Blue Cross Blue Shield of Michigan

2019 Hospital Pay-for-Performance Program

Peer Groups 1-4

November 2018

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Table of Contents

Program Overview 3
What's New in 2019 3
Payment Methodology 4
Prequalifying Condition 4
Collaborative Quality Initiatives 6
Great Lakes Partners for Patients Hospital Improvement Innovation Network *7*
OB Initiative *8*
CQI Performance Index *8*
CQI Data Abstraction and Reporting Funding Support *9*
Blue Cross supported 9
MHA-Sponsored 9
Payment Schedule 9
Hospital Cost Efficiency 10
Michigan Value Collaborative 11
2019 Measure Expectations *11*
MVC Bonus Point *12*
Timeline of the 2018 and 2019 MVC-based P4P Performance Measure *12*
MVC Support for Hospitals *13*
All-Cause Readmissions Domain 13
2019 P4P Readmission Rate Performance (30%) *13*
Health Information Exchange 15
Performance Scoring Multiplier Methodology 17
Blue Cross-sponsored hospital CQI programs 18
CQI Scoring Method 19
CQI Performance Index Scorecards 20
General CQI Participation Requirements 20
2019 OBI Performance Index 22
Hospital Cost Efficiency Calculations 24
Cost per case compared to Statewide Mean *24*
Cost per case compared to a NHIPI-based Target Inflation Factor *25*
Cost per case Expanded Measurement Period *25*
Hospital MVC Calculations 27
Health Information Exchange Measures and Data Elements 29
HIE Measures 1, 2, 3 and 4: ADT, Common Key Service and Med Rec *30*
HIE Measure 5: Send CCDA *30*
ADT, Med Rec Common Key Service Conformance Thresholds 31

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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, cost efficiency and population-health management. In 2019, the program will pay hospitals, in aggregate, an additional 5 percent of statewide inpatient and outpatient operating payments – nearly $190 million statewide.

The P4P program structure and measures are developed with input from hospitals through the Participating Hospital Agreement Incentive Committee. Hospital performance on most program measures is evaluated on a calendar-year basis and the P4P rate a hospital earns, based on its 2019 P4P program performance, will be applied to its inpatient and outpatient operating payments, starting July 1, 2020.

What's New in 2019

The 2019 P4P program year will closely follow the structure, performance measurement and incentive framework of the 2018 program year. The following table summarizes the 2019 P4P program structure:

2019 Program Components and Weights	
Prequalifying Condition (**updated**)	0%
Collaborative Quality Initiatives	40%
Hospital Cost Efficiency	5%
Michigan Value Collaborative	10%
All-Cause Readmissions Domain	30%
Health Information Exchange	15%

New to the P4P program, the 2019 program year will introduce requirements for hospitals to be eligible to earn leftover P4P money back through the P4P multiplier.

With changes to the Health Information Exchange component in 2019, the Hospital Cost Efficiency measure weight has decreased by 5 percent while the Health Information Exchange measure weight has increased by 5 percent. Notable updates to the HIE component can be found in the HIE section of the program guide.

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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 2019. P4P participating hospitals will also have the opportunity to request patient-level readmissions information to help assist readmission reduction efforts.

Payment Methodology

The 2019 P4P program maintains that the statewide *aggregate* P4P payout is equal to the full 5 percent value of the program. Although some hospitals will continue to earn a P4P rate less than 5 percent, some high-performing hospitals will earn P4P rates greater than 5 percent.[1]

As introduced with the 2014 program year, the 2019 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.

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

- 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.

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, 2020.**

[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 percent of its inpatient operating payment only. Non-model hospitals will also not be eligible to receive any unearned incentive.

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

1. Conduct regular patient safety 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

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Collaborative Quality Initiatives 40%

As introduced in 2016, the 2019 P4P program will offer hospitals the opportunity to earn a fixed percent of the program's potential incentive based upon its performance across Blue Cross-supported CQIs and MHA quality initiatives. The amount of incentive allocated to CQI performance (40 percent) will be equal for all hospitals regardless of the number of CQIs a hospital is eligible for.

Hospitals eligible for and participating in more than 10 CQIs will be scored using only the top 10 individual CQI performance scores, with preference given to Blue Cross-supported CQIs. Hospitals participating in fewer CQIs will have a greater portion of the program's potential incentive allocated to performance on an individual initiative.

The below chart provides the potential program weight per CQI, depending on the number of initiatives chosen:

Number of Eligible/Participating CQIs	Overall Potential Incentive, CQI Domain	Potential Incentive per Blue Cross-sponsored 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%

In 2019, **six** of the Blue Cross-sponsored CQIs have been categorized as "required" CQIs (see Appendix B for a list of eligible CQIs). New to the list of required CQIs, is the Blue Cross-sponsored OB Initiative that has the goal of reducing cesarean deliveries for low risk pregnancies.

If your hospital is eligible for participation in a "required" CQI and, at the time of enrollment, voluntarily elects not to participate, your hospital will forfeit the ability to earn the associated program weight and P4P incentive attributed to that CQI. This will only count against your hospital after it has been provided the opportunity to participate through an enrollment application process. If your hospital has not been recruited or is ineligible to participate in a "required" CQI, then it will not be penalized for non-participation. There will be no negative affect on its P4P score

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if a hospital is deemed ineligible, has not been recruited for participation or has been recruited for and voluntarily elects not to participate in a "non-required" CQI.

Separate from P4P scoring, designation as a Blue Distinction® Center by the Blue Cross and Blue Shield Association will require participation in a related CQI program.[2]

To find out whether your hospital is eligible for a specific CQI and its potential affect on your hospital's 2019 P4P score, contact Blue Cross' CQI administration team at CQIPrograms@bcbsm.com.

Great Lakes Partners for Patients Hospital Improvement Innovation Network

Beginning with the 2017 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 Hospital Improvement Innovation Network initiative, named Great Lakes Partners for Patients HIIN. In 2019, all targeted improvement work will occur under the Great Lakes Partners for Patients HIIN and as such, the MHA Keystone center will not be enrolling hospitals in individual collaboratives.

In 2019, hospital participation in the HIIN is **optional** and will be weighted equivalent to two CQI programs – exact weights vary depending on total number of CQIs a hospital is participating in. For hospitals participating in nine of Blue Cross' CQIs, the program weight assigned to the HIIN will be capped at 4 percent.

The HIIN focuses 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 Appendix G.

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

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[2] Designation as a Blue Distinction Center by the Blue Cross and Blue Shield Association requires participation in a related CQI. If your hospital is currently designated as a BDC and voluntarily elects not to participate in the corresponding CQI, it will lose its BDC status. A hospital's BDC designation status will only come into question upon your hospital's recruitment in the associated CQIs. Refer to appendix B for which CQIs are associated with BDC designation status.

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OB Initiative

Launched in January 2018, the Obstetric Initiative (OBI) is an interdisciplinary collaborative quality initiative with the goal of engaging maternity care providers and hospitals in a collaborative effort to safely reduce the use of primary cesarean delivery and to improve health outcomes of Michigan women and infants. OBI plans to initially focus on reducing admissions for women in the early stages of labor as a way to reduce c-sections and improve outcomes. OBI provides a community for maternity care providers to share and learn from each other, educational webinars, evidence-based resources, and actionable data to improve the quality of obstetric care. An OBI Performance Index scorecard outlining measure requirements can be found in Appendix C.

CQI Performance Index

A hospital's P4P score for each CQI is determined by its performance on specific measures related to that CQI. The measures and corresponding weights tied to each measure are referred to as the hospital's CQI Performance Index scorecard. Each index consists of both performance and participation-based measures. Performance measures are related to quality and clinical process improvement and outcomes, such as reductions in morbidity or surgical complications. Participation measures are related to program participation and engagement, such as meeting attendance and timely data submission.

Each CQI's performance index is developed by the corresponding CQI coordinating center and discussed with participating hospital clinical champions and Blue Cross before they are finalized. The measures in each CQI index scorecard are reviewed annually, and updated if applicable, with increasing weight given to performance measures (versus participation measures) as programs become more established.

The most recent Performance Index scorecard for each CQI will be made available from the corresponding CQI coordinating center, as well as displayed on the Blue Cross website, by the end of December 2018. Our website is the following:

https://www.bcbsm.com/providers/value-partnerships/hospital-pay-for-performance.html

A hospital's score on each CQI Performance Index is determined by the corresponding coordinating center. Each coordinating center will provide participating hospitals with a mid-year scorecard to identify your performance progress as well as a final scorecard (distributed first quarter of the following year). Blue Cross is provided with a final aggregate score for each corresponding CQI that, will be used in your hospital's final P4P score calculations. An example of how the combined score is calculated is provided in Appendix B.

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Specific questions regarding scoring index measures should be directed to the applicable CQI coordinating center.

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 models for each CQI are 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.

MHA-Sponsored

Hospitals in peer groups 3 and 4 who participate in the MHA HIIN initiative are eligible for a $20,000 participation payment from Blue Cross. This payment is intended to help smaller hospitals with the additional costs they incur to participate in the HIIN. Hospitals must be participating as of Jan. 1, 2019, to be eligible for this payment.

Hospitals in peer groups 1 and 2 aren't eligible for a MHA HIIN participation payment. However, any hospital that hasn't reached the 10 CQI scoring maximum may earn P4P credit for the HIIN initiative. Active participation in HIIN is determined by the MHA Keystone Center.

Payment Schedule

Hospitals will receive their 2019 CQI data abstraction funding as a lump-sum add-on to their Blue Cross interim payment, or BIP, during the second quarter of 2019. If a hospital is not on the BIP system, it will be issued a check for the total amount. Hospital Pay-for-Performance administrators, chief executive officer, chief financial officer, and other stakeholders designated by the hospital will be notified via email when the payment is issued.

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Hospital Cost Efficiency 5%

Blue Cross will continue to reward hospitals for a decrease in or more efficient management of hospitals' inpatient cost structure – lowering overall facility payments, thus furthering improvement in the overall population-based cost of care.

Hospitals will have the opportunity to earn 5 percent of their P4P incentive through performance on two Hospital Cost Efficiency Measures, each weighted at 50 percent:

1) Cost per Case compared to Statewide Mean
2) Cost per Case compared to Target Inflation Factor – NHIPI

The 2019 program will continue to use similar scoring tiers from previous program years to measure both performance and improvement:

Cost per Case compared to Statewide Mean	Score
More than 0.5 standard deviation below	125%
Within 0.5 standard deviation of statewide mean	90%
Between 0.5 and 1.0 standard deviation above	50%
More than 1.0 standard deviation above	0%
Cost per Case compared to Target Inflation Factor (NHIPI)	**Score**
Actual ≤ 25% of target	125%
Actual more than 25% but ≤ 50% of target	90%
Actual more than 50% but ≤ 75% of target	75%
Actual more than 75% but ≤ 100% of target	62.5%
Actual more than 100% but ≤ 125% of target	50%
Actual more than 125% but ≤ 175% of target	37.5%
Actual more than 175% of target	0%

For example, a hospital scoring 90 percent on the Statewide Mean and 50 percent on the Target Inflation components will receive an overall Hospital Cost Efficiency measure performance of **70 percent.**

As in years past, hospitals have the opportunity to earn more points than the total value for each measure, but its combined score is capped at 100 percent.

The 2019 P4P program measures hospital cost efficiency using each hospital's standardized cost per case. The cost per case value is based on hospital-specific margin files (full cost model),

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excluding non-acute services such as psychiatric, rehabilitation and substance abuse. The cost per case is also adjusted for a hospital's case mix index, graduate medical education, capital expenses and bad debt.

Similar to previous P4P program years, cost per case calculations are made using three years of cost data. For the 2019 program year (for P4P incentives beginning July 2020), the calculation will be made using cost data from 2016, 2017 and 2018, as follows:

- 2016 FYE costs and cases will be weighted at 15 percent
- 2017 FYE costs and cases will be weighted at 35 percent
- 2018 FYE costs and cases will be weighted at 50 percent

Michigan Value Collaborative 10%

The Michigan Value Collaborative is a collaborative quality initiative funded by Blue Cross. Established in 2013, MVC aims to help Michigan hospitals achieve the best possible patient outcomes at the lowest reasonable cost by using high-quality data and best practice sharing to drive collaborative quality improvement. MVC provides hospital leaders with claims-based utilization and episode cost 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 costs for Blue Cross' PPO and Medicare fee-for-service claims. In the future, MVC reports will include BCN and Medicaid claims data, but only Blue Cross' PPO and Medicare fee-for-service data will be applied to the 2019 measure.

2019 Measure Expectations

In 2016, hospitals selected two service lines to be measured for performance in 2018 and 2019. However, before a hospital is eligible to earn points for the selected service lines, it must first meet the quality requirement, which stipulates its in-hospital mortality or related readmission rate for the selected service line is above the 10th percentile in the performance year.

Hospitals meeting the quality requirement can earn up to five points for reducing total episode costs for each of its selected service lines.

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Improvement may be demonstrated by either year-over-year improvement within the hospital or through absolute achievement compared to a peer group, as shown in the following table:

Points Earned	Year-over-Year Improvement Baseline: Hospital service line total episode costs for the most recently available 12-month period	Absolute Achievement Baseline: MVC cohort group service line total episode costs for the most recently available 12-month period
1 Point	Baseline Mean	50th Percentile
2 Points	Baseline Mean - (5% * Standard Deviation)	60th Percentile
3 Points	Baseline Mean - (10% * Standard Deviation)	70th Percentile
4 Points	Baseline Mean - (15% * Standard Deviation)	80th Percentile
5 Points	Baseline Mean - (20% * Standard Deviation)	90th Percentile

MVC Bonus Point

If a hospital doesn't earn full points for a service line, but its performance didn't decline from the baseline year, it may be eligible for a bonus point. The bonus point will be awarded if the aggregate episode cost of all hospitals selecting the same service line decreases by at least 5 percent. The purpose of the bonus point is to encourage hospitals to reduce costs through collaboration, rather than competition. However, the maximum points a hospital may receive for the MVC measure is 10, even if the hospital is eligible for the bonus point.

Refer to Appendix E for an example of the MVC score calculation. A detailed description of the 2018 and 2019 performance-based measure is also provided in the separate Background and Technical Document found on the **bcbsm.com** P4P site.

Timeline of the 2018 and 2019 MVC-based P4P Performance Measure

The MVC performance measurement periods and associated analytic and incentive timelines are summarized in the following table:

	2018 P4P Program	2019 P4P Program
Baseline Period	CY 2015	CY 2016
Performance Period	CY 2017	CY 2018
Data Analysis/Claims Adjudication	CY 2018	CY 2019
Performance impacts incentives effective	July 1, 2019 through June 30, 2020	July 1, 2020 through June 30, 2021

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MVC Support for Hospitals

The MVC Coordinating Center hosts a series of virtual workgroups based on input from its hospital partners. The primary goal of these workgroups is to provide hospital leaders with a highly accessible platform to share best practices and challenges facing hospitals 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 and host semi-annual meetings to provide a venue for the sharing of best practices and additional insights.

All-Cause Readmissions Domain 30%

In 2019, P4P participating hospitals will have the opportunity to earn 30 percent of their potential P4P incentive within the All-Cause Readmissions domain. Hospitals will earn incentives for demonstrating favorable year-over-year improvements in their own 30-day all-cause readmission rate.

2019 P4P Readmission Rate Performance (30%)

To help promote hospital and physician collaboration across the care continuum and align measurement reporting and incentives with CMS requirements, the 2019 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.

2019 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 2019 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 2018 baseline period and 2019 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

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them against a national rate. Similarly, the 2019 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 vs. 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 2019CY 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%

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Health Information Exchange 15%

The Health Information Exchange component of the P4P program is designed to ensure that 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.

Hospitals will earn a portion of their HIE points through continued data quality conformance standards for previously implemented use cases. The remaining points will be earned per the table below (additional scoring detail can be found in Appendix F):

Measure Number	Measure Description	Total Points Available	Points Available by Quarter			
			1Q	2Q	3Q	4Q
1	Maintain ADT data quality conformance for both a) complete routing, and b) complete mapping of required data elements	2	0.50	0.50	0.50	0.50
2	Maintain ADT adherence to coding standards	3	0.75	0.75	0.75	0.75
3	Receive, send, and maintain Common Key Service attribute	3	n/a	1.0	1.0	1.0
4	Maintain Med Rec data quality conformance for specified data elements	5	1.25	1.25	1.25	1.25
5	Transmit complete CCDA within 24 hours of discharge	1	Begin transmitting by April 1, 2019			
6	Sign MiHIN System for Opioid Overdose Surveillance (SOS) Use Case	1	This measure is no longer required. All hospitals participating in the ADT use case will automatically earn this point.			

Hospitals should be aware the Michigan Department of Health and Human Services is establishing an electronic medicinal and illicit drug poisoning surveillance system to support automated referrals when a drug poisoning is reported. MiHIN will be supporting MDHSS' communication to hospitals regarding the requirements for using their existing ADT transmissions to meet the MDHSS surveillance system's administrative rules.

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More information on the MDHHS surveillance and referral system, including contact information, is available at:

https://connectingmichigan.net/wp-content/uploads/2019/03/MDHHS-1.pdf

More information on the Reporting of Poisonings due to the Use of Prescription or Illicit Drugs Emergency Rules is available at:

https://www.michigan.gov/documents/opt/Reporting_of_Poisonings_Due_to_Use_of_Prescription_and_Illicit_637072_7.pdf

- Please note, these emergency rules will be supplanted with the final, permanent version, once they have passed the rulemaking process.

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Performance Scoring Multiplier Methodology

The below chart displays how the CQI incentive pool is calculated, based on actual CQI performance and the redistribution of unearned CQI dollars. In this example, the 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, $2.6 million in this example, is then redistributed to hospitals via a scoring multiplier.

In years past, the total unearned incentive for the entire P4P program was distributed equally to all hospitals. However, the 2019 P4P uses a performance scoring multiplier introduced in 2014 that keeps unearned incentive dollars within each specific program measure and redistributes that amount to hospitals differentially, based on the normalized performance on each measure as compared to their peers. Additionally, the scoring measure takes into account the relative size of each hospital to ensure that the additional incentive received is proportionate to each hospital's overall potential incentive.

Hospital Name	**Collaborative Quality Initiatives** (Fixed 40% of P4P Incentive)							
	Potential CQI Incentive (Fixed 40%)	CQI Performance	Earned CQI Incentive (Performance)	Unearned CQI Incentive	Normalized Performance	Additional CQI Incentive Earned	Total Earned CQI Incentive ($, %*)	
Hospital A	$100,000	95%	$95,000	$5,000	0.8750	$16,852	$111,852	111.85%
Hospital B	$250,000	80%	$200,000	$50,000	0.5000	$24,074	$224,074	89.63%
Hospital C	$350,000	78.57%	$275,000	$75,000	0.4643	$31,296	$306,296	87.51%
Hospital D	$500,000	100%	$500,000	$0	1.0000	$96,296	$596,296	119.26%
Hospital E	$750,000	93.33%	$700,000	$50,000	0.8333	$120,370	$820,370	109.38%
Hospital F	$800,000	91.25%	$730,000	$70,000	0.7813	$120,370	$850,370	106.30%
Hospital G	$1,500,000	60%	$900,000	$600,000	0.0000	$0	$900,000	60%
Hospital H	$2,250,000	88.89%	$2,000,000	$250,000	0.7222	$312,963	$2,312,963	102.80%
Hospital I	$3,500,000	100%	$3,500,000	$0	1.0000	$674,074	$4,174,074	119.26%
Hospital J	$10,000,000	85%	$8,500,000	$1,500,000	0.6250	$1,203,704	$9,703,704	97.04%
Total	**$20,000,000**		**$17,400,000**	**$2,600,000**		**$2,600,000**	**$20,000,000**	**100.00%**

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Blue Cross-sponsored 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.	No
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
MHA Sponsored Program		
Great Lakes Partnership for Patients Hospital Improvement Innovation Network, or HIIN	Two-year, CMS-sponsored collaborative focused on implementing person and family engagement practices, enhancing antimicrobial stewardship, building cultures of high reliability, reducing readmissions and addressing 11 areas of patient harm.	No

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*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 two CQIs that it has been recruited and is eligible for and the optional and the MHA-sponsored HIIN initiative (weighted as two CQIs).

Its total CQI weight is 40 percent.

Its individual CQI weight is 10 percent – 2 CQI Programs + HIIN weighed 2x

Its performance on CQI No. 1 is 80 percent.

Its performance on CQI No. 2 is 90 percent.

Its performance on the MHA-sponsored HIIN is 100 percent.

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

	Index Score		**CQI Weight**		**Earned Score/ Potential Score**
CQI No. 1	80%	X	10%	=	8%
CQI No. 2	90%	X	10%	=	9%
HIIN	100%	X	20%	=	20%
Total CQI Aggregate Score	**93%**		**40%**		**37%**

In this example, Hospital A earned a total CQI score of 37 percent out of a potential 40 percent. Hospital A left on the table approximately 3 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.

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CQI Performance Index Scorecards

The CQI Performance Index Scorecards will be made available as a separate addendum to the 2019 Pay-for-Performance Program guide in mid- to late-December 2018, 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 2019 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.

- Identification of "physician champions" at participating sites who can affect change, collaborate in generating data for enhanced knowledge and analysis of processes and outcomes of care
- Identification of an administrative contact at participating sites
- Thoroughly and accurately collect comprehensive data (i.e., no consistent pattern of errors or omissions with regard to 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

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- 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

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2019 OBI Performance Index

Measure Name	Measure Description	Points
OBI Commitment	A hospital assembles a multi-stakeholder team (physician, CNM, nursing, administration, and QI) with one point person as the main point of contact. This team signs a letter by February 1, 2019 formally joining OBI and committing to support and champion efforts to reduce the primary cesarean delivery rates at their institution.	**5**
Participation in OBI	Combination of meeting and webinar attendance.	**15**
	Semi Annual Meeting Attendance	**10**
	At least one member of the multi-stakeholder team attends BOTH the MVC OBI Semi Annual Meetings in April 2019 AND November 2019	10
	At least one member of the multi-stakeholder team attends the MVC OBI Semi Annual Meetings in April 2019 OR November 2019	3
	Educational Webinar Attendance	**5**
	A member of multi-stakeholder team attends 4/4 OBI educational webinars	5
	A member of multi-stakeholder team attends 3/4 OBI educational webinars	4
	A member of multi-stakeholder team attends 2/4 OBI educational webinars	2
	A member of multi-stakeholder team attends 1/4 OBI educational webinars	1
Communication	Combination of provider education and peer-to-peer engagement.	**20**
	Providers Education	**5**
	Disseminate the OBI recorded webinar link to maternity care providers and L&D staff regarding contemporary data regarding length of latent labor, benefits of completing latent labor outside hospitals, and effect on primary cesarean delivery rate by January 31, 2019. Have > 20% of your maternity care providers and L&D staff complete the brief survey questions immediately following the webinar by March 15, 2019.	5
	Peer-to-Peer Engagement	**15**
	Video workgroup conference: member of the multi-stakeholder team participates in OBI-facilitated 1st quarter 2019 meeting	3.5
	Video workgroup conference: member of the multi-stakeholder team participates in OBI-facilitated 2nd quarter 2019 meeting	3.5
	Video workgroup conference: member of the multi-stakeholder team participates in OBI-facilitated 3rd quarter 2019 meeting	4
	Video workgroup conference: member of the multi-stakeholder team participates in OBI-facilitated 4th quarter 2019 meeting	4

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Data Validation	**Meet two data validation deadlines**	**15**
	Report data regarding 30 patients for BCBSM PPO data validation by March 2019 via OBI online portal.	7.5
	Report data regarding 30 patients for birth certificate data validation by June 2019 via OBI online portal.	7.5
Data Reporting	**Meet two data reporting deadlines**	**15**
	Report on NTSV patients regarding process measures by September 2019 via OBI online portal.	7.5
	Report on NTSV patients regarding process measures by December 2019 via OBI online portal.	7.5
Implementation (Choose Option A *or* Option B)	**OPTION A: OBI CHECKLIST**	**30**
	Develop a strategy and timeline to implement the OBI Checklist in your facility by June 2019 via OBI online portal.	15
	Evaluate your strategy and timeline for OBI Checklist implementation in your facility by September 2019 via OBI online portal.	7.5
	Evaluate your strategy and timeline for OBI Checklist implementation in your facility by December 2019 via OBI online portal.	7.5
	OPTION B: RPC Promoting Spontaneous Progress in Labor Bundle	**30**
	Develop your strategy and timeline to implement the RPC Spontaneous Labor Bundle in your facility by June 2019 via OBI online portal.	15
	Evaluate your strategy and timeline for RPC Spontaneous Labor Bundle implementation in your facility by September 2019 via OBI online portal.	7.5
	Evaluate your strategy and timeline for RPC Spontaneous Labor Bundle implementation in your facility by December 2019 via OBI online portal.	7.5
Total		**100**

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Hospital Cost Efficiency Calculations

Cost per case compared to Statewide Mean

One portion of each hospital's efficiency score is based on the number of standard deviations its cost per case is away from the statewide mean. This is also referred to as the hospital's "standard normal score" and is calculated as follows:

$$\text{Hospital Standard Normal Score} = \frac{\text{hospital cost per case — statewide average (mean) cost per case}}{\text{standard deviation of statewide average cost per case}}$$

The statewide average (mean) cost per case is calculated by totaling each hospital's cost per case and dividing by the number of hospitals participating in the P4P program:

$$\text{Statewide Average (Mean)} = \sum \text{(hospital cost per case) / number of participating hospitals}$$

The standard deviation in the above calculation is defined as the square root of the average squared deviation from the mean, as shown in the following formula:

$$\text{Standard Deviation} = \text{SQRT (} \sum \text{(hospital CPC - statewide average CPC)}^2 \text{ / number of hospitals)}$$

Applying this calculation to a single hypothetical hospital, assume the following:

- Hospital A's cost per case = $8,103
- Overall statewide average cost per case is $7,700
- Standard deviation of the statewide average cost per case is $1,000
- Standard normal score for this hospital is calculated as follows:

$$\text{Hospital A standard normal score} = \frac{(\$8{,}103 - \$7{,}700)}{\$1{,}000} = 0.403$$

Hospital A's standard normal score is between -0.5 and 0.5. Therefore, Hospital A earns a measure performance of 90 percent for this performance-based cost efficiency component.

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Cost per case compared to a NHIPI-based Target Inflation Factor

The remainder of each hospital's efficiency score is based on a comparison of the change in its cost per case to a target inflation amount, which is calculated using the National Hospital Input Price Index. For example:[3]

- Hospital A's cost per case at the beginning of the measurement period is $8,000
- The reported NHIPI for the same period is 3 percent
- Hospital A's target cost per case increase is calculated as follows: $8,000 x 0.03 = $240

This target increase is compared to its actual increase, as follows:

- Hospital A's actual cost per case at the end of the measurement period is $8,103. Therefore, its actual cost per case increase is:

  $8,103 - $8,000 = $103
- Hospital A's actual cost per case increase is divided by its target cost per case increase:

  $103 ÷ $240 = 43%

Cost per case Expanded Measurement Period

In 2019, the standardized inpatient cost per case is calculated using a three-year rolling average. This longer measurement period is designed to minimize the effect of short-term variations on hospital cost per case scores. At the same time, the average is weighted to more heavily emphasize recent performance, as follows:

- For the 2019 program year (P4P incentives effective July 2020 the calculation will be made using data from 2016, 2017 and 2018.
  - 2016 costs and cases will be weighted at 15 percent
  - 2017 costs and cases will be weighted at 35 percent
  - 2018 costs and cases will be weighted at 50 percent

Using these weights, each hospital's cost per case is calculated as follows:

$$\text{2019 hospital cost per case} = \frac{(0.15 \times \text{2016 costs}) + (0.35 \times \text{2017 costs}) + (0.50 \times \text{2018 costs})}{(0.15 \times \text{2016 cases}) + (0.35 \times \text{2017 cases}) + (0.50 \times \text{2018 cases})}$$

[3]For simplicity this example uses a measurement period of only one year. However, the cost per case measurement period is based on a three-year measurement period for the 2019 program, as described in a subsequent section of this appendix.

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The weighted statewide mean cost per case for each measurement period will be calculated in the same manner. For the 2019 program year (P4P rate effective July 2020), the hospital-specific inflation targets will be calculated using the same rolling averages, as shown in the following formulas:

$$\text{3-year weighted target inflation} = \frac{(0.15 \times 2015 \text{ costs} \times 2014 \text{ NHIPI}) + (0.35 \times 2016 \text{ costs} \times 2015 \text{ NHIPI}) + (0.50 \times 2017 \text{ costs} \times 2016 \text{ NHIPI})}{(0.15 \times 2015 \text{ cases}) + (0.35 \times 2016 \text{ cases}) + (0.50 \times 2017 \text{ cases})}$$

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Hospital MVC Calculations

Program years 2018 and 2019

The following is an illustration of how the scoring system will be applied for program year 2019 for a fictitious hospital (Hospital A) selecting joint replacement. All dollar amounts provided below are for illustrative purposes only.

In 2019, Hospital A meets the quality requirement by performing above the 10th percentile on the mortality and related readmission measure. Eligible service lines include (a minimum of 20 cases in the past 12 months of MVC data was required for service line eligibility):

Acute Myocardial Infarction
Congestive Heart Failure
Pneumonia
Colectomy (non-cancer)
Coronary Artery Bypass Graft
Joint Replacement (hip and knee episodes combined)
Spine Surgery (labeled as "Other spine" on MVC registry)

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

Service line	Mean costs for baseline period	MVC Winsorized[4] Standard deviation based target for baseline period	Mean costs in 2019 performance period
Joint replacement	$16,393	$2,100	$16,871

Hospital A's 2019 cost *improvement* targets for joint replacement are calculated as follows (see Page 11 for the target cost reduction methodology):

2019 year over year *improvement* targets	Points
$16,393	1
$16,393 – (0.05 x $2,100) = $16,288	2
$16,393 – (0.10 x $2,100) = $16,183	3
$16,393 – (0.15 x $2,100) = $16,078	4
$16,393– (0.20 x $2,100) = $15,973	5

Because Hospital A's mean episode cost for joint replacement in 2019 exceeds its baseline period targets, it doesn't earn any points for year-over-year *improvement*. However, because Hospital A's 2019 episode

[4] The utility of winsorization is to mitigate the effect of extreme outlier cases. Cases will be winsorized at the 99th percentile. For more information, please refer to the MVC Technical Document.

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costs for joint replacement are well below its cohort's average episode cost for joint replacement it's eligible for *achievement* points.

	Mean costs for baseline period
Hospital A's Cohort	$19,202
Hospital A	$16,871

2019 *achievement* targets	Points
$19,202 (50th percentile)	1
$18,883 (60th percentile)	2
$18,378 (70th percentile)	3
$17,502 (80th percentile)	4
$16,792 (90th percentile)	5

Hospital A will earn 4 points for absolute *achievement* because its 2019 joint replacement costs are ranked between the 80th and 90th percentiles.

As stated on Page 11, a bonus point may be earned if all hospitals working on the same service line achieve a 5 percent or greater improvement in total episode costs and the hospital's own performance didn't decline from the baseline year. In this illustrative example, all hospitals in the state working on joint replacement reduced average episode costs by more than 5 percent (data not shown). However, since Hospital A's 2019 joint replacement costs were higher than its baseline costs, it would not be eligible to earn an additional bonus point as part of its *collaboration* goal.

For 2019, Hospital A will earn a total of 4 points for its joint replacement service line. Its 2019 pneumonia service line performance would be scored separately using the same methodology.

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Health Information Exchange Measures and Data Elements

Overview

In its January 2018 Health Information Exchange Fact Sheet, CMS states its expectation for HIE sender and receiver collaboration.[5] 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 accommodate 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 utilized by a patient's providers. To facilitate this vision, Blue Cross updated the hospital HIE conformance standards for 2019. The intent is to have hospitals continually improve the data that flows through the Michigan Health Information Network, ensuring it is complete and actionable when it is received by the practitioners using the information. The new data quality conformance requirements will focus on data transmitted through MiHIN for the ADT, Med Rec and Common Key Service use cases.

The 2019 HIE component of the P4P will also require hospitals to transmit a full care summary document through MiHIN within 24 hours of discharge (most hospitals are already doing this under the Medication Reconciliation use case). Although hospitals will be scored on whether they send all required data elements, in 2019 only the medication reconciliation data elements will be subject to specific conformance standards. All other fields will be analyzed to inform conformance standards for future program years. They will also be analyzed to determine whether they can be used to meet other requirements, such as the Joint Commission's mandate that discharge summaries contain certain components[6] and the new CMS Transition of Care measure.

[5] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HealthInformationExchange_2017.pdf

[6]The Joint Commission requirements include reason for hospitalization, significant findings, procedures and treatment provided, patient's discharge condition, patient and family instructions, and attending physician's signature.

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Scoring

HIE Measures 1, 2, 3 and 4: ADT, Common Key Service and Med Rec

Conformance thresholds will apply to measures 1, 2, 3 and 4. Specific conformance thresholds for these sections are outlined in the next section. For these 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 at the relevant threshold.
- For mapped fields, updated mapping tables must be submitted to MiHIN when changes occur.
- If a hospital is notified by Blue Cross it is not in conformance, it must address the issue and regain conformance within 30 days of the notification.
- Unless otherwise noted, a hospital will earn points for each quarter in which it maintains full conformance or regains full conformance within 30 days notification from Blue Cross.
  - A hospital will earn 0.00 points for each quarter in which it remains out of conformance following 30 days notification from Blue Cross.

HIE Measure 5: Send CCDA

Hospitals will earn one point for this measure by populating the following fields on the CCDA. Most hospitals already meet this requirement via the Medication Reconciliation use case. The data in these fields will be tracked to develop benchmarks for future P4P conformance standards, **but they will not be scored in 2019**.

Advance Directives
Discharge Instructions
Functional Status
Immunizations
Plan of Care
Procedures
Progress Notes
Reason for Referral
Results/Laboratory Values
Social History
Tests Ordered
Vital Signs

Blue Cross will work with hospitals, the Michigan Hospital Association (MHA), and PGIP providers to improve CCDA field standards and definitions for all CCDA fields.

The transmission of the CCDA will also be tracked to determine whether ADT discharge notifications (AO3 transmissions) are consistently followed by an associated CCDA transmission within 24 hours. In 2019 hospitals will be notified, but not scored, if there is an inadequate match rate in the two transmission types. Conformance in match rates may be scored in 2020.

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ADT, Med Rec Common Key Service Conformance Thresholds

The following tables list the 2019 data fields and performance thresholds required for all ADT, Med Rec and Common Key transmissions (HIE measures 1, 2, 3 and 4). **New fields for scoring in 2019 are shown in bold and italic.**

Measure 1 - ADT: Complete Routing Data (population of fields) and Mapping – 2 points	
Group A: Complete routing	**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%***
Group B: Complete Mapping	**Threshold**
MSH-4.1: Sending Facility- Hospital OID	≥95% of populated messages
PV1-36: Discharge Disposition	≥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~~

*New field that is not subject to conformance thresholds until 2Q19

Measure 2 - ADT: Maintain Adherence to Coding Standards – 3 points		
Relevant Fields	**Complete Routing Threshold**	**Coding Standard**
PV1-7.1: Attending Doctor ID	≥95%	NPI
PV1-17.1: Admitting Doctor ID	≥95%	NPI
DG1-3.1: Diagnosis Code ID	≥95%	ICD10
DG1-3.2: Diagnosis Code Description	≥95%	

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Measure 3 – Common Key Conformance – 3 points	
Common Key Service Relevant Fields	**Complete Routing Threshold**
PID-3.42: Unique Identifier	***≥95% of populated messages***
PID-3.5: Identifier Type	***≥95% of populated messages***

Measure 4 - Med Rec: Conformance Thresholds and Performance Coding – 5 points	
CCDA – Med Rec Relevant Fields	**Complete Routing Threshold**
Visit ID	≥95%
Patient Date of Birth	≥95%
Patient Gender	≥95%
Patient SSN – when available	Not scored
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	By the end of 3Q2019, hospitals must reach a compliance rate of 50% or better. By the end of 4Q2019, hospitals must reach a conformance rate of 75% or better.
Discharge Medication Begin Date	
Discharge Medication End Date*	
Discharge Medication Dose Unit	
Discharge Medication Dose Quantity	
Discharge Medication Instructions	
Discharge Medication Status*	
Discharge Medication Code (RxNorm or NDC)	
Allergies	≥95%
Active Problems Present	≥95%
Chief Complaint	≥95%
Visit Diagnosis Code (ICD10)	≥95%
Visit Diagnosis Description	≥95%

*Field is not subject to conformance scoring in 2019.

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MHA Keystone Center / Great Lakes Partners for Patients (GLPP) Hospital Improvement Innovation Network (HIIN) Scoring Index

2019 BCBSM Pay for Performance Program Requirements

Peer Groups 1 – 4

Table 1: Component	Weight	Scoring Frequency	Reporting Timeframe
Data submission: Outcome Measures *(Please see the Encyclopedia Of Measures)*	30%	Monthly	Jan. – Dec. 2019
Performance: Improvement on ADE - Opioids, Falls and Sepsis measures *(individual improvement from HIIN baselines)*	40%	Once	Varies by measure *(see Table 3)*
Storyboard/Poster: Improvement activity project *(see topic areas in Table 4)*	30%	Once	**Due by August 1, 2019** *(To be digitally displayed at a fall MHA conference)*

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, Sepsis and Opioid Adverse Drug Events *(see Table 3 for additional detail)* • Improvement from HIIN baseline on 3 of 3 measures • Improvement from HIIN baseline on 2 of 3 measures • Improvement from HIIN baseline on 1 of 3 measures	50 points *(10 bonus*)* **40 points** *(Full points)* 20 points
Storyboard/Poster *(see Table 4 for additional detail)* Safety Improvement Activity Project • Develop and implement a plan to drive improvement and share results around the areas of **Falls, Health Disparities, Opioids, Pressure Ulcers, Readmissions, Sepsis, Surgical Site Infections or Ventilator Associated Events. **** • 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	HIIN Baseline	Performance Period – Final Score
Falls with Injury: All documented patient falls with an injury level of minor or greater *(KDS-HIIN-Falls-1)*	*Returning HEN 2.0 Hospitals:* Q1 2016 *New GLPP HIIN Hospitals:* Q4 2016	Jan. – Dec. 2019
Sepsis: Post-op Sepsis *(KDS-HIIN-SEPSIS-1)* *Or* Sepsis Mortality *(KDS-HIIN-SEPSIS-2)*	Q4 2015 – Q3 2016	Jan. – Sept. 2019
Opioid Adverse Drug Events: Use of naloxone among inpatients receiving opioids *(KDS-HIIN-ADE-4)*	Q4 2016	Jan. – Dec. 2019

Hospitals will be scored on their own performance over time, and whether they are demonstrating improvement in rates from the designated (hospital-specific) baseline to the listed performance period. Baseline rates must be entered in order for performance measures to be scored. This aligns with how the MHA Keystone Center will track performance of hospitals in the HIIN for all measures. Hospitals that maintain rates in the top quartile of all participating PG1-4 hospitals will receive full points for improvement.

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: **Falls, Health Disparities, Opioids, Pressure Ulcers, Readmissions, Sepsis, Surgical Site Infections or Ventilator Associated Events.**** • Improvement activity should have started within the last year (August 2018 – August 2019) • Storyboard must be submitted on the MHA template to receive the full 30 points. The template will be available on the MHA Community Site. Questions about the template can be sent to keystonep4p@mha.org • Hospitals must individually submit their unique storyboards **by August 1, 2019 for credit**; late submissions will be docked points. • Overall Hospital System submissions will not be accepted. • MHA Keystone will display the storyboards electronically at a MHA Keystone conference and on the Community Site; attendance to the conference is not required.

Along with the storyboard posters being digitally displayed on the MHA Community Site, several hospital teams will be selected by MHA Keystone to present their storyboard at a MHA Keystone conference, in a short presentation, to discuss their work with attendees.

***If you wish to do a storyboard on a different topic area it must be approved by the Keystone Center.*

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) is strongly encouraged, however attendance does not affect your P4P scores.