HMS Pay for Performance & Value Based Reimbursement Q & A Sessions

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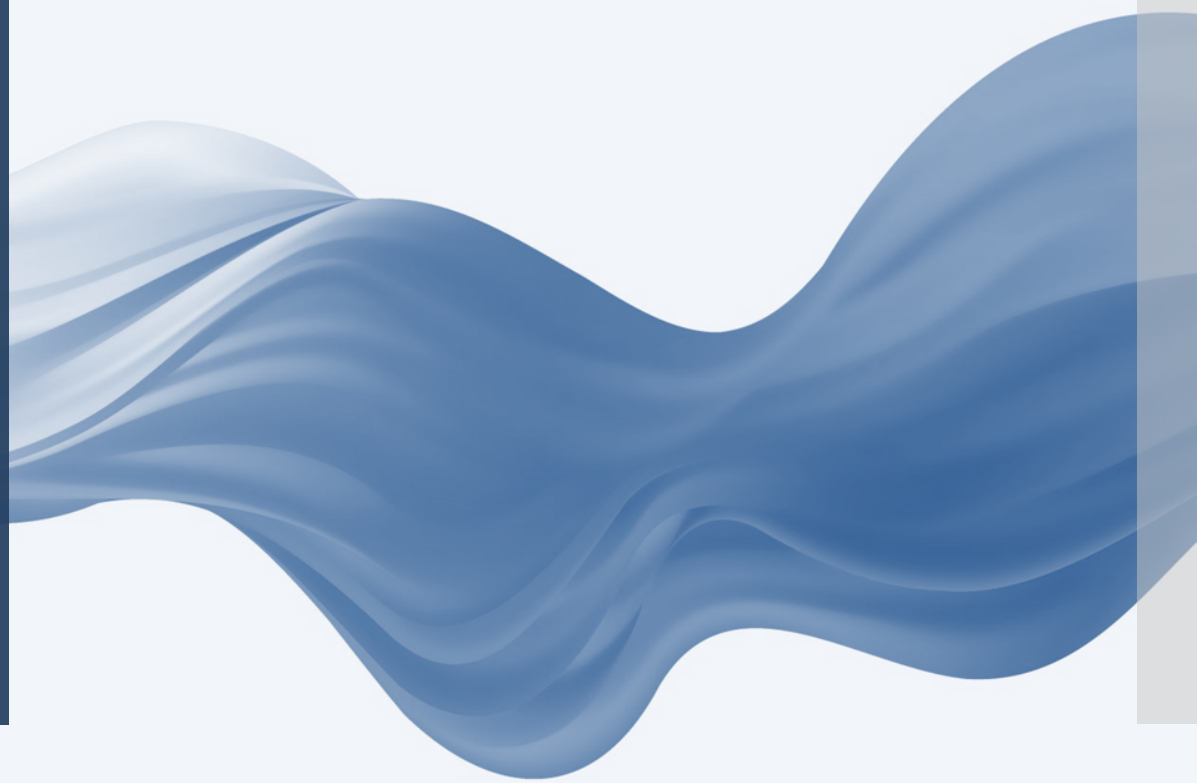
General Overview

- Starting in 2023, HMS will have 2 incentive programs
  - Pay for Performance (P4P)
  - Value Based Reimbursement (VBR)
- P4P is our HMS Performance Index
- VBR is a new (for HMS) incentive for participating physicians that aligns with our HMS quality goals
  - Incentive is structured by physician specialties
    - Hospitalists/Infectious Diseases Physicians who participate in Antimicrobial Stewardship
    - Interventional Radiologists
    - Critical Care Physicians

2023 Pay for Performance



2023 HMS Performance Index

- 30/70 split between participation & performance
- Cohort 2022 – Modified index focused largely on participation
- Collaborative performance measure required
  - Everyone gets or loses points based on collaborative average
  - Catheter to Vein Ratio (CVR) & Lumen documentation measure will remain as is in 2023
- Performance targets must continue to be a stretch
  - BCBSM does not expect all hospitals to achieve full points
  - Cut-offs based on the adjusted model
- 3 Pay for Performance (P4P) Indexes
  - Hospitals who joined prior to 2020
  - Hospitals who joined in 2020 & 2021
  - Hospitals who joined in 2022
- New Stratified PICC Quality Improvement Strategy

Performance Index Updates

- Timeliness of data collection at Mid-Year & End of Year – *All Hospitals*
  - Sepsis cases will be included in timeliness calculations
- Antimicrobial – *All Hospitals except Cohort 2022*
  - Increase Use of 5 Days of Antibiotic Treatment in Uncomplicated CAP
    - Full point threshold: ≥60% -> ≥65% (top ¼ of hospitals)
  - Reduce Use of Antibiotics in Patients with ASB
    - Full point threshold: ≤12% -> ≤10% (top ¼ of hospitals)
  - Retire – Fluoroquinolone Measure
  - New – Reduce Use of Inappropriate Empiric Broad-Spectrum Antibiotics for Patients with Uncomplicated CAP
    - Full point threshold: ≤15% (top 1/3 of hospitals)

New Stratified PICC Quality Improvement Strategy

- Situation
  - The majority of the hospitals who joined HMS prior to 2020 have plateaued in improvements in our existing PICC measures
    - PICC ≤ 5 Days
    - Increasing single lumens (non-ICU)
    - Avoiding PICCs in patients with chronic kidney disease
  - Driving more appropriate PICC selection/use varies across all hospitals using a one size fits all approach is not ideal
  - Over the last 3 years, we have brought on 3 cohorts of hospitals where improvement in the above in our existing PICC measures is appropriate
- Goal
  - Identify a strategic plan for our original cohort of hospitals that is meaningful to all hospitals while also maintaining the existing measures for our newer cohorts

New Stratified PICC Quality Improvement Strategy

- For Hospitals who joined HMS prior to 2020, we are replacing the current PICC measures with **one** new measure with two possible routes
  - Oncology
    - Reduce triple lumens and reduce short term use (≤ 5 days)
    - Participate in workgroup to determine appropriate vascular access device, including PICCs, for hematology/oncology patients
  - Critical Care
    - Reduce triple lumens
    - Participate in workgroup to determine appropriate vascular access device, including PICCs, for critical care patients
- For Hospitals who joined HMS in 2020 & 2021
  - Reducing PICC short term dwells (≤ 5 Days)
  - Increasing single lumen PICCs in non-ICU
  - Reducing PICC use in patients with chronic kidney disease (CKD)
- For Hospitals who joined HMS in 2022
  - Modified index focused largely on participation

New Stratified PICC Quality Improvement Strategy
Hematology/Oncology & Critical Care

Hospitals who joined HMS prior to 2020 only

8/9	15	**Reduce Triple Lumen PICCs in Special Populations – Oncology or Critical Care**	
		Oncology	
		≤ 25% of PICCs placed in oncology patients[17] are triple lumens and in for ≤5 Days **AND** participation in special population workgroup[13,14,15]	15
		≤ 25% of PICCs placed in oncology patients[17] are triple lumens and in for ≤5 Days **OR** participation in special population workgroup[13,14,15]	10
		> 25% of PICCs placed in oncology patients[17] are triple lumens and in for ≤5 Days **AND** No participation in special population workgroup[13,14,15]	0
		OR	
		Critical Care (ICU)	
		≤ 30% of PICCs placed in critical care patients[16] are triple lumens **AND** Participation in special population workgroup[13,14,15]	15
		≤ 30% of PICCs placed in critical care patients[16] are triple lumens **OR** Participation in special population workgroup[13,14,15]	10
		> 30% of PICCs placed in critical care patients[16] are triple lumens **AND** No Participation in special population workgroup[13,14,15]	0

Workgroups will take place at the 3 collaborative wide meetings during the year and each group must have 3 attendees – 1) Quality Professional, 2) Physician (1 of 3 must be specialist), 3) Vascular Access Team Member or Interventional Radiology

New Stratified PICC Quality Improvement Strategy

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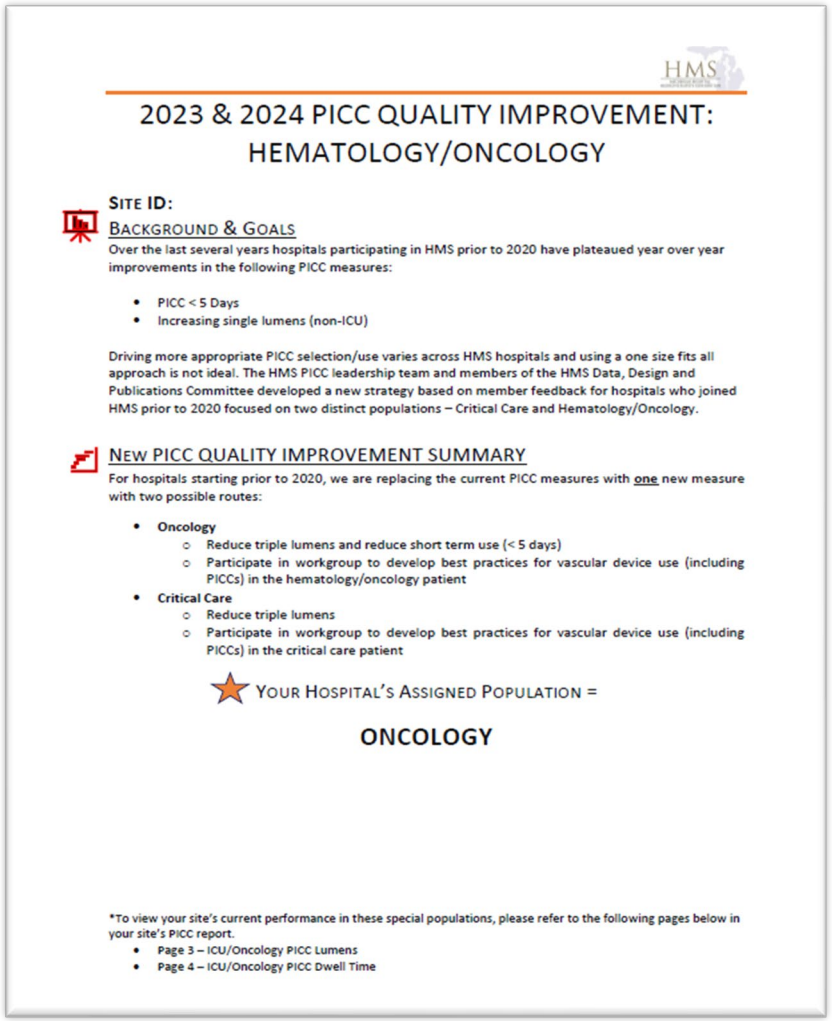
Hospitals who joined HMS prior to 2020 only

- Hospitals have been included in either the hematology/oncology or the critical care group based on case volumes over a 1-year period
- Low volume hospitals are paired with full volume hospitals within their system or in a low volume group
- 1- pager provided at November Collaborative Wide Meeting



HMS

2023 & 2024 PICC QUALITY IMPROVEMENT: HEMATOLOGY/ONCOLOGY

SITE ID:

BACKGROUND & GOALS

Over the last several years hospitals participating in HMS prior to 2020 have plateaued year over year improvements in the following PICC measures:

- PICC < 5 Days
- Increasing single lumens (non-ICU)

Driving more appropriate PICC selection/use varies across HMS hospitals and using a one size fits all approach is not ideal. The HMS PICC leadership team and members of the HMS Data, Design and Publications Committee developed a new strategy based on member feedback for hospitals who joined HMS prior to 2020 focused on two distinct populations – Critical Care and Hematology/Oncology.

NEW PICC QUALITY IMPROVEMENT SUMMARY

For hospitals starting prior to 2020, we are replacing the current PICC measures with one new measure with two possible routes:

- **Oncology**
  - Reduce triple lumens and reduce short term use (< 5 days)
  - Participate in workgroup to develop best practices for vascular device use (including PICCs) in the hematology/oncology patient
- **Critical Care**
  - Reduce triple lumens
  - Participate in workgroup to develop best practices for vascular device use (including PICCs) in the critical care patient

YOUR HOSPITAL'S ASSIGNED POPULATION =

ONCOLOGY

*To view your site's current performance in these special populations, please refer to the following pages below in your site's PICC report.

- Page 3 – ICU/Oncology PICC Lumens
- Page 4 – ICU/Oncology PICC Dwell Time

Hospitals Who Joined in 2020 & 2021

- Antimicrobial Measures – same as the rest of the Collaborative
  - Increase Use of 5 Days of Antibiotic Treatment in Uncomplicated CAP
  - Reduce Use of Antibiotics in Patients with ASB
  - New – Reduce Use of Inappropriate Empiric Broad-Spectrum Antibiotics for Patients with Uncomplicated CAP
- Collaborative Wide Measure - same as the rest of the Collaborative
  - Catheter to Vein Ratio (CVR) & Lumen documentation measure
- PICC – specific to Cohort 2020 and 2021
  - Reducing PICC short term dwells (≤ 5 Days)
  - Increasing single lumen PICCs in non-ICU
  - Reducing PICC use in patients with chronic kidney disease (CKD)

Hospitals Who Joined in 2022

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2023 Michigan Hospital Medicine Safety Consortium Collaborative Quality Initiative Performance Index Scorecard Cohort 2022 (Sites Starting in 2022)			
Measure	**Weight**	**Measure Description**	**Points**
1	15	**Timeliness of HMS Data at Mid-Year and End of Year[1]**	
		On time ≥ 95% at Mid-Year AND End of Year	15
		On time ≥ 95% at Mid-Year OR End of Year	8
		On time < 95% at Mid-Year AND End of Year	0
2	15	**Completeness[1] and Accuracy[2,3] of HMS Data**	
		≥ 95% of registry data complete & accurate, semi-annual QI activity surveys completed, AND audit case corrections completed by due date	15
		< 95% of registry data complete & accurate, semi-annual QI activity survey not completed OR audit case corrections not completed by due date	0
3	20	**Consortium-wide Meeting Participation[4] – clinician lead or designee**	
		3 meetings	20
		2 meetings	10
		1 meeting	0
		No meetings	0
4	20	**Consortium-wide Meeting Participation[4] – data abstractor, QI staff, or other**	
		3 meetings	20
		2 meetings	10
		1 meeting	0
		No meetings	0
5	10	**PICC Quality Improvement[6]**	
		Convene a vascular access committee at least quarterly to review PICC use and outcomes **AND** use MAGIC or a related decision-tool to determine PICC appropriateness	10
		Convene a vascular access committee at least quarterly to review PICC use and outcomes **OR** use MAGIC or a related decision-tool to determine PICC appropriateness	5
		No vascular access committee meetings convened AND no use of MAGIC or a related decision-tool to determine PICC appropriateness	0
6	5	**PICC/Midline Documentation[6]**	
		Submit PICC AND midline (if hospital inserts midlines) insertion template including documentation of catheter-to-vein ratio and number of lumens	5
		Local PICC AND midline (if hospital inserts midlines) insertion template including documentation of catheter-to-vein ratio and number of lumens not submitted	0
7	10	**Antimicrobial Quality Improvement- Guidelines[6]**	
		Submit UTI and CAP guidelines developed locally (aligned with HMS recommendations)[5]	10
		Local UTI and CAP guidelines not submitted or not aligned with HMS recommendations	0
8	5	**Antimicrobial Quality Improvement- Intervention Description[6]**	
		Submit a description of one intervention you have done, are doing or plan on doing for each • Decrease antibiotic treatment for patients with uncomplicated CAP to 5 days • Decrease unnecessary treatment of ASB • Decreasing broad-spectrum use in patients with uncomplicated CAP	5
		Description of interventions not submitted	0
Optional Bonus			
Optional	5	Specialist[7] attendance at 1 or more of the special population workgroup[8] meetings during the calendar year	5
		Total (Max points = 100)	

Participation

PICC/Midline QI

Antimicrobial QI

Bonus Points!

New: BONUS POINTS!

- For the first time, our 2023 Performance Index will have an optional 5 points bonus section focused on participation at special population workgroups to determine appropriate vascular device use
- Ways to receive the 5-point bonus
  - Hospitals who joined HMS prior to 2020
    - Specialist attends all 3 special population workgroup meetings within assigned workgroup area
    - Specialist attends 1 or more special population workgroup meetings that is not within assigned workgroup area
  - Hospitals who joined HMS in 2020, 2021 or 2022
    - Specialist attends 1 or more special population workgroup meeting

Summary – Pay for Performance – PICC/Midline Measures

Pay for Performance (P4P) – PICC /Midline Measures						
	Increase Catheter to Vein Ratio Doc. for PICC and Midline	**Reduce triple lumen PICCs and < 5-day dwell times in heme/onc patients and participate in special population workgroup**	**Reduce triple lumen PICCs placed in critical care patients and participate in special population workgroup**	**Reduce eGFR**	**PICC < 5 Days**	**Single Lumen use in Non-ICU**
Assessment Period	Q4 2023	Q1 – Q4 2023	Q1 – Q4 2023	Q4 2023[2]	Q4 2023[2]	Q4 2023[2]
PICC Insertions	08/03/23 – 11/08/23	11/24/22 - 11/08/23	11/24/22 - 11/08/23	08/03/23 – 11/08/23	08/03/23- 11/08/23	08/03/23 – 11/08/23
Method	Raw Collaborative Average	Raw Hospital Specific Average[1]	Raw Hospital Specific Average[1]	Adjusted Hospital Specific	Adjusted Hospital Specific	Adjusted Hospital Specific
Hospitals	All (except Cohort 2022)	Hospitals in Oncology Cohort – Prior to 2020	Hospitals in Critical Care Cohort – Prior to 2020	2020 & 2021 Cohorts	2020 & 2021 Cohorts	2020 & 2021 Cohorts

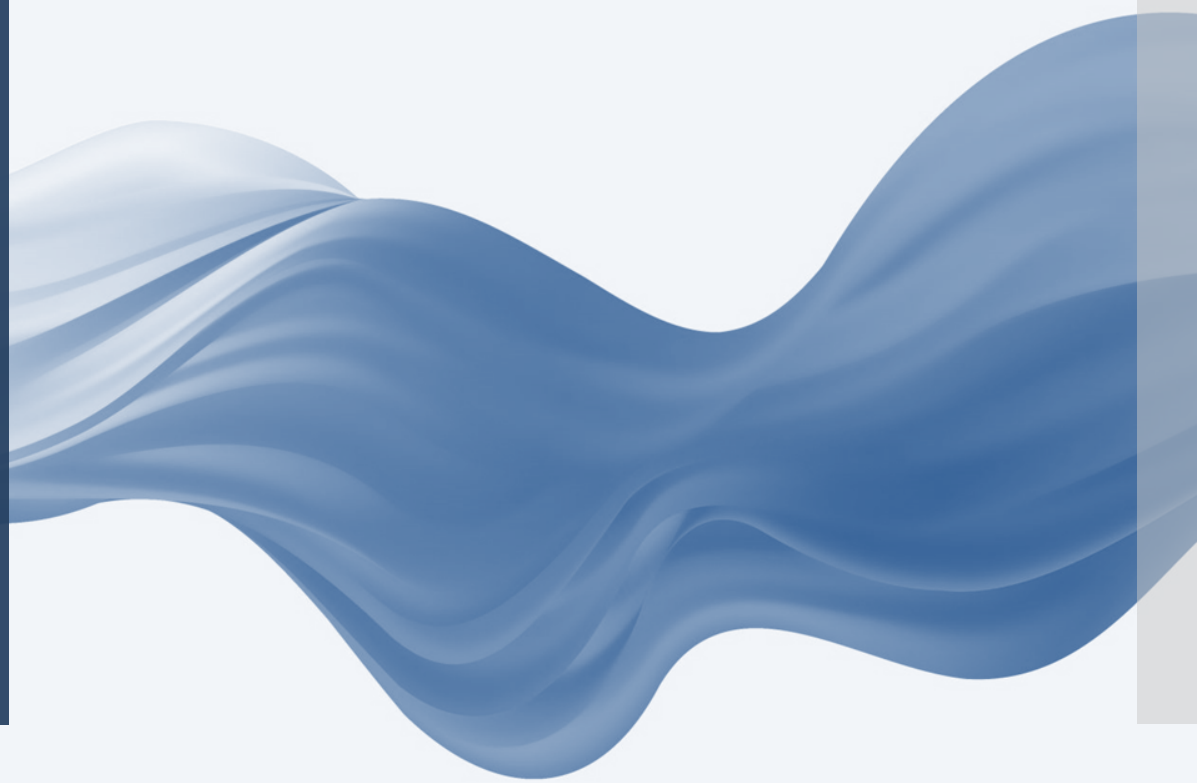
1. Except for those with hospital pairings
2. Adjusted model uses improvement over 1 year to inform the fourth quarter score

Summary – Pay for Performance – ABX Measures

Pay for Performance (P4P) – ABX Measures			
	Increase Use of 5 Days of Antibiotic Treatment in Uncomplicated CAP	**Reduce Use of Inappropriate Empiric Broad-Spectrum Antibiotics for Patients with Uncomplicated CAP**	**Reduce Use of Antibioticsg in Patients with ASB**
Assessment Period	Q4 2023[1]	Q4 2023[1]	Q4 2023[1]
Patient Discharges	08/03/23 – 11/08/23	08/03/23- 11/08/23	08/03/23 – 11/08/23
Method	Adjusted Hospital Specific	Adjusted Hospital Specific	Adjusted Hospital Specific
Hospitals	All Cohorts – Except 2022	All Cohorts – Except 2022	All Cohorts – Except 2022

1. Adjusted model uses improvement over 1 year to inform the fourth quarter score

2024 Value Based Reimbursement (VBR)



What is Value-Based Reimbursement (VBR)?

- The Value Partnerships Program at Blue Cross Blue Shield Michigan (BCBSM) develops and maintains quality programs to align practitioner reimbursement with quality-of-care standards, improved health outcomes and controlled health care costs.
- Practitioner reimbursement earned through these quality programs is referred to as value-based reimbursement, or VBR.
- The VBR Fee Schedule sets fees at greater than 100% (maximum of 105%) of the Standard Fee Schedule.
- We are excited to share that HMS will be launching a new optional VBR program based on performance and participation in HMS initiatives for physicians in select specialties

2024 VBR Timeline

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Present - Oct *2022*
Measure Planning

Nov. 2 *2022*
Notify CQI Participants

Jan - Nov *2023*
2024 Measurement Period

Dec *2023*
Submit Physician Eligibility to BCBSM

2024 3/1/24 – 2/28/25
3-5% VBR via claims – *if Eligible*

Measures by Physician Specialty

Hospitalists and Infectious Diseases Physicians*

Increase Use of 5 Days of Antibiotic Treatment in Uncomplicated CAP
Hospital Specific Measure

≥ 65% uncomplicated CAP cases receive 5 days of antibiotics **OR**
≥ 65% relative increase in the number of uncomplicated CAP cases that receive 5 days of antibiotics during the performance year

Interventional Radiology

Increase Catheter to Vein Ratio Documentation for PICC and Midline devices among Interventional Radiologists
Collaborative Measure

≥ 65% of Catheter to Vein Ratio (CVR) is documented for both PICCs/Midlines by Interventional Radiology (out of all IR lines placed)

Critical Care

Reduce triple lumen PICCs placed in critical care patients and participate in special population workgroup
Hospital Specific Measure

- ≤ 30% of PICCs placed in critical care patients are triple lumens
- If critical care physician attends all 3 meetings per year entire specialty group at hospital receives credit – virtual option will be available

*Infectious diseases physicians involved in stewardship programs at local hospital

VBR Eligibility

- To be eligible for 2024 CQI VBR, the practitioner must:
  - Meet the performance targets set by the collaborative
  - Be a member of a PGIP physician organization for at least one year
  - Submit NPI number to the HMS Coordinating Center via the HMS Semi-Annual Fall QI Survey

Summary

Value Based Reimbursement (VBR)			
	Increase Use of 5 Days of Antibiotic Treatment in Uncomplicated CAP	**Increase Catheter to Vein Ratio Documentation for PICC and Midline**	**Reduce triple lumen PICCs placed in critical care patients and participate in special population workgroup**
Specialists	Hospitalists and Infectious Diseases Physicians[1]	Interventional Radiology	Critical Care
Assessment Period	Q3 2023	Q3 2023	Q1 – Q3 2023
Discharge Dates/PICC Insertions	05/11/23 – 08/02/23	05/11/23 – 08/02/23	11/24/22 - 08/02/23
Method	Adjusted – Hospital Specific	Raw Collaborative Average	Raw- Hospital Specific
Hospitals	All	All	All

1. Infectious diseases physicians involved in stewardship programs at local hospital

Key Concept: Hospital Specific Funding Structure

- Each hospital is unique in terms of funding structure (i.e., physicians employed by the hospital vs. privately funded)
- The incentive will be distributed through the Physician Organization (PO)
- Engagement in VBR (by the participating physicians) may depend on how your hospital is structured
- Example
  - At Michigan Medicine, the hospitalists are employed by the hospital and incentive payments would be distributed to the hospital as opposed to the Michigan Medicine Hospitalists specifically

Key Concept: How will the physicians be identified?

- HMS does not collect physician specific data in our registries so all VBR assessments will be based at the hospital or collaborative level
- For those hospitals/physicians that are eligible for the VBR incentive, HMS will be collecting the National Provider Identifier (NPI) number for each specialty at your hospital
  - Hospitalists and Infectious Diseases Physicians
  - Interventional Radiology
  - Critical Care
- The NPI's will be collected in the Fall 2023 Annual QI Survey
- Each hospital will be responsible for obtaining the list of NPI numbers and the Physician Champion must approve of the final list

Key Concept:
Critical Care Participation in Workgroup

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Critical Care

Reduce triple lumen PICCs placed in critical care patients and participate in special population workgroup

Hospital Specific Measure

- ≤ 30% of PICCs placed in critical care patients are triple lumens
- If critical care physician attends all 3 meetings per year entire specialty group at hospital receives credit – virtual option will be available

- For the Critical Care participation measure, if one critical care physician (can be different physician each meeting) from your hospital attends all 3 meetings during the year, the **entire** critical care physician team at your hospital would be eligible for the incentive

FAQ
To Date

Q & A : Why the New PICC QI Strategy?

- **Question**: After reviewing the slides from the collaborative wide meeting, can you please elaborate on the rationale for the format of the workgroup to meet the PICC metric?
- **Answer:** The new PICC strategy related to PICC use in hematology/oncology patients and critical care patients was developed over the last year based on feedback from our participating hospitals on further areas for improvement. These patient populations have been identified by HMS hospitals as challenging to determine the best approach. The main focus of this new strategy is to identify, as a Collaborative, the best approach to device use in these specific patient populations. This is why the workgroups are so important and include the multidisciplinary providers that are key thought leaders in this area (i.e. quality staff, the specialist physician [i.e. hematologist/oncologist or Critical Care Physician, Vascular Access or Interventional Radiology]). The goal is to (try!) to come to a consensus that our Collaborative can use for decision making – similar to how we developed the MAGIC guidelines.

Q & A : P4P & VBR Oncology

- **Question:** Is there reimbursement attached to this oncology PICC initiative?
- **Answer:** Yes, for the Performance Index (P4P) there is a reimbursement associated with hematologist/oncologist participation. For Value Based Reimbursement (VBR) for hematologist/oncologists physicians, there is no reimbursement incentive given logistics and overlapping with other CQI's.

Q & A: P4P & VBR Critical Care/Hematology/Oncology Hospital Pairings

- **Question**: Please provide more detail about the hospital pairing. Does it mean our score will be combined with the paired hospital?

- **Answer:** The hospital pairing is for data aggregation purposes. For hospitals that have small numbers of patients, we combined hospitals who have larger volumes within their system or with other smaller hospitals. Yes, the scores will be combined for assessment purposes for the performance index. We will be updating our reports to include hospital pairings for these specific measures as appropriate. We may have some sessions at upcoming collaborative wide meetings with hospital pairings as we determine necessary. We do not anticipate any outside meetings unless certain systems choose to do this on their own.

Q & A: P4P & VBR Critical Care/Hematology/Oncology Hospital Pairings

- **Question**: Since the score is combined, we will need participation from only 1 critical specialist for both hospitals to meet the measure?

- **Answer:** The scores are combined just for data purposes (i.e., determining the threshold for the <30%). This does not include the participation component in the population workgroup. So even though the hospitals are paired together, 2 critical care specialists would need to attend – 1 from each hospital.

- **Question:** When you say the scores are combined for data purposes, will the P4P scorecard reflect the combined scores, or will each site be scored individually for P4P purposes?

- **Answer:** Yes, the P4P scorecard (and data reports) distributed in 2023 will reflect the combined score (as well as the site-specific score). Please note, this is just for this measure and not the other antimicrobial measures.

Q & A : P4P & VBR Workgroup Participation

- **Question:** Please confirm the guidelines for the oncology PICC initiative. I thought I understood that the specialist would need to attend 1 of the 3 meetings to receive points? If they attended all 3 then there would be bonus points?
- **Answer:** Yes, if you are specifically speaking of the Performance Index for HMS (or P4P), then the specialist only needs to attend 1 of 3 meetings to receive the main points (non-bonus). Please note that for the oncology piece, there is also a second component which is meeting the threshold below for triple lumens and those in for < 5 Days. (see below)

Oncology	
≤ 25% of PICCs placed in oncology patients[17] are triple lumens **AND** in for ≤5 Days **AND** participation in special population workgroup[13,14,15]	15

If they attend all 3 of the work group meetings, they will receive the bonus points (total of 5 points)

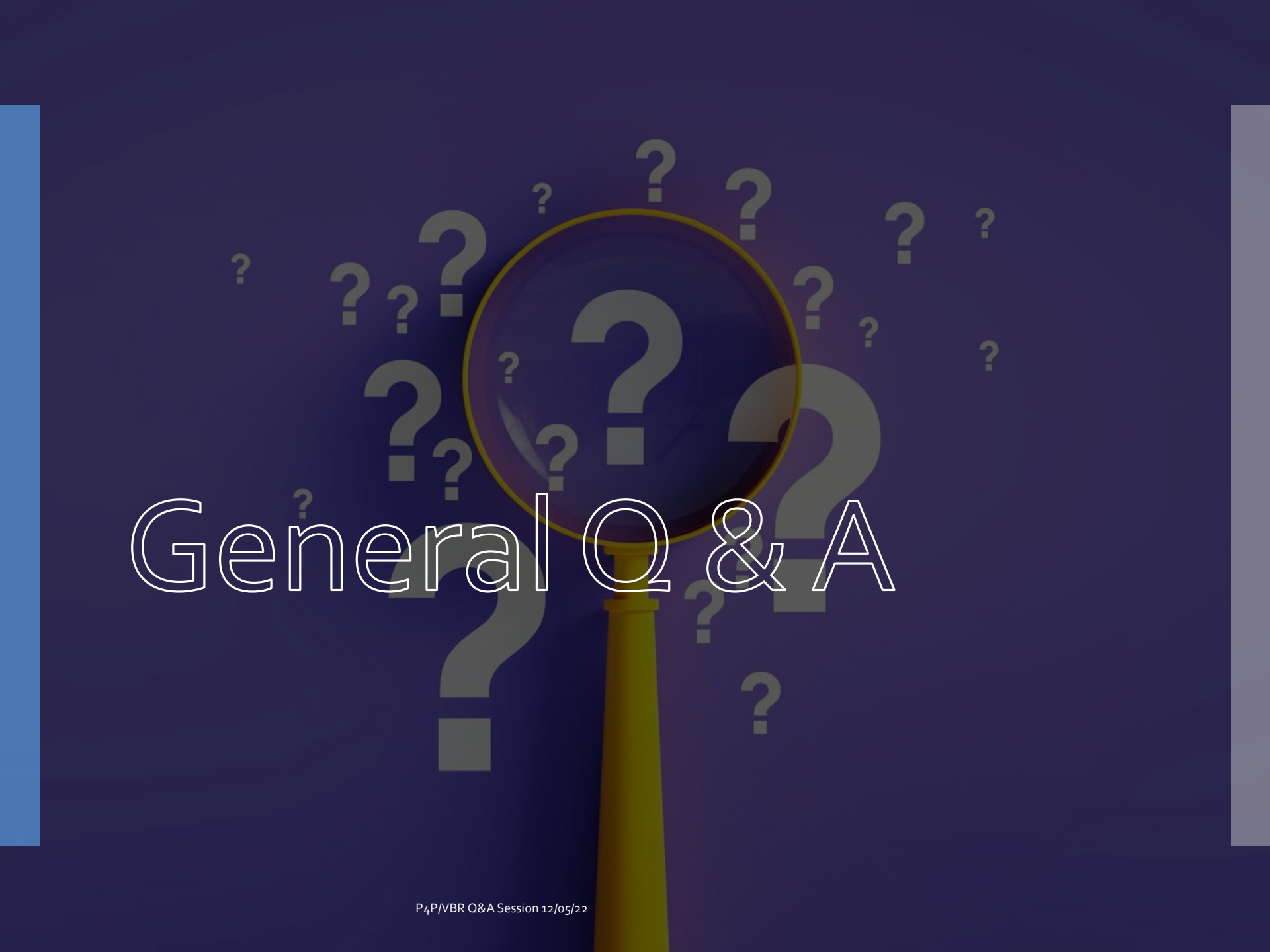
Q & A: P4P & VBR
Workgroup- In person vs. virtual

- **Question:** This looks like they are required to attend all 3 but it was originally said in our meeting that only the March meeting would be virtual. Also, as the vascular access team representative do I need to attend all 3 meetings? In person or virtual?

- **Answer:** You are correct, our March meeting will ONLY be virtual for everyone, including the special population workgroup. For July and November, the special population workgroup **only** (not the regular HMS Collaborative Wide Meeting), we will be allowing both in person and virtual attendance to count for participation. Of note, for our July and November Collaborative Meetings (the main meeting – not the workgroup) will only be in person. We are just making this exception for the special population workgroups.

Q & A : P4P & VBR Workgroup Attendance Tracking

- **Question**: Can you also clarify how many times the workgroup will be meeting and detail how meeting the metric will be assessed?
- **Answer:** The workgroup will be meeting 3 times during the calendar year on the day of the Collaborative Wide Meeting (immediately following or prior to the main meeting). I anticipate the meetings to be 1-2 hours at most. The hope is to keep these at 1 hour but we do anticipate case review/site presentations so I can't promise 1 hour. To track attendance at our March Meeting (which is 100% virtual), we will be tracking participation via zoom registration/attendance tracking. Zoom will tell us who attended and the times they attended. During the registration process, we will ask the specific specialty to be able to track this. For the July and November meetings, we will be tracking attendance via zoom (similar to previously described) and also through a mechanism in person that our administrative team is still finalizing. Either way during the registration process we will be asking for the name and specialty they represent.



General Q & A

Resources

- HMS Website

https://mi-hms.org

- VBR Fact Sheet
- FAQ distributed after meetings conclude
- Pay for Performance Cheat Sheet – Distributed in early January

For Members

Information and resources for use by participating hospitals can be found on this page.

General Resources

- CQI Performance Index
- HMS Adjusted Model Resources
- HMS Value Brochure

Initiative-Specific Resources

- Antimicrobial Use Resources
- PICC Resources
- Midline Resources
- VTE Resources (Retired Initiative)

Data Entry

- PICC/Midline Data Entry
- Antimicrobial Data Entry
- COVID Data Entry
- Sepsis Data Entry

Meeting and Publication Resources

Collaborative-Wide Meetings

- Past Meetings
- Upcoming Meetings

Publications Guidelines and Process

- Publications Review Form
- Publication Policy

DDP Abstractor Expectations

- Data, Design, & Publications Committee Abstractor Expectations