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, 2019 through March 31, 2020. Performance in the program determines up to 6 percent of a rural hospital's payment rate, effective October 1, 2020.

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 discuss each year's pay-for-performance program and evaluate 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 2019-2020

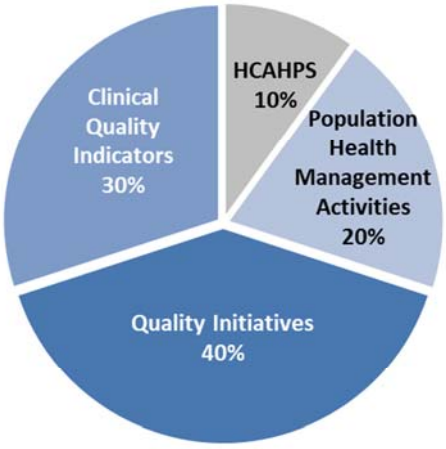
Although the overall structure of the program remains largely unchanged, notable enhancements in the 2019-2020 program year include:

- IMM-2: Influenza Vaccination Coverage has been retired and a new measure has been added.
- HCAHPs reporting has moved from full-credit for reporting to a composite score measuring performance.

2019-2020 Pay-for-Performance Program structure

Critical Access Hospitals (CAH)

- CMS Outpatient Measures:
  - OP – 5a
- CMS Influenza Measures:
  - OP – 27
- Readmissions
- EDTC Composite Measure



Health of the Community:

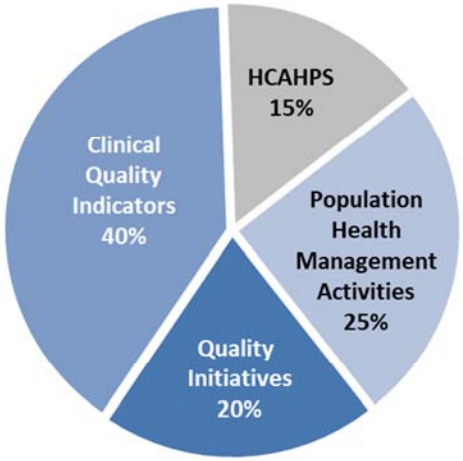
1. HCAHPS - **UPDATED**
2. Population Health Management Activities:

- Population Health Champion
- Admit, Discharge, Transfer (ADT) Notification Service

- MICAH Quality Network Participation
- MHA Hospital Improvement Innovation Network (HIIN)

Non-Critical Access Hospitals (Non-CAH)

- CMS Outpatient Measures:
  - OP – 5a
- 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

- MHA Hospital Improvement Innovation Network (HIIN)

Pre-qualifying condition & CEO attestation form

Pre-qualifying 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 pre-qualifying condition. Each must conduct a hospital-wide patient safety assessment survey at least once every two years, in either 2018 or 2019. There are three eligible surveys:

- Hospital Survey on Patient Safety Culture
- Safety Assessment Questionnaire
- MHA SCORE Survey

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 and 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, 2020.**

Health of the community (CAH 30%; Non-CAH 40%)

The overall health of the community component structure remains unchanged from the 2018-2019 program year.

2019-2020 health of the community requirements include:

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

HCAHPS survey

Although the structure of the health of the community component remains unchanged from the 2018-2019 program year, the HCAHPS component has been updated. New for the 2019-2020 program year, hospital performance will be measured on **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?

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

Population health management champion attestation

The 2019-2020 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 2019-2020 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	Communicate EMR vendor, version and any plans to change or upgrade products to MiHIN and BCBSM	1.0	1.0	n/a	n/a	n/a
2	Continued transmission of ADT notifications with all core data fields	5.0	1.25	1.25	1.25	1.25
3	Transmitting ADT notifications that meet the data quality conformance threshold	3.0	n/a	1.0	1.0	1.0
4	Sign Medication Reconciliation use case in preparation for its implementation in the 2020-2021 P4P (work with MiHIN to complete this requirement)	1.0	n/a	n/a	n/a	1.0

* 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 30%; Non-CAH 40%)

The clinical quality indicator program component of the 2019-2020 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) measures composite score*	7.5%	N/A
PSI 90 Patient Safety and Adverse Events Composite	N/A	10.0%
OP - 5a Median time to ECG - overall (AMI & chest pain)	7.5%	10.0%
NQF 1789 Hospital-Wide All-Cause Unplanned Readmissions	7.5%	10.0%
OP-27 Immunization for Influenza Among Healthcare Personnel	7.5%	10.0%

*Includes the following components:

1. EDTC-1: Administrative Communication
2. EDTC-2: Patient Information
3. EDTC-3: Vital Signs
4. EDTC-4: Medication Information
5. EDTC-5: Physician or Practitioner Generated Information
6. EDTC-6: Nurse Generated Information
7. EDTC-7: Procedures and Tests

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 2019-2020 P4P program will introduce 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, the first 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 current program year and communicated to hospitals **in the summer of 2019.**

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 initiatives (CAH 40%; Non-CAH 20%)

The quality initiatives program component requires hospitals to participate in the following initiatives:

- Michigan Critical Access Hospital Quality Network participation
- MHA Great Lakes Partners for Patients Hospital Improvement Innovation Network

Michigan Critical Access Hospital Quality Network participation
Participation in the MICAHQN and attendance at quarterly meetings is mandatory for all CAH facilities and is weighted at 20 percent of the overall program.

MHA Great Lakes Partners for Patients Hospital Improvement Innovation Network
Beginning with the 2017-2018 program year, the MHA, in partnership with the Illinois Health and Hospital Association and Wisconsin Hospital Association, combined Keystone collaborative efforts into a single, two-year-long, with an optional third year, Hospital Improvement Innovation Network initiative, named Great Lakes Partners for Patients HIIN. In 2019-2020, all targeted improvement work will continue to occur under the Great Lakes Partners for Patients HIIN.

Hospital participation in the HIIN is **required** and will be weighted at 20 percent of the overall program for both CAH and non-CAH.

The HIIN will focus on implementing person and family engagement practices, enhancing antimicrobial stewardship, building cultures of high reliability, reducing readmissions and

addressing 11 types of inpatient harm. A HIIN performance index scorecard outlining measure requirements can be found in at the end of this program guide.

Although enrollment in the HIIN closed on **November 10, 2016,** hospitals can still join for Blue Cross purposes. In addition, hospitals planning to participate in a HIIN other than the Great Lakes Partners for Patients may still be eligible for points and should contact the MHA Keystone Center for more information at KeystoneP4P@mha.org.

Quality Initiative Performance Index (Appendix F)

A hospital's quality initiative score is determined by its performance on specific measures related to MICAHQN and MHA HIIN initiative and will each be worth up to 20 percent. Performance index scores will be shared with hospitals prior to their submission to Blue Cross. Hospitals should contact either the MHA Keystone or MICAHQN representative if interested in obtaining performance status at any time during the program period.

Pay-for-performance incentive payments

Blue Cross will communicate pay-for-performance payment rates to hospitals by the summer of 2020 with rates becoming effective October 1, 2020. The 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 percent 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 percent maximum is subtracted from your overall reimbursement rate. If applicable, any rate adjustments made for the 2018-2019 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.

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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 regarding MICAH Quality Network measure performance may contact Crystal Barter at Crystal.Barter@hc.msu.edu or 517-432-0006.

Blue Cross' Peer Group 5 Pay-for-Performance Program
Population Health Champion Attestation
April 1, 2019 through March 31, 2020 P4P (Due June 1, 2020)

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 on working 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: Admission, Discharge and Transfer notification service

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	Communicate EMR vendor, version and any plans to change or upgrade products to MiHIN and BCBSM	1.0	1.0	n/a	n/a	n/a
2	Continued transmission of ADT notifications with all core data fields	5.0	1.25	1.25	1.25	1.25
3	Transmitting ADT notifications that meet the data quality conformance threshold	3.0	n/a	1.0	1.0	1.0
4	Sign Medication Reconciliation use case in preparation for its implementation in the 2020-2021 P4P (work with MiHIN to complete this requirement)	1.0	n/a	n/a	n/a	1.0

Data Conformance Measures

ADT Measure #3

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.

Maintain data quality conformance for specific aspects of ADT transmissions - 3 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 (3Q18, 4Q18, and 1Q19).
    - 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.
    - A hospital will earn 0.50 points for each quarter in which it maintains partial conformance, or regains partial conformance within 30 days notification from Blue Cross.
    - A hospital will earn 0.00 points for each quarter in which it remains out of conformance within 30 days notification from Blue Cross.

The following tables list the 2019 data fields and performance thresholds required for ADT transmissions.

Measure 3 - ADT: Complete Routing Data (population of fields), Mapping, and Adherence to Coding Standards – 4 points	
Group A: Complete Routing	**Threshold for Full Conformance**
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%
PV1-44: Admit Date/Time	≥95%
PV1-45: Discharge Date/Time	≥95%
PID-29: Patient Death Date/Time	≥95%
PID-30: Patient Death Indicator	≥95%
Group B: Complete Mapping	**Threshold for Full Conformance**
MSH-4.1: Sending Facility-Health System OID	≥95% of populated messages
MSH-4.2: Sending Facility-Hospital OID	≥95% of populated messages
PV1-36: Discharge Disposition	≥95% of populated messages
PV1-37: Discharged to Location	≥95% of populated messages
PID-8: Patient Gender	≥95% of populated messages
PID-10: Patient Race	≥95% of populated messages
PID-22: Ethnic Group	≥95% of populated messages
PV1-2: Patient Class (e.g., observation bed)	≥95% of populated messages
PV1-4: Admission Type	≥95% of populated messages
PV1-14: Admit Source	≥95% of populated messages
DG1-6: Diagnosis Type	≥95% of populated messages
PV1-10: Hospital Service	≥95% of populated messages
PV1-18: Patient Type	≥95% of populated messages
Group C: Adherence to Coding Standards	**Threshold for Full Conformance**
PV1-7.1: Attending Doctor ID	≥95%
PV1-17.1: Admitting Doctor ID	≥95%
DG1-3.1: Diagnosis Code ID	≥95%
DG1-3.2: Diagnosis Code Description	≥95%

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/or service lines affected

    d. Expected milestone dates and/or completion date

5. Communication and evaluation plan

MHA Keystone Center
A Certified Patient Safety Organization

Blue Cross Blue Shield of Michigan
A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

A Voluntary Collaborative to Improve Quality and Save Lives

CAH and Non-CAH Hospitals

***Table 1*: Components**	**Weight**	**Scoring Frequency**	**Reporting Timeframe**
Data submission: Outcome Measures *(Please see the Encyclopedia Of Measures)*	30%	Monthly	Apr. 2019 – March 2020
Performance: Improvement on ADE -Opioids, Falls and PFE-5 *(individual improvement from baseline)*	40%	Once	Varies by measure *(see Table 3)*
Storyboard/Poster: Improvement activity project *(see topic areas in Table 4)*	30%	Once	Due by **November 1, 2019**

***Table 2*: Component Description**	**Available Points**
Data Submission • At least 90% of outcome data submitted across 12-month period • 70 – 89% of all outcome data submitted across 12-month period • Less than 70% of all outcome data submitted across 12-month period *(Hospitals will only be scored for the submission of outcome data they are eligible to collect. Please reference the HIIN Encyclopedia of Measures for a complete list of the required measures)*	**30 points** 15 points 10 points
Performance on outcomes for Falls, Opioid Adverse Drug Events and PFE metric 5 *(see Table 3 for additional detail)* • Improvement from designated baseline on 3 of 3 measures • Improvement from designated baseline on 2 of 3 measures • Improvement from designated baseline on 1 of 3 measures	45 points *(5 bonus*)* **40 points** *(Full points)* 25 points
Storyboard/Poster *(see Table 4 for additional detail)* • Develop and implement a plan to drive improvement and share results around the areas of **Adverse Drug Events, Falls, Health Disparities, High Reliability Culture, Opioids, Person and Family Engagement, Readmissions, Sepsis or Surgical Site Infections.** • Create a storyboard to display your improvement activity (Storyboards must follow the template elements to receive the full 30 points *(see template)*	**30 points**
Total Possible Points	**100 points***

Table 3: Performance Measures	Baseline	Performance Period – Final Score
Falls with Injury: All documented patient falls with an injury level of minor or greater *(Numerator from KDS-HIIN-Falls-1)* *(EXCEPTION: If a hospital has sustained zeros in their baseline for this measure they get an exception for 1 event.)*	Q4 2016-Q3 2017	Apr. 2019 – March 2020
Opioid Adverse Drug Events: Use of naloxone among inpatients receiving opioids *(Numerator from KDS-HIIN-ADE-4)*	Q4 2016-Q3 2017	Apr. 2019 – March 2020
Person & Family Engagement: Metric 5 At least one or more patient representatives who serve on a Governing and/or leadership board as a patient representative (*KDS-HIIN-PFE-5*)	Dec 2018 status *(See Table 5 for current baseline)*	March 2020 Show improvement from baseline OR maintain "Fully Implemented" *(Using a designated alternative listed for this metric is accepted)*

*Hospitals will be scored on their own performance over time, and whether they are demonstrating improvement in their **numerators** from the designated (hospital-specific) baseline to the listed performance period. Baseline data must be entered for performance measures to be scored.*

Table 4: Storyboard Improvement Activity
General Guidelines • **What are you doing to increase safety in these areas?** Storyboards should share activity to drive improvement around these areas: **Adverse Drug Events, Falls, Health Disparities, High Reliability Culture, Opioids, Person and Family Engagement, Readmissions, Sepsis** or **Surgical Site Infections**. • Improvement activity should have started within the last year (November 2018 - November 2019) • Storyboard must be submitted on the MHA template to receive the full 30 points. The template is available on the MHA Community Site in PowerPoint format. • Hospitals must individually submit their unique storyboards **by November 1, 2019 for credit**; late submissions will be docked points. Submissions should be emailed to keystonep4p@mha.org • Overall hospital system submissions will not be accepted. • MHA Keystone will display the storyboards electronically on the MHA Community Site and at the annual Michigan Center for Rural Health Critical Access Hospital Conference in Traverse City, November 7-8, 2019. *Several hospital teams will be selected by the MHA Keystone to present their storyboard at the annual MCRH Critical Access Hospital conference, in a short presentation, to discuss their work with attendees.*

General HIIN Participation Requirements:
Participation in HIIN-wide quality improvement activities and/or site-specific or targeted activities (*such as Improvement Action Networks (IANs), Regional learning sessions (RLS), Simulation events, Safe Tables, or Site Visits* (*Maximum requests = 4 per year*)) related to achieving the aims of the HIIN (20% reduction in all-cause harm and 12% reduction in preventable readmissions over a two-year period) is strongly encouraged, however attendance does not affect your P4P scores.