New Hospital Pay-for-Performance Program
July 2006
Hospital Pay-for-Performance Program

Program Overview

On July 1, 2006, BCBSM began implementing a new Hospital Pay-for-Performance program for short-term acute care hospitals. Under the new program, hospitals can earn additional amounts on their inpatient and outpatient payments if they meet specific performance targets. These targets include measures for quality, resource efficiency and participation in selected collaborative quality initiatives.

• Beginning July 2006, hospitals are able to earn up to 3 percent of their combined inpatient and outpatient operating payments. This is compared to the Hospital Incentive Program that was previously in place, in which hospitals could earn up to an additional 4 percent of their inpatient operating payments only.

• In July 2007 hospitals will be able to earn up to 4 percent of their combined inpatient and outpatient operating payments.

• Beginning in July 2008, hospitals may be eligible for an additional one percent of their combined inpatient and outpatient operating payments. Whether hospitals earn this additional amount will be determined by a comparison of the statewide average cost per adjusted admission with a regional benchmark.

Hospitals must meet specific prequalifying conditions to be eligible to participate in the new program.

Program performance is measured on a calendar year basis. The amount each hospital earns based on its performance becomes effective on July 1 following the measurement year.

All program measures are reviewed on an annual basis. Final program design and subsequent modifications are determined by BCBSM, with input from the Michigan Health & Hospital Association and hospitals via a P4P Advisory Group.

There is a two-year transition period from the previous Hospital Incentive Program to the new Hospital P4P program. During this time, no hospital will earn less in total incentive payments than it would have under the program design that was previously in place. The transition period ends on July 1, 2008.
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Prequalifying Conditions

Hospitals must meet certain prequalifying conditions to be eligible to participate in the program. Hospitals do not earn specific payments for meeting the prequalifying conditions.

Some prequalifying conditions are applicable to the entire program. That is, if a hospital fails to meet the condition, it forfeits its eligibility for the entire P4P payment. Others pertain only to a specific component of the program. If the hospital does not meet the condition, it is not precluded from earning an incentive for the other components of the program.

A hospital is not subject to a prequalifying condition if it is not applicable to the services it provides. For example if hospitals are asked to report data on a specific procedure, but a hospital does not perform a sufficient volume of that procedure, it will not be penalized.

Beginning July 1, 2006 hospitals must meet the following pre-qualifying conditions:

- Publicly report all applicable performance indicators to the Centers for Medicare & Medicaid Services.
- Participate in all selected Collaborative Quality Initiatives for which it is eligible. (This pre-qualifying condition pertains only to the CQI component of the program.)

Beginning in 2007, hospitals will also be expected to implement and maintain specified culture of safety, medication safety and patient safety practices.
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Program Components

Quality

In 2006 the quality component is weighted at 65 percent.

Beginning in 2007, the weight for this component will be between 45 percent and 55 percent.

In 2006, hospital quality scores are based on the following:

1. **Clinical Quality indicators**

   **Heart failure**
   - Assessment of left ventricular function
   - Left ventricular ejection fraction less than 40 percent prescribed angiotensin converting enzyme inhibitors or angiotensin receptor blockers at discharge.
   - Discharge instructions

   **Pneumonia**
   - Percentage of patients administered an antibiotic within four hours of arrival at hospital
   - Initial antibiotic selection consistent with current recommendations
     - For non-intensive care unit patients
   - Pneumococcal vaccine (screening or administration) prior to discharge

   **Surgical infection prevention for select surgeries**
   - Prophylactic antibiotic received within one hour prior to surgical incision
   - Prophylactic antibiotic selection for surgical patients (measured, but not scored)
   - Prophylactic antibiotics discontinued within 24 hours after surgery end time (excluding CABG or other cardiac and vascular surgery)

   **SIP measures are scored for the following select surgeries**
   - coronary artery bypass graft and other cardiac surgery
   - hip and knee arthroplasty
   - colon surgery
   - hysterectomy
   - vascular surgery
2. **Patient Safety**

Hospitals with an ICU are scored on the following five ventilator bundle measures.

1. Assess weaning
2. Follow commands
3. Head of bed greater than 30 degrees
4. Deep vein thrombosis prophylaxis
5. Stress ulcer disease prophylaxis

Hospitals that do not have an ICU are scored on the following:

- Culture of safety
- Medication Safety Practices
- Patient safety practices (NQF)
- High-technology tools

3. **Health of the Community**

Hospitals must implement a project addressing the needs of the community they serve and meet the goals of their project. In order to earn this portion of the incentive, hospitals must choose from one of the following two topics:

- Tobacco control, including prevention and cessation
- Physical activity and nutrition
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Efficiency

Efficiency is weighted at 35 percent.

Hospital efficiency is measured by hospitals’ standardized inpatient cost per case relative to the 2004 statewide mean. The following table shows the amount of the efficiency component a hospital will earn, based on its position to the statewide mean:

<table>
<thead>
<tr>
<th>Hospital Standardized Cost Per Case Relative to Statewide Mean</th>
<th>Efficiency Component Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than 0.5 standard deviation below</td>
<td>35 percent</td>
</tr>
<tr>
<td>Within 0.5 standard deviation, inclusive</td>
<td>30 percent</td>
</tr>
<tr>
<td>More than 0.5 standard deviation above</td>
<td>15 percent</td>
</tr>
<tr>
<td>More than one standard deviation above</td>
<td>0 percent</td>
</tr>
</tbody>
</table>

In 2006, this comparison will be made using 2004 cost data. In 2007, hospitals’ 2005 cost per case will be compared to the 2004 statewide mean, but the mean will be trended forward by the annual hospital update factor. It is anticipated that additional efficiency measures will be added in the future.
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Collaborative Quality Initiatives

The CQI component is weighted between 10 percent and 20 percent.

Hospitals are evaluated on their participation in the following six CQI programs:

- Blue Cross Blue Shield of Michigan Cardiac Consortium (BMC2)
- Michigan Cardiac Surgery Collaborative Initiative
- Michigan Bariatric Surgery Collaborative
- Michigan Surgery Quality Collaborative
- Michigan Breast Oncology Initiative
- MHA Keystone Project for hospital associated infections

The weight of this component for a specific hospital is determined by the number of CQIs in which it is eligible to participate, as shown in the following table:

<table>
<thead>
<tr>
<th>Number of CQIs in which a hospital is eligible to participate</th>
<th>Weight of the CQI Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>One or two</td>
<td>10 %</td>
</tr>
<tr>
<td>Three or four</td>
<td>15 %</td>
</tr>
<tr>
<td>Five or more</td>
<td>20 %</td>
</tr>
</tbody>
</table>

For each hospital the combined weight of the CQI and quality components totals 65 percent. Therefore hospitals with a higher CQI weighting have a lower weight applied to their quality component. Conversely hospitals with a lower CQI weighting have a higher weight applied to their quality component. The relationship between these two components is shown in the following table:

Relative Weighting of Program Components

<table>
<thead>
<tr>
<th>CQI</th>
<th>Quality</th>
<th>Efficiency</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 %</td>
<td>55 %</td>
<td>35 %</td>
<td>100 %</td>
</tr>
<tr>
<td>15 %</td>
<td>50 %</td>
<td>35 %</td>
<td>100 %</td>
</tr>
<tr>
<td>20 %</td>
<td>45 %</td>
<td>35 %</td>
<td>100 %</td>
</tr>
</tbody>
</table>
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To qualify for this portion of the P4P program, a hospital must first participate in all selected CQIs for which it is eligible. If a hospital chooses not to participate in one or more CQIs for which it is eligible, it will forfeit this portion of the P4P program. However, the relative weights of the other program components will remain as specified in the previous table.
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Regional Benchmark Cost Comparison

Beginning in July 2008, hospitals will be eligible to earn up to an additional 1 percent of their combined inpatient and outpatient operating payments. The amount hospitals earn will be determined by a comparison of the statewide average cost-per-adjusted admission² with a regional benchmark, as described below.

This will not be a hospital-specific measure. Instead, it will be applied equally to all hospitals participating in the P4P program.

Application of Benchmark

In 2004, the Michigan cost-per-adjusted admission was 3.7 percent lower than the average of its regional peers (Wisconsin, Illinois, Ohio, Indiana and Pennsylvania). It was also the lowest of all six states in the region.

A similar comparison will be made using 2006 data and each subsequent year thereafter. Hospitals will be awarded up to 1 percent based on the following two comparisons:

1. If the Michigan cost-per-adjusted admission stays the same or improves relative to the regional mean, hospitals will earn between 0.5 percent and 1 percent. If the Michigan cost-per-adjusted admission deteriorates relative to the regional mean, hospitals will not earn an amount based on this first comparison.

In 2008, the amount hospitals earn under this first comparison will be determined as follows:

<table>
<thead>
<tr>
<th>Michigan Cost-Per-Adjusted Admission Relative to Regional Mean</th>
<th>Amount Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 3.5 percent below</td>
<td>0.0 %</td>
</tr>
<tr>
<td>3.0 percent to 3.9 percent below (that is, status quo)</td>
<td>0.5 %</td>
</tr>
<tr>
<td>Greater than 3.9 percent below</td>
<td>1.0 %</td>
</tr>
</tbody>
</table>
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2. If hospitals earn less than the full 1 percent based on the first comparison, they will be able to earn an additional 0.5 percent if the Michigan cost-per-adjusted admission remains lower than all other states in the region. If the Michigan cost-per-adjusted admission does not remain lower than all other states in the region, hospitals will not earn this additional 0.5 percent.

The total amount hospitals earn based on these two comparisons will not exceed 1 percent.

*Adjusted admissions = inpatient admissions + outpatient equivalent admissions.
Outpatient equivalent admissions = outpatient revenue ÷ inpatient revenue per admission.
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Patient Satisfaction

In the future, hospitals will be scored on their patient experiences. It is anticipated this will be measured using Medicare’s patient satisfaction tool, the Hospital Consumer Assessment of Health Providers and Systems Survey, once the tool has been implemented and results are available. If the H-CAHPS tool is determined not to be feasible or sufficient, an alternative measurement tool will be used.
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Hospital P4P Advisory Group

A P4P Advisory Group provides input to BCBSM on the various program elements, including the development of measures, thresholds and component weights. The P4P Advisory Group includes clinical quality experts, hospital staff with direct patient care involvement, other representatives deemed critical to the input process and BCBSM and MHA staff. Final program design is determined by BCBSM.

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