information on potential in-hospital complications and adverse events following surgeries, procedures, and childbirth
        - Can be used to help hospitals identify potential adverse events that might need further study and provide the opportunity to assess the incidence of adverse events and in-hospital complications using administrative data found in the typical discharge record
        - For more information, download the Patient Safety Indicators Brochure*

- Participate in a federally qualified patient safety organization
    - Federally listed by the Agency for Healthcare Research and Quality
    - Provides a secure environment to assist health care providers collect, aggregate, and analyze data to identify and reduce safety risks, learn from errors, and prevent future harm
    - For more information, visit AHRQ PSO*

3. Ensure results of the patient safety assessment and improvement activities are shared with the hospital's governing body and incorporated into a board-approved, multidisciplinary patient safety plan that is regularly reviewed and updated.

*Blue Cross Blue Shield of Michigan and Blue Care Network don't own or control this website.

Collaborative Quality Initiatives 40%

Hospitals can earn up to 40% of their P4P points based on performance across Blue Cross-supported CQIs.

Individual CQI weights

The CQI component of the P4P is weighted equally for all hospitals, regardless of the number of CQIs a hospital participates in. Therefore, hospitals participating in fewer CQIs will have a greater portion of their incentive allocated to each initiative, while hospitals participating in a greater number of CQIs will have a smaller portion allocated to each initiative. Hospitals eligible for and participating in more than 10 CQIs will be scored using only the top 10 individual CQI performance scores.

The following chart provides the weight per CQI based on the number of initiatives a hospital participates in:

Number of CQIs	Overall potential incentive	Potential incentive per CQI
1	40%	40%
2	40%	20%
3	40%	13.33%
4	40%	10%
5	40%	8%
6	40%	6.67%
7	40%	5.71%
8	40%	5%
9	40%	4.44%
10+	40%	4%

Required CQIs

In 2022, seven of the Blue Cross-sponsored CQIs have been categorized as "required" (see Appendix B). No new CQIs were added to the required CQI category for 2022, nor were any removed from the required category.

If your hospital is recruited to participate in a "required" CQI, but declines to participate, your hospital will forfeit the points attributed to that CQI. If your hospital is not recruited to participate in a "required" CQI, it will not be penalized for nonparticipation.

To find out whether your hospital is eligible for a specific CQI and its potential effect on your hospital's 2022 P4P score, contact Blue Cross' CQI administration team at CQIPrograms@bcbsm.com.

CQI data abstraction and reporting funding support

Blue Cross supported

Eligible hospitals participating in Blue Cross-supported CQIs may have the opportunity to receive annual funding support, **outside of the P4P**, for a portion of the costs they incur for data abstraction and reporting. These additional funds are designed to minimize potential cost barriers to participation, including abstracting medical record data, patient follow-up and reporting for Blue Cross, BCN, Medicare, Medicaid, uninsured and self-insured cases. The data abstraction funding model for each CQI is developed by its respective coordinating center with review by Blue Cross' CQI administration.

In return for these additional funds, hospitals are expected to comply with all participation expectations agreed to upon joining the initiative (refer to Appendix B). These expectations and your hospital's compliance are both determined by each CQI's coordinating center and Blue Cross. Specific participation expectations for each CQI are available from the associated coordinating center.

Payment schedule

Hospitals that participate in CQIs are reimbursed 80% of the estimated costs associated with medical record data abstraction. These costs are determined using a data abstraction model specific to each CQI and projected hospital case volumes.

Previously, data abstraction costs were reimbursed via an annual payment. Effective July 1, 2021 this methodology was modified. Specifically, BCBSM converted each hospital's payment amount into a "per-unit" add-on to its payment rate, effective on the first day of each hospital's own fiscal year. Subsequent updates to the per-unit amount will be reviewed with hospital contracting staff.

Michigan Value Collaborative 10%

The Michigan Value Collaborative (MVC) represents a partnership between 99 Michigan hospitals and 40 physician organizations (POs) which aims to improve the health of Michigan through sustainable high-value healthcare. Supported by Blue Cross Blue Shield of Michigan, MVC helps its members better understand their performance using robust multi-payer data, customized analytics, and at-the-elbow support. As part of this, MVC fosters a collaborative learning environment to enable providers to learn from one another in a cooperative, non-competitive space.

MVC provides hospital and physician organization leaders with claims-based utilization and episode payment data to empower local quality improvement activities, many of which are tied to the quality initiatives in Blue Cross' CQIs. MVC data supplies condition-specific, price-standardized, and risk-adjusted 30- and 90-day total episode payments for Blue Cross' PPO, Blue Cross' Medicare Advantage, Blue Care Network's HMO, BCN's Medicare Advantage and Medicare fee-for-service claims. Some MVC reports also include Medicaid claims data, but these data are not included in the 2022 measure.

2022 measure expectations

In mid-2021, hospitals were asked to select two conditions to be measured for performance in 2022 and 2023. As before, for a hospital to be eligible to earn points for its selected conditions, it must first meet the quality requirement. This stipulates that its in-hospital mortality or related readmission rate for the selected condition is not statistically below the 10th percentile in the relevant performance year.

Hospitals meeting the quality requirement can earn up to five points for reducing total episode payments for each of its selected conditions. Improvement may be demonstrated by either year-over-year improvement within the hospital or through absolute achievement compared to a cohort of peers. Points are calculated using z-score thresholds. Z-scores reflect the standardized percent reduction from a baseline payment. For improvement points, the baseline is the hospital's payment from the baseline period, and for achievement the baseline is the cohort's average payment during the baseline period.

$$\textbf{Improvement Z} - \textbf{Score}$$

$$= \frac{Baseline\ Payment - Hospital\ Mean\ Performance\ Payment}{MVC\ All\ Standard\ Deviation\ from\ Baseline}$$

Achievement Z – Score

$$= \frac{MVC\ Cohort\ Mean\ at\ Baseline - Hospital\ Mean\ Performance\ Payment}{MVC\ All\ Standard\ Deviation\ from\ Baseline}$$

Points earned	Z-Score Threshold
1 point	<0
2 points	0 - <0.05
3 points	0.05 - <0.1
4 points	0.1 - <0.15
5 points	0.15 - <0.2

MVC bonus point

Participants are able to earn two bonus points by completing one questionnaire per selected condition and submitting these to the MVC Coordinating Center by November 1st of each Program Year. The purpose of this is to gather examples of quality improvement initiatives in operation at MVC member hospitals to share with the Collaborative. Moving forward, this will help support members in reducing costs through collaboration.

Please note that the maximum points a hospital may receive for the MVC measure is 10, even if the hospital earns bonus points. Please refer to Appendix D for an example of the MVC score calculation. A more detailed description of the 2022 performance-based measure can be found in the MVC Component of the BCBSM P4P Program Technical Document.

Timeline of the 2022 MVC-based P4P performance measure

	2022 P4P program
Baseline period	CY 2019
Performance period	CY 2021
Data analysis and claims adjudication	CY 2022

MVC support for hospitals and physician organizations

The MVC Coordinating Center hosts a series of virtual workgroups based on input from its hospital and physician organization (PO) partners. The primary goal of these workgroups is to provide hospital and PO leaders with a highly accessible platform to share best practices and challenges facing institutions throughout the state of Michigan. The ideas and strategies outlined in these discussions also serve as a foundation and framework for collaborative learning and best practice sharing at MVC meetings.

The MVC Coordinating Center will also continue its work to improve the utility of the MVC data registry website, disseminate hospital and PO specific performance reports, offer custom reports as requested, facilitate virtual regional networking events, undertake virtual hospital and PO site visits, and host semi-annual meetings to provide a forum for the sharing of best practices and additional insights.

All-cause readmissions domain 30%

In 2022, P4P participating hospitals will have the opportunity to earn 30 percent of their potential P4P incentive within the all-cause readmission's domain. Hospitals will earn incentives for demonstrating favorable year-over-year improvements in their own 30-day all-cause readmission rate. Note: hospitals electing to participate in the Claims Pilot Project will have their readmission weight reduced to 20%, with 10% re-allocated to the Claims Pilot Project.

2022 P4P readmission rate performance

To continue to promote hospital and physician collaboration across the care continuum and align measurement reporting and incentives with CMS requirements, the 2022 P4P program will continue to use the NQF-endorsed hospital-wide all-cause unplanned readmission measure (HWR; NQF 1789) developed by Yale University and CMS.

P4P readmissions performance is assessed using only Blue Cross commercial membership claims (PPO, POS, and Traditional products for Michigan adult residents ages 18 to 64).

Due to the adaptation of this measure to a commercially insured population, this measure **won't be risk standardized** according to CMS methodology. Additionally, readmission data used within the P4P isn't adjusted for variations in patient mix, market, or geography. Consequently, a hospital's all-cause readmissions performance and earned incentive will be measured as each hospital's own year-over-year improvement, across a 2021 baseline period and 2022

measurement period or **as each hospital's own confidence interval as compared to the Michigan P4P participating hospital statewide average**.

Readmission scoring methodology

Introduced in the 2018 program, confidence intervals are a range of values so defined that there is a specified probability that the value of the parameter lies within it. On hospital compare, CMS calculates hospital-specific confidence intervals for the majority of its measures and compares them against a national rate. Similarly, the 2022 P4P program will calculate hospital-specific confidence intervals and compare them against the **Michigan P4P participating hospital statewide average**.

The more favorable methodology (current method versus confidence intervals) will be used for a hospital if any of the following conditions are met:

- Hospital shows improved readmission rate, regardless if rates are above P4P statewide average.
- Hospital 2022CY readmission rate is less than the P4P statewide average.
- Hospital is considered low volume (<250 IP discharges).

All other hospitals will continue to be scored based on the current year-over-year improvement method.

1. Year-over-year improvement (current method)

Year-over-year improvement (relative % change)	Points earned	Example baseline	Example performance
More favorable than -2.5% improvement	100%	10%	Less than 9.75%
Between +/-2.5%	50%	10%	9.75% to 10.25%
Less favorable than +2.5%	0%	10%	Greater than 10.25%

2. Confidence intervals (new method)

Confidence interval	Points earned
Entire confidence interval is less than P4P statewide average	100%
P4P statewide average falls within confidence interval	50%
Entire confidence interval is greater than the P4P statewide average	0%

Health information exchange 20%

The health information exchange component of the P4P program is designed to ensure caregivers have the data they need to effectively manage the care of their patients. The HIE component is focused on improving the quality of data transmitted through the Michigan Health Information Network statewide service, expanding the types of data available through the service, and developing capabilities that will help facilitate statewide data exchange going forward.

In its January *2018 Health Information Exchange Fact Sheet*, CMS states its expectation for HIE sender and receiver collaboration.[2] The intent is to promote data quality from the initiating provider so the receiving provider can incorporate the data into its patient-associated processes of care. If the receiver is unable to use the sender's data, then the receiver is unable to provide patients with appropriate and timely care. Blue Cross shares CMS' vision of promoting the transmission of quality data that can be effectively used by a patient's providers.

The table below summarizes the 2022 HIE measures and weights. Changes from the 2021 program are as follows:

- The overall weight of the HIE component has increased from 15 points to 20 points.
  - The weights of specific measures have changed accordingly, as shown in the table.
- Statewide labs conformance is now required, specific fields will be determined later in 2021.
- The claims pilot project has also been added to the program, hospitals electing to participate in the pilot will have 10 all-cause readmissions points reallocated to the HIE portion of program.

Details on all the HIE measures can be found in Appendix E.

[2] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HealthInformationExchange_2017.pdf (Blue Cross Blue Shield of Michigan and Blue Care Network don't own or control this website.)

Measure number	Measure description	Total points possible	Points available by quarter			
			1Q	2Q	3Q	4Q
1	Maintain ADT data quality conformance with inclusion of the common key	5	1.25	1.25	1.25	1.25
2	Maintain CCDA data conformance for inpatient, observation, and ED visits	5	1.25	1.25	1.25	1.25
3	Transmit all ambulatory CCDA data	4	1.00	1.00	1.00	1.00
4	Maintain data conformance for statewide lab result data	4	1.00	1.00	1.00	1.00
5	Participate in one or more HIE pilot projects	2	Point requirements and timelines will be determined by the specific pilot. Hospitals will receive clear and timely written communications regarding any pilot expectations.			
NA	Participate in claims pilot project	10	Participation in the claims pilot project			

Performance scoring multiplier methodology

The table below displays how the CQI incentive pool is calculated, based on actual CQI performance and the redistribution of unearned CQI dollars. In this example, an overall CQI incentive pool of $20 million is calculated based on the potential CQI incentive for each hospital, determined by individual CQI eligibility. The earned CQI incentive is then determined by multiplying each hospital's actual CQI performance by its potential CQI incentive amount. The unearned dollars resulting from less than 100 percent CQI performance, which is $2.6 million in this example, is then redistributed to hospitals by a scoring multiplier.

Continuing in 2022, before the unearned CQI incentive dollars are redistributed to hospitals, some of these unearned dollars will be used to give a bonus to hospitals that participate in *all* CQIs for which they have been recruited. This bonus is intended to recognize and reward hospitals for the additional work and resource commitment it takes to participate in all multiple CQI programs. The potential bonus amount for each hospital is based on the number of CQIs it is recruited to participate in, as follows:

CQI Count	Bonus Amount
1-4 CQIs	$20,000
5-9 CQIs	$50,000
≥10 CQIs	$75,000

If a hospital drops out of a CQI, it is no longer eligible for this bonus. Similarly, if a hospital is recruited to join a CQI, regardless of whether or not it's a required CQI, and chooses not to join, it will not receive the bonus.

The Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE) CQI is exempt from being held to the bonus criteria due to the significant IT component of ASPIRE required to join. Hospitals who are unable to join ASPIRE when invited will not be penalized.

Hospital name	**Collaborative Quality Initiatives** (Fixed 40% of P4P incentive)								
	Potential CQI Incentive (fixed 40%)	CQI performance	Earned CQI incentive	CQI full-participation bonus	Unearned CQI incentive	Scoring Multiplier (hospital earned/ total earned)	Additional CQI incentive earned	Total earned CQI incentive ($, %*)	
Hospital A	$100,000	95%	$95,000			0.5%	$13,404	$108,404	108.4%
Hospital B	$250,000	80%	$200,000			1.1%	$28,218	$228,218	91.3%
Hospital C	$350,000	78.57%	$275,000	$20,000		1.6%	$38,800	$333,800	95.4%
Hospital D	$500,000	100%	$500,000			2.9%	$70,546	$570,546	114.1%
Hospital E	$750,000	93.33%	$700,000			4.0%	$98,764	$798,764	106.5%
Hospital F	$800,000	91.25%	$730,000	$50,000		4.2%	$102,997	$882,997	110.4%
Hospital G	$1,500,000	60%	$900,000			5.2%	$126,983	$1,026,983	68.5%
Hospital H	$2,250,000	88.89%	$2,000,000			11.5%	$282,184	$2,282,184	101.4%
Hospital I	$3,500,000	100%	$3,500,000			20.1%	$493,822	$3,993,822	114.1%
Hospital J	$10,000,000	85%	$8,500,000	$75,000		48.9%	$1,199,282	$9,774,282	97.7%
Total	**$20,000,000**		**$17,400,000**	**$145,000**	**$2,455,000**		**$2,455,000**	**$20,000,000**	**100.0%**

APPENDIX B

Hospital CQI programs		Required CQI
CQI name	**Description**	**Yes/No**
Michigan Cardiovascular Consortium, or BMC2 *	Improve the quality of care and reduce health care costs for patients undergoing percutaneous coronary interventions, vascular surgery and carotid interventions by reducing complications and focusing on the appropriate use.	Yes
Michigan Bariatric Surgery Consortium, or MBSC *	Innovate the science and practice of metabolic and bariatric surgery through comprehensive, lifelong, patient-centered obesity care.	Yes
Michigan Emergency Department Improvement Collaborative, or MEDIC	Advance the science and delivery of emergency care for adult and pediatric patients across a diversity of emergency department settings.	No
Michigan Society of Thoracic and Cardiovascular Surgeons, or MSTCVS, Quality Collaborative*	Improve the quality of care for patients who undergo cardiac surgery, general thoracic surgical procedures, transcatheter valve replacements and perfusion practices.	Yes
Michigan Surgical Quality Collaborative, or MSQC	Develop and implement practical approaches to better outcomes and lower costs for patients undergoing general surgery by focusing on reducing venous thromboembolism, surgical site infections and implementing enhanced recovery programs.	Yes
Michigan Trauma Quality Improvement Project, or MTQIP	Improve the quality of care administered to trauma patients, while reducing the costs associated with trauma care.	Yes
Hospital Medicine Safety, or HMS, Consortium	Improve the quality of care for hospitalized medical patients who are at risk for adverse events.	Yes
Michigan Radiation Oncology Quality Consortium, or MROQC	Improve the quality of the radiation treatment experience for patients with breast or lung cancer by identifying best practices in radiation therapy that minimize the side effects that patients may experience from radiation treatment.	No
Michigan Arthroplasty Registry Collaborative for Quality Improvement, or MARCQI*	Engage hospitals and physicians in quality improvement activities for patients undergoing hip and knee joint replacement surgery procedures.	No
Michigan Anticoagulation Quality Improvement Initiative, or MAQI2	Improve the safety, quality of care and outcomes of patients requiring anticoagulation.	No
Michigan Spine Surgery Improvement Collaborative, or MSSIC*	Engages orthopedic surgeons and neurosurgeons with the aim of improving the quality of care of spine surgery, by improving patient care outcomes and increasing efficiency of treatment.	No
Anesthesiology Performance Improvement and Reporting Exchange, or ASPIRE	Integrate surgeon and anesthesiologist perspectives to assess variation in practice, identify best practices, and measure process adherence and patient outcomes to improve the quality of anesthesiology care.	No
Integrated Michigan Patient-centered Alliance on Care Transitions, or I-MPACT	Works with hospitals, providers, community service organizations, patients and families using standard practices and innovative processes to improve care transitions for patients.	No
OB Initiative (OBI)	Reduce cesarean deliveries for low-risk pregnancies.	Yes

*Participation associated with maintenance of Blue Distinction Center designation status

CQI scoring method

The tables in this appendix list the measures used to score hospital performance on each CQI. The measures within each index apply to a hospital only if it is eligible to participate in the corresponding CQI. Each CQI index is scored on a 100-point basis.

A hospital participating in multiple CQIs will have its index scores combined into one overall score. For example, assume the following:

Hospital A participates in 5 CQIs (for which it has been recruited and is eligible)

Its total CQI weight is 40 percent.

Its individual CQI weight is 8 percent – 5 CQI Programs

Its performance on CQI No. 1 is 80 percent.

Its performance on CQI No. 2 is 90 percent.

Its performance on CQI No. 3 is 100 percent.

Its performance on CQI No. 4 is 80 percent.

Its performance on CQI No. 5 is 90 percent.

Hospital A's overall CQI score is calculated as follows:

	Index score		**CQI weight**		**Earned score or potential score**
CQI No. 1	80%	X	8%	=	6.40%
CQI No. 2	90%	X	8%	=	7.20%
CQI No. 3	100%	X	8%	=	8.00%
CQI No. 4	80%	X	8%	=	6.40%
CQI No. 5	90%	X	8%	=	7.20%
Total CQI aggregate score	**88%**		**40%**		**35.20%**

In this example, Hospital A earned a total CQI score of 35.20 percent out of a potential 40 percent. Hospital A left on the table approximately 4.80 percent of its potential maximum incentive reward tied to CQIs. See Appendix A for a more detailed breakdown of how unearned CQI incentive dollars are distributed to hospitals within the CQI incentive pool based on a comparative CQI performance.

CQI performance index scorecards

The CQI performance index scorecards will be made available as a separate addendum to the 2022 Pay-for-Performance program guide in mid- to late-December 2021, as well as made available through each coordinating center.

All performance index measures and weights are established by the CQI coordinating centers. The weights and measures of a specific CQI index may be adjusted for newly participating hospitals. The coordinating center for each CQI will evaluate and score each hospital's performance index and submit the final aggregate score to Blue Cross.

The measurement period for each performance index measure is January through December, unless otherwise noted.

Specific questions and comments pertaining to the performance index measures should be directed to the respective CQI coordinating center. Contact information will be available in the performance index scorecard addendum to the 2022 P4P program guide.

General CQI participation requirements

General expectations that Blue Cross has for CQI site participants and affiliated clinicians are listed below. Each CQI also has developed distinct expectations for participation, which are made available by the respective CQI coordinating centers.

- Identify "physician champions" at participating sites who can affect change, collaborate in generating data for enhanced knowledge and analysis of processes and outcomes of care
- Identify an administrative contact at participating sites
- Thoroughly and accurately collect comprehensive data (i.e., no consistent pattern of errors or omissions regarding data elements) on patient cases, as specified by the coordinating center on all cases
- Submit data in a timely manner for entry into registry, in the format specified by the coordinating center
- Respond to queries from the coordinating center in a timely manner
- Cooperate with data quality audits conducted by the coordinating center
- Attend and participate in all collaborative meetings (either the physician champion, administrative project lead or an assigned designee who has the ability to impart QI within the organization)
- Participate in collaborative-wide QI activities or site-specific initiated QI activities related to the work of the CQI

- Demonstrate that comparative performance reports provided by the CQI are actively used in QI efforts
- Participate in inter-institutional QI activities (e.g., sharing best practices)
- Report on the effect of QI activities and provide examples of specific QI interventions to the coordinating center
- Obtain institutional approval for CQI data collection requirements, as specified by the coordinating center (i.e., Institutional Review Board approval)
- Maintain personnel to collect data
- Obtain signatures required for the site's data use agreement or business associate agreements, which are to be signed by the site's president or CEO or a site representative who holds sign-off authority for the hospital and in the case of the signed data use agreement, returned to the coordinating center
- Contribute data and information that could be used in academic publications

Hospital MVC calculations

Program year 2022

The following is an illustration of how the scoring system will be applied for program year 2022 for a fictitious hospital (Hospital A) selecting joint replacement and pneumonia. All dollar amounts provided below are for illustrative purposes only.

In 2022, Hospital A meets the quality requirement by performing above the 10th percentile on the mortality and related readmission measure for both conditions.

Hospital A's 30-day mean episode payments for joint replacement are outlined below:

Condition	Hospital mean payment for baseline period	Hospital mean payment in 2021	Cohort baseline payment	MVC standard deviation at baseline
Joint replacement	$19,405	$18,524	$19,654	$4,812

Hospital A's 2022 improvement and achievement z-scores for joint replacement are calculated below:

$$Achievement = \frac{\$19{,}654 - \$18{,}524}{\$4{,}812} = 0.23 \text{ z-score value}$$

$$Improvement = \frac{\$19{,}405 - \$18{,}524}{\$4{,}812} = 0.18 \text{ z-score value}$$

Hospital A will earn 5 points for absolute achievement and 4 points for improvement based on z-scores. Achievement is the higher of the two scores, meaning that Hospital A will be scored 5/5 possible points for joint replacement.

Z-score threshold	Point value
<0	0
0 – <0.05	1
0.05 – <0.1	2
0.1 – <0.15	3
0.15 – <0.2	4
0.2+	5

Achievement

0.23 z-score value

→ 5 Achievement Points

Improvement

0.18 z-score value

→ 4 Improvement Points

Hospital A's pneumonia condition is scored separately using the same methodology. For the purpose of this example, assume that Hospital A scores just 1 point for its pneumonia condition. During 2022, Hospital A also submits two questionnaires (one each for joint replacement and pneumonia) to the MVC Coordinating Center, meaning they are eligible for 2 bonus points. Summing all points (5 + 1 + 2), Hospital A is awarded a total of 8/10 points for the MVC Component of the BCBSM P4P Program in 2022.

Health Information Exchange measures

HIE measures 1, 2 and 3: ADT, exchange and ambulatory CCDA, and statewide lab results

The Blue Cross conformance standards are designed to continually improve the data that flows through the Michigan Health Information Network, ensuring it is complete and actionable when it's received by the practitioners using the information. Data quality conformance requirements are focused on four MiHIN use cases: ADT, Common Key Service, Exchange CCDA, and Statewide Lab Results.

In previous years, Blue Cross monitored hospital conformance. When a hospital fell out of conformance, Blue Cross sent a letter notifying the hospital it must resolve the issue within 30 days. This process has been retired. Moving forward, MiHIN will send notifications to hospitals if they have been out of conformance for more than 30 days. If the hospital is unable to regain conformance within 30 days, it will lose points for that measure.

For applicable measures:

- A hospital will be considered in conformance if all fields are populated at or above the relevant threshold.
- A hospital will be considered out of conformance if one or more fields is not populated or formatted at the relevant threshold.
- A hospital will not earn points for any quarter in which it remains out of conformance following 30 days notification via the MiHIN conformance reports.
- For mapped fields, updated mapping tables must be submitted to MiHIN when changes occur.

Conformance thresholds apply to all inpatient, observation, and ED visits. Specific conformance thresholds for each measure are outlined in the tables below.

Measure 1: Maintain ADT data quality conformance with inclusion of the common key – 5 points

Hospital will earn five points for maintaining ADT data conformance. The following table shows the required ADT data fields and performance thresholds. Messages must meet and maintain the associated conformance threshold across all three categories: complete routing, complete mapping, and adherence to coding standards. In 2022, ADT conformance will include the common key attribute, which must be populated on 60% of notifications.

Measure 1 – ADT and CKS conformance thresholds – 5 points	
Group A: complete routing – messages must be populated with all the following fields	**Threshold**
PID-5.1: Patient Last Name	≥95%
PID-5.2: Patient First Name	≥95%
PID-7: Patient Date of Birth	≥95%
PID-11.5: Patient Zip	≥95%
PV1-19: Visit Number	≥95%

PV1-37: Discharged to Location	≥95%
PV1-44: Admit Date/Time	≥95%
PV1-45: Discharge Date/Time	≥95%
PID-29: Patient Death Date/Time	≥95%
PID-30: Patient Death Indicator	≥95%
IN1-3: Insurance Company ID	≥95%
IN1-4: Insurance Company Name	≥95%
PID-3.1 Common Key	≥60%
Group B: complete mapping – MiHIN mapping tables must be kept current for the following fields. *	**Threshold**
MSH-4.1: Sending Facility- Hospital OID	≥95%
PV1-36: Discharge Disposition	≥95%
PID-8: Patient Gender	≥95%
PID-10: Patient Race	≥95%
PID-22: Ethnic Group	≥95%
PV1-2: Patient Class (e.g., observation bed)	≥95%
PV1-4: Admission Type	≥95%
PV1-14: Admit Source	≥95%
DG1-6: Diagnosis Type	≥95%
PV1-10: Hospital Service	≥95%
Group C: adherence to coding standards — values must be sent using the standard indicated below *	**Threshold**
PV1-7.1: Attending Doctor ID (NPI)	≥95%
PV1-17.1: Admitting Doctor ID (NPI)	≥95%
DG1-3.1: Diagnosis Code ID (ICD10)	≥95%
DG1-3.2: Diagnosis Code Description	≥95%

*Group B and C fields must be populated on at least 95% of messages, as well as being correctly mapped or formatted

Measure 2: Maintain CCDA data conformance for inpatient, observation, and ED visits – 5 points

Hospitals will earn five points for maintaining CCDA data conformance for all inpatient, observation, and ED visits. The following table shows the required CCDA data fields and performance thresholds required in 2022.

- In previous years OID – object identifier was required however not scored, in 2022 OIDs is expected and measured.
- There are several fields at the bottom of the table that do not have conformance thresholds in 2022. However, hospitals are expected to transmit these fields so the information can be analyzed for potential future conformance development.

Measure 2 – Exchange CCDA: conformance thresholds and ambulatory data transmission – 6 points	
CCDA – med rec relevant fields	**Complete routing threshold**
OID – object identifier	≥95%
Visit ID	≥95%

Patient Date of Birth	≥95%
Patient Gender	≥95%
Patient First Name	≥95%
Patient Last Name	≥95%
Patient Address	≥95%
Patient City	≥95%
Patient Zip Code	≥95%
Encounter Type	≥95%
Attending Provider First Name	≥95%
Attending Provider Last Name	≥95%
Attending Provider NPI	≥95%
Attending Provider Phone	≥95%
Admission Medications Present	≥95%
Discharge Medication Name	≥75%
Discharge Medication Begin Date	≥75%
Discharge Medication Dose Unit	≥75%
Discharge Medication Dose Quantity	≥75%
Discharge Medication Instructions	≥75%
Discharge Medication Code (RxNorm or NDC)	≥75%
Allergies	≥95%
Active Problems Present	≥95%
Chief Complaint	≥95%
Visit Diagnosis Code (ICD10)	≥95%
Visit Diagnosis Description	≥95%
Vital Signs	≥95%
Immunizations	≥50%
Results/Laboratory	≥95%
Patient SSN – when available	Not scored
Discharge Medication End Date	Not Scored
Discharge Medication Status	Not Scored
Advanced Directives	Not Scored
Discharge Instructions	Not Scored
Functional Status	Not Scored
Plan of Care	Not Scored
Procedures	Not Scored
Progress Notes	Not Scored
Reason for Referral	Not Scored
Social History	Not Scored
Tests Ordered	Not Scored

Measure 3: Transmit all ambulatory CCDA data – 4 points

Hospitals will earn four points by transmitting all ambulatory CCDA data for all patients. This includes outpatient hospitals visits and office visits to physicians sharing the hospital's EMR, both employed and non-employed. There are no conformance thresholds. Instead, hospitals will be scored only on whether they transmit the data. The data will be analyzed with the intent of developing conformance standards for future program years.

Measure 4: Transmit all statewide lab data – 4 points

Hospitals will earn four points for transmitting all statewide lab data. The below table contains the fields that are proposed for 2022 pending analysis completion by MiHIN.

Measure 4 – Transmit all Statewide Lab Result data **– 4 points**	
ORU message – lab result relevant fields	**Routing threshold**
MSH-10: Message Control ID	To be determined
MSH-3.1: Sending Application Namespace ID	To be determined
MSH-4.1: Sending Facility Namespace ID	To be determined
MSH-4.2: Sending Facility Universal ID Date/Time of Message	To be determined
MSH-9.2: Trigger Event	To be determined
PID-10: Race	To be determined
PID-11.1: Street Address	To be determined
PID-11.5: ZIP	To be determined
PID-13: Home Phone	To be determined
PID-2: Patient ID	To be determined
PID-22: Ethnic Group	To be determined
PID-3.1: Patient Identifier Value	To be determined
PID-5.1: Patient Family Name	To be determined
PID-5.2: Patient Given Name	To be determined
PID-7: DOB	To be determined
PID-8: Gender	To be determined
PV1-2: Patient Class	To be determined
ORC-1: Order Control	To be determined
ORC-12: Ordering Provider	To be determined
ORC-3: Filler Order Number	To be determined
OBR-1: Set ID - OBR	To be determined
OBR-14: Date and Time Specimen Received	To be determined
OBR-15: Specimen Source	To be determined
OBR-16: Ordering Provider	To be determined
OBR-22: Results Rpt/Status Chng - Date/Time	To be determined
OBR-25: Result Status	To be determined
OBR-3: Filler Order Number	To be determined

OBR-32: Principal Result Interpreter	To be determined
OBR-4: Universal Service Identifier	To be determined
OBR-7: Observation Date/Time	To be determined
TQ1-: Set ID	To be determined
OBX-: Set ID - OBX	To be determined
OBX-11: Observation Results Status	To be determined
OBX-14: Date and Time of Observation	To be determined
OBX-16: Responsible Observer	To be determined
OBX-18: Instance Identifier	To be determined
OBX-19: Date and Time of Analysis	To be determined
OBX-2: Value Type	To be determined
OBX-23: Performing Organization Name	To be determined
OBX-24: Performing Organization Address	To be determined
OBX-29: Observation Type	To be determined
OBX-3: Observation Identifier	To be determined
OBX-3: Observation Identifier	To be determined
OBX-5: Observation Value	To be determined
OBX-6: Units	To be determined
OBX-7: Reference Ranges	To be determined
OBX-8: Abnormal Flags	To be determined
SPM-1: Set ID - SPM	To be determined
SPM-2: Specimen ID	To be determined
SPM-4: Specimen Type	To be determined

Measure 5: participate in one or more HIE pilot projects – 2 points

Hospitals can earn two points by participating in selected pilot projects in collaboration with PGIP organizations. For example, some hospitals will be selected to participate in a PGIP pilot whereby a patient's physician uses ADT notifications to engage the hospital ED and avert unnecessary inpatient admissions.

Hospitals selected to participate in a pilot will be given clear expectations in writing at the time they are invited to participate. Hospitals that decline to participate or do not meet expectations for the pilot will forfeit points allocated to Measure 5. If a hospital is not selected to participate in a pilot, the two points for this measure will be reallocated to other measures.

Claims Pilot Project – 10 points

Hospitals electing to participate in the claims pilot project by submitting all-payer claims data to MiHIN for the expansion of chronic care/population health CQIs will have 10 all-cause readmissions points reallocated to the HIE portion of the program (see appendix F for additional details). Participation is not required; for hospitals not participating in the pilot, all-cause readmissions will remain at 30%. Hospitals choosing to participate will have Q1 and Q2 for implementation.

Claims Pilot Project

Data Specifications

Format for Data Submission

- X12 837, the standard format for exchanging information between healthcare partners
    - Hospitals currently generate claims data in this format for submission to payers or a claims clearinghouse

Data Submission Process

- Hospitals have flexibility in how to submit the data to MiHIN:
    1. Direct file transfer via SFTP (Secure File Transfer Protocol)
        - Most hospitals already have an SFTP connection established with MiHIN
    2. File submission from a claim's clearinghouse to MiHIN
        - Requires data sharing agreement between the hospital and the clearinghouse permitting data transfer to MiHIN and an agreement between the clearinghouse and MiHIN

Data Privacy and Security

- MiHIN will only share the minimum data necessary with those participating in the CQIs in full compliance with the HIPAA Privacy Rule, which permits a covered entity to disclose PHI, with certain limits and protections, for treatment, payment, and health care operations activities
- MiHIN is HITECH certified with highest level of requirements and safeguards in place
- Blue Cross will not have access to the claims data submitted to MiHIN
- Hospitals currently submit all-payer clinical data to MiHIN
- Hospitals must execute a new use case exhibit that governs the submission and use of claims data

The Value of Hospital Claims Data for the Expansion of Chronic Care/Population Health CQIs

Combining all-payer claims data with clinical data and patient-reported data is key to the success of the data hub being created to support the chronic condition/population-based CQIs. Including claims in the data hub offers the following benefits:

- **Aggregation of Data**
    - Claims data, combined with clinical and patient-reported data, provides a holistic patient picture, longitudinally over time across providers and services

- **Ease of Use**
    - Claims data is coded/structured, which makes it relatively easy to consume and integrate with other data for analysis. Clinical data from EHRs is often buried in

notes and attached documents, and not readily available for extraction/integration.

- **Identification of Service Use**
  - Access to claims data allows for the tracking and identification of individuals that have not used a necessary health care service; this is particularly useful for underserved populations
  - Access to claims allows for the measurement of the success of CQI interventions, such as successful referrals and receipt of necessary services
  - Allows for identification of patients at risk of high cost/low value care

<u>The Value to Hospitals of Contributing Claims to the Data Hub</u>

- **Data Abstraction**
  - Manual data abstraction is expensive and inefficient, and it is vital to reduce the cost of data collection
  - Providing claims data to the data hub can potentially reduce the need for some components of manual data abstraction over the long term
    - Ultimately, if the need for data abstraction is reduced, the funding could be redeployed to support other Quality Improvement work