Michigan Value Collaborative

Frequently Asked Questions

What is the Michigan Value Collaborative (MVC)?

The Michigan Value Collaborative (MVC) represents a partnership between 100 Michigan hospitals and 40 physician organizations (POs) that aims to improve the health of Michigan through sustainable, high-value healthcare. Supported by Blue Cross Blue Shield of Michigan (BCBSM), 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.

Who can participate in MVC?

As with other Collaborative Quality Initiatives (CQI) and Physician Group Incentive Program (PGIP) programs, the consortium is open to all clinically relevant providers. As MVC focuses on a wide range of conditions and procedures, almost all hospitals and physician organizations in Michigan are invited to participate. The MVC Coordinating Center works with a varied team of quality improvement leaders, data analysts, and physicians within each organization.

Why should my hospital or physician organization participate in MVC?

MVC uses high-quality data to drive collaboration and quality improvement. MVC offers hospitals access to a data registry allowing them to benchmark their care utilization to the state, track changes over time, and identify areas of cost opportunity. All members also receive specialized reports pushed directly to their inbox and can request custom analytic reports. In addition, MVC hosts a number of activities that bring together hospitals and physician organizations to discuss best practices and form collaborations. These activities range from individual site visits to collaborative-wide meetings.

Is participation in MVC activities voluntary?

Attendance at MVC meetings and participation in its improvement activities are voluntary yet highly encouraged. Participation in MVC meetings and activities can be beneficial to optimizing costs and patient outcomes, and it provides members access to a community of their peers. Regardless of whether members actively participate, hospitals engaging in BCBSM's hospital-based incentive models will have their performance assessed based on MVC data for all members in Michigan.

What does participation in MVC entail?

Participating members are invited to network with other hospitals and physician organizations through a variety of avenues, such as workgroups and collaborative-wide meetings. Members are asked to send at least one or two leaders who have responsibility for managing cost and quality to each collaborative-wide, semi-annual meeting, where the Coordinating Center will review new performance data, empirical analysis of best practices, and collaborative strategies for improving quality and efficiency. Members are not required to collect and submit data.

Which individual(s) should represent my hospital or physician organization?

We leave that to each MVC member, but the activities of MVC might be most relevant to Chief Medical Officers, Chief Quality Officers, Pay-for-Performance Administrators, or others with similar responsibilities. Given the financial nature of the performance data, and the increasing focus by government and commercial payers on the overall effectiveness and efficiency of care on a population basis, MVC's work will also be of interest to CFOs and/or CEOs and other CQI leaders.

Does participation in this project require Institutional Review Board (IRB) approval?

No. MVC is a quality improvement initiative, not a research program. Moreover, all analyses and reports will be based on de-identified claims data.

What data does the MVC registry contain?

The MVC registry contains BCBSM PPO Commercial and Medicare Advantage, Blue Care Network HMO Commercial and Medicare Advantage, Medicaid, and Medicare Fee-For-Service claims data for Michigan beneficiaries. The data includes all healthcare services with associated paid claims. Measures are based on the utilization of services, not actual costs.

How recent is the data?

As of December 2021, the registry contains BCBSM/BCN claims data through October 2021 (index events through July 2021), Medicare FFS claims data through December 2020 (index events through September 2020), and Medicaid claims data through June 2020 (index events through September 2020). The data registry is updated based on the most current claims data received.

How are episode payments determined?

Members will receive risk-adjusted and price-standardized measures of 30-day and 90-day episode payments around hospitalizations and outpatient surgeries for common conditions and procedures. Episode costs are risk-adjusted to account for differences in case mix across hospitals or physician organizations. They are also "price standardized" to the Medicare fee schedule to remove differences based on payer, geography, negotiated contracts, wage index, and inflation.

How does MVC risk adjust data?

MVC performs risk adjustment using observed/expected (O/E) ratios. The numerator in this ratio is the average of all observed payments for a particular hospital or physician organization member. The denominator is the average of all expected payments for that member. This ratio is multiplied by the statewide expected mean payment to arrive at the "risk-adjusted payment" for that member. The expected payment is calculated using a two-step linear regression model with multiple covariates including payer, age, gender, HCC comorbidities, six-month prior spending, and condition-specific factors. The same methodologic approach is used for the risk adjustment of utilization rates, except a two-step logistic regression model is employed.

How is an episode of care defined?

The episode of care begins with an index event (inpatient or outpatient) and extends 30 or 90 days from the discharge date. The episode is defined by four main payment components: a facility index payment, professional payment, post-acute care payment, and readmission payment. These components are further outlined in both the "Episode of Care Payment Components Model" and Technical Document on the MVC registry. To access the registry, please click here.

How can an MVC member use the registry most effectively?

The MVC registry allows users to view standardized performance data for all payers. A user can compare service-specific utilization and payment rates with their peers, track their own trends over time, perform patient drill downs, and gain valuable information about the patient populations they serve. These capabilities allow a user to identify areas of opportunity to potentially focus quality improvement efforts.

How can I access my hospital's data on the registry?

For partner hospitals, click here to login to the MVC registry. If you are affiliated with a partner hospital, yet need access to the registry, click here to request access. For a list of partner hospitals, click here. For nonparticipating hospitals, contact the MVC Coordinating Center at michiganvaluecollaborative@gmail.com for more information on accessing the registry.

Will the performance data on the registry be kept confidential?

A hospital is able to view its own performance data against several comparisons. Hospital-specific performance data is not accessible by other hospitals, but data on utilization and cost derived from BCBSM-paid claims will be available to BCBSM.

Which facilities are included in the online data registry?

Hospitals that are current MVC partner hospitals and have elected to participate are reported on the registry. For a list of partner hospitals, click here.

What resources are available to use for learning how to use the registry?

One-on-one sessions are offered to everyone within two weeks of gaining access to the registry and as requested by members. For more information or to request a registry review, contact the MVC Coordinating Center at michiganvaluecollaborative@gmail.com.

What are the expectations of members regarding using MVC data?

We hope that members will use MVC data to help identify improvement opportunities; identify and share best practices; and design, implement, and evaluate statewide interventions. At the local level, we encourage healthcare leaders to use MVC data to understand and improve their comparative efficiency, both overall and across individual specialties. For conditions or procedures where members have "room to move," we expect that members may use both MVC cost data and clinical quality data from the other CQI programs as guides to their internal improvement activities.

How do we schedule meetings with MVC leadership to further discuss the data reports?

The MVC Coordinating Center is available to meet with you and others from your institution to review your data and discuss additional support opportunities. Simply contact the MVC Coordinating Center (michiganvaluecollaborative@gmail.com) to register your interest.

What additional resources, aside from the data registry, are available to MVC participants?

The MVC Coordinating Center provides analytic support, including annual hospital-specific performance reports, to all participating members. To further support quality improvement efforts, hospitals or physician organizations may participate in site visits, workgroups, and collaborative-wide meetings. There is also a weekly MVC blog that features research and news in healthcare, MVC updates, and featured quality initiatives.

Does MVC collaborate with other clinical quality initiatives?

MVC regularly collaborates with the other BCBSM collaborative quality initiatives (CQIs) to promote value. By combining clinical and claims data, we can evaluate the value of healthcare in Michigan and the cost effectiveness of quality improvement projects.

How can my hospital or physician organization find current information on MVC events, meetings, and quality initiatives?

In addition to contacting the MVC Coordinating Center at michiganvaluecollaborative@gmail.com, hospitals may stay up-to-date with MVC by visiting the MVC website and subscribing to the MVC blog.