Program overview

Blue Cross Blue Shield of Michigan designates small, rural, acute care facilities that provide access to care in areas where no other care is available as peer group 5 facilities. Additionally, many of these facilities are also classified as critical access hospitals by Medicare. Blue Cross' Peer Group 5 Hospital Pay-for-Performance program gives these hospitals an opportunity to demonstrate value to their communities and customers by meeting expectations for access, effectiveness and quality of care.

The program described in this document is effective April 1, 2020, through March 31, 2021. Performance in the program determines up to 6 percent of a rural hospital's payment rate, effective October 1, 2021.

The peer group 5 community can provide valuable feedback about the Hospital Pay-for-Performance Program through its advisory group. This group is dedicated to collaboratively discussing each year's pay-for-performance program and evaluating measures to ensure each positively challenges rural hospitals to deliver the most value to the communities they serve. The advisory group includes representatives from Blue Cross, Michigan Health & Hospital Association and members of the peer group 5 community. Membership and contact information can be found in Appendix A. Peer group 5 hospitals may contact these representatives to share comments related to the program, and any comments received will be presented at future advisory group meetings for consideration.

Program enhancements in 2020-2021

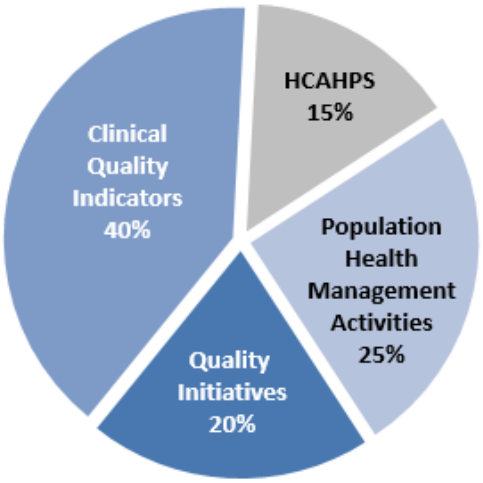
Although the overall structure of the program remains largely unchanged, notable enhancements in the 2020-2021 program year include:

- OP–5a: Median time to ECG-overall (AMI & chest pain) has been retired and the ED-2 (New Version-CMS111 submitted through eCQM) measure has been added.
- Hospital Improvement Innovation Network initiative, named Great Lakes Partners for Patients HIIN retired effective March 31, 2020, and the program's weight will be redistributed to remaining measures.
- Readmission rates will remain reporting only for the next year, measured on the submission of an alternative readmissions activity template, and then re-evaluated for future program years. Hospitals with a low volume of IP admissions may focus on ED process to avoid readmissions in lieu of alternative readmissions activities on the template.

2020-2021 Pay-for-Performance program structure

Critical Access Hospitals (CAH)

- CMS ED Measures:
  - ED - 2
- CMS Influenza Measures:
  - OP – 27
- Readmissions
- EDTC Measures



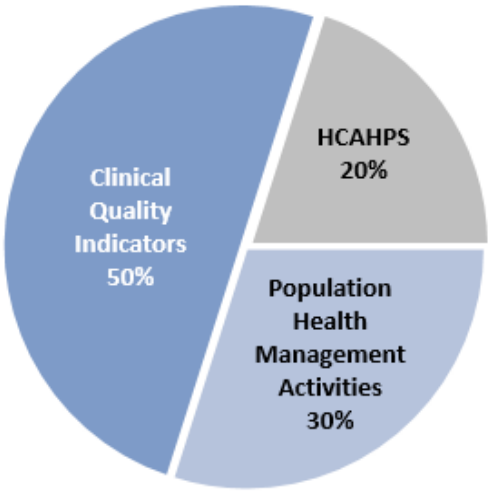
Health of the Community:

1. HCAHPS - **UPDATED**
2. Population Health Management Activities:
   - Population Health Champion
   - Admit, Discharge, Transfer (ADT) Notification Service

- MICAH Quality Network Participation

Non-Critical Access Hospitals (Non-CAH)

- CMS Outpatient Measures:
  - ED - 2
- CMS Influenza Measures:
  - OP – 27
- Readmissions
- PSI 90



Health of the Community:

1. HCAHPS - **UPDATED**
2. Population Health Management Activities:
   - Population Health Champion
   - Admit, Discharge, Transfer (ADT) Notification Service

Prequalifying condition and CEO attestation form

Prequalifying condition

For peer group 5 hospitals to participate in the Hospital Pay-for-Performance program, each much first meet the culture of patient safety survey prequalifying condition. Each must conduct a hospital-wide patient safety assessment survey at least once every two years, in either 2020 or 2021. There are two eligible surveys:

- *Hospital Survey on Patient Safety Culture*
- *Safety Assessment Questionnaire*

The survey can be assessed by a vendor, online assessment tool or a hospital self-assessment process, but the assessment process must provide guidance on how to make improvements in patient safety culture. A hospital wishing to use an alternative survey may contact Blue Cross for review and consideration.

CEO attestation form

The Hospital Pay-for-Performance program also requires hospitals to submit a yearly CEO attestation to Blue Cross, certifying that the information being sent to Blue Cross is true to the best of the knowledge of each hospital. This form also provides documentation for each of the individual program components, outlines information on the results of the patient safety assessment and describes any activities the hospital plans to implement to address findings. Completed CEO attestation forms should be submitted to Blue Cross by email at P4PHospital@bcbsm.com **by June 1, 2021.**

Health of the community (CAH 40%; Non-CAH 50%)

2020-2021 health of the community requirements include:

Measure name	Program weight CAH	Program weight non-CAH
HCAHPS survey participation performance	15%	20%
Population health management champion attestation	15%	15%
HIE ADT notification service	10%	15%

HCAHPS survey

The general structure of the health of the community component remains unchanged from the 2019-2020 program year. Hospitals will continue to be measured using **one of the following** HCAHPS composite measures:

1. **Care transition composite**
   - Q23: During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.
   - Q24: When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
   - Q25: When I left the hospital, I clearly understood the purpose for taking each of my medications.

2. **Discharge information composite**
   - Q19: During this hospital stay did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
   - Q20: During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?

Due to changes in the measures, for the 2020-2021 program year, hospital scoring will be determined on a participation basis (report only). Hospital performance will then be measured for the 2021-2022 program year.

Hospitals can either submit HCAHPS data directly to Blue Cross or submit through a vendor.

Population health management champion attestation

The 2020-2021 program year will continue to offer peer group 5 hospitals the opportunity to designate a population health champion who will serve as the point of contact for all population-health management activities and collaboration efforts with other health care providers in the community and across care settings.

Blue Cross continues to encourage champions to review the Blue Cross population insights reporting and share insights with appropriate representatives within their hospitals and other care providers. Additionally, champions will be required to fill out an attestation form (Appendix C) analyzing population insights reporting and explaining current population health management activities within their organization.

HIE ADT notification service

The Health Information Exchange (HIE) component is designed to ensure caregivers have the data they need to effectively manage the care of their patient population. 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.
The 2020-2021 HIE component is designed to:

- Recognize continued participation in the statewide ADT notification service
- Improve the data quality available to caregivers for effective care transitions and population management

Hospitals can earn the 10 points allocated to the HIE component through the following measures (additional scoring detail can be found in Appendix D):

Measure Number	Measure Description	Total Points Available	Points Available by Quarter			
			1Q	2Q	3Q	4Q
1	Transmitting ADT notifications that meet the data quality conformance threshold	4.00	1.0	1.0	1.0	1.0
2	Transmit Exchange CCDA Data	4.50	n/a	1.5	1.5	1.5
3	Participate in one or more HIE pilot projects	1.50	n/a	n/a	n/a	n/a

* Implementation issues in executing successful ADT transmission that are beyond a hospital's reasonable ability to resolve will be considered by Blue Cross when scoring the measure.

Clinical quality indicators (CAH 40%; Non-CAH 50%)

The clinical quality indicator program component of the 2020-2021 program year will replace IMM-2 with a new readmission measure. Program weight per measure remains similar to last year, and program weights for measures with less than 20 cases will be equally redistributed across remaining eligible measures.

CMS indicator	Program weight CAH	Program weight non-CAH
EDTC Emergency Department Transfer Communication (EDTC) measure score* (**report only** for 2020-21)	10%	N/A
PSI 90 Patient Safety and Adverse Events Composite	N/A	12.5%
ED-2 (New Version-CMS111 submitted through eCQM) Median time (in minutes) from admit decision time to time of departure from the ED for patients admitted to inpatient status (**report only** for 2020-21)	10%	12.5%
NQF 1789 Hospital-Wide All-Cause Unplanned Readmissions	10%	12.5%
OP-27 Immunization for Influenza Among Healthcare Personnel	10%	12.5%

*Includes the following components:

1. EDTC-1: Home Medications
2. EDTC-2: Allergies and/or Reactions
3. EDTC-3: Medications Administered in ED
4. EDTC-4: ED Provider Note
5. EDTC-5: Mental Status/Orientation Assessment
6. EDTC-6: Reason for Transfer and/or Plan of Care
7. EDTC-7: Tests and/or Procedures Performed
8. EDTC-8: Tests and/or Procedures Results

NQF 1789 Hospital-Wide All-Cause Unplanned Readmission Measure

To help align with the larger PG 1-4 P4P program and achieve robust coordination across the care continuum, the 2020-2021 P4P program will continue to include the NQF-endorsed Hospital-Wide All-Cause Unplanned Readmission Measure (HWR; measure #1789) developed by Yale University and the Centers for Medicare and Medicaid Services (CMS). Blue Cross recognizes the low volume of admissions-readmissions that rural hospitals face and as such, this year will be measured on the submission of an alternative readmission activity template (see Appendix E for details).

Scoring thresholds

Hospitals will be scored on the clinical quality indicator measures by comparing actual performance against scoring thresholds. Blue Cross encourages that thresholds increase each year or that measures be retired when nearly all hospitals meet equal to or greater than 95 percent compliance. Each June, representatives from Blue Cross, MHA and the hospital community meet to review the prior year's hospital performance on these measures and establish new scoring thresholds. Because the quality data from the previous program year isn't available until June 1, thresholds are established during the first quarter of the current program year and communicated to hospitals **in the summer of 2020.**

For scoring thresholds that include a range, hospitals earn full points for scoring above the range, zero points for scoring below the range or points equal to performance falling within the range. For example, for a scoring threshold of 93 to 95 percent, a score greater than 95 percent will earn a hospital 100 percent. A score less than 93 percent will earn the hospital 0 percent. And hospitals performing within the range will earn points equal to the performance rate.

Quality initiative (CAH only — 20%)

The quality initiative program component requires hospitals to participate in the Michigan Critical Access Hospital Quality Network. Participation in the MICAHQN and attendance at quarterly meetings is mandatory for all CAH facilities and is weighted at 20% of the overall program.

Pay-for-performance incentive payments

Blue Cross will communicate pay-for-performance payment rates to hospitals by the summer of 2021 with rates becoming effective October 1, 2021. Blue Cross' Peer Group 5 Hospital Pay-for-Performance program, established by Blue Cross' Participating Hospital Agreement for peer group 5 facilities, determines up to six percentage points of a participating hospital's inpatient and outpatient payment rate. Regardless of a hospital's fiscal year end, the pay-for-performance payment rate is effective for a 12-month period beginning on October 1.

Pay-for-performance payment rates are calculated by multiplying a facility's final score by the 6% maximum payment rate that each peer group 5 hospital is eligible to receive. For those hospitals earning a score less than 100 percent, the difference between the corresponding payment rate and 6% maximum is subtracted from your overall reimbursement rate. If applicable, any rate adjustments made for the 2019-2020 pay-for-performance program year will be added back. In October, hospitals earning less than the full 6 percentage points attributed to performance can expect to receive a revised rate sheet from Blue Cross' Facility Reimbursement department.

Peer Group 5 Hospital representatives

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Michigan Critical Access Hospital Quality Network

Measure name	Weight	Measure performance	Points earned
Participation in MiCAH meetings	100	All four meetings (in-person or teleconference)	100
		Two or three meetings	75
		One meeting	25
		Didn't attend any meetings	0

Hospitals with questions about MICAH Quality Network measure performance may contact Crystal Barter at Barthcry@msu.edu or 517-432-0006.

Blue Cross' Peer Group 5 Pay-for-Performance Program
Population Health Champion Attestation
April 1, 2020 through March 31, 2021 P4P (Due June 1, 2021)

I certify that I have reviewed the *Population Insights Report* and population profiling tool for Peer Group 5 Pay-for-Performance program, and it is true to the best of my knowledge.

Printed name – population health champion	Title
Signature	Email
Facility	Facility code

- PGIP physician organizations with whom hospital has a shared patient population:

Physician organization	Sub-physician organization

- Using Blue Cross' *Population Insights Report*, identify partnering PGIP PO **utilization** measures showing opportunity for improvement, if applicable:

Utilization metrics	

- For the above, identify any interventions currently in place to improve utilization rates. If none, explain how your hospital intends to work on the issue:

❖ Fill out the table below according to current population health management activities your hospital is participating in:

Population health activities	
Does your hospital currently participate in an accountable care organization? If yes, which one?	
ACO participants	
What population health activities does your hospital participate in as part of an ACO?	
What are your long-term goals of ACO participation?	
Are there any programs or population health management activities your hospital participates in outside of ACO-related activities?	
Non-ACO participants	
What are your barriers to entry in participating in an ACO?	
Are you participating in any population health management activities (i.e., actively engaging with physician partners to better coordinate care)?	

Peer Group 5 P4P Program – Health Information Exchange:

Detail for criteria for participation in the MiHIN notification service

Measure Number	Measure Description	Total Points Available	Points Available by Quarter			
			1Q	2Q	3Q	4Q
1	Transmitting ADT notifications that meet the data quality conformance threshold	4.00	1.0	1.0	1.0	1.0
2	Transmit Exchange CCDA Data	4.50	n/a	1.5	1.5	1.5
3	Participate in one or more HIE pilot projects	1.50	n/a	n/a	n/a	n/a

Data Conformance Measures

ADT Measure #1:

To track ADT quality conformance on the required fields, hospitals will receive a weekly report from MiHIN. This report will include a hospital's results on each of the required fields for the given week and those results will be color coded green, yellow and red in relation to the thresholds established for full (green), partial (yellow), and non(red)-conformance.

Transmit ADT notifications that meet the data quality conformance threshold - 4 points

The specific ADT quality conformance requirements are outlined in the table below.

- Conformance will be scored using the red, yellow and green performance threshold levels established for each ADT data category.
    - A hospital is considered to be in full conformance with ADT data quality expectations if it maintains a green performance level *across all categories*.
    - A hospital is considered to be in partial conformance if it maintains a combination of green and yellow performance levels across all categories.
    - A hospital is considered to be out of conformance if it maintains a red performance level in one or more categories.
- If a hospital is notified by BCBSM that it is not in full conformance, it must address the issue and regain conformance within 30 days of the notification to continue earning P4P points.
- Hospital conformance will be scored on a quarterly basis with up to 1.0 point earned each quarter (2Q20, 3Q20, 4Q20, and 1Q21).
    - A hospital will earn 1.0 point for each quarter in which it maintains full conformance or regains full conformance within 30 days notification from Blue Cross. Overall conformance score must be 75% or higher.

- A hospital will earn 0.75 points for each quarter in which it maintains partial conformance or regains partial conformance within 30 days notification from Blue Cross. Overall conformance score must be 50% or higher.
- A hospital will earn 0.25 points for each quarter in which it remains out of conformance within 30 days notification from Blue Cross. Overall conformance score must be more than 25%.

The following tables list the 2020 data fields and performance thresholds required for ADT transmissions.

Measure 1 – ADT: Conformance Thresholds – 4 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%
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%

Exchange CCDA Measure #2:

Hospitals will earn 4.5 points by transmitting Exchange CCDA (previously Medication Reconciliation) messages. The data will be analyzed with the intent of developing conformance standards for future program years.

The points for this measure will be earned as follows:

- Q1 2020: Begin onboarding with MiHIN to send CCDA messages (0 points).
- Q2 2020: Begin sending by end of Q2 (1.5 points).
- Q3 2020: Continue sending CCDAs (1.5 points).
- Q4 2021: Continue sending CCDAs (1.5 points).

Participate in one or more HIE pilot projects Measure #3

Hospitals will earn 1.5 points by participating in selected pilot projects in collaboration with PGIP organizations.

Hospitals selected to participate in a pilot will be given clear expectations in writing at the time they are invited to participate. If hospital is not selected to participate in a pilot, the 1.5 points for this measure will be added distributed as follows:

- Measure 1 (ADT conformance) will be reweighted at 5 points.
- Measure 2 (CCDA conformance) will be reweighted at 5 points.

Option chosen for hospital-specific activity:

	Option 1: Development of a post-acute network strategy
	Option 2: Collaboration plan with local social service agencies to better understand and address patients' social determinants of care
	Option 3: Establish process to identify potentially preventable readmissions
	Option 4: Develop process to use PG 1-4 P4P Health Information Exchange (HIE) activities meaningfully for the purposes of improving care transitions and readmission reduction
	Other: Please describe any current readmission-reducing efforts in place that do not fall into one of the above categories

High-level narrative describing plan or intervention, including (but not limited to) the below elements:

(Please feel free to use additional space or alternative format, if desired.)

1. Activity purpose, priorities and goals

2. Descriptions of internal roles and responsibilities

3. Process for external stakeholder engagement, if applicable

4. Core measures and measurement processes:

    a. Baseline readmission measurement

    b. Targeted performance goal

    c. Populations and service lines affected

    d. Expected milestone dates and completion date

5. Communication and evaluation plan