Blue Cross Blue Shield of Michigan

2017 Hospital Pay-for-Performance Program

Peer Groups 1-4

November 2016

VALUE Partnerships

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Program Overview

The Blue Cross Blue Shield of Michigan (BCBSM) Hospital Pay-for-Performance (P4P) 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 2017, the program will pay hospitals, in aggregate, an additional five percent of statewide inpatient and outpatient operating payments – nearly $190 million statewide.

The P4P program structure and measures are developed with input from hospitals via the Participating Hospital Agreement (PHA) 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 2017 P4P program performance, will be applied to its inpatient and outpatient operating payments effective July 1, 2018.

What's New in 2017

The 2017 P4P Program Year will closely follow the structure, performance measurement and incentive framework of the 2016 program year. The following table summarizes the 2017 P4P program structure:

2017 Program Components and Weights	
Prequalifying Condition	0%
Collaborative Quality Initiatives (CQI)	40%
Hospital Cost Efficiency	10%
Michigan Value Collaborative (MVC)	10%
All-Cause Readmission Domain 1) Readmission Rate Performance 2) Alternative Readmission Measure(s)	Sliding Scale: **At least 20%** Maximum 10%
Health Information Exchange (HIE)	10%

The amount of P4P incentive dedicated to readmission rate performance has increased to 20% of the program's overall incentive. The remaining 10% of the All-Cause Readmissions domain can be earned through hospital participation in up to two (of six) alternative readmission measures, worth 5% each. If participation in any of the measures is discontinued, the program weight will be shifted toward the readmission rate performance (up to 30%).

Hospitals will continue to be eligible to have the opportunity to earn a fixed 40% of the program's potential incentive for performance across MHA and CQI initiatives. The CQI domain will be capped at 40%, regardless of the number of participating initiatives. Hospitals eligible for and participating in more than ten CQIs will be scored using only the top ten individual CQI performance scores, with preference given to BCBSM sponsored CQI programs.

All P4P-participating hospitals must first meet a patient-safety prequalifying condition to be eligible to participate in and receive incentives for performance within the P4P program.

Beginning in 2017, the MHA Keystone Center will no longer enroll hospitals into individual collaboratives. Instead, hospitals will have the opportunity to engage with the Great Lakes Partners for Patients Hospital Improvement Innovation Network (HIIN), a two-year initiative sponsored by CMS, to address areas of patient harm and readmission reduction efforts. Hospital participation in the HIIN is **optional** in 2017 and will be weighted equivalent to **two** CQI programs – exact weights vary depending on total number of CQIs a hospital is participating in. Preference will continue to be given to BCBSM-sponsored CQI programs for hospitals in ten or more collaboratives.

Participation in the Michigan Value Collaborative (MVC) continues to be a requirement for all P4P-participating hospitals and is worth 10% of the program's potential incentive. In 2017, hospitals will begin to earn points for the MVC measure based on hospital-specific performance.

The 2017 program maintains that the Hospital Cost Efficiency and Health Information Exchange (HIE) measures are each also worth 10% of the program's potential incentive. Notable updates to the HIE component can be found in the HIE section of the program guide.

To help hospitals better assess their performance across all program measures throughout the program year, BCBSM will continue to provide hospitals with quarterly, **informational** P4P performance reports into 2017. P4P-participating hospitals will also have the opportunity to request patient-level readmissions information to help assist readmission reduction efforts.

Payment Methodology

The 2017 P4P program maintains that the statewide *aggregate* P4P payout is equal to the full five 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 in 2014, the 2017 P4P program will continue to utilize 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.

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

[1] If a hospital's reimbursement arrangement does not comply with the formula established within the BCBSM 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.

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.

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
    - Review compliance with the Agency for Healthcare Research Patient Safety indicators at least once every 18 months
    - Participate in a federally-qualified patient safety organization
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

Hospital compliance with this prequalifying condition is determined via CEO attestation.

Collaborative Quality Initiatives 40%

As introduced in 2016, the 2017 P4P program will offer hospitals the opportunity to earn a fixed 40% of the program's potential incentive based upon its performance across MHA and BCBSM-sponsored CQI initiatives. The amount of incentive allocated to CQI performance (40%) will be equal for all hospitals regardless of the number of CQIs a hospital is eligible for.

The CQI program domain will remain capped at 40%, regardless of the number of participating initiatives. Hospitals eligible for and participating in more than ten CQIs will be scored using only the top ten individual CQI performance scores, with preference given to BCBSM-sponsored 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 BCBSM-sponsored CQI
1	40%	40.00%
2	40%	20.00%
3	40%	13.33%
4	40%	10.00%
5	40%	8.00%
6	40%	6.67%
7	40%	5.71%
8	40%	5.00%
9	40%	4.44%
10 +	40%	4.00%

In 2017, five (5) of the BCBSM-sponsored CQIs have been categorized as "Required" CQIs (see Appendix B for a list of eligible CQIs). In addition, individual MHA Keystone collaboratives have been replaced by the Great Lakes Partners for Patients Hospital Improvement Innovation Network (HIIN) – pg. 7 for details.

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 impact on its P4P score 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 Cross Blue Shield Association (BCBSA) Blue Distinction Center (BDC) will require participation in a related CQI program.[2]

Recruitment efforts are made annually to enroll eligible hospitals into CQI programs. During 2017, recruitment efforts will be made to engage eligible sites into the following initiatives to begin participation in 2018, including: I-MPACT, MEDIC and MTQIP (please refer to Appendix B for CQI program names).

[2] Designation as a BCBSA Blue Distinction Center® (BDC) 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.

Eligible sites are identified through the biennial BCBSM Hospital Services Survey and / or by each individual CQI's coordinating Center. To find out whether your hospital is eligible for a specific CQI and its potential impact on your hospital's 2017 P4P score, please contact BCBSM administration at CQIPrograms@bcbsm.com

Great Lakes Partners for Patients Hospital Improvement Innovation Network (HIIN)

For the 2017 program year, the MHA, in partnership with the Illinois Health and Hospital Association and Wisconsin Hospital Association, has combined Keystone collaborative efforts into a single, two-year long Hospital Improvement Innovation Network (HIIN) initiative, named Great Lakes Partners for Patients HIIN. In 2017, 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 2017, 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.

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 will be made available to hospitals by the end of December 2016.

Although enrollment in the HIIN closed on **November 10th, 2016,** hospitals that desire to join for BCBSM 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.

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. Some measures are related to program participation and engagement, such as meeting attendance and timely data submission. Other measures are performance-based and related to quality and clinical process improvement and outcomes, such as reductions in morbidity or surgical complications.

Each CQI's performance index is developed by the corresponding CQI coordinating center and discussed with participating hospital clinical champions 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 BCBSM website, by the end of December 2016. Our website is the following:

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

The 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). BCBSM is provided with a final aggregate score for each corresponding CQI, which in turn, 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.

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

CQI Participation Payments

BCBSM-Sponsored

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

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 BCBSM. 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 January 2, 2017 to be eligible for this payment.

Hospitals in peer groups 1 and 2 are not eligible for a MHA HIIN participation payment. However, any hospital that has not 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 2017 CQI participation funding as a lump-sum add-on to their BCBSM interim payment (BIP) during the second quarter of 2017. If a hospital is not on the BIP system, it will be issued a check for the total amount. Hospital Pay-for-Performance administrators, CEO, CFO, and other stakeholders designated by the hospital will be notified via email when the payment is issued.

Hospital Cost Efficiency 10%

BCBSM 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 10% of their P4P incentive through performance on two Hospital Cost Efficiency Measures, each weighted at 50%:

1) Cost per Case compared to Statewide Mean

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

The 2017 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 $\leq$ 25% of target	125%
Actual more than 25% but $\leq$ 50% of target	90%
Actual more than 50% but $\leq$ 75% of target	75%
Actual more than 75% but $\leq$ 100% of target	62.5%
Actual more than 100% but $\leq$ 125% of target	50%
Actual more than 125% but $\leq$ 175% of target	37.5%
Actual more than 175% of target	0%

For example, a hospital scoring 90% on the Statewide Mean and 50% on the Target Inflation components will receive an overall Hospital Cost Efficiency measure performance of **70.0%.**

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%.

The 2017 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), excluding non-acute services such as psychiatric, rehabilitation and substance abuse services. 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 2017 program year (for P4P incentives beginning July 2018) the calculation will be made using cost data from 2014, 2015, and 2016, as follows:

- 2014 FYE costs and cases will be weighted at 15 percent
- 2015 FYE costs and cases will be weighted at 35 percent
- 2016 FYE costs and cases will be weighted at 50 percent

Michigan Value Collaborative (MVC) 10%

The Michigan Value Collaborative is a collaborative quality initiative (CQI) funded by BCBSM. 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 the BCBSM CQIs. MVC data supplies condition-specific, price-standardized, and risk-adjusted 30- and 90-day total episode costs for BCBSM PPO and Medicare fee-for-service claims.

In recognition of MVC's emerging role as a convener of utilization data and infrastructure for sharing best practices for improving episode cost-efficiency and quality, BCBSM has placed an increased emphasis on hospital activities related to MVC participation. In 2016, MVC participation was removed from the CQI domain and became a stand-alone measure weighted at 10% of the program's incentive. As part of a 3-year rollout of this component, 2017 marks the beginning of BCBSM measuring 30-day episode cost performance based on data from MVC.

A detailed description of the proposed 2017 and 2018 performance-based measure is provided in the separate Background and Technical Document found on the bcbsm.com P4P site. A brief summary of the 2017 and 2018 performance-based measure is provided on the following page.

2017 Measure Expectations

In 2017, hospitals will receive points for the following activities:

2017 MVC-based P4P Components	
40 Points	MVC participation (meeting and webinar attendance, data validation)
30 Points	Year-over-year improvement for Service Line A total episode costs
30 Points	Year-over-year improvement Service Line B total episode costs

In 2016, hospitals selected two service lines (Service line A and Service line B, see below) to be measured for performance in 2017 and 2018.

Eligible service lines include (a minimum of twenty cases in the past twelve months of MVC data was required for service line eligibility):

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

Summary of the 2017 and 2018 MVC-based P4P Performance Measure

Measure:	Risk-adjusted, price-standardized total episode costs
Data Sources:	BCBSM PPO plus Medicare fee-for-service claims
Episode Duration:	Index hospitalization plus 30 days post-discharge
Number of Service Lines:	Voluntary selection of two service lines from a pool of seven
Eligible Service Line Pool (7):	Acute myocardial infarction, congestive heart failure, pneumonia, joint replacement (hip and knee episodes combined), colectomy (non-cancer), coronary artery bypass graft, spine surgery[3]
Minimum Case Requirement:	20 cases – including both BCBSM PPO and Medicare FFS – for each service line over the most recently available12 month period

[3] On the MVC registry website, this service line is labeled "Other Spine"

Quality Requirement:	No points for this performance measure if a hospital, adjusted for case volume, is ranked below the 10th percentile in the performance year for condition-specific in-hospital mortality or related readmissions. Confidence intervals will be used to ensure that these hospitals are true statistical outliers
Baseline:	Hospital service line total episode costs for a 12 month period prior to the start of the program year
Performance Year:	Hospital service line total episode costs for the most recently available 12 month period at the end of the program year
Scoring System for 2017:	Scoring based on internal year-over-year improvement
Scoring System for 2018:	Scoring based on internal year-over-year improvement or achievement relative to MVC cohort group
Collaboration Goals:	Bonus points in 2018 for all MVC hospitals working on the same service line if those hospitals achieve a ≥5% service line cost improvement[4]

Timeline of the 2017 and 2018 MVC-based P4P Performance Measure

	2017 P4P Program *Incentive Effective: 7/1/2018*	**2018 P4P Program** *Incentive Effective: 7/1/2019*
Baseline Period	CY 2014	CY 2015
Performance Period	CY 2016	CY 2017
Data Analysis/Claims Adjudication	CY 2017 (services provided CY 2016)	CY 2018 (services provided CY 2017)

MVC Support for Hospitals

The MVC Coordinating Center will host 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 will 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.

[4] The maximum points attainable is 10 even for those hospitals earning a bonus point.

All-Cause Readmissions 30%

In 2017, P4P-participating hospitals will have the opportunity to earn 30% 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, as well as through participation in hospital-specific activities focused on readmission reduction efforts. Appendix D provides additional information on these alternative readmission activities.

All-Cause Readmission Domain (2016 – 2018)

Beginning in 2016, BCBSM began a three-year transition to 30% readmission rate performance. The table below reflects the timeline of this transition.

	2016 P4P Program *Incentive effective: 7/1/2017*	**2017 P4P Program** *Incentive Effective: 7/1/2018*	**2018 P4P Program** *Incentive Effective: 7/1/2019*
Readmission Rate Performance	At least 10%	At least 20%	30%
Alternative Readmission Activities	Maximum 20%	Maximum 10%	0%
Baseline Period	CY 2015	CY 2016	CY 2017
Performance Period	CY 2016	CY 2017	CY 2018

2017 P4P Readmission Rate Performance (At least 20%)

To help promote hospital and physician collaboration across the care continuum and align measurement reporting and incentives with CMS requirements, the 2017 P4P program will continue to utilize the NQF-endorsed Hospital-Wide All-Cause Unplanned Readmission Measure (HWR; NQF 1789) developed by Yale University and the Centers for Medicare and Medicaid Services (CMS).

2017 P4P readmissions performance is assessed using only BCBSM commercial membership claims (PPO/POS/Traditional products for Michigan adult residents aged 18-64).

Due to the adaptation of this measure to a commercially insured population, this measure **will not be risk-standardized** according to CMS methodology. Additionally, readmission data used within the 2017 P4P is not 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 2016 baseline period and 2017 measurement period.

Readmission Rate Performance Expectations and Associated Incentive:

Year-over-Year Improvement (Relative % Change)	Performance Rate
More favorable than -2.5% improvement	100%
Between +/- 2.5%	50%
Less favorable than +2.5%	0%

2017 P4P Alternative Readmission Activities (Up to 10%)

In 2017, hospitals will continue to have the opportunity to engage in additional, alternative readmission related initiatives intended to help build capabilities to support readmission reduction efforts and year-over-year improvements in their own readmission rates. The 2017 program will allow hospitals to continue their participation in up to two alternative readmission activities and P4P incentive will be allocated toward meeting expectations within the selected initiative; however, the weight placed on each activity has decreased to **5% per initiative** (up to 10% total).

Hospitals are asked to choose up to two activities or process improvements from the following list:[5]

1. Designate champion(s) responsible for readmission reduction efforts and attendance at statewide readmission meetings intended to share best practices
2. Participate in Joint Commission and MHA Keystone Senior Leadership High Reliability Assessment
3. Develop a post-acute network strategy
4. Collaborate with local social service agencies to better understand and address patients' social determinants of care
5. Submit a plan to identify potentially preventable readmissions
6. Develop a process to use PG1-4 P4P HIE messages and activities meaningfully for purposes of care transitions and readmission reduction

Engagement in each alternative readmission activity is worth up to 5%, with a maximum of 10%. Hospitals will minimally be eligible to receive 20% of the 2017 program's incentive for traditional readmission rate performance. In the event a hospital chooses to participate in less than two alternative readmission activities, the weight of the readmission rate performance measure would increase accordingly, up to 30%.

[5] Hospitals may engage in up to two alternative readmission activities, which will be deducted from the readmission rate performance weight; Hospitals are encouraged to continue participation in the initiatives selected during the 2016 program year through 2018. If participation in any of the activities are discontinued, the program weight will be shifted toward the readmission rate performance (up to 30%).

Health Information Exchange (HIE) 10%

The Health Information Exchange (HIE) 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 (MiHIN) statewide service, expanding the types of data available through the service and developing capabilities that will help facilitate statewide data exchange going forward.

Since the HIE component was introduced to the P4P program in 2014, hospitals have significantly improved the availability and quality of admission, discharge, transfer and discharge medication data available to caregivers across the state. These efforts will continue to be recognized, with hospitals earning a portion of their HIE points through continued data quality conformance standards for previously implemented use cases. The remaining points will be earned by participating in at least one new HIE use case through the MiHIN statewide service each new P4P program year. These new use cases will be in addition to the use cases the hospital implemented in prior years to earn P4P incentive related to the HIE measure domain.

2017 Health Information Exchange Component

Data Conformance – 4 Points	
Hospitals can earn up to four points for maintaining data quality standards for all implemented use cases. If a hospital is not meeting data quality standards, it will be notified by BCBSM and given 30 days to meet the standard.	
1 Point	Measure 1a: Maintain data quality conformance for all ADT transmissions • See Appendix E for detailed conformance standards
1 Point	Measure 1b: Maintain data quality conformance for all discharge medication transmissions • Specific conformance measures will be communicated to hospitals by March 31st, 2017
2 Points	Measure 1c: Maintain data quality conformance for additional use case implemented as required by 2016 P4P program • Specific conformance measures will be communicated to hospitals by March 31st, 2017
New Use Case – 6 points	
Hospitals can earn up to six points for implementing one new use case in 2017. See Appendix E for information on the specific implementation milestones and associated point allocations for each eligible use case.	
6 Points	Measure 2: Implement one or more new use cases from the following list: • Common Key Service • Exchange Statewide Lab Results • Find Patient Record

Hospitals will be given adequate notice to meet all use cases expectations and due dates, and will not be penalized for delays caused by MiHIN's readiness to implement a specific activity. Specific use cases may also be considered mandatory by the end of 2018. If so, BCBSM will notify hospitals at least one year in advance of the mandatory due date.

As a reminder, the P4P incentive allocated to the HIE component is fixed at 10% of the overall program's incentive. Any unearned funds in the HIE component will be redistributed to hospitals using a normalized approach, providing a larger portion of unearned funds to higher performing hospitals.

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 $20,000,000 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% CQI performance, $2,600,000 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 2017 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	95.00%	$95,000	*$5,000*	0.8750	$16,852	$111,852	111.85%
Hospital B	$250,000	80.00%	$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	100.00%	$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	60.00%	$900,000	*$600,000*	0.0000	$0	$900,000	60.00%
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	100.00%	$3,500,000	*$0*	1.0000	$674,074	$4,174,074	119.26%
Hospital J	$10,000,000	85.00%	$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%**

2017 BCBSM-Sponsored Hospital CQI Programs		Required CQI
CQI Name	**Description**	**Yes/No**
Michigan Cardiovascular Consortium *	Improve the quality of care and reduce health care costs for patients undergoing cardiovascular procedures by reducing complications and focusing on the appropriate use	Yes
Michigan Bariatric Surgery Consortium (MBSC) *	Improve the quality of care and reduce health care costs for patients undergoing bariatric surgery	Yes
Michigan Emergency Department Improvement Collaborative (MEDIC)	Improve the quality and cost efficiency of emergency care for adult and pediatric patients	No
Michigan Society of Thoracic and Cardiovascular Surgeons (MSTCVS) Quality Collaborative *	Improve the quality of care and reduce health care costs for patients who undergo cardiac surgery by reducing the risk of complications and improving treatment methods for cardiac surgery	Yes
Michigan Surgical Quality Collaborative (MSQC)	Evaluate and improve the quality of general and vascular surgery, by reducing complications, length of stay, and surgical site infections while reducing health care costs	Yes
Michigan Trauma Quality Improvement Project (MTQIP)	Improve the quality of care for trauma patients, reducing morbidity and mortality, and reducing costs of trauma care	Yes
Hospital Medicine Safety (HMS) Consortium	Improve the quality of care for medical patients at risk for hospital-associated Venous Thromboembolism (VTE) while reducing health care costs	No
Michigan Radiation Oncology Quality Consortium (MROQC)	Improve the quality of care for lung and breast cancer patients by determining which patients are most likely to benefit from Intensity Modulated Radiation Therapy (IMRT)	No
Michigan Arthroplasty Registry Collaborative for Quality Improvement (MARCQI) *	Improve the quality of care in patient outcomes related to hip and knee joint replacement surgery while reducing costs of arthroplasty surgery	No
Michigan Anticoagulation Quality Improvement Initiative (MAQI2)	Improve the outcomes and safety for patients receiving anticoagulation therapy while reducing health care costs	No
Michigan Spine Surgery Improvement Collaborative (MSSIC) *	Improve patient functional outcomes, reduce surgical complications, and reduce costs associated with spine surgery	No
Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE)	Aims to reduce variation in intraoperative anesthesia practices, resulting in reduced complications and better outcomes for patients	No
MHA Sponsored Program		
Great Lakes Partnership for Patients Hospital Improvement Innovation Network (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 eleven areas of patient harm.	No

*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 three CQIs that they have been recruited and are eligible for and the optional and the MHA-sponsored HIIN initiative (weighted as two CQIs).

Its total CQI weight is 40%

Its individual CQI weight is 8% (40% / 3 CQIs + HIIN = 8%)

Its performance on CQI #1 is 80%

Its performance on CQI #2 is 90%

Its performance on CQI #3 is 100%

Its performance on the MHA-sponsored HIIN is 100%

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

	Index Score		**CQI Weight**		**Earned Score/ Potential Score**
CQI #1	80%	X	8%	=	6.4%
CQI #2	90%	X	8%	=	7.2%
CQI #3	100%	X	8%	=	8.0%
HIIN	100%	X	16%	=	16.0%
Total CQI Aggregate Score	**94.0%**		40%		**37.6%**

In this example, Hospital A earned a total CQI score of 37.6 percent out of a potential 40 percent. Hospital A left on the table approximately 2.4 percent of their potential maximum incentive reward tied to CQIs.

See Appendix A for a more detailed breakdown of how unearned CQI incentive dollars are distributed to hospitals within the CQI incentive pool based on a comparative CQI performance.

CQI Performance Index Scorecards

The CQI Performance Index Scorecards will be made available as a separate addendum to the 2017 Pay-for-Performance Program guide in mid- to late-December 2016, 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 BCBSM.

The measurement period for each Performance Index measure is January through December, unless otherwise noted.

Specific questions/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 2017 P4P Program Guide.

General BCBSM CQI Participation Requirements

General expectations that BCBSM 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 that has the ability to impart QI within the organization)
- Participate in collaborative-wide QI activities and/or site-specific initiated QI activities related to the work of the CQI

- Demonstrate that comparative performance reports provided by the CQI are actively used in QI efforts
- Participate in inter-institutional QI activities, (e.g., sharing best practices)
- Report on the impact 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 [IRB] approval)
- Maintain personnel to collect data
- Obtain signatures required for the site's Data Use Agreement and/or Business Associate Agreements, which are to be signed by the site's President/CEO or a site representative that holds sign-off authority for the hospital and in the case of the signed Data Use Agreement, returned to the Coordinating Center
- Contribute data and information that could be used in academic publications

Hospital 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:

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

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:

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

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:

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

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% for this performance-based cost efficiency component.

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:[6]

- Hospital A's cost-per-case at the beginning of the measurement period is $8,000
- The reported NHIPI for the same period is 3.0%
- 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 2017, the standardized inpatient cost-per-case is calculated using on 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 2017 program year (P4P incentives effective July 2018 the calculation will be made using data from 2014, 2015, and 2016.
  - 2014 costs and cases will be weighted at 15 percent
  - 2015 costs and cases will be weighted at 35 percent
  - 2016 costs and cases will be weighted at 50 percent

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

$$\text{2017 hospital cost-per-case} = \frac{(0.15 \times \text{2014 costs}) + (0.35 \times \text{2015 costs}) + (0.50 \times \text{2016 costs})}{(0.15 \times \text{2014 cases}) + (0.35 \times \text{2015 cases}) + (0.50 \times \text{2016 cases})}$$

[6] 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 2017 program, as described in a subsequent section of this appendix.

The weighted statewide mean cost-per-case for each measurement period will be calculated in the same manner. For the 2017 program year (P4P rate effective July 2018), the hospital-specific inflation targets will be calculated using the same rolling averages, as shown in the following formulas:

$$\text{3-yr weighted target inflation} = \frac{\begin{array}{c}(0.15 \times \text{2013 costs} \times \text{2012 NHIPI}) \\ + (0.35 \times \text{2014 costs} \times \text{2013 NHIPI}) \\ + (0.50 \times \text{2015 costs} \times \text{2014 NHIPI})\end{array}}{(0.15 \times \text{2013 cases}) + (0.35 \times \text{2014 cases}) + (0.50 \times \text{2015 cases})}$$

2017 P4P – Alternative Readmission Activities

In 2017, P4P-participating hospitals have the opportunity to earn 30% of their potential incentive within the All-Cause Readmissions domain. Hospitals will earn incentives for demonstrating year-over-year improvements in their own 30-day all-cause readmission rate as well as through participation in additional hospital-specific activities focused on readmissions. Over the next two program years, an increasing amount of the program's incentive will be focused on readmission performance with decreasing emphasis on alternative readmission-related activities.

To help hospitals prepare for the transition toward increasing emphasis on readmissions performance, BCBSM has provided hospitals the opportunity to engage in additional readmissions-related initiatives intended to help support year-over-year improvements in their own readmission rates. Participation in **up to two** additional initiatives will fall under the all-cause readmissions domain and P4P incentive will be allocated toward meeting expectations within each initiatives.

2017 P4P Readmission Domain (30% of Program's Incentive)		
Readmission Rate Performance	Improvements in each hospital's own year-over-year readmission rate	At least 20%
Hospital-specific activity focused on readmissions* (Choose Two)	**Option 1:** Designation of champion(s) responsible for readmission reduction efforts and attendance at statewide readmission summit	Maximum 10% (Choose up to two activities worth 5% each)
	Option 2: Participation in Joint Commission and MHA Keystone Senior Leadership High Reliability Assessment	
	Option 3: Development of a post-acute network strategy	
	Option 4: Collaboration plan with local social service agencies to better understand and address patients' social determinants of care	
	Option 5: Establish process to identify potentially preventable readmissions	
	Option 6: Develop process to use PG 1-4 P4P Health Information Exchange (HIE) activities meaningfully for the purposes of improving care transitions and readmission reduction	

Alternative Readmission Activity Descriptions

The below readmission alternatives serve as a conduit for promoting statewide collaboration focused on reducing avoidable readmissions:

Option 1: Designation of champion(s) responsible for readmission reduction efforts and attendance at statewide readmission summit

Hospitals electing to choose option 1 as an alternative measure will designate a readmission champion within their site who is responsible for leading readmission reduction efforts. This individual should also have the authority to implement new initiatives or change processes to improve readmission performance at their facilities or health systems.

As part of this option, Champions are required to attend a statewide readmission summit where they will have the opportunity to share best practices with their peers and engage with National keynote speakers in a safe, open environment. Summit details, including date and location, are forthcoming.

Beyond the attendance requirement at the statewide readmission summit, readmission champions will have the responsibility to submit a detailed plan outlining the changes or process improvements made using key learnings and takeaways from summit presentations. While the plan is open-ended, proposals should directly lend themselves to describing how the hospital plans to build infrastructure in 2017 to support improvement in its readmission rate performance in future P4P program years.

Option 2: Participate in The MHA Keystone and The Joint Commission Center for Transforming Healthcare Senior Leadership High Reliability Organization (HRO) Program

The MHA Keystone Center, through its patient safety and quality improvement efforts, has entered a new partnership with the Center for Transforming Healthcare to assist Michigan hospitals in becoming highly reliable organizations (HROs). HROs have a strong safety culture that allows them to anticipate the unexpected and contain errors so they do not become larger or continuous issues. HROs are not error free, but they are resilient and able to respond to and learn from errors to prevent their reoccurrence.

Performance would be demonstrated through the development of an annual action plan based on the hospital's Oro 2.0™ assessment and subsequent submission to the MHA Keystone Center. Following participation in the Oro 2.0™ assessment, hospital leadership teams create an action plan that is based on areas that demonstrate opportunity for improvement in moving the hospital on the HRO journey. The annual plan is to be submitted to the MHA Keystone Center, by **March 31, 2017**, to allow for identification of opportunities to support the hospital in their HRO journey. More information on HROs and the Oro™2.0 High Reliability Organizational Assessment can be found here. Questions about completing the assessment through the MHA Keystone Center initiative can be directed to Gary Roth, DO, Chief Medical Officer at the MHA.

The four remaining alternative readmission measures (options 3-6) are focused on hospital-specific activities and processes focused on making improvements to positively affect readmission rates. The criteria used to evaluate hospital submissions for these hospital-specific activities is solely based on completeness – with hospitals receiving full-credit for submitting plans addressing each of the elements listed in the "Template for hospital-specific Alternative Readmission Activity" included in this document. However, hospitals that approach these alternative readmission activities objectively position themselves to perform more favorably on the readmission performance measure as it represents a greater portion of the P4P incentive in future program years. Hospitals selecting more than one of the below options are required to submit **separate** proposals for each alternative readmission activity chosen. These proposals will be due after the program year ends with the standard CEO Attestation form in the **first quarter of 2018.**

Option 3: Developing a post-acute network strategy

Hospitals electing to choose option 3 as an alternative measure should focus their efforts on actively identifying high quality post-acute care for their patients and effectively transitioning patients to the appropriate level of care after leaving the hospital. The development of a post-acute network strategy is intentionally non-prescriptive, but BCBSM has several programs already in place – such as the Skilled Nursing Facility Pay-for-Performance (SNF P4P) program – that could serve in partnership with an acute care provider's efforts to meet this measure's requirements.

Option 4: Collaboration plan with local social service agencies to better understand and address patients' social determinants of care

Hospitals electing to choose option 4 as a readmission alternative measure should actively build relationships with local community leaders to better understand the social determinants of the community's population, allowing hospitals to pinpoint key areas for reducing readmission risk.

Social determinants of health – such as access to social and economic opportunities – have an effect a wide range of health outcomes and are therefore play a key role in readmission rates. This thinking is in line with CMS' recent Accountable Health Communities Model, a pilot assessing social determinants of Medicare and Medicaid beneficiaries with the hope of directing them to community-based services while improving the quality and affordability of care.

Option 5: Establish process to identify potentially preventable readmissions

Hospitals electing to choose option 5 as an alternative readmission measure will benefit from creating a comprehensive plan that develops a strategy for identifying potentially preventable readmissions and using that data to drive process improvements that prevent similar readmissions in the future. As the populations served across hospitals are unique, it is within each hospital's discretion to determine the best course of action for preventing these readmissions.

<u>Option 6</u>: Develop process to use PG 1-4 P4P Health Information Exchange (HIE) activities meaningfully for the purposes of improving care transitions and readmission reduction

To leverage the efforts hospitals have been making in advancing Health Information Exchange (HIE) activities across the state within the P4P since 2014, hospitals have the opportunity to use this data to effectively manage the care of their patient population through improved care transitions and medication reconciliation. Hospitals choosing option 6 should outline how HIE information has been incorporated into daily care processes so caregivers can act upon the information to improve patient transitions.

Option chosen for hospital-specific activity (check **one** per individual template):

	Option 1: Champion plan to implement learnings from statewide readmission summit
	Option 3: Development of a post-acute network strategy
	Option 4: Collaboration plan with local social service agencies to better understand and address patients' social determinants of care
	Option 5: Establish process to identify potentially preventable readmissions
	Option 6: Develop process to use PG 1-4 P4P Health Information Exchange (HIE) activities meaningfully for the purposes of improving care transitions and readmission reduction

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

Health Information Exchange Measures and Data Elements

ADT Transmission Data Quality Expectations and Thresholds

In 2017, the specific expectations hospitals are expected to meet for the ADT data quality measure, including definitions, scoring, field definitions and performance thresholds are summarized below.

Measure #1a: Maintain data quality conformance for all ADT transmissions - 1 point

- 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.
- Hospital conformance will be scored on a quarterly basis with up to 0.25 point earned each quarter.
    - A hospital will earn 0.25 point for each quarter in which it maintains full conformance, or regains full conformance within 30 days notification from MiHIN.
    - A hospital will earn 0.10 point for each quarter in which it maintains partial conformance, or regains partial conformance within 30 days notification from MiHIN.
    - A hospital will earn 0.00 point for each quarter in which remains out of conformance within 30 days notification from MiHIN.
- MiHIN will track hospital performance and provide quarterly reports to BCBSM.

ADT Conformance Thresholds and Performance Coding

The following tables list the data fields and performance thresholds required for all ADT notifications. In 2017, hospitals are expected to send all fields, including *all three* categories outlined in section 3.

1. Complete Routing Data (population of fields)

Green	Yellow	Red
All 12 fields are populated at or above the relevant threshold	9 -11 fields are populated at or above the relevant threshold	Fewer than 9 fields are populated at or above the relevant threshold

Relevant Fields	Threshold
MSH-4: Sending Facility	≥95%
PID-5.1: Patient Last Name	≥95%
PID-5.2: Patient First Name	≥95%
PID-7: Patient Date of Birth	≥95%
PID-8: Patient Sex	≥95%
PID-11.5: Patient Zip	≥95%
PID-19: Patient SSN*	≥85%
PV1-19: Visit Number	≥95%
IN1-3: Insurance Company ID	≥90%
IN1-4: Insurance Company Name	≥90%
IN1-36: Policy Number	≥90%

*Social security number for newborns and babies < 6 months old can be coded using the hospital's EMR's default process. All others must have a valid social security number or be left blank.

ADT Conformance Thresholds and Performance Coding (Continued)

2. Complete Mapping

Green	Yellow	Red
At least 12 fields are mapped at or above the relevant threshold, with the 13th field mapped at 85% or higher	7 - 12 fields are mapped at or above the relevant threshold	0 – 6 fields are mapped at or above the relevant threshold

Relevant Fields	Threshold
PID-8: Patient Sex	≥95% of populated messages
PID-10: Patient Race	≥95% of populated messages
PID-22: Ethnic Group	≥95% of populated messages
PV1-2: Patient Class	≥95% of populated messages
PV1-4: Admission Type	≥95% of populated messages
PV1-14: Admit Source	≥95% of populated messages
IN1-17: Insured's Relationship to Patient	≥95% of populated messages
DG1-6: Diagnosis Type	≥95% of populated messages
IN1-3 & IN1-4: Insurance Company ID and Name	≥90% of populated messages
MSH-4: Sending Facility	≥95% of populated messages
PV1-10: Hospital Service	≥95% of populated messages
PV1-18: Patient Type	≥95% of populated messages
PV1-36: Discharge Disposition	≥95% of populated messages

3. Adherence to Coding Standards

Green	Yellow	Red
All three coding groups have all fields at or above threshold	At least two of the coding groups have all fields at or above threshold	Fewer than two of the coding groups have all fields at or above threshold

	Relevant Field	Threshold
Coding group 1	MSH-4.1: Sending Facility Hospital	≥95%
	MSH-4.2: Sending Facility Health System	≥95%
Coding group 2	DG1-3.1: Diagnosis Code ID	≥95%
	DG1-3.2: Diagnosis Code Text	≥95%
	DG1-3.3: Diagnosis Code Name of Coding System	≥95%
Coding group 3	PV1-7: Attending Doctor ID	≥95%
	PV1-17 Admitting Doctor ID	≥95%

Common Key Service

The Common Key Service (CKS) is a unique patient attribute generated by MiHIN and stored in the State of Michigan's Master Person Index (MPI), which has robust processes for identifying and managing information about patients with a high degree of accuracy. MiHIN will use the CKS to increase the patient match rate for information passing through the statewide service. MiHIN will also pass the Common Key to each patient's caregivers, who will store the information and attach it to subsequent transmissions for that patient.

In addition to improving the rate and accuracy of patient matches by MiHIN, providers can use the Common Key to securely connect patient data from outside sources to the correct medical record within their own systems. This will foster effective data sharing across multiple organizations with disparate systems and nomenclature and improve the efficiency and accuracy of data exchange for all users, including hospitals, physician offices and other caregivers.

The CKS activities and associated P4P points are outlined in the following table:

	Common Key Service	**P4P Points**
Common Key Implementation Activities	The following activities pertain to the full implementation of the Common Key Service:	
	• Fully execute CKS data sharing agreement	0.5
	• Complete onboarding kickoff activities with MiHIN - Confirm connectivity testing in production environment - Receive initial messages	0.5
	• Receive and store a common key in a production environment	1.0
	• Add common key to all outbound ADT and med rec messages	2.0
	• Meet all CKS data conformance requirements	2.0

Exchange Statewide Lab Results (ESLR)

Doctors, labs, and other healthcare professionals have a critical need to easily exchange and access clinical lab data to help with clinical decision support, trending analyses, population health management, medication management, and numerous other care activities. Lab results need to be presented in a timely manner and in a format that is usable and actionable so the recipients can deliver efficient and effective patient care. Timely, efficient electronic exchange of statewide lab results can positively influence the quality, efficiency and cost of healthcare.

The Exchange Statewide Lab Results Use Case enables the secure, electronic transfer of clinical lab data among trusted data sharing organizations to achieve this exchange. The exchange of lab data among providers has also been targeted by the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) for Meaningful Use Stage 1 and 2 requirements.

The ESLR implementation activities and associated P4P points are outlined in the following table:

Exchange Statewide Lab Results (ESLR)	**P4P Points**
Participate in Statewide Labs workshop meetings and provide feedback to MiHIN, if requested	0.5
Ensure HIE QO engagement - Work with HIE QO to sign Exchange Statewide Lab Results Use Case agreement	0.5
Connect to MiHIN test environment	1.0
Send initial set of production messages to MiHIN test environment for validation	1.0
Meet validation criteria for production messages	2.0
Initiate production transmission of messages to MiHIN - A hospital that successfully begins production of lab messages in a production environment by the relevant due date (December 1, 2017 for peer group 1 and 2 hospitals and March 1, 2018 for peer group 3 and 4 hospitals) will earn the full six points on this measure, regardless of whether it earned points on each of the previous steps.	Full points

Find Patient Record

When a doctor or other healthcare professional needs a patient's health information from another provider, it can be very difficult and time-consuming to find, request and receive the information. This can hinder the ability of the healthcare team to make informed treatment decisions, especially in emergency situations, leading to sub-optimal care, unnecessary costs and avoidable complications.

The Find Patient Record Use Case helps participating organizations quickly, securely and electronically ask any other organization participating in this use case if they have records for a given patient and if so, to electronically share information about that patient. This enables the caregiver to make more informed medical decisions, which can improve patient outcomes.

Hospitals that choose to engage in the Find Patient Record Use Case will earn credit towards their Blue Cross P4P HIE component, as outlined in the following table:

Find Patient Record (FPR)	P4P Points
Ensure engagement of HIE qualified organization - Hospital's HIE QO indicates its willingness to participate by signing the MiHIN Find Patient Record Use Case Agreement	0.5
Establish a connection with MiHIN to exchange FPR test messages	1.0
Begin testing of FPR and response requests with MiHIN simulator - Most hospitals will need to complete three or more testing iterations, with each iteration showing capability improvement	1.0
Designate initial trading partner(s) to exchange FPR production messages	0.5
Complete FPR and response testing requests with MiHIN - FPR and response requests will be considered complete when messages meet use case specifications	2.0
Initiate exchange of FPR in MiHIN production environment - A hospital that initiates exchange of FPR in a production environment by the relevant due date (December 1, 2017 for peer group 1 and 2 hospitals and March 1, 2018 for peer group 3 and 4 hospitals) will earn the full six points on this measure, regardless of whether it earned points on each of the previous steps.	Full points

Michigan Value Collaborative (MVC) Appendix

2017 Performance Index Scorecard for MVC-based episode cost measure

Measure	Weight	Measure Description	Points Earned
1	40	*Meeting attendance and consistency*	
		At least 1 representative present at both MVC meetings	20
		At least 1 representative is a consistent attendee at both meetings in 2017	20
2	60	*Year-over-year performance*	
		Hospital total episode costs for service line A: 1 point = baseline mean 2 points = baseline mean – 0.10 * standard deviation based target 3 points = baseline mean – 0.15 * standard deviation based target	30
		Hospital total episode costs for service line B: 1 point = baseline mean 2 points = baseline mean – 0.10 * standard deviation based target 3 points =- baseline mean – 0.15 * standard deviation based target	30

*Two service lines were selected by hospitals in 2016; a minimum of 20 cases in the past 12 months of MVC data is required for service line eligibility. Eligible target service lines include:

1. Acute Myocardial Infarction
2. Congestive Heart Failure
3. Pneumonia
4. Colectomy (non-cancer)
5. Coronary Artery Bypass Graft
6. Joint Replacement (hip and knee episodes combined)
7. Spine Surgery (also labeled as “Other spine” on MVC registry)