COLORADO
Department of Health Care Policy & Financing

2017 Hospital Quality Incentive Payment (HQIP) Program

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Overview of the HQIP Program

The Hospital Quality Incentive Payment (HQIP) Program is offered by the State of Colorado under the Colorado Medicaid program. Colorado Medicaid is administered by the Colorado Department of Health Care Policy and Financing (HCPF) and provides health care benefits for qualified Colorado residents. The HQIP Program is one part of the Hospital Provider Fee Program and provides incentive payments to hospitals for improving health care and patient outcomes.

Program Authority

The Colorado Health Care Affordability Act (House Bill 09-1293), Section 25.5-4-402.3, Colorado Revised Statute, authorizes HCPF to assess a hospital provider fee to generate additional federal Medicaid matching funds to expand health care access, improve the quality of care for clients served by public health insurance programs, increase funding for hospital care for Medicaid and uninsured clients, and to reduce cost-shifting to private payers.

The statute further authorizes HCPF to "… pay an additional amount based upon performance to those hospitals that provide services that improve health care outcomes for their patients. This amount shall be determined by the state department based upon nationally recognized performance measures established in rules adopted by the state board. The state quality standards shall be consistent with federal quality standards published by an organization with expertise in health care quality, including but not limited to, the Centers for Medicare and Medicaid Services, the agency for healthcare research and quality, or the national quality forum."

A 13-member Hospital Provider Fee Oversight and Advisory Board (Advisory Board), including five hospital members; one statewide hospital organization member; one health insurance organization or carrier member; one health care industry member; two consumers; one health insurance member; and two HCPF members, provide oversight of the Hospital Provider Fee Program. This Advisory Board is responsible for working with HCPF and the Medical Services Board to develop the hospital provider fee model, monitor the implementation of the bill, help with preparation of annual reports on this program, and ensure that the Medicaid and Child Health Plan *Plus* (CHP+) eligibility expansions are implemented as intended.

The Advisory Board appointed a subcommittee comprised of staff from hospitals, the Colorado Hospital Association and the Department to provide recommendations on the quality portion of the statute. The major tasks of the subcommittee include:

1. Recommend performance measures that form the basis of the incentive payment.
2. Recommend how payments should be made.
3. Communicate with hospitals.
4. Gather and analyze data required for the performance measures.

The subcommittee recommends performance measures and scoring to the Advisory Board. HCPF calculates the incentive payments based on measures and scoring approved by the Advisory Board. Once approved, the HCPF Medical Services Board and the Centers for Medicare and Medicaid Services

(CMS) must then approve the payments. Incentive payments are made once all approvals have been obtained. Hospital participation in the HQIP program is voluntary.

2017 HQIP Subcommittee

The HQIP subcommittee is comprised of staff from hospitals, the Colorado Hospital Association, and the Department. The members of the subcommittee for 2017 are as follows:

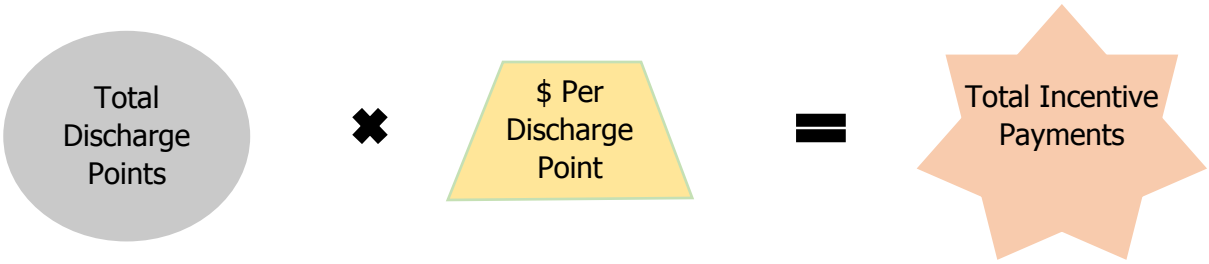
Thomas MacKenzie, MD, Chief Medical Officer and Chief Quality Officer, Denver Health
David Solawetz, Director of Quality, Process Improvement and Clinical Informatics, Middle Park Medical Center
Bonnie Wasli, Chief Financial Officer, Valley view
Lindy Garvin, Vice President of Quality Improvement and Patient Safety, HealthONE
Nancy Griffith, Colorado Hospital Association
Janet McIntyre, Colorado Hospital Association
Matt Haynes, Colorado Department of Health Care Policy and Financing
Heidi Walling, Colorado Department of Health Care Policy and Financing

Incentive Payment Calculation

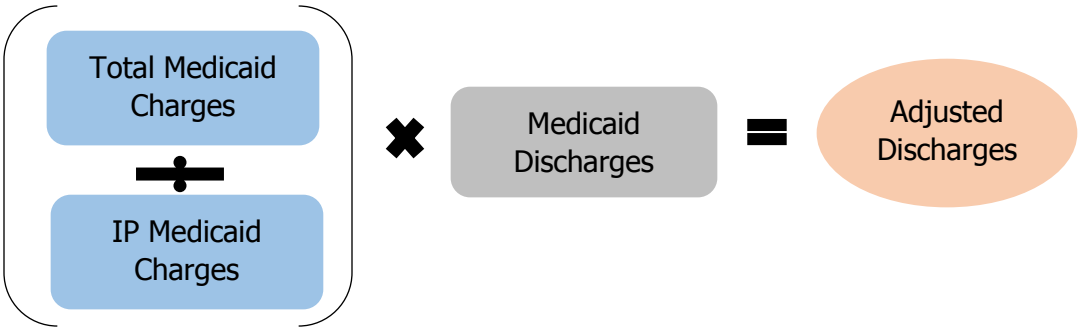
The HQIP incentive payments are based on each hospital's performance on the measures recommended by the HQIP Subcommittee and approved by the Advisory Board. Data to assess performance is obtained from a variety of sources: hospitals report to the Department on selected measures and data is obtained from Medicaid claims data, Hospital Compare, and other sources for other measures.

The total amount of funds available for incentive payments for 2016/17 was approximately $90 million (this may not be the amount available in 2017/18). The incentive payment calculation is displayed below.

Annual adjusted discharges are multiplied by the total quality points earned by a hospital to determine total discharge points. Total discharge points is then multiplied by the dollars per discharge point to arrive at the total incentive payment.



Adjusted discharges are calculated by dividing the total Medicaid charges by inpatient Medicaid charges. This quotient is multiplied by total inpatient Medicaid discharges to arrive at Adjusted Discharges. This calculation is done to derive a metric that represents total inpatient and outpatient volume combined.



Dollars per Discharge Point

A hospital's performance level determines the quality points earned. The $ per Discharge Point (above) is dependent on the total quality points earned by a hospital. The higher the total quality points, the more money each discharge point is worth.

Hospitals can earn anywhere from 0 to 50 points for the HQIP program. This point range is divided into five, ten-point tiers. Each ascending tier has a higher dollar per discharge point amount. The dollar amount for Tier 1 is determined by the available annual funding and the statewide distribution of the quality points. Each subsequent tier adds an additional amount equal to 50% of Tier 1. In other words, the dollar per discharge point for Tier 2 is 1.5 times the Tier 1 amount, Tier 3 is 2 times Tier 1, Tier 4 is 2.5 times Tier 1, and Tier 5 is 3 times Tier 1. The following example illustrates the tiered per-adjusted-discharge-point payment amounts (a Tier 1 amount of $5.00 per discharge point is assumed for illustration purposes).

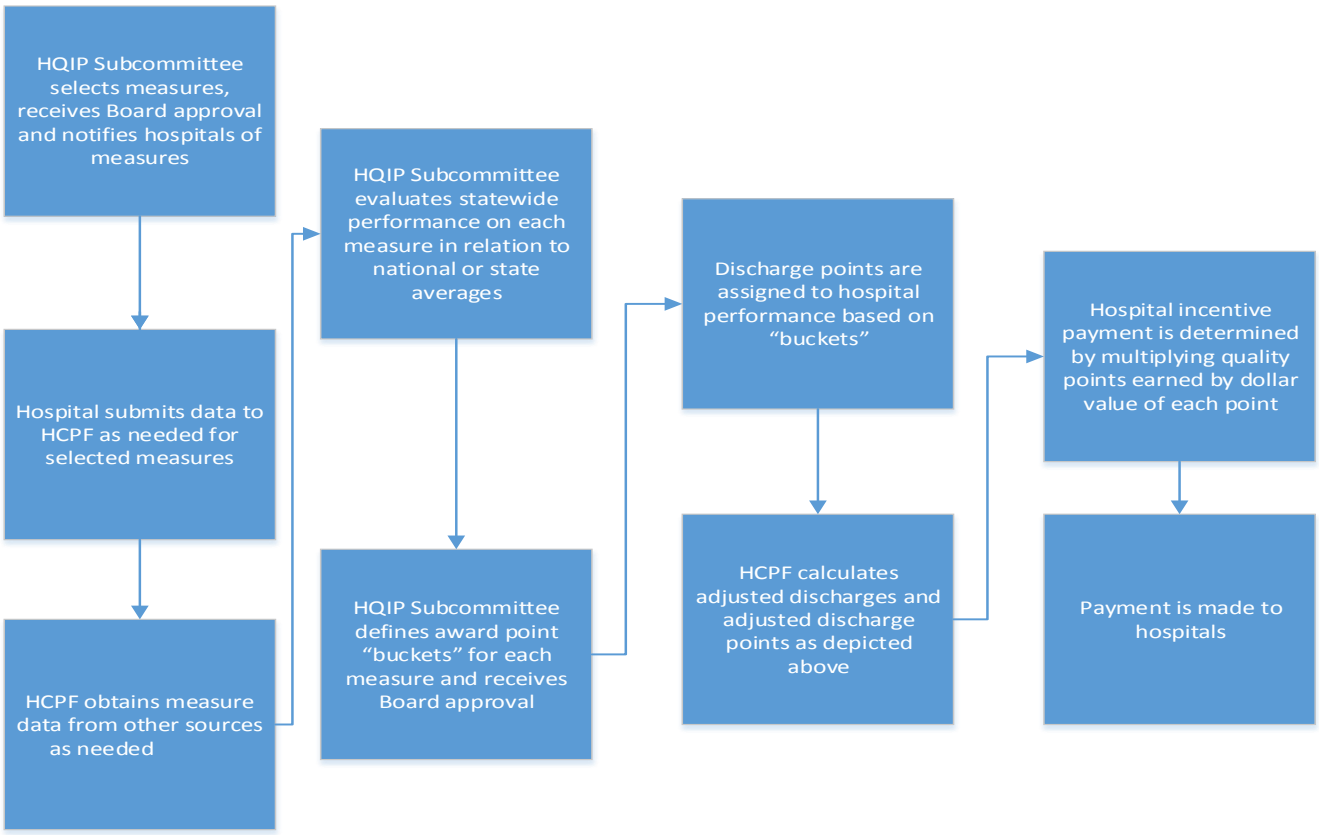
Example: Payment Tiers based on Total Quality Points Earned

Tier	Total Quality Points	Dollar per Discharge Point
1	1-10	$5.00
2	11-20	$7.50
3	21-30	$10.00
4	31-40	$12.50
5	41-50	$15.00

The above table shows that if a hospital earned 23 total quality points, the hospital would be paid $10.00 per discharge point. If a hospital earned 46 total quality points, the hospital would be paid $15.00 per discharge point.

Annual HQIP Process

The annual HQIP process is depicted by the following flowchart.



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Measure Information

In 2017, there will no longer be a distinction between Base Measures and Supplemental Measures. Hospitals will be requested to complete all eight measures. They will be scored on the first five measures for which they are eligible (in the order presented below) for a maximum possible score of 50 points.

Maintenance Measures are measures that are important to quality of care and patient safety but have little room for improvement over current statewide performance levels. The HQIP subcommittee will continue to review the statewide rates to be sure that gains are maintained. No points are assigned for Maintenance measures.

2017 Measures

Measures for the year beginning January 1, 2017 are listed below. Hospitals will be requested to complete all eight measures. They will be scored on the first five measures for which they are eligible (in the order presented below) for a maximum possible score of 50 points, 10 points for each measure.

Detailed information about each measure, criteria required to meet each measure, and reporting requirements for each measure begins on page 9.

Measures in **Bold** are prospective—focusing on activities in 2017. All other measures are retrospective—focusing on activities in 2016, as indicated below.

2017 HQIP Measures	Measure Steward	Data Source	Populations Included	Effective Service Dates
1. Culture of Safety	**HQIP Subcommittee**	**Hospital**	**All Patients**	**January 1, 2017 – December 31, 2017**
2. Active Participation in RCCOs	**HQIP Subcommittee**	**Hospital**	**N/A**	**January 1, 2017 – December 31, 2017**
3. Cesarean Section	Joint Commission: PC-02A	Hospital	All Patients	January 1, 2016 – December 31, 2016
4. HCAHPS - Percentage of patients who gave their hospital a rating of "9" or "10" on a scale of 0 (lowest) to 10 (highest).	HCAHPS	Hospital Compare	All Patients	Rates shown on Hospital Compare as of July 2017
5. 30-Day All-Cause Readmissions	CMS/HCPF	HCPF/MMIS Claims Data	All Medicaid Patients	January 1, 2016 – December 31, 2016
6. Emergency Department Process	**HQIP Subcommittee**	**Hospital**	**All Medicaid ED Patients**	**January 1, 2017 – December 31, 2017**
7. Advanced Care Planning	NQF: measure ID 0326	Hospital	All Patients	January 1, 2016 – December 31, 2016
8. Tobacco Screening and Follow-Up	Joint Commission: TOB-01, TOB-03	Hospital	All Medicaid Patients 18+	January 1, 2016 – December 31, 2016

2017 Maintenance Measures	Measure Steward	Data Source	Effective Service Dates
1. PE/DVT	AHRQ	CHA Hospital Report Card	January 1, 2016 – December 31, 2016
2. CLABSI	CDC	CDPHE	August 1, 2016 – July 31, 2016
3. Early Elective Deliveries	Joint Commission PC-01	CMS	January 1, 2016 – December 31, 2016

Changes from the Prior Year

For HQIP 2017, there will no longer be a distinction between Base Measures and Optional Measures. Hospitals will be requested to complete all eight measures. They will be scored on the first five measures for which they are eligible (in the order presented below) for a maximum possible score of 50 points.

Measure	2017 Order	2016 Order
Culture of Safety[1]	1	5
Active Participation in RCCOs*[2]	2	6
Cesarean Section	3	2
HCAHPS	4	4
30-Day All-Cause Readmissions	5	3
Emergency Department Process	6	1
Advanced Care Planning	7	7
Tobacco Screening and Follow-Up	8	8

[1] All hospitals are considered eligible for the Culture of Safety and Active Participation in RCCOs measures.
[2] All hospitals are considered eligible for the Culture of Safety and Active Participation in RCCOs measures.

Culture of Safety:

- Points will no longer be awarded for planning a Patient Family Advisory Council (PFAC). Points will only be awarded for active PFACs in calendar year 2017.
- A fifth activity for Adverse Event Reporting was added. Hospitals will be required to describe their adverse event reporting system and the process(es) in place to address reported events. This process must be in place by April 1, 2017.

Active Participation in RCCOs:

- All hospitals are now considered eligible for this measure.
- A criteria for notification of appropriate RCCO of ED visits within 24 hours of visit was added (formerly part of Emergency Department Process Measure). The notification must include the chief complaint/reason for the visit.
- Notification of inpatient admissions must now include the chief complaint/reason for the admission.
- The "all or nothing" scoring previously used for this measure was changed to a variable point methodology based on the number of criteria/activities met.
- The inpatient admission and ED visit notification criteria are required to earn points for this measure.

Cesarean Section:

- A criteria was added to describe the process of notifying physicians of their respective Cesarean Section rates and how they compare to other physicians' rates and the hospital average; this must be implemented by April 1, 2017. The hospital has discretion over how to format the report and disclosures for statistical significance. Hospitals will be required to include a blank example of the report that is provided to physicians for this purpose.

HCAHPS:

- No changes.

30-Day All Cause Readmissions:

- No changes.

Emergency Department Process:

- The criteria to notify the RCCO of ED visits within 24 hours of visit was removed from this measure and added to the Active Participation in RCCOs measure.
- Hospitals will be required to submit copies of written policies or guidelines for the two opioid related attestations in this measure.

Advanced Care Planning:

- No changes.

Tobacco Screening and Follow-Up:

- Providers will submit data related to both TOB-01 (screening) and TOB-03 (follow-up). However, points will be based only upon rate for TOB-03.

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Measures Details

#1 Culture of Safety (up to 10 points)

This measure is designed to promote a culture of safety in hospitals. Hospitals can choose to implement/report on any four of the following five activities for up to 10 points:

#1: Patient and Family Advisory Council

#2: Patient Safety and Hospital Leadership

#3: Patient Safety Survey *(choose either 3A or 3B)*

#4: Daily Unit Safety Briefings/Huddles

#5: Adverse Event Reporting (by 4/1/2017)

Definitions, criteria and reporting requirements for each of these activities is provided below.

Patient and Family Advisory Council

Measure Definition: An established council with members who are former patients or family members of former patients.

Measure Criteria:

- The council must meet at least four times in calendar year 2017. Note that planning meetings for PFAC will not be eligible for points in the 2017 HQIP program.
- At least three council members must be former patients or family members of former patients.
- The purpose of the council should be to provide advice and guidance regarding patient safety and/or patient experience issues identified by council members.
- There should be demonstration by the organization that such advice and guidance was taken into consideration in the planning and improvement of patient care experience and outcomes.

Patient Safety and Hospital Leadership

Measure Definition: One of the following is conducted on a regular basis:

- Leadership Safety Rounds, defined as planned visits to the appropriate hospital departments by hospital executive(s) or senior leaders for the purpose of demonstrating leadership's commitment to a strong patient safety program and identifying and responding to patient safety concerns identified by hospital staff. A senior leader is defined as someone at a Division Director level or higher.

OR

- Daily Leadership Safety Huddles/Briefings, defined as short, daily meetings attended by a hospital executive or senior leader in which representatives from all departments gather to report on potential clinical safety concerns for the day. A senior leader is defined as someone at a Division Director level or higher.

Measure Criteria:

- Leadership Safety Rounds should be attended weekly by a hospital executive or senior leader. Hospital executives or senior leaders will round on at least 50% of the hospital departments during a year.

- Daily Leadership Safety Huddles/Briefings are conducted with the appropriate personnel seven days per week. A hospital executive or senior leader (or designee on weekends) will attend the meeting. A senior leader is defined as someone at a Division Director level or higher.

Patient Safety Survey

Measure Definition: Completion of a survey that gathers data regarding hospital staff's perceptions of the organization's safety culture and demonstration of actions taken by the hospital to address issues identified by survey responses.

One of the following is required:

a. For hospitals new to conducting Patient Safety Survey: A validated Patient Safety Survey (such as AHRQ's) conducted in the first quarter of 2017 AND a project plan to improve the poorest scores is developed in the second quarter of 2017 AND that project plan is implemented in the second half of 2017.

OR

b. For hospitals who have previously conducted a Patient Safety Survey: a validated Patient Safety Survey (such as AHRQ's) conducted in the last 24 months AND a project plan to improve poorest scores was developed and implemented throughout 2017.

Measure Criteria:

- Survey must include at least ten questions related to a safety culture and can be combined with another survey of hospital staff.
- Safety culture questions must be from a survey tool that has been tested for validity and reliability.
- Survey questions can be part of another survey tool as long as it meets the above criteria.
- Safety culture survey has been administered within the past 24 months.
- Actions taken in response to the survey should address those survey questions that demonstrated the poorest scores on the survey.

Daily Unit Safety Briefings/Huddles

Measure Definition: Short meetings held in nursing units and in clinical departments to identify possible patient safety issues or concerns.

Measure Criteria:

- Meetings should be held daily
- Meetings should be led by unit or department leader or designee
- All available department/unit staff should be present

Adverse Reporting Events

Measure Definition: Hospital describes system for reporting on and responding to Adverse Events. Must be in place by April 1, 2017

Measure Criteria:

- Must allow anonymous reporting
- Reports should be received from a broad range of personnel
- Summaries of reported events must be disseminated in a timely fashion
- A structured mechanism must be in place for reviewing reports and developing action plans

Hospitals choosing the *Culture of Safety* measure will be required to provide documentation described below. Documentation should give a high-level picture of the *Culture of Safety* initiative/s for the time period January 2017 through December 2017. We are interested in what is being done and the results/effect on patient care. The documentation should not exceed two pages.

#1: Patient and Family Advisory Council—a summary (1-2 paragraphs) that includes the following elements: the number of meetings held from January 2017 to December 2017, one or two of the major discussion topics and any actions planned or implemented as a result of the discussion.

#2: Patient Safety and Hospital Leadership --a short summary (1-2 paragraphs) of some of the issues identified and addressed during these meetings/discussions.

#3: Patient Safety Survey--a short summary (1-2 paragraphs) of survey findings as relates to the lowest scores, what is planned for 2017 as a result of the survey and the number of staff completing the survey.

#4 Daily Unit Safety Briefings/Huddles --a short summary (1-2 paragraphs) of some of the issues identified and the number and description of the units on which briefings are conducted.

#5 Adverse Event Reporting – a short summary (1-2 paragraphs) describing the Adverse Reporting system, some of the issues identified and addressed as a result of adverse event reporting. **Must be in place by April 1, 2017.**

#2: Active Participation in RCCOs (up to 10 points)

Hospitals must meet the criteria (1 and 2) AND as at least one of the additional elements under #3a – 3e listed below:

1. Notification to RCCO of Emergency Department visit within 24 hours of ED visit with chief complaint/reason for visit (RCCO name and contact information is on Medicaid's eligibility verification notice).
2. Notification to RCCO of Inpatient Hospitalization admission with chief complaint/reason for visit (RCCO name and contact information is on Medicaid's eligibility verification notice).

AND as many of the following elements below:

3a. Joint efforts to improve population health
3b. Care coordination collaboration (e.g., sharing of care transition plan)
3c. Case management collaboration (e.g., conversations between case managers, RCCO case manager invited to case conferences, etc.)
3d. Collaboration on high utilizers to decrease ED visits and IP admissions
3e. Participation in RCCO level advisory committee meetings or similar meetings.

Hospitals will be required to inform HCPF of the criteria they intend to undertake throughout 2017. A random check of participation will be assessed by the RCCO.

#3 Cesarean Section (up to 10 points)

This measure uses the JCAHO calculation and sampling for PC-02A in the perinatal care measure set, described in the following link: https://manual.jointcommission.org/releases/TJC2014A1/. This measure counts the number of cesarean sections performed during 2016 on all patients (not just patients with Medicaid coverage).

- To be eligible for a score on the hospital's submitted data of their 2016 Cesarean Section rate, the hospital will be required to describe their process for notifying physicians of their respective Cesarean Section rates and how they compare to other physicians' rates and the hospital average.
- **This process must be in place by 4/1/2017.**
- The hospital has discretion over how to format the report and disclosures for statistical significance.
- Hospitals will be required to include a blank example of the report that is provided to physicians for this purpose.

#4 HCAHPS (up to 10 points)

This measure is based on the question on the HCAHPS survey showing the percentage of patients who gave the hospital a rating of a "9" or "10" on a scale from 0 (lowest) to 10 (highest). Data from this measure will be taken from the most current data on Hospital Compare to provide a patient-mix adjustment to the data.

#5 30-Day All-Cause Readmission (up to 10 points)

The readmission calculation is defined by the Centers for Medicare and Medicaid Services (CMS) and counts Medicaid clients with readmissions during 2016. Hospitals do not need to submit data for this measure. Patients must be continuously enrolled in Medicaid for at least 365 days prior to the discharge date to be included in this measure; therefore, the numerators, denominators and subsequent readmission rates will be lower than a hospital calculates with its own data.

Here is a link to the specifications for this Readmissions measure.

#6 Emergency Department Process Measure (up to 10 points)

The following interventions should be effective during the period January 1, 2017 through December 31, 2017.

1. All discharged ED patients are given information about local primary care clinics if they have no PCP.
2. All discharged ED patients are provided information about available nurse advice lines.
3. ED policies or guidelines that state providers will not provide replacement prescriptions for opioids that are lost, destroyed or stolen are in effect by January 1, 2017. Hospital will be required to submit a copy of this policy/guideline.
4. ED policies or guidelines are in place indicating no long acting opioids are prescribed in the ED are in effect by January 1, 2017. Hospital will be required to submit a copy of this policy/guideline.

Data submission is not required for this measure. Hospitals will be asked to attest to the initiatives they will implement or maintain.

#7: Advance Care Planning (Advance Directives) (up to 10 points)

The *Advance Care Planning* measure is based on the definition provided by the National Quality Forum (NQF) for the number of patients 65 years of age or older who have an advanced care plan documented or who did not wish to provide an advance care plan. Measure specifics can be found on the NQF website (measure ID: 0326).

Hospitals will be required to submit data from calendar year 2016 to HCPF.

Random sampling is allowed (see sampling guidelines below).

#8: Tobacco Screening and Follow-Up (up to 10 points)

The *Tobacco Screening and Follow-Up* measure is based on the Joint Commission definitions for the number of patients 18 years of age or older who were screened for tobacco use and, if positive, referred to or refused evidence based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication at discharge (TOB-01 and TOB-03, Screening for Tobacco Use and

Tobacco Use Treatment Provided or Offered). The measures are also National Quality Forum (NQF) endorsed and details can be found on the NQF website (measure IDs #1651 and 1656).

Hospitals will be required to submit data from calendar year 2016 to HCPF.

Random sampling is allowed (see sampling guidelines below).

Rates for TOB-01 and TOB-03 must be submitted; however, only TOB-03 (follow-up) will be scored.

Maintenance Measures (MM)

MM #1: PE/DVT (no points)
Hospitals do not need to submit data for this measure. The data source for this measure is the Colorado Hospital Report Card.

MM #2: CLABSI (no points)
Hospitals do not need to submit data for this measure. The data source for this measure is the NHSN data submitted to the Colorado Department of Public Health and Environment.

MM #3 Early Elective Deliveries (no points)

This measure uses the JCAHO calculation and sampling for PC-01 in the perinatal care measure set, described in the following link: https://manual.jointcommission.org/releases/TJC2014A1/.

Measure Resources

Advance Care Planning
https://www.auanet.org/common/pdf/practices-resources/quality/pqrs-toolkit/2014/2014-Measure-47.pdf

Colorado MOST form: http://www.polst.org/wp-content/uploads/2012/11/CO-MOST-Form.pdf

Care Transitions
http://healthy-transitions-colorado.org/

Culture of Safety
General resource: http://www.jointcommission.org/topics/patient_safety.aspx

Patient and Family Advisory Council http://www.ipfcc.org/advance/Advisory_Councils.pdf

Adverse Event Reporting: https://psnet.ahrq.gov/primers/primer/13/voluntary-patient-safety-event-reporting-incident-reporting

Patient and Family Advisory Council Toolkits:
http://c.ymcdn.com/sites/www.theberylinstitute.org/resource/resmgr/webinar_pdf/pfac_toolkit_shared_version.pdf

http://www.patient-experience.org/Resources/Best-Practices/Case-Studies/Patient-Advisory-Council-Toolkit.aspx

http://www.nichq.org/sitecore/content/medical-home/medical-home/resources/pfac-toolkit

Hospital Safety Leadership:
http://www.ihi.org/resources/Pages/Changes/DevelopaCultureofSafety.aspx

HQIP/CMS 30-day All-Cause Readmissions Specifications:
https://www.colorado.gov/pacific/sites/default/files/2016%20March%20HQIP%2030-day%20all-cause%20readmission%20measure.pdf

Safety Huddle (video): http://www.hret.org/resources/5750004127

Patient Safety Survey from AHRQ http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/index.html Note that the Colorado Hospital Association provides access to the Patient Safety Survey via an online tool for hospital use. Survey results are calculated and provided to the hospital for analysis and planning.

Standup Daily Unit Safety Briefings:
http://www.ihi.org/resources/Pages/Changes/ConductSafetyBriefings.aspx

Standup Daily Unit Safety Briefings:
http://www.ihi.org/resources/Pages/Tools/SafetyBriefings.aspx

Sampling

Hospitals that use JCAHO sampling for a measure can report the data as sampled for JCAHO. Hospitals that are not JCAHO accredited may sample use the sample size requirements below.

Sampling is allowed for Advanced Care Planning and Tobacco Screening (TOB-01) and Follow-Up (TOB-03)

Sample Size Requirements

Hospitals can use sampling to report HQIP measures. The size of the sample depends on the number of cases that qualify for a measure. Hospitals need to use the next highest whole number when determining their required sample size. The sample must be a random sample (i.e. every third record, every fifth record, etc.), taken from the entire 12 months of the year and cannot exclude cases based on physician, other provider type or unit.

Hospitals selecting sample cases must include at least the minimum required sample size. The sample size table below shows the number of cases needed to obtain the required sample size. A hospital may choose to use a larger sample size than is required.

Hospitals selecting sample cases for a measure must ensure that the annual patient population and annual sample size for each measure sampled meet the following conditions:

Annual Sample Size

Annual number of patients meeting measure denominator	Minimum Required Sample Size "n"
>1500	322
101-1500	20% of discharges in denominator, but minimum of 30 discharges reviewed
30 -100	100%
0 - 29	Sample size is too small. Hospital is not eligible for this measure.

Examples

- A hospital's number of elective deliveries is 77 patients for the year. Using the above table, no sampling is allowed – 100% of the cases should be reviewed.
- A hospital's number of deliveries is 401 patients for the year. Using the above table, the required sample size is 80 cases (401 x .20 = 80) for the year.