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Rural Hospital and Physician Participation in Private Sector Quality Initiatives

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Key Findings

- In six states with significant rural populations, private insurers are implementing initiatives designed to improve the quality and efficiency of care provided by physicians and hospitals.
- These insurers' motivations included employer requests for fee-for-value hospital contracting, and desires for increased efficiency and to align incentives with national quality standards.
- Participation is voluntary in the majority of programs. Eleven of the twelve programs provide direct financial incentives to providers.
- These initiatives use a wide range of quality measures, including Centers for Medicare and Medicaid Services (CMS) and National Committee for Quality Assurance (NCQA) measures, as well as measures developed for state and local initiatives and hospital networks.
- Although the majority of these initiatives do not specifically address rural providers, one hospital program and two physician programs do.
- Limited data are publicly available on the impact of these initiatives on rural hospitals, physicians, or consumers.

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Purpose

The purpose of this project is to analyze private sector quality reporting and quality improvement initiatives being implemented by dominant insurers in states with significant rural populations.

Background

The National Strategy for Quality Improvement in Health Care, developed by the Department of Health and Human Services to guide implementation of the Affordable Care Act, envisions ongoing national, state, and local efforts to improve the quality of health care. National Quality Strategy priorities include making health care more patient-centered, accessible, and safe; promoting effective communication and coordination of care; and making quality care more affordable by reducing costs and reforming payment systems. The first annual progress report on the National Quality Strategy reinforced the point that achieving these aims will require "true collaboration" between the private and public sectors.[1]

Public reporting of quality measures and "pay-for-performance" financial incentives have been advocated as strategies to improve quality. Several Federal programs focus on public reporting and financial incentives to improve quality in hospitals and physician practices, including the Centers for Medicare & Medicaid Services (CMS) Hospital Inpatient and Outpatient Quality Reporting Programs, Hospital Compare, Hospital Value-Based Purchasing initiative, Physician Quality Reporting System, and Medicare and Medicaid Electronic Health Record (EHR) Meaningful Use Incentive Programs. Many private sector quality initiatives are also being implemented, including projects funded by private foundations, value-based purchasing initiatives spearheaded by purchaser-led health care coalitions, and a variety of health plan/health insurer initiatives.[2-3] These include: 1) designation of high-performing hospitals and physician groups based on various quality and efficiency metrics (e.g., Centers of Excellence); 2) performance-based contracts with providers that link payment to achievement of certain quality thresholds; 3) reimbursement incentives for physician practices to participate in activities such as case management, care coordination, and development of Primary Care Medical Homes; and 4) health plan incentives for participating providers to adopt EHRs and achieve meaningful use.

Some private sector quality initiatives could potentially have a significant impact on the quality of rural health care, particularly in rural markets that are dominated by a single large insurer, as these insurers are likely to have

both the resources to implement an initiative and sufficient leverage to motivate rural provider participation. Health insurance markets are highly concentrated in many states.[4] A single health insurer, often a Blue Cross and Blue Shield (BCBS) company, covers 50% or more of the individual insurance market in 29 states,[5] 50% or more of the large group insurance market in 31 states,[6] and 50% or more of the small group market in 27 states.[7] Many of these states have sizeable rural populations. As CMS moves further in the direction of implementing value-based purchasing for hospitals and merit-based incentive payments for physicians, there may be lessons to be learned from private sector quality initiatives, especially in rural areas.

Approach

This project involved a review of the literature and collection of primary data from websites and interviews with insurer/health plan representatives in multiple states with significant rural populations. The research team identified dominant private insurers in several states with significant rural populations, using national reports on the health insurance market[4] and Census data on rural populations. We reviewed websites and related materials from those insurers to identify relevant quality initiatives potentially involving rural physicians and hospitals. We selected insurers in six states, representing each of the four census regions, for interviews. Because BCBS is the dominant insurer in many states with rural populations, the plans selected were all independent licensees of BCBS.

Using interview protocols developed to collect standardized information on each initiative, we conducted telephone interviews with insurer/health plan representatives. Interview questions addressed their motivations for implementing the initiatives, participation by rural hospitals or physicians, quality measures and financial incentives used, and any evidence of the impact on the quality of care provided to rural patients. A content analysis of the interview notes was performed to identify common themes and characteristics.

Results: Physician Initiatives

This section describes the motivation for implementing each physician initiative, participation by physicians in the initiative, and quality measures and financial incentives used.

The six profiled physician quality initiatives were implemented between 2011 and 2013. Although interviews with insurer/plan representatives revealed a range of motivations for implementing the six initiatives, most cited reducing costs and improving health outcomes as primary motivating factors (Table 1).

Eligibility Criteria & Rural Physician Participation

Participation in all six profiled physician quality initiatives is voluntary, and providers must meet certain criteria to participate. Primary care providers in the BCBS Alabama

Table 1. Profiled Physician Quality Initiatives and Motivations for Implementation

State	Quality Initiative	Motivations for Implementation
Alabama	BCBS Primary Care Value-Based Purchasing Program (PCVBP)	• Help providers conform to national standards and monitor major health issues • Improve ratings for Medicare and health reform • Reduce cost of care for members
Kansas	BCBS Professional Providers Quality Based Reimbursement Program (QBRP)	• To be able to offer plans in health insurance marketplace
Michigan	BCBS Patient Centered Medical Home (PCMH) and Physician Group Incentive Program (PGIP)	• Enhance program aimed at increasing primary care and specialty care collaborations
New Hampshire	Anthem Enhanced Personal Health Care Program (EPHC)	• Control costs, while improving health outcomes and access to health care
South Carolina	BCBS Patient Centered Medical Home (PCMH)	• Progress towards achieving the Triple Aim of increased patient satisfaction, increased quality outcomes, and decreased cost
Utah	Regence BCBS Total Cost of Care Program (TCC)	• Provide physicians with cost data for services received by patients inside and outside of their practice, coupled with tracking quality metrics

network must submit claims and receive payments electronically, and have 24/7 phone care available in order to participate in the PCVB program. Primary care providers in the BCBS Kansas network are eligible to participate in the QBRP program if they fully transact business electronically, accept electronic remittance advice documents, and receive all business communications electronically. The Michigan PCMH model requires physicians to be part of a larger physician organization participating in the Physician Group Incentive Program (PGIP); PGIP is open to all practitioners in the BCBS Preferred Provider Organization and traditional networks. To participate in the BCBS South Carolina PCMH, providers must provide access during office hours, use data for population management, provide care management, support the self-care process, track referrals and follow-up, and continuously measure and improve performance.

Of the six profiled programs, the South Carolina PCMH program is the only one with 100% participation by rural providers. Participation rates in the other programs vary. Alabama BCBS reports that the majority of primary care providers participate in the PCVB program. In Kansas, about 36% of primary care physicians participate in QBRP, while 40% to 50% participate in Michigan's PCMH program, and 75% participate in New Hampshire's EPHC program. The Utah TCC program began with the voluntary participation of the Central Utah Clinic, a large, multi-specialty medical group comprised of 71 clinic locations throughout the state; 18 are located in rural counties, and eight rural clinics have primary care practices.

Quality Measures and Financial Incentives

The six physician programs measure quality in a variety of ways. Four programs reward practices for achieving national PCMH designation. Several programs include measures that focus on proper management of a particular disease or condition (e.g., diabetes, hypertension, congestive heart failure, and asthma). Other commonly-used measures relate to medications (e.g., percentage of generic prescriptions used, whether or not persistent medications are monitored on an annual basis) and preventive care (e.g., vaccination and mammogram rates, and well-child visits). Table 2 (Appendix) describes the specific quality measures used in each initiative.

In the Alabama PCVBP, providers must receive a score of at least 70 in the following three categories to be eligible for the related value-based payment: efficiency (generic and preferred drug utilization); administrative (board certification, risk coding criteria, NCQA PCMH and Diabetes Recognition, active e-prescriber); and effectiveness of care (physician quality indicators, satisfaction). Alabama physicians can receive anywhere from 5% to 20% fee enhancements on Evaluation and Management (E&M) CPT codes when they meet the minimum point threshold in the three measured performance categories: efficiency, administrative, and effectiveness of care.

The Kansas QBRP has two tiers of incentives. Tier 1, which applies to all providers regardless of specialty, rewards providers for utilizing the insurer's electronic self-service portal to obtain patient eligibility, benefit information and claim status; participating in the Kansas Health Information Exchange; using electronic prescribing methods; and prescribing generic prescriptions at least 75% of the time. Tier 2 applies to office-based primary care (defined as family practice, general practice, general internal medicine, and pediatrics) physicians and associated physician assistants and advanced practice nurses, who are rewarded for NCQA Diabetes Recognition; NCQA or URAC PCMH recognition; measles, mumps and rubella (MMR) vaccine and mammography rates. The QBRP program allows physicians to choose the quality component they would like to improve and offers a percentage rate increase for each individual component. Additionally, any provider practicing in a rural county (defined by BCBS Kansas as less than 13,000 residents) is reimbursed their traditional allowance for E&M codes + 5% + any QBRP earnings (the additional 5% is separate from QBRP participation).

In Michigan's PCMH program, a two-pronged approach encourages physicians to excel in implementation of PCMH capabilities and improve quality performance. In the 'implementation program,' each capability has an associated (proprietary) dollar amount; practices are paid for capability implementation twice a year. More advanced practices participate in the 'designation program,' in which physician groups that have excelled (generally implementing at least 40 capabilities) are further incentivized to improve quality measurements. Providers in the designation program receive an implementation payment, along with an additional 10% fee enhancement on E&M codes for the

extra time spent with patients. Providers who are part of a PGIP provider organization that achieves a high value at a population level receive an additional 10% enhancement on E&M codes.

Rural providers participating in the New Hampshire EPHC program are evaluated on five composite measures: acute and chronic care management (e.g., medication adherence, diabetes care), preventive care (pediatric and adult); utilization (e.g., ambulatory care sensitive admissions); and clinical quality improvement (e.g., breast cancer screening, well child visits). Small and independent physician practices receive a per member per month (PMPM) care coordination payment to cover prevention activities not eligible for fee-for-service reimbursement, while physicians in a hospital-owned organization have an ACO-like payment structure with upside and downside risk. Providers must generate a certain amount of shared savings, as well as meet a quality performance (market) threshold for their attributed member population, in order to be eligible to financially benefit from the pooled shared savings of the organization.

The South Carolina PCMH program uses national benchmarks from NCQA and CMS to develop quality measures for diabetes, congestive heart failure, and hypertension. It uses a blended payment methodology: a fee for service payment is made for services such as office visits; a prospective payment is made on a PMPM basis to compensate the practice for the additional or enhanced services it provides to eligible members with targeted chronic diseases (diabetes, hypertension, congestive heart failure); and payment for results such as clinical processes and outcomes and patient experience of care. After each performance year, practices are eligible for bonuses based on quality measure improvements established in individual contracts. The bonus is provided as an adjustment to the PMPM care coordination fee for the following performance year.

The Utah TCC program uses 15 process-related HEDIS measures focused on proper management of chronic conditions such as diabetes, high blood pressure, and asthma; tracking/lowering BMI, and patient satisfaction survey results. Physicians have no financial risk to participate. Cost trend benchmarks are based on prior year claims. Each TCC group is asked to beat the benchmark cost trend by 1-3%, depending on their assigned target, to start to earn a shared savings amount. The group is eligible to receive a (proprietary) percentage of the surplus if they receive a satisfactory quality performance score. If the group does not reach the quality benchmarks in the first year, they are at risk of losing 30% of their portion of the shared surplus. In the second year, not meeting the quality benchmark costs them 50% of their portion of shared savings; and in the third year, if the group generates shared savings, but does not meet the quality benchmarks, they will receive no payout on their eligible shared savings.

Table 3. Profiled Hospital Quality Initiatives and Motivations for Implementation

State	Quality Initiative	Motivations for Implementation
Alabama	BCBS Hospital Tiered Network	• Demand from large employers to offer a quality/cost-based network
Kansas	BCBS Hospital Quality Based Reimbursement Program (QBRP)	• Response to ACA requirements for health insurance marketplaces / exchanges
Michigan	BCBS Peer Group 5 Hospital Pay-for-Performance (for small rural hospitals; Peer Groups 1-4 are for medium and large hospitals)	• Recognized difference in needs and capabilities of urban and rural hospitals • Increase accountability and improve efficiency in rural hospitals
New Hampshire	Anthem Quality-in-Sights Hospital Incentive Program (Q-HIP)	• Align incentives with national quality standards • Support hospitals in QI efforts
South Carolina	BCBS Hospital Recognition Program	• Evolve quality reporting program into payment for excellence program • Respond to customer demands for fee-for-value approach to contracting
Utah	Regence BCBS Pay For Performance (P4P) Program	• Control costs • Encourage fee-for-value • Tie reimbursement increases to pay-for-performance

Results: Hospital Initiatives

Interviews with insurer/plan representatives revealed a range of motivations for implementing the six profiled hospital quality initiatives; most cited a desire to improve efficiency (Table 3, previous page).

Eligibility Criteria and Rural Hospital Participation

Participation is voluntary in four of the six profiled hospital programs. Michigan BCBS requires hospital participation by contract, and imposes a financial penalty for non-compliance; all rural hospitals and Critical Access Hospitals (CAHs) participate. In New Hampshire, 16 out of 24 acute care hospitals in the Anthem network currently participate in the Q-HIP program; all hospitals will have to participate in the Q-HIP program in order to receive fee increases when it is time to renegotiate their contracts. Alabama's four CAHs are not eligible to participate in the Hospital Tiered Network program; all other rural hospitals participate.

To participate in the Kansas Hospital QBRP program, rural hospitals must file claims electronically, accept electronic remittance advice, and use the insurer's electronic portal for inpatient precertification and continued stay reviews. About 75 of the 84 CAHs in Kansas participate; three rural hospitals that are not CAHs also participate. All rural hospitals in South Carolina, including CAHs, participate in the BCBS Hospital Recognition Program.

No rural hospitals are participating in the BCBS Utah Pay for Performance Program at this time, which the insurer attributes to challenges with human resources and information technology, and small volume. Rural hospitals that lack the volume to participate individually could participate if they were part of a hospital system; the program would assess the overall performance of all hospitals in the system in aggregate.

Hospital Quality Measures and Financial Incentives

Although these six programs measure quality in different ways, most assess hospital quality in a multifaceted way, using multiple types of measures, e.g., patient satisfaction, process-of-care performance, and community health benchmarks. Table 4 (Appendix) describes the specific measures used in each initiative.

To achieve 'Tier 1' status in the Alabama Hospital Tiered Network program, participating hospitals must score at least 80 points in each of three measurement categories: fiscal, quality, and outcomes. The fiscal category is scored on a hospital's willingness to enter into payment agreements that benefit members, performance against financial benchmarks across inpatient and outpatient services, and risk-adjusted readmission rate performance. The quality category reflects a hospital's commitment to improving the quality of patient care. The outcomes category includes process of care, outcome, patient experience, and infection control measures. In addition, hospitals that achieve Blue Distinction Center of Excellence Recognition qualify for points. This program does not have direct financial incentives, but Tier 1 hospitals are expected to increase patient volume, since costs are reduced for plan members who go to a Tier 1 hospital rather than a Tier 2, Tier 3 or non-participating hospital. About 79% of the rural acute care hospitals in BCBS Alabama's network have achieved Tier 1 status.

The Kansas QBRP program requires hospitals to participate in Kansas Hospital Engagement Network (HEN) activities, use the World Health Organization surgical safety checklist, and obtain eligibility, benefit and claim status electronically. Eight required quality measures are based on benchmarks from CMS, Quality Health Indicators (QHi), American Hospital Association (AHA) / Health Research and Educational Trust (HRET), and the Kansas HEN. Hospitals that meet any or all of the measures can earn a rate increase (the amount of the incentive is proprietary); each measure is assessed independently.

The Michigan Peer Group 5 program assesses hospital performance in three categories: community health (a community service plan, HCAHPS surveys, and population health management plan), clinical quality indicators (outpatient AMI/chest pain and ED measures), Michigan Hospital Association Keystone Hospital Associated Infections indicators (adverse drug events, CAUTI, falls and pressure ulcers, sepsis); and Michigan Critical Access Hospital Quality Network (MICAHQN) quality improvement initiatives. BCBS Michigan works with each rural hospital to define the quality indicators that are most appropriate for them. Each year, a quality threshold range is decided based on the previous year's performance, and hospitals must score at or above that threshold in order to receive their increase in payment. Up to 6% of the hospital's

payment is dependent on the quality measure scores.

The New Hampshire Q-HIP program measures hospital quality in terms of patient satisfaction, patient safety, and health outcomes. Scores are compiled using a flexible scorecard methodology, which only evaluates rural hospitals on services that they can offer. The quality measures are based on standards supported by nationally-recognized quality groups such as the American College of Cardiology, the Institute for Healthcare Improvement, and the Joint Commission. Reimbursement increases are based on the hospital's quality score, on a scale of 1 to 100 points; the points associated with each quality metric are proprietary. The hospitals are paid retrospectively for their performance in the Q-HIP program. The Q-HIP program is an enterprise-wide Anthem program, and scoring differs for each market and each hospital contract.

The South Carolina Hospital Recognition Program measures hospital quality in terms of patient satisfaction, clinical processes, and health outcomes. Quality benchmarks are set for each hospital based on claims from the previous year; each quality metric is worth a certain point value (the amount is proprietary). A total of 100 points can be earned; if a benchmark is missed, the corresponding points are deducted. Hospitals are eligible to receive incentive payments for meeting quality benchmarks and improving quality, which vary depending on hospital bed-size category (e.g., the highest-performing hospital and the hospital with the greatest improvement in quality in the bed size category receive reward payments). The Medical Consumer Price Index is used to determine the reward payments.

The Utah P4P program assesses hospital quality using HCAHPS survey results, CMS measures, and Leapfrog scores. Hospital data are used to identify a baseline measurement of quality performance, and measured annually to determine performance improvement. As noted earlier, no rural hospitals are currently participating in the program.

Discussion

Rural Aspects of Initiatives

These initiatives vary significantly in the extent to which their design and implementation take into account the unique characteristics of rural hospitals and physician practices, such as the scope of services provided and patient volume. They range on a continuum from programs that exclude certain rural providers (e.g., CAHs or small rural practices) to programs specifically designed to focus on the quality improvement needs of rural providers.

Interviewees from Michigan, Kansas, and South Carolina reported having close working relationships with the rural community and local hospital and physician organizations, which have played a critical role in developing quality improvement programs that are feasible for rural providers. As part of the BCBS Michigan Peer Group 5 program, CAHs are required to participate in MICAHQN, a quality network convened by the Michigan Center for Rural Health, which brings hospitals together to share best practices and recognizes them for their quality improvement work. The Michigan Center for Rural Health has found the BCBS population management program to be a useful resource for rural hospital leaders. Since small hospitals do not have data analytic departments, it has been helpful for them to receive information from BCBS on how population health management may affect patient care in the future.

Assessing the impact of the profiled initiatives on rural providers and patients is complicated by the limited publicly-available information about some programs. A few insurers were not willing to share the specific quality measures used or the amount of incentives, viewing them as proprietary information. Several insurers indicated that they do not collect or analyze data on program outcomes separately for rural and urban providers and patients.

Other reported challenges in assessing program outcomes included short time frames since implementing the initiatives and changes in the quality measures being used. For example, BCBS Kansas reported that they use CMS quality measures, which CMS has modified fairly frequently, causing the insurer to change its measures and reducing its ability to successfully measure when improvement occurs over time.

Conclusions & Implications

In six geographically diverse states with significant rural populations, dominant private insurers are implementing a range of initiatives designed to improve the quality and efficiency of care provided by physicians and hospitals. The profiled insurer quality initiatives are being implemented in the context of multiple public and private quality improvement initiatives such as CMS quality reporting and value-based purchasing, Hospital

Engagement Networks, Institute for Healthcare Improvement programs, etc. The abundance of initiatives focuses attention on quality issues and allows insurers to build synergistically on national, state, and regional efforts, but also can make it difficult to attribute improvements in quality to a single initiative. Limited data are available on the impact of these initiatives on rural hospitals and physicians or consumers. ■

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Appendix

Table 2. Quality Measures Used in Physician Quality Initiatives

Alabama BCBS Primary Care Value-Based Payment Program
Efficiency • Generic Drug Utilization Performance: percent of generic prescription • Preferred Drug Utilization Performance: percent of preferred drugs
Administrative • Board certification is required • New risk coding criteria: audit, practice management software diagnosis exercise, diagnosis code submission, attest to use of a certified coder, attend medical documentation and coding meeting, complete ICD-10 readiness survey • NCQA Patient-Centered Medical Home Level • NCQA Diabetes Recognition Program • Active e-prescriber
Effectiveness of Care • Physician quality process of care measure • Overall physician satisfaction measure
Kansas BCBS Physician Quality Based Reimbursement Program
Tier 1: All eligible contracting professional providers • Portal used to electronically obtain patient eligibility, benefit information, and claims status • Participate in Kansas Health Information Exchange • Use of electronic prescriptions: access member benefit information for eligibility, formulary, and medication history minimum of 45 times per quarter • Minimum generic prescribing of 75% for all members with prescription drug benefit
Tier 2: Office-based primary care physicians, PAs and APRNs • NCQA recognition for Diabetes Recognition Program • NCQA and/or URAC PCMH recognition • 60% of children with one MMR vaccine by 2nd birthday • 60% of women age 50+ with mammogram
Michigan BCBS Patient Centered Medical Home
Phase I: Apply PCMH capabilities and tools from 12 domains: coordination of care; extended access; individual care management; linkage to community services; patient-provider partnership; patient registry; patient web portal; performance reporting; preventive services; self-management support; specialist referral process; test results tracking
Phase II: Designate PCMH practices and maintain designation status
New Hampshire Anthem Enhanced Personal Health Care
Acute and Chronic Care Management • Medication adherence, proportion of days covered • Diabetes care • Annual monitoring for persistent medications • Other acute and chronic care measurement
Preventive Care • Pediatric prevention • Adult prevention
Utilization • Ambulatory care sensitive admissions • Pediatric ambulatory care sensitive admissions • Generic dispensing rate for specific therapeutic classes

Table 2 (Continued). Quality Measures Used in Physician Quality Initiatives

(Continued) New Hampshire Anthem Enhanced Personal Health Care

Clinical Quality Improvement

- Breast cancer screening
- Medication adherence: Statins
- Diabetes: HbA1c testing
- Well child visits ages 3-6 years old
- Appropriate testing for children with pharyngitis

NCQA PCMH Recognition

- Percent of provider organization locations with Level 2 or 3 recognition

South Carolina BCBS Patient Centered Medical Home

Diabetes Measures

- HbA1C exam in past 12 months
- HbA1C in past 12 months with most recent < 8
- Blood pressure exam in past 12 months
- Blood pressure exam in past 12 months < 140/90
- LDL-Cholesterol exam in past 12 months
- LDL-Cholesterol exam in past 12 months < 100
- Microalbumin exam in past 12 months
- BMI documentation in past 12 months
- Improved BMI since baseline
- Diabetic retinal exam in the past 12 months

Congestive Heart Failure Measures

- Ejection fraction exam in the past 12 months
- Most recent EF ≤ 40% with documentation of ACE1 or ARB in past 12 months
- Most recent EF≤ 40% with documentation of beta blocker in past 12 months
- Pneumococcal vaccine within past 10 years
- Influenza-A vaccine within past 12 months

Hypertension Measures

- BP exam in the last 12 months
- BP exam in the past 12 months with the most recent < 140/90
- BMI documentation in the past 12 months
- Most recently recorded BMI < 30
- Creatinine exam measurement in the past 12 months
- Generic Prescription Dispensing Rate
- Documentation of smoking status

Utah Regence BCBS Total Cost of Care Program

*Examples of Quality Metrics (a subset of 15 HEDIS metrics used)**

- Proper management of diabetes
- Blood pressure control
- Tracking/lowering BMI
- Asthma management
- Persistent use of beta-blockers after heart attack
- Patient Satisfaction: third party administered patient satisfaction survey

*These were shared as examples of metrics used. Regence BCBS of Utah reported that the specific measures are proprietary, and declined to share them.

Table 4. Quality Measures Used in Hospital Quality Initiatives

Alabama BCBS Primary Care Value-Based Payment Program
Fiscal Benchmarks • Preferred outpatient facility/ambulatory surgery center contract • Percent allowed to Medicare • Readmission rates
Quality Benchmarks • Concurrent Utilization Review Program (CURP) audit score, evaluation with a clinical auditor, CURP Quality Improvement Process • Transition of Care documented policies and procedures in place and sharing outcomes for the transition of care process • Participating in quality collaboration meetings • Implementation of policy to eliminate medically unnecessary early elective deliveries and reported rate ≤ 5% • Completion of National Health and Safety Network trainings • Hospital Engagement Network Collaboration • Glycemic Control Policy in place and data reporting results for specified time period
Outcomes Benchmarks • Patient experience performance - hospital performs at or above national average • CMS core measure average performance • Outperforms national average on any of three CMS outcomes measures • Hospital is Blue Distinction Center of Excellence • AHQI benchmarking status / CMS CLABSI SIR rate
Kansas BCBS Hospital Quality Based Reimbursement Program
Required Measures • Implement policy prohibiting non-medically indicated elective deliveries prior to 39 weeks gestation • 75% of eligible pneumonia patients had blood cultures performed in the ED prior to initial antibiotic received in hospital for ED admissions • Patients with CAUTI per 1000 urinary catheter days • Healthcare associated infections per 100 inpatient days • Unassisted patient falls per 100 inpatient days • Inpatients readmitted within 30 days for any reason
Low Inpatient Volume Measures for hospitals with 1000 or fewer inpatient days • Participation in >3 Hospital Engagement Network webinars/events in preceding 6 months • World Health Organization (WHO) surgical safety checklist use required
Michigan BCBS Peer Group 5 Hospital Pay for Performance
Health of the Community Program • Community Service Plan • HCAHPS survey responses • Population Health Management Attestation
Outpatient Quality Indicators • Aspirin at arrival- overall (AMI & chest pain) • Median time to ECG- overall (AMI & chest pain) • Median time from ED arrival to ED departure for discharged ED patients • Door to diagnostic evaluation by qualified medical personnel
Quality Initiatives • Michigan Critical Access Hospital Quality Network (MICAHQN) meetings • MHA Keystone Initiatives: adverse drug events, CAUTI, falls and pressure ulcers, sepsis

Table 4 (Continued). Quality Measures Used in Hospital Quality Initiatives

New Hampshire Anthem Quality-in-Sights Hospital Incentive Program (Q-HIP)

Angioplasty
- Heart attack diagnosis-to-angioplasty time <90 minutes
- Proportion of angioplasty procedures with vascular access site injury requiring treatment or major bleeding
- Patient prescribed cholesterol lowering drug (statin) at discharge
- Risk adjusted mortality

Heart failure
- Discharge instructions

Pneumonia
- Blood cultures performed in ED prior to initial antibiotic
- Initial antibiotic selection

Surgical Infection Prevention
- Preventive antibiotic given 1 hour before surgery
- Preventive antibiotic selection for surgical patients
- Preventative antibiotic stopped within 24 hours after surgery
- Cardiac surgery patients with 6AM post-op serum glucose
- Urinary catheter removed on postoperative day 1 or postoperative day 2
- Surgery patients on beta blockers that received beta blocker during procedure
- Surgery patient received appropriate measures to prevent blood clots within 24 hours prior to surgery and 24 hours after surgery

South Carolina BCBS Hospital Recognition Program (Quality measures are from the CMS Value-Based Purchasing Program)

Patient Satisfaction
- HCAHPS survey results

Clinical Process Measures
- Acute Myocardial Infarction
- Pneumonia
- Heart failure
- Surgical care improvement
- Healthcare Associated Infections

Health Outcome Measures
- 30 day AMI, heart failure, and pneumonia mortality rates

Utah Hospital P4P Program

- Medicare HCAHPS survey*
- Leapfrog scores*
- CMS Measures such as C-section rates, avoidable ER visits, readmission rates*

* These are examples of quality metrics used. Regence BCBS in Utah reported that the specific measures are proprietary, and declined to share them.