Blue Cross Blue Shield of Michigan

2025 Hospital Pay-for-Performance Program

Peer Groups 1 through 4

October 2024

VALUE Partnerships

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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 and population-health management. The program pays hospitals, in aggregate, an additional 5% of statewide inpatient and outpatient operating payments — over $200 million statewide.

The P4P program structure and measures are developed with input from hospitals through the P4P Measurement Workgroup. The P4P rate earned during the 2025 program year will be applied to inpatient and outpatient operating payments starting October 1, 2026.

To help hospitals better assess their performance across all program measures throughout the program year, Blue Cross will provide hospitals with quarterly **informational** P4P performance reports. Hospitals also may request patient-level readmissions information to assist in readmission reduction efforts.

What's new in 2025

The 2025 P4P program year will follow the component weights of the 2024 program year, with the following updates:

- The Claims Pilot Project continues – new hospitals electing to participate and submit a signed Use Case Exhibit to MiHIN by July 1, 2025.
- For hospitals who successfully incorporate standardization of the codes used in the race and ethnicity fields, a bonus point in the HIE component will be rewarded.
- Health Information Exchange component scoring has been simplified for a number of related fields – please see Appendix E for details.

2025 program components and weights	
Prequalifying condition	0%
Collaborative Quality Initiatives (CQIs)	40%
Michigan Value Collaborative (MVC)	10%
Plan All-cause readmission (PCR)	30%*
Health information exchange (HIE)	20%*

* Subject to change depending on Claims Pilot Project participation

Payment methodology

Statewide **aggregate** P4P payout is equal to the full 5% value of the program. Although some hospitals will earn a P4P rate less than 5%, some high-performing hospitals may earn P4P rates greater than 5%.[1]

The performance scoring multiplier concept will be used to redistribute any unearned incentive dollars differentially within each program component. This allows a larger portion of unearned incentive to go the highest-performing hospitals in each individual program component.

A fixed-dollar bonus will be given to hospitals who participate in all CQIs for which they have been recruited and meet eligibility criteria for participation. This bonus is paid from the unearned incentive dollars within the CQI component. A hospital is defined as "recruited" if at any time since a CQI's program inception, a hospital was recruited by the CQI's coordinating center and meets participation eligibility criteria set forth by the CQI's coordinating center (the coordinating center acts as the program manager office for a CQI's activities). This requirement predates the implementation of this bonus. If a hospital is determined ineligible for the bonus, an exception can be requested if either of the following conditions are met:

- Hospital provides documentation they no longer meet the eligibility criteria to participate in that CQI.
- Hospital confirms that CQI is no longer accepting new hospitals participants.

All other remaining unearned dollars will be paid based on the multiplier concept.

This chart provides the potential bonus by hospital, depending on the number of CQIs in which they participate:

Number of eligible or participating CQIs	Potential unearned dollar fixed bonus
1-4 CQIs	$20,000
5-9 CQIs	$50,000
10 or more CQIs	$75,000

To be eligible to earn multiplier dollars, hospitals must meet **one** of the following criteria:

- CMS hospital star rating of at least 2
- Leapfrog hospital safety grade of at least a C

[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% of its inpatient operating payment only. Non-model hospitals also won't be eligible to receive any unearned incentive.

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 meet a patient-safety prequalifying condition to be eligible to receive incentives for performance in the P4P program. Hospital compliance with this prequalifying condition is determined by CEO attestation due by **March 31, 2026.**

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

1. Conduct regular patient 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.

*Blue Cross Blue Shield of Michigan and Blue Care Network don't own or control this website.

Collaborative Quality Initiatives 40%

Hospitals can earn up to 40% of their P4P points based on performance across Blue Cross-supported CQIs.

Individual CQI weights

The CQI component of the P4P is weighted equally for all hospitals, regardless of the number of CQIs a hospital participates in. Therefore, hospitals participating in fewer CQIs will have a greater portion of their incentive allocated to each initiative, while hospitals participating in a greater number of CQIs will have a smaller portion allocated to each initiative. Hospitals participating in more than 10 CQIs will be scored using only the top 10 individual CQI performance scores.

The following chart provides the weight per CQI based on the number of initiatives a hospital participates in:

Number of CQIs	Overall potential incentive	Potential incentive per 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%

Required CQIs

In 2025, seven of the Blue Cross-sponsored CQIs have been categorized as “required” (see Appendix B). No new CQIs were added to the required CQI category for 2025, nor were any removed from the required category.

If a hospital is recruited to participate in a "required" CQI, but declines to participate, the hospital will forfeit the points attributed to that CQI. If a hospital isn't recruited to participate in a "required" CQI, there is no penalty for nonparticipation.

To find out whether your hospital is eligible for a specific CQI and its potential effect on your hospital's 2025 P4P score, contact Blue Cross' CQI administration team at CQIPrograms@bcbsm.com.

CQI data abstraction and reporting funding support

Funding support

Eligible hospitals participating in Blue Cross-supported CQIs may 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 model for each CQI is 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 the hospital's compliance are determined by each CQI's coordinating center and Blue Cross. Specific participation expectations for each CQI are available from the associated coordinating center.

Payment schedule

Hospitals that participate in CQIs are reimbursed 84% of the estimated costs associated with medical record data abstraction. These costs are determined using a data abstraction model specific to each CQI and projected hospital case volumes.

Blue Cross converted each hospital's payment amount into a "per-unit" add-on to its payment rate, effective on the first day of each hospital's own fiscal year. Subsequent updates to the per-unit amount will be reviewed with hospital contracting staff.

Michigan Value Collaborative 10%

The Michigan Value Collaborative represents a partnership between 105 Michigan hospitals and 40 physician organizations which aims to improve the health of Michigan through sustainable high-value health care. Supported by Blue Cross Blue Shield of Michigan, MVC helps its members better understand their performance using robust multi-payer data, customized analytics, and at-the-elbow support. As part of this, MVC fosters a collaborative learning environment to enable providers to learn from one another in a cooperative, non-competitive space.

MVC provides hospital leaders with claims-based utilization and episode payment 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-day and 90-day total episode payments for Blue Cross Blue Shield of Michigan Commercial PPO, Blue Cross Blue Shield of Michigan Medicare Advantage PPO, Blue Care Network HMO, BCN Advantage and Medicare fee-for-service claims. MVC reports also often include Medicaid claims data, but these data are not included in the 2025 measure.

2025 measure expectations

In the fall of 2022, hospitals were asked to select one episode metric and one value metric to be measured for Program Years 2024 and 2025. As before, for a hospital to be eligible to earn points for its selected metrics, it must first meet the quality requirement. This stipulates that it's in-hospital mortality or related readmission rate for the selected condition isn't statistically below the 10th percentile in the relevant performance year.

Points From 30-Day Total Episode Payments

Each hospital chose one of six conditions to be evaluated on using mean total 30-day episode payment. Each hospital's condition-specific total episode payment will be assessed for year-over-year improvement compared to its baseline year and for achievement respective to the appropriate MVC cohort. Hospitals must meet the minimum in-hospital mortality and readmission rate quality threshold for the selected condition in order to earn points. Provided the threshold is met, hospitals will earn the higher of their improvement or achievement points for up to four points. MVC's 2025 Episode Spending Condition options are: chronic obstructive pulmonary disease (COPD), colectomy (non-cancer), congestive heart failure (CHF), coronary artery bypass graft (CABG), joint replacement (hip and knee), and pneumonia.

$$\textbf{Improvement Z} - \textbf{Score} = \frac{Hospital\ Baseline\ Payment - Hospital\ Mean\ Performance\ Payment}{MVC\ All\ Standard\ Deviation\ from\ Baseline}$$

$$\textbf{Achievement Z} - \textbf{Score} = \frac{MVC\ Cohort\ Mean\ at\ Baseline - Hospital\ Mean\ Performance\ Payment}{MVC\ All\ Standard\ Deviation\ from\ Baseline}$$

Z-Score Thresholds for Assigning Episode Spending Points

Z-score Threshold	Point Value
<0	0 Points
0 - <0.05	1 Point
0.05 - <0.1	2 Points
0.1 - <0.15	3 Points
>0.15	4 Points

Points From Value Metrics

All value metrics are evidence-based, actionable measures of utilization for specific clinical contexts. Hospitals will be rewarded for high rates of high-value services or low rates of low-value services. Each hospital's chosen value metric will be assessed for year-over-year improvement compared to its baseline year and for achievement respective to the appropriate MVC cohort. Hospitals will earn the higher of their improvement or achievement points for up to four points. MVC's 2025 Value Metric options are: cardiac rehabilitation within 90 days after CABG, cardiac rehabilitation within 90 days after percutaneous coronary intervention (PCI), follow-up within 7 days after CHF, follow-up within 14 days after COPD, follow-up within 7 days after pneumonia, preoperative testing before low-risk surgeries, and 30-day risk-adjusted readmissions after sepsis.

High Value Metrics	Low Value Metrics
Improvement Z-score $\frac{Hospital\ performance - Hospital\ baseline}{MVC\ All\ standard\ deviation\ from\ baseline}$	**Improvement Z-score** $\frac{Hospital\ baseline - Hospital\ performance}{MVC\ All\ standard\ deviation\ from\ baseline}$
Achievement Z-score $\frac{Hospital\ performance - Cohort\ baseline}{MVC\ All\ standard\ deviation\ from\ baseline}$	**Achievement Z-score** $\frac{Cohort\ baseline - Hospital\ performance}{MVC\ All\ standard\ deviation\ from\ baseline}$

Z-Score Thresholds for Assigning Value Metric Points

Z-score Threshold	Point Value
<0	0 Points
0 - <0.25	1 Point
0.25 - <0.50	2 Points
0.50 - <0.75	3 Points
>0.75	4 Points

Engagement Points

Hospitals can earn up to two points by completing certain engagement activities during each program year. These points are intended to increase engagement with other hospitals and the MVC Coordinating Center. The engagement points menu will be distributed to participating sites. The MVC Coordinating Center reserves the right to make changes to eligible engagement activities and their point values in the future but will communicate all P4P-eligible engagement activities prior to and during Program Year 2025.

Please refer to Appendix D for an example of the MVC score calculation. A more detailed description of the 2025 performance-based measures can be found in the MVC Component of the BCBSM P4P Program Technical Document on MVC's website.

Timeline of the 2025 MVC-based P4P performance measure:

Baseline period	CY 2022
Performance period	CY 2024
Data analysis and claims adjudication	CY 2026

MVC support for hospitals and physician organizations

The MVC Coordinating Center hosts a series of virtual workgroups based on input from its hospital and physician organization partners. The primary goal of these workgroups is to provide hospital and physician organization leaders with a highly accessible platform to share best practices and challenges facing institutions 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 continue its work to improve the utility of the MVC data registry website, disseminate hospital and physician organization specific performance reports, offer

custom reports as requested, facilitate regional networking events, conduct virtual and in-person hospital and physician organization site visits, and host semi-annual meetings to provide a forum for the sharing of best practices and additional insights.

Readmissions 30%

In 2025, P4P participating hospitals will have the opportunity to earn 30% of their potential P4P incentive based on readmission performance. Each hospital will be evaluated based upon performance determined by the NCQA-endorsed Plan All-Cause Readmissions (PCR) metric. PCR assesses the rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge among commercial members. A change to this metric allows introduction of risk adjustment to readmission performance in the P4P and aligns performance measurement across all Blue Cross value-based programs.

Note: Hospitals electing to participate in the Claims Pilot Project will have their readmission weight reduced to 20%, with 10% reallocated to the Claims Pilot Project. Hospitals that participated in the Claims Pilot Project in 2024 and continue to participate in 2025, will continue to receive the 10%.

Readmission scoring methodology:

With the introduction of risk adjustment, readmission performance can be further stratified. Readmissions will now be scored based on combination of year-over-year trend and relative ranking performance. Year-over-year performance will compare the hospital's previous calendar year performance against the current program year performance. For hospitals meeting specific criteria, confidence interval scoring will remain. Final score will be based upon the best score achieved through either the year-over-year percent trend performance or relative ranking:

Year-over-year trend % change	Score	Example baseline	Example performance
More favorable than -2.5% year-over-year improvement	100%	10%	< 9.75%
Year-over-year improvement up to -2.5%	75%	10%	9.75% - 10%
Increase of 2.5% or less	50%	10%	>10% to 10.25%
Increase of >2.5%	0%	10%	>10.25%

Relative ranking	Score
Readmission rate ranking in Quartile 1	100%
Readmission rate ranking in Quartile 2	75%
Readmission rate outperforms P4P statewide readmission rate	50%
Decile improvement, 1 decile	25%

Confidence Intervals

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 them against a national rate. Similarly, the 2025 P4P program will calculate hospital-specific confidence intervals and compare them against the **Michigan P4P participating hospital statewide readmission rate**.

The more favorable methodology (year-over-year trend and relative ranking versus confidence intervals) will be used for a hospital if any of the following conditions are met:

- Hospital shows improved readmission rate (regardless of performance against the P4P statewide readmission rate)
- Hospital 2025CY readmission rate is less than the P4P statewide readmission rate.
- Hospital is considered low volume (<250 IP discharges)

Confidence interval	Score
Entire confidence interval is less than P4P statewide readmission rate	100%
P4P statewide readmission rate falls within confidence interval	50%
Entire confidence interval is greater than the P4P statewide readmission rate	0%

Health Information Exchange 20%

The Health Information Exchange component of the P4P program is designed to ensure caregivers have the data they need to effectively manage the care of their patients. 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.

In its January 2018 Health Information Exchange Fact Sheet, CMS states its expectation for HIE sender and receiver collaboration.[2] 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 use 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 used by a patient's providers.
The following table summarizes the 2025 HIE measures and weights. Changes from the 2024 program are as follows:

- The Claims Pilot Project continues – new hospitals electing to participate and submit a signed Use Case Exhibit to MiHIN by July 1, 2025, will have 10 readmissions points reallocated to the HIE portion of program.

- One HIE bonus point for standardization of the codes used in the race and ethnicity fields. Hospitals earning full HIE points are still eligible for the additional point.

To earn the extra bonus point, hospitals should update their data collection approach and practices to ask about race/ethnicity in a single question and update the categories based on revised federal guidance. The single question should be as follows:

What is your race and/or ethnicity?

Select all that apply.

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Middle Eastern or North African

[2] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HealthInformationExchange_2017.pdf (Blue Cross Blue Shield of Michigan and Blue Care Network don't own or control this website.)

- Native Hawaiian or Pacific Islander
- White
- Unknown

To earn the extra bonus point, hospitals must submit a screenshot of their data collection approach by 10/1/2025. Although using the categories noted above is preferable, if the hospital uses more or different categories than those on the list above, they must provide a crosswalk for converting their categories to the federal categories. Hospitals should submit their screenshot and crosswalk (if applicable) to Joshua Amundson (jamundson@bcbsm.com) by 10/1/2025.

- Note: (HL7 specifications have not yet changed to allow for combined race and ethnicity reporting, so Blue Cross is not requiring a change in the way the hospital report race and ethnicity to MIHIN via the HL7 specifications.)

Details on the HIE measures can be found in Appendix E.

All participating facilities of the Blue Cross P4P program will monitor their data submission and conformance using the MiHIN MiGateway Conformance Module.

Measure number	Measure description	Total points possible	Points available by quarter			
			1Q	2Q	3Q	4Q
1	Maintain ADT data quality conformance with inclusion of the common key	6	1.50	1.50	1.50	1.50
2	Maintain CCDA data conformance for inpatient, observation, and ED visits	6	1.50	1.50	1.50	1.50
3	Transmit all ambulatory CCDA data	4	1.00	1.00	1.00	1.00
4	Maintain data conformance for statewide lab result data	4	1.00	1.00	1.00	1.00
NA	Participate in Claims Pilot Project	10	Participation in the Claims Pilot Project			

Performance scoring multiplier methodology

Table B below displays how the CQI incentive pool is calculated, based on actual CQI performance and the redistribution of unearned CQI dollars. In this example, an 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% CQI performance, which is $2.45 million in this example, is then redistributed to hospitals by a scoring multiplier.

Continuing in 2025, before the unearned CQI incentive dollars are redistributed to hospitals, some of these unearned dollars will be used to give a bonus to hospitals that participate in *all* CQIs for which they have been recruited. This bonus is intended to recognize and reward hospitals for the additional work and resource commitment it takes to participate in all multiple CQI programs. The potential bonus amount for each hospital is shown in table A below:

Table A. Multi-CQI Bonus

CQI Count	Bonus Amount
1-4 CQIs	$20,000
5-9 CQIs	$50,000
≥10 CQIs	$75,000

If a hospital drops out of a CQI, it's no longer eligible for this bonus. Similarly, if a hospital is recruited to join a CQI, regardless of if it's a required CQI or not, and chooses not to join, it won't receive the bonus.

The Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE) CQI is exempt from being held to the bonus criteria due to the significant IT component of ASPIRE required to join. Hospitals who are unable to join ASPIRE when invited will remain eligible for the bonus.

Table B. CQI Performance Multiplier Methodology

Hospital name	**Collaborative Quality Initiatives** (Fixed 40% of P4P incentive)								
	Potential CQI Incentive (fixed 40%)	CQI performance	Earned CQI incentive	CQI full-participation bonus	Unearned CQI incentive	Scoring Multiplier (hospital earned/ total earned)	Additional CQI incentive earned	Total earned CQI incentive ($, %*)	
Hospital A	$100,000	95%	$95,000			0.5%	$13,404	$108,404	108.4%
Hospital B	$250,000	80%	$200,000			1.1%	$28,218	$228,218	91.3%
Hospital C	$350,000	78.57%	$275,000	$20,000		1.6%	$38,800	$333,800	95.4%
Hospital D	$500,000	100%	$500,000			2.9%	$70,546	$570,546	114.1%
Hospital E	$750,000	93.33%	$700,000			4.0%	$98,764	$798,764	106.5%
Hospital F	$800,000	91.25%	$730,000	$50,000		4.2%	$102,997	$882,997	110.4%
Hospital G	$1,500,000	60%	$900,000			5.2%	$126,983	$1,026,983	68.5%
Hospital H	$2,250,000	88.89%	$2,000,000			11.5%	$282,184	$2,282,184	101.4%
Hospital I	$3,500,000	100%	$3,500,000			20.1%	$493,822	$3,993,822	114.1%
Hospital J	$10,000,000	85%	$8,500,000	$75,000		48.9%	$1,199,282	$9,774,282	97.7%
Total	**$20,000,000**		**$17,400,000**	**$145,000**	**$2,455,000**		**$2,455,000**	**$20,000,000**	**100.0%**

Hospital CQI programs		
CQI name	**Description**	**Required 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.	Yes
Michigan Radiation Oncology Quality Consortium, or MROQC	Improve the quality of the radiation treatment experience for patients with breast, lung, or prostate cancer or cancer that has spread to the bones 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
OB Initiative, or OBI	Reduce cesarean deliveries for low-risk pregnancies.	Yes

*Participation associated with maintenance of Blue Distinction Specialty Care 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 5 CQIs (for which it has been recruited and is eligible)

Total CQI weight is 40%.

Individual CQI weight is 8% – 40%/5 CQI Programs

Performance in CQI No. 1 is 80%.

Performance in CQI No. 2 is 90%.

Performance in CQI No. 3 is 100%.

Performance in CQI No. 4 is 80%.

Performance in CQI No. 5 is 90%.

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

	Index score		**CQI weight**		**Earned score or potential score**
CQI No. 1	80%	X	8%	=	6.4%
CQI No. 2	90%	X	8%	=	7.2%
CQI No. 3	100%	X	8%	=	8.0%
CQI No. 4	80%	X	8%	=	6.4%
CQI No. 5	90%	X	8%	=	7.2%
Total CQI aggregate score	**88%**		**40%**		**35.2%**

In this example, Hospital A earned a total CQI score of 35.2% out of a potential 40%. Hospital A left on the table approximately 4.8% 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.

CQI performance index scorecards

The CQI performance index scorecards will be made available as a separate addendum to the 2025 Pay-for-Performance program guide in mid- to late-December 2024. In addition, each CQI performance index scorecard will be 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 2025 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.

- Identify "physician champions" at participating sites who can affect change, collaborate in generating data for enhanced knowledge and analysis of processes and outcomes of care.
- Identify an administrative contact at participating sites.
- Thoroughly and accurately collect comprehensive data (i.e., no consistent pattern of errors or omissions regarding 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 (attendees include the physician champion, administrative project lead and/or an assigned designee who can impart QI within the organization).
- Participate in collaborative-wide QI activities 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 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.

MVC Scoring Calculations

Program Year 2025

The following is an illustration of how the scoring system will be applied for program year 2025 for a fictitious hospital (Hospital A). In this example, Hospital A selected CHF for their 30-day episode payment condition and cardiac rehabilitation after CABG as their value metric. All dollar amounts provided below are for illustrative purposes only. For PY 2025, the performance period is calendar year 2024, and the baseline year is calendar year 2022. In program year 2025, Hospital A meets the quality requirement by performing above the 10th percentile of in-hospital mortality and related readmissions. Meeting this requirement means the hospital is eligible to earn P4P points for the MVC Component of the BCBSM P4P Program.

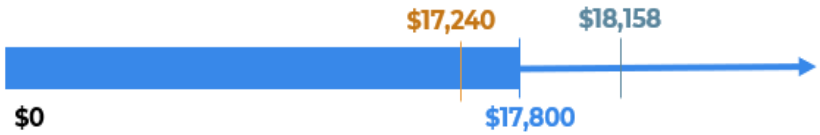
Scoring for Episode Spending Metric

Hospital A's 30-day mean price-standardized risk-adjusted total episode costs for CHF in the performance year are shown on the line below ($17,800), along with their baseline year ($18,158), their cohort's baseline year ($17,240), and the MVC all standard deviation for CHF ($3,100).

Step 1

Calculate four numbers:

- Hospital Performance Year Payment
- Hospital Baseline Year Payment
- Cohort's Baseline Year Payment
- MVC All Standard Deviation



MVC All Standard Deviation = $3,100

Step 2

Plug into z-score equation

Improvement Z-score

$$\frac{\textit{Hospital baseline} - \textit{Hospital performance}}{\textit{MVC All standard deviation from baseline}} = \frac{\$18{,}158 - \$17{,}800}{\$3{,}100} = \mathbf{0.12}$$

Achievement Z-score

$$\frac{\textit{Cohort baseline} - \textit{Hospital performance}}{\textit{MVC All standard deviation from baseline}} = \frac{\$17{,}240 - \$17{,}800}{\$3{,}100} = \mathbf{-0.18}$$

Step 3

Translate z-scores into points

Z-Score	Points
<0	0
0 - <0.05	1
0.05 - < 0.1	2
0.1 - < 0.15	3
0.15+	4

Improvement

0.12 z-score value

→ 3 Improvement Points

Achievement

-0.18 z-score value

→ 0 Achievement Points

Conclusion: Hospital A earns 3 points for their CHF episode payment.

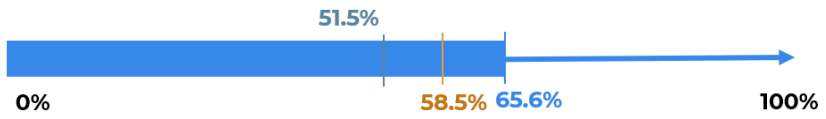
Scoring for Value Metric

Hospital A's cardiac rehabilitation rate after CABG in the performance year was 65.6%. Two years before in the baseline year, their cardiac rehabilitation rate after CABG was 51.5%. Their cohort's baseline rate was 58.5%, and the MVC All standard deviation is 13.7%.

Step 1

Calculate four numbers:

- Hospital Performance Year Rate
- Hospital Baseline Year Rate
- Cohort's Baseline Year Rate
- MVC All Standard Deviation for CR after CABG (Baseline Year)



MVC All Standard Deviation = 13.7%

Step 2

Plug into z-score equations

Improvement Z-score

$$\frac{Hospital\ performance\ -\ Hospital\ baseline}{MVC\ All\ standard\ deviation\ from\ baseline} = \frac{65.6\ -\ 51.5}{13.7} = \mathbf{1.029}$$

Achievement Z-score

$$\frac{Hospital\ performance\ -\ Cohort\ baseline}{MVC\ All\ standard\ deviation\ from\ baseline} = \frac{65.6\ -\ 58.5}{13.7} = \mathbf{0.518}$$

Step 3

Translate z-scores into points

Z-Score	Points
<0	0
0 - <0.25	1
0.25 - <0.50	2
0.50 - <0.75	3
0.75+	4

Improvement

1.029 z-score value

→ **4 Improvement Points**

Achievement

0.518 z-score value

→ **3 Achievement Points**

Conclusion: Hospital A earns 4 points for the Cardiac Rehab After CABG Value Metric

Health Information Exchange Measures

Measure 1 – ADT
Measure 2 – Exchange CCDA (Hospital)
Measure 3 – Ambulatory (Outpatient) CCDA
Measure 4 – Statewide Lab results

The Blue Cross conformance standards are designed to continually improve data that flows through the Michigan Health Information Network, ensuring it is complete and actionable when it's received by practitioners using the information.

Hospitals are expected to monitor conformance using the MiGateway Conformance Module. MiHIN also sends notifications to hospitals monthly.

For Measure 1:

- A hospital will be considered in conformance and receive full points if **all** fields are populated at or above the relevant threshold.
- A hospital will be considered in conformance and receive two thirds of the points if **26 of 27** fields are populated at or above the relevant threshold.
- A hospital will be considered in conformance and receive one third of the points if **25 of 27** fields are populated at or above the relevant threshold.
- The following fields will be combined for scoring purposes – missing more than 1 field in any category, will only count as missing a single field.

    - PID-5.1 , PID-5.2
    - PID-29 , PID-30
    - IN-1.3 , IN-1.4
    - DG1-3.1 , DG1-3.2 , DG1-6

For Measure 2:

- A hospital will be considered in conformance and receive full points if **all** fields are populated at or above the relevant threshold.
- A hospital will be considered in conformance and receive two thirds of the points if **27 of 28** fields are populated at or above the relevant threshold.
- A hospital will be considered in conformance and receive one third of the points if **26 of 28** fields are populated at or above the relevant threshold.
- The following fields will be combined for scoring purposes – missing more than 1 field in any category, will only count as missing a single field.

    - Patient First Name, Patient Last Name
    - Patient Address, Patient City, Patient Zip Code
    - Attending Provider First Name, Attending Provider Last Name
    - Discharge Medication Dose Unit, Discharge Medication Dose Quantity
    - Visit Diagnosis Code (ICD10), Visit Diagnosis Description

For Measure 3:

- A hospital will be considered in conformance and receive full points if Ambulatory CCDA data is transmitted for all patients.
- There is no conformance thresholds currently assigned.

For Measure 4:

- A hospital will be considered in conformance and receive full points if **all** fields are populated at or above the relevant threshold.
- A hospital will be considered in conformance and receive two thirds of the points if **18 of 19** fields are populated at or above the relevant threshold.
- A hospital will be considered in conformance and receive one third of the points if **17 of 19** fields are populated at or above the relevant threshold.
- The following fields will be combined for scoring purposes – missing more than 1 field in any category, will only count as missing a single field.
    - PID-5.1, PID-5.2
    - PID-11.1, PID-11.5

Specific conformance thresholds for each measure are outlined in the tables below.

Measure 1: Maintain ADT data quality conformance with inclusion of the common key – 6 points

Hospitals can earn up to six points for maintaining ADT data conformance. The following table shows the required ADT data fields and performance thresholds. Messages must meet and maintain the associated conformance threshold across all three categories: complete routing, complete mapping, and adherence to coding standards.

Measure 1 – ADT and CKS Conformance Thresholds – 6 points	
Group A: Complete Routing – messages must be populated with all the following fields	Threshold
PID-5.1: Patient Last Name	≥95%
PID-5.2: Patient First Name	≥95%
PID-7: Patient Date of Birth	≥95%
PID-11.5: Patient Zip	≥95%
PV1-19: Visit Number	≥95%
PV1-37: Discharged to Location	≥95%
PV1-44: Admit Date/Time	≥95%

PV1-45: Discharge Date/Time	≥95%
PID-29: Patient Death Date/Time	≥95%
PID-30: Patient Death Indicator	≥95%
IN1-3: Insurance Company ID	≥95%
IN1-4: Insurance Company Name	≥95%
PID-3.1 Common Key	≥60%
Group B: Complete Mapping – MiHIN mapping tables must be kept current for the following fields *	Threshold
MSH-4.1: Sending Facility- Hospital OID	≥95%
PV1-36: Discharge Disposition	≥95%
PID-8: Patient Sex	≥95%
PID-10: Patient Race	≥95%
PID-22: Ethnic Group	≥95%
PV1-2: Patient Class (e.g., observation bed)	≥95%
PV1-4: Admission Type	≥95%
PV1-14: Admit Source	≥95%
DG1-6: Diagnosis Type	≥95%
PV1-10: Hospital Service	≥95%
Group C: Adherence to Coding Standards — values must be sent using the standard indicated below *	Threshold
PV1-7.1: Attending Doctor ID (NPI)	≥95%
PV1-17.1: Admitting Doctor ID (NPI)	≥95%
DG1-3.1: Diagnosis Code ID (ICD10)	≥95%
DG1-3.2: Diagnosis Code Description	≥95%

*Group B and C fields must be populated on at least 95% of messages, as well as being correctly mapped or formatted

Measure 2: Maintain CCDA data conformance for inpatient, observation, and ED visits – 6 points

Hospitals can earn up to six points for maintaining CCDA data conformance for all inpatient, observation, and ED visits. The following table shows the required CCDA data fields and performance thresholds required. There are several fields at the bottom of the table that do not have conformance thresholds yet. However, hospitals are expected to transmit these fields so the information can be analyzed for potential future conformance development.

APPENDIX E

Measure 2 – Exchange CCDA Conformance Thresholds – 6 points	
CCDA – Med Rec Relevant Fields	Threshold
Visit ID	≥95%
Patient Date of Birth	≥95%
Patient Sex	≥95%
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	≥50%
Discharge Medication Begin Date	≥50%
Discharge Medication Dose Unit	≥50%
Discharge Medication Dose Quantity	≥50%
Discharge Medication Instructions	≥50%
Discharge Medication Code (RxNorm or NDC)	≥50%
Allergies	≥95%
Active Problems Present	≥95%
Chief Complaint	≥95%
Visit Diagnosis Code (ICD10)	≥95%
Visit Diagnosis Description	≥95%
Vital Signs	≥95%
Immunizations	≥50%
Results/Laboratory	≥95%
Patient SSN – when available	Not scored

Discharge Medication End Date	Not Scored
Discharge Medication Status	Not Scored
Advanced Directives	Not Scored
Discharge Instructions	Not Scored
Functional Status	Not Scored
Plan of Care	Not Scored
Procedures	Not Scored
Progress Notes	Not Scored
Reason for Referral	Not Scored
Social History	Not Scored
Tests Ordered	Not Scored

Measure 3: Transmit all ambulatory (outpatient) CCDA data – 4 points

Hospitals will earn four points by transmitting all ambulatory (outpatient clinic) CCDA data for all patients. This includes outpatient encounters and office visits to physicians or APPs sharing the hospital's EMR, both employed and non-employed. There are no conformance thresholds currently. Instead, hospitals will be scored only on whether they transmit the data. The data will be analyzed with the intent of developing conformance standards for future program years.

Measure 4: Statewide lab data conformance – 4 points

Hospitals can earn up to four points for statewide lab data conformance. The table below contains the fields required. There are several fields at the bottom of the table that don't have conformance thresholds yet. However, hospitals are expected to transmit these fields so the information can be analyzed for potential future conformance development.

Measure 4 – Statewide Lab Result Data Conformance Thresholds – 4 points	
ORU message – lab result relevant fields	Threshold
MSH-10: Message Control ID	75%
MSH-3.1: Sending Application Namespace ID	75%
MSH-4.1: Sending Facility Namespace ID	75%
MSH-4.2: Sending Facility Universal ID Date/Time of Message	75%

MSH-9.2: Trigger Event	75%
PID-10: Race	75%
PID-11.1: Street Address	75%
PID-11.5: ZIP	75%
PID-2: Patient ID**	75%
PID-5.1: Patient Last Name	75%
PID-5.2: Patient First Name	75%
PID-7: DOB	75%
PID-8: Sex	75%
PV1-2: Patient Class	75%
OBR-16: Ordering Provider	75%
OBX-11: Observation Results Status	75%
OBX-2: Value Type	75%
OBX-3: Observation Identifier	75%
OBX-5: Observation Value	75%
OBR-22: Results Rpt/Status Chng - Date/Time	Not Scored
OBR-25: Result Status	Not Scored
OBR-3: Filler Order Number	Not Scored
OBR-32: Principal Result Interpreter	Not Scored
OBR-4: Universal Service Identifier	Not Scored
OBX-19: Date and Time of Analysis	Not Scored
OBX-23: Performing Organization Name	Not Scored
OBX-24: Performing Organization Address	Not Scored
OBX-6: Units	Not Scored
OBX-7: Reference Ranges	Not Scored
PID-13: Home Phone	Not Scored
PID-22: Ethnic Group	Not Scored
PID-3.1: Patient Identifier Value	Not Scored
ORC-1: Order Control	Not Scored
ORC-12: Ordering Provider	Not Scored
ORC-3: Filler Order Number	Not Scored

OBR-1: Set ID - OBR	Not Scored
OBR-14: Date and Time Specimen Received	Not Scored
OBR-15: Specimen Source	Not Scored
OBX-8: Abnormal Flags	Not Scored

** Either PID 2 or PID 3 will be accepted and neither measure will be scored until available in MiGateway

Claims Pilot Project – 10 points

Hospitals electing to participate in the Claims Pilot Project by submitting all-payer claims data to MiHIN for the expansion of chronic care/population health CQIs will have 10 of their Plan All-Cause Readmission (PCR) points reallocated to the HIE portion of the program (see appendix F for additional details). Participation is not required; for hospitals not participating in the pilot, Plan All-Cause Readmission (PCR) will remain at 30 points. **Hospitals choosing to participate must submit the signed Use Case Exhibit to MiHIN by July 1, 2025**. Hospitals who have already signed the UCE must continue sending all pre-adjudicated claims as confirmed by MiHIN, to continue to receive the reallocated 10 points.

Claims Pilot Project

Data Specifications – contact MiHIN for further details

Format for Data Submission

- X12 837, the standard format for exchanging information between health care partners.
    - Hospitals currently generate claims data in this format for submission to payers or a claim clearinghouse.

Data Submission Process

- Hospitals have flexibility in how to submit the data to MiHIN:
    1. Direct file transfer via SFTP (Secure File Transfer Protocol)
        - Most hospitals already have an SFTP connection established with MiHIN.
    2. File submission from a clearinghouse to MiHIN
        - Requires data sharing agreement between the hospital and the clearinghouse permitting data transfer to MiHIN and an agreement between the clearinghouse and MiHIN.
- Hospitals should submit claims data at a frequency that is consistent with existing processes, as much as daily, to enable the timely use of information to support the Population Health CQIs

Data Privacy and Security

- MiHIN will only share the minimum data necessary with those participating in the CQIs in full compliance with the HIPAA Privacy Rule, which permits a covered entity to disclose PHI, with certain limits and protections, for treatment, payment, and health care operations activities.
- MiHIN is HITECH certified with highest level of requirements and safeguards in place.
- Blue Cross will not have access to the claims data submitted to MiHIN.
- Hospitals currently submit all-payer clinical data to MiHIN.
- Hospitals must execute a new use case exhibit that governs the submission and use of claims data.

The Value of Hospital Claims Data for the Expansion of Chronic Care/Population Health CQIs

Combining all-payer claims data with clinical data and patient-reported data is key to the success of the data hub being created to support the chronic condition/population-based CQIs. Including claims in the data hub offers the following benefits:

- **Aggregation of Data**
    - Claims data, combined with clinical and patient-reported data, provides a holistic patient picture, longitudinally over time across providers and services.

- **Ease of Use**
  - Claims data is coded/structured, which makes it relatively easy to consume and integrate with other data for analysis. Clinical data from EHRs is often buried in notes and attached documents, and not readily available for extraction/integration.
- **Identification of Service Use**
  - Access to claims data allows for the tracking and identification of individuals that have not used a necessary health care service; this is particularly useful for underserved populations.
  - Access to claims allows for the measurement of the success of CQI interventions, such as successful referrals and receipt of necessary services.
  - Allows for identification of patients at risk of high cost/low value care.

The Value to Hospitals of Contributing Claims to the Data Hub

- **Data Abstraction**
  - Manual data abstraction is expensive and inefficient, and it is vital to reduce the cost of data collection.
  - Providing claims data to the data hub can potentially reduce the need for some components of manual data abstraction over the long term.
    - Ultimately, if the need for data abstraction is reduced, the funding could be redeployed to support other Quality Improvement work.

MiHIN Contacts for technical questions regarding claims pilot project:

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