MVC Component of the BCBSM
Pay-for-Performance Program

TECHNICAL DOCUMENT

Program Years
2026 and 2027

2024 | NOVEMBER

MICHIGAN VALUE COLLABORATIVE

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Executive Summary

I. Program Overview

Beginning in 2018, Blue Cross Blue Shield of Michigan (BCBSM) allocated 10% of its Pay-For-Performance (P4P) Program to an episode of care spending metric based on Michigan Value Collaborative (MVC) claims data. This metric measured hospital performance using price-standardized, risk-adjusted 30-day total episode payments for BCBSM Preferred Provider Organization (PPO), BCBSM Medicare Advantage, Blue Care Network (BCN) Health Maintenance Organization (HMO), BCN Medicare Advantage, and Medicare Fee-For-Service (FFS). In 2022, BCBSM approved the addition of claims-based value metrics in program years (PYs) 2024 and 2025. These value metrics are evidence-based, actionable measures that show variability across the state. In 2024, the BCBSM P4P Quarterly Workgroup approved changes to how hospitals are evaluated in the PY26-27 cycle, including the addition of a health equity metric. This document outlines the evaluated components in the PY26-27 cycle.

II. Timeline

The MVC Coordinating Center will assess claims from the performance years (encounters occurring in 2025 and 2026) during PY 2026 and PY 2027 and will provide a final score for the MVC-based measure to BCBSM for payment in 2027 and 2028, respectively.

III. Earning Points

Points From 30-Day Total Episode Payments

Each hospital will choose one of four conditions to be evaluated on using mean total risk-adjusted, price-standardized 30-day episode payment. Each hospital's condition-specific total episode payment will be assessed for year-over-year improvement compared to its baseline year and for achievement respective to the appropriate MVC cohort. Hospitals must meet the minimum in-hospital mortality and readmission rate quality threshold for the selected condition to earn points. Provided the threshold is met, hospitals will earn the higher of their improvement or achievement points for a total of 0 – 3 points.

Points From Value Metrics

All value metrics are evidence-based, actionable measures of utilization for specific clinical contexts. Hospitals will be rewarded for high rates of high-value services or low rates of low-value services. Each hospital's chosen value metric will be assessed for year-over-year improvement compared to its baseline

year and for achievement respective to the appropriate MVC cohort. Hospitals will earn the higher of their improvement or achievement points for a total of 0 – 4 points.

Points From Health Equity Measure
Health Equity between payer-specific all-cause readmissions will be evaluated for each hospital through the calculation of a population-weighted, risk-adjusted index of disparity. Each hospital's index of disparity will be assessed for year-over-year improvement compared to its baseline year and for achievement respective to the appropriate MVC cohort. Hospitals will earn the higher of their improvement or achievement points for a total of 0 – 1 point.

Engagement Points
Hospitals can earn 0 – 2 points by completing certain engagement activities during each program year.

Introduction

I. Purpose
The purpose of this document is to provide information on the MVC Component of the BCBSM P4P Program for PYs 2026 and 2027. Information on past cycles can be found in previous technical documents (PY2020-2021, PY2022-2023, PY2024-2025). Information regarding future PYs will have separate documentation.

II. Background
BCBSM's P4P Program recognizes hospitals that excel in quality of care, cost-efficiency, and population health management. Beginning in 2018, BCBSM allocated 10% of its P4P program to a performance evaluation based on MVC data. MVC is a Collaborative Quality Initiative (CQI) funded by the BCBSM Value Partnerships program. MVC's purpose is to improve the health of Michigan through sustainable, high-value healthcare**.** MVC works to achieve this purpose by adhering to the Value Partnerships philosophy of using high-quality data to drive collaborative quality improvement. Table 1 summarizes how MVC fits into the larger BCBSM P4P Program. To learn more about BCBSM's 2021 Hospital P4P Program, please refer to their documentation.

Table 1: BCBSM P4P Program

2025 Program Components and Weights	
Prequalifying Condition	0%
Collaborative Quality Initiatives	40%
Michigan Value Collaborative	**10%***
All-Cause Readmissions Domain	30%
Health Information Exchange	20%

***The 10% allocation to MVC is separate from the 40% assigned to other CQIs.*

III. MVC Guiding Principles

In designing and implementing the MVC Component of the BCBSM P4P Program, the MVC Coordinating Center has been guided by the following core principles:

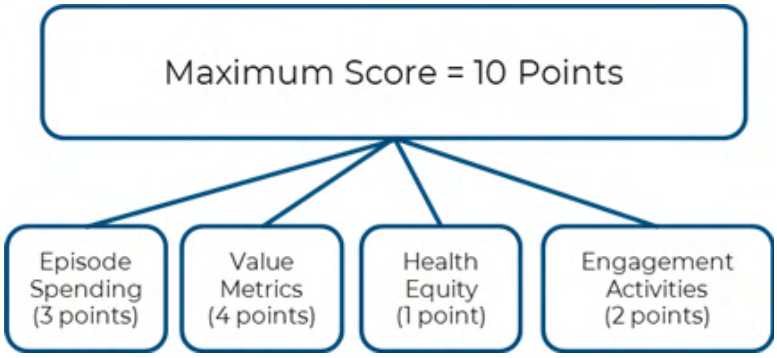
1. The measure will reflect the BCBSM Value Partnerships philosophy of using high-quality data to drive collaborative quality improvement.
2. The measure will be fair, valid, and transparent.
3. The measure will align with existing BCBSM and Centers for Medicare and Medicaid Services (CMS) hospital quality measures when possible and be consistent with Value Partnerships' CQI principles.
4. The measure will encourage examination and use of MVC data to drive value improvement and reward those efforts.

P4P Measure Methodology

I. Overall Structure

The MVC Component of the BCBSM P4P Program is scored out of 10 points and consists of four different elements: 30-day total episode spending (worth up to three points), value metrics (worth up to four points), a health equity measure (worth one point), and engagement activities (worth up to two points).

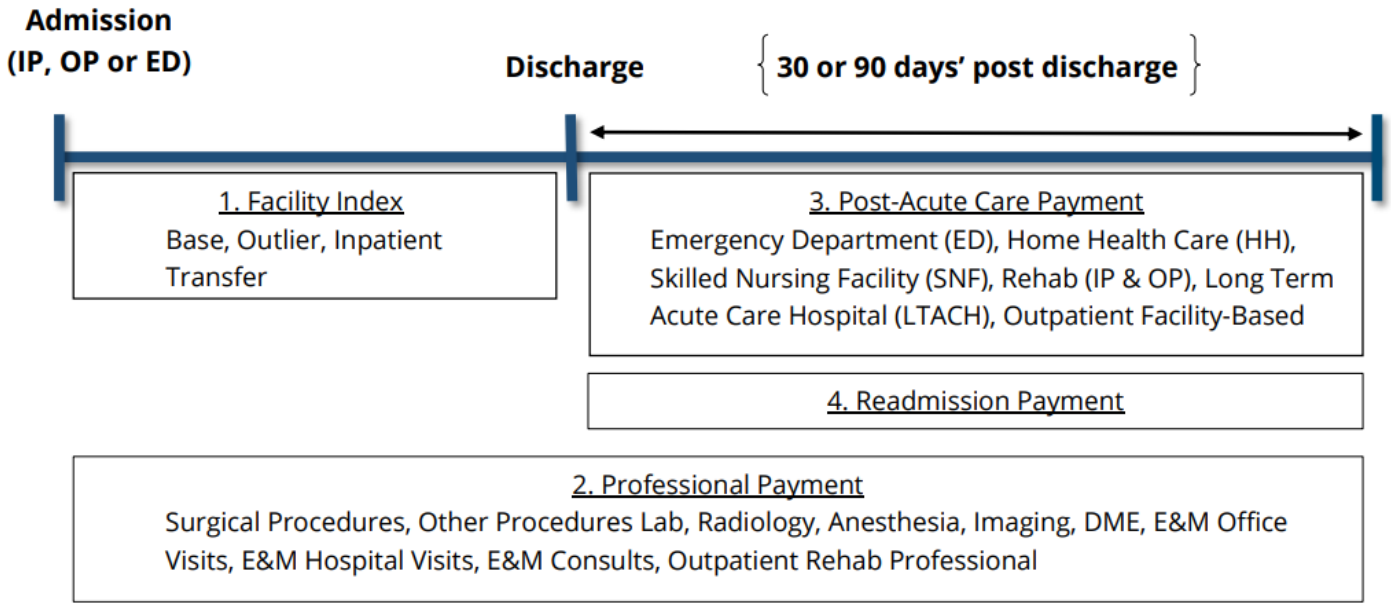
Figure 1: Point Breakdown



MVC Episodes

The episode payment and value metric components of the program depend on claims that are organized into MVC's episode structure. Figure 2 describes the anatomy of an MVC episode.

Figure 2: Anatomy of an MVC Episode



II. Data Sources

PYs 2026 and 2027 utilize all available claims from the payers below:

- BCBSM PPO
- BCBSM Medicare Advantage PPO
- BCN HMO
- BCN Medicare Advantage
- Medicare FFS
- Michigan Medicaid *(added for PY26-27)*

With the addition of Michigan Medicaid, the MVC Component of the BCBSM P4P Program now includes all payers in MVC's data portfolio, representing approximately 84% of Michigan's insured population.

III. Program Timeline

Hospitals will be assessed on their episode payment and value metrics from the performance period compared to their baseline period. The performance and baseline periods include index admissions occurring between January 1 and December 31 for that calendar year. The MVC Coordinating Center will compare performance and baseline years during the program year, and final scores on the MVC-based measure will be sent to BCBSM for payment during the payment year. Figure 3 outlines the timeline for each stage in program years 2026 and 2027.

Figure 3: Timeline for PYs 2026 and 2027

IV. 30-Day Episode Spending

Hospitals can earn up to three points based on their average 30-day episode payment for their selected condition. This 30-day episode measure is price standardized to the Medicare FFS schedule and risk adjusted for age, gender, history of prior high spending, end-stage renal disease, and 79 comorbidities based on hierarchical condition categories and condition-specific risk adjusters. Figure 2 shows the components of an MVC episode. For more information regarding MVC's price standardization and risk adjustment methodology, as well as the breakdown of the episode structure, please see the MVC Data Guide.

Exclusions

Episodes will be excluded from the episode spending metric scoring if any of the following are true:

- Patient was transferred from the initial facility during the index event.
- Patient has a discharge disposition on the index event of having died inpatient or being discharged to hospice.
- Index DRG is outside of the core DRGs for an inpatient episode for the given condition (with the exception of outpatient PCI procedures, which do not have a DRG) (Table 2).

Condition Selection

Hospitals select one condition from the list below for evaluation using 30-day episode spending. Only episodes that meet the MVC episode definitions for these conditions and (for inpatient episodes) have a core DRG based on CMS definitions are included in scoring (Table 2). The PCI episode spending condition includes both outpatient (MVC PCI episodes without a DRG) and inpatient (PCI and AMI episodes with a core PCI DRG) episodes. The selection of eligible conditions reflects the dual goals of 1) maximizing the hospital's choice in terms of where to focus its efforts and 2) alignment of MVC measures with existing cost and quality improvement initiatives from CMS, BCBSM, and other CQIs. Condition selection will take place in 2024 for evaluation in program years 2026 and 2027.

Table 2. Condition Options for the MVC Component of the BCBSM P4P Program

Episode Spending Condition Options for PYs 2026 and 2027	
Condition	**DRGs**
Chronic obstructive pulmonary disease (COPD)	190, 191, 192, 202, 203
Congestive heart failure (CHF)	291, 292, 293
Coronary artery bypass graft (CABG)	231, 232, 233, 234, 235, 236
Percutaneous Coronary Intervention (PCI)	246, 247, 248, 249, 250, 251

Minimum Case Requirements

The MVC Coordinating Center selected the minimum episode volume requirements of 20 cases per year based on several empirical analyses. Minimum case thresholds were set to maximize the reliability of the episode cost metric and the number of eligible hospitals for each condition. Hospitals are eligible for a condition based on their baseline year episode volume.

Improvement, Achievement, and Z-Scores

Hospitals can earn points toward the 30-day episode spending component by either reducing their episode spending between the baseline year and performance year (improvement) or by having an average episode payment in the performance year lower than their cohort average (achievement) in the baseline year. Hospitals will earn the higher of their improvement or achievement points. For the 30-day episode spending component, risk-adjusted, price-standardized mean total episode payments are inputted into the improvement and achievement equations. These equations each yield a Z-score, a statistical value describing the distance from the mean of a distribution.

Points are assigned based on Z-scores, which reflect the standardized percent reduction from the baseline period. Improvement Z-scores are calculated by subtracting the hospital's mean performance payment from the mean baseline payment and dividing that difference by the MVC standard deviation (Figure 4). Achievement Z-scores are calculated by subtracting the hospital's mean performance payment from the cohort's mean baseline payment and dividing the difference by the MVC standard deviation (Figure 5). The intent of each formula is to account for each hospital's baseline mean costs and the condition-specific variability. The MVC mean and standard deviation will include all eligible episodes, and the average payment will be winsorized at the 99th percentile, meaning any values above the 99th percentile will be given the value of the 99th percentile. Winsorization is used to mitigate the impact of extreme outlier payments.

Figure 4. Improvement Z-score Equation

$$\text{Improvement Z-score} = \frac{\textit{Hospital baseline} - \textit{Hospital performance}}{\textit{MVC All standard deviation from baseline}}$$

Figure 5. Achievement Z-Score Equation

$$\text{Achievement Z-score} = \frac{\text{Cohort baseline} - \text{Hospital performance}}{\text{MVC All standard deviation from baseline}}$$

The output of the Z-score formulas will then be used to assign points according to Table 3 below. The Z-score thresholds will be the same for improvement and achievement points within the episode spending component. The set of Z-score thresholds is different than those for the value metric component because of the differences between rates and payments. These thresholds are based on historical data, and the MVC Coordinating Center reserves the right to change the Z-score thresholds as new data become available in order to maintain a fair program.

Table 3. Z-Score Thresholds for Assigning Episode Spending Points

Z-score Threshold	Point Value
<0	0 Points
0 - <0.1	1 Point
0.1 - <0.2	2 Points
>0.2	3 Points

Quality Thresholds

In order to earn points in the 30-day episode spending component, a hospital must first meet the quality threshold. Hospitals will not be eligible to receive 30-day episode spending points for a condition if they are ranked in the bottom 10th percentile in the performance year for condition-specific in-hospital mortality and related readmissions. The Coordinating Center will evaluate discharge disposition to determine inpatient mortality and the presence of readmission payments to calculate readmission rates. Confidence intervals will be used to ensure that hospitals not meeting the thresholds are true statistical outliers.

Shifting Targets

While the Z-score thresholds remain constant over time, the target payments associated with the Z-scores can shift as the baseline payments change. The baseline year total-episode values shift for three reasons related to the continual addition of data into the MVC registry. First, incorporating new Medicare data into the MVC registry may result in small changes to standardized prices, which are calculated based on all available Medicare data. Second, the risk-adjustment process uses data from all payers and all years, so risk-adjustment models change with every data update. Third, methodological improvements may need to be made based on changes in billing practices over time. For more information on MVC risk adjustment, please refer to the MVC Data Guide. Hospitals will be scored using the targets shown on the registry when the full

performance year of data is available. It is important to note that these targets will be captured by the Coordinating Center and any changes to the targets after this time will not affect scoring. Appendix F has more information related to why MVC does not freeze targets.

V. Value Metrics

Hospitals can earn up to four points by choosing one value metric on which to be evaluated. Value metrics are specific measures of utilization in particular contexts. All value metrics are evidence-based, actionable measures that show variability across the state. Hospitals will be rewarded for high rates of high-value services and low rates of low-value services.

Guiding Principles

The MVC Coordinating Center developed the list of value metric options using the following guiding principles:

- Each value metric must be measurable in MVC data
- Utilization should be varied across the state
- The incentivized service must be evidence-based
- Each value metric must be actionable on the part of hospitals
- Alignment where possible with other CQI efforts

List of Value Metrics and Definitions

After soliciting feedback from the BCBSM P4P workgroup and several clinicians, the value metric options were originally established for PYs 2024 and 2025 and have been updated for PYs 2026 and 2027. To ensure alignment with the Michigan Hospital Medicine Safety Consortium (HMS), MVC's sepsis value metric was changed from a 30-day risk-adjusted readmission metric to a 14-day follow-up metric. If preoperative testing is selected as a value metric, three low-risk surgeries (cholecystectomy, hernia repair, and lumpectomy) will be scored collectively. Unlike episode spending conditions, MVC episodes evaluated for value metrics are not restricted based on index DRG inclusion in the core DRGs for a given condition (Table 2). Hospitals must choose one of the seven value metrics for the PY26-27 two-year cycle (Table 4).

Exclusions

Episodes will be excluded from the value metric scoring if any of the following are true:

- Patient was transferred from the initial facility during the index event.
- Patient has a discharge disposition on the index event of having died inpatient or having been discharged to hospice.

Table 4. Value Metric Definitions

Value Metric	Numerator	Denominator	Reward
Cardiac rehabilitation after CABG	Episodes that included one cardiac rehabilitation visit within 90 days of discharge.	Includes all MVC-defined CABG episodes.	High rates
Cardiac rehabilitation after percutaneous	Episodes that included one cardiac rehabilitation visit within 90 days of discharge.	Includes all MVC-defined PCI episodes and acute myocardial infarction (AMI) episodes with a	High rates

coronary intervention (PCI)		PCI DRG (246, 247, 248, 249, 250, 251).	
7-day follow-up after CHF	Episodes that included at least one outpatient follow-up visit (in-person or remote) within seven days of discharge. Visits that occur after a readmission, inpatient procedure, emergency department visit, skilled nursing facility admission, or a visit for inpatient rehabilitation are not considered follow-up.	Includes MVC-defined CHF episodes where the patient was discharged to home or home health and did not utilize SNF, inpatient rehab, or LTACH within seven days of discharge.	High rates
14-day follow-up after COPD	Episodes that included at least one outpatient follow-up visit (in-person or remote) within 14 days of discharge. Visits that occur after a readmission, inpatient procedure, emergency department visit, skilled nursing facility admission, or a visit for inpatient rehabilitation are not considered follow-up.	Includes all MVC-defined COPD episodes where the patient was discharged to home or home health and did not utilize SNF, inpatient rehab, or LTACH within seven days of discharge.	High rates
7-day follow-up after pneumonia	Episodes that included at least one outpatient follow-up visit (in-person or remote) within seven days of discharge. Visits that occur after a readmission, inpatient procedure, emergency department visit, skilled nursing facility admission, or a visit for inpatient rehabilitation are not considered follow-up.	Includes all MVC-defined pneumonia episodes where the patient was discharged to home or home health and did not utilize SNF, inpatient rehab, or LTACH within seven days of discharge.	High rates
14-day follow-up after sepsis	Episodes that included at least one outpatient follow-up visit (in-person or remote) within 14 days of discharge. Visits that occur after a readmission, inpatient procedure, emergency department visit, skilled nursing facility admission, or a visit for inpatient rehabilitation are not considered follow-up.	Includes all MVC-defined sepsis episodes where the patient was discharged to home or home health and did not utilize SNF, inpatient rehab, or LTACH within seven days of discharge.	High rates

Preoperative testing	Episodes where preoperative testing occurred in the 30 days prior to MVC-defined laparoscopic cholecystectomy, inguinal hernia repair, and lumpectomy procedures for any of the following test types: urinalysis, pulmonary function, chest x-ray, electrocardiography, blood tests (complete blood count, coagulation tests, basic metabolic panel, and comprehensive metabolic panel), and cardiac tests (transthoracic echocardiogram and cardiac stress tests).	Includes elective and outpatient MVC-defined cholecystectomy (laparoscopic only – CPT codes 47562, 47563), inguinal hernia repair, and lumpectomy episodes with a length of stay between 0 and 2 days. Episodes with certain comorbidities are excluded (see Appendix C). Episodes with an emergency department revenue code during the index event are excluded.	Low rates

Minimum Case Requirements

The MVC Coordinating Center selected the minimum episode volume requirements of 20 cases in the baseline year to be eligible to select a value metric. This minimum episode volume was set based on several empirical analyses, and minimum case thresholds help to maximize the reliability of the value metric and the number of eligible hospitals for each value metric.

Improvement, Achievement, and Z-Scores

Hospitals can earn points in the value metric component by either improving their own rates over time (improvement) or by comparing favorably against their cohort (achievement). Hospitals will earn the higher of their improvement or achievement points. For the value metric component, the hospital baseline year rate, hospital performance year rate, and each cohort's baseline year rate are entered into the improvement and achievement equations. These equations each yield a Z-score, a statistical value describing the distance from the mean of a distribution.

Points are assigned based on Z-scores, which reflect the standardized percent reduction from the baseline period. Value metric scores are calculated using the standard deviation of the average rate across all MVC hospitals with at least 20 cases in the baseline year for a given value metric (the MVC standard deviation). Improvement Z-scores are calculated by subtracting the hospital's mean performance year rate from the mean baseline rate and dividing that difference by the MVC standard deviation (Figure 6). Achievement Z-scores are calculated by subtracting the hospital's mean performance year rate from the cohort's mean baseline rate and dividing the difference by the MVC standard deviation (Figure 6). The intent of each formula is to account for each hospital's baseline and the metric-specific variability.

Figure 6. Improvement and Achievement Z-score Equations for High and Low Value Metrics

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

The output of the Z-score formulas will then be used to assign points according to Table 5 below. The Z-score thresholds will be the same for improvement and achievement points within the value metric component. This set of Z-score thresholds is different than those for the episode spending component because of the differences between rates and payments. These thresholds are based on historical data, and the Coordinating Center reserves the right to change the Z-score thresholds as new data become available in order to maintain a fair program.

Table 5. Z-Score Thresholds for Assigning Value Metric Points

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

VI. MVC Cohorts

MVC cohorts are designed to compare hospitals with similar characteristics for specific conditions and metrics. Recognizing that episode payments or value metric utilization may vary across cohorts, a participant's achievement is compared to hospitals within their assigned cohort. All hospitals are assigned to cohorts for each condition and metric regardless of the hospital's selections. Hospitals are not assigned to a cohort if they do not provide that service within their hospital. In general, each MVC cohort is comprised of structurally similar hospitals identified by case mix index (CMI), bed size, and critical access status.

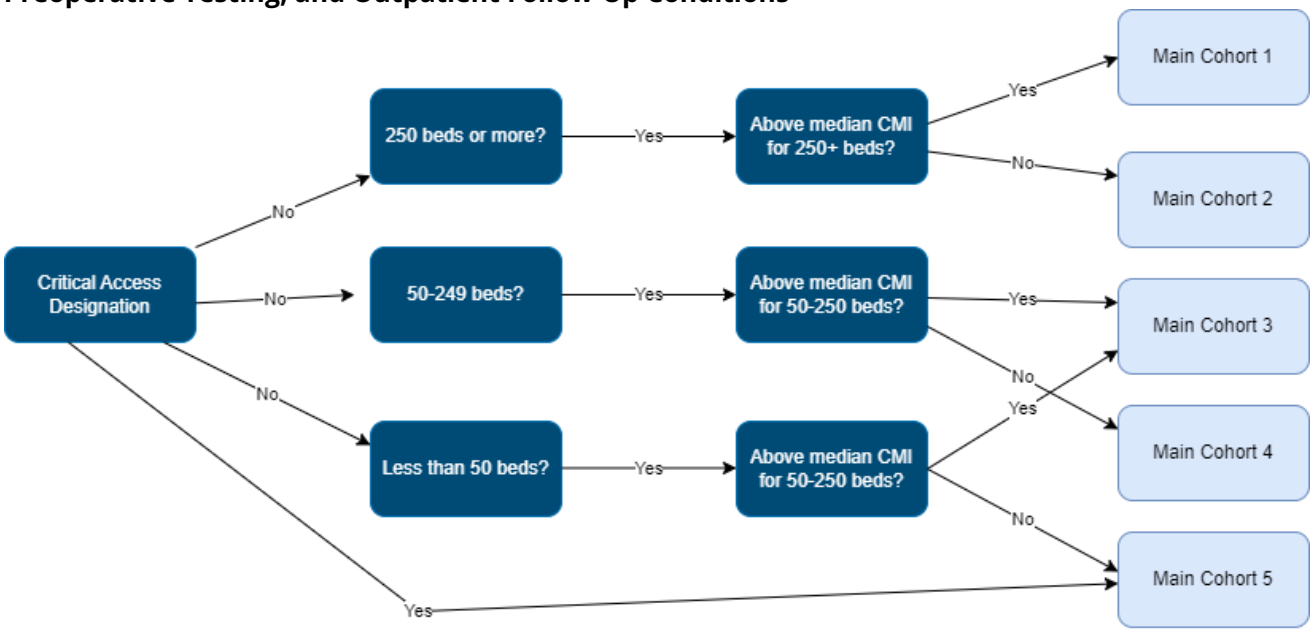
Cohort Methodology
Cohorts were reassigned in October 2024 for PYs 2026 and 2027. Cohort designations can be found in the resource section of the MVC website.

The main cohort is defined for the following episode payment conditions and value metrics: CHF, COPD, preoperative testing, and all outpatient follow-up conditions. Additional sets of cohorts are defined separately for CABG and PCI. The CABG and PCI cohorts are the same for both the episode payment and value metric components of the program.

CHF, COPD, Preoperative Testing, and Outpatient Follow-Up
The average case mix index is calculated for all hospitals using episodes from inpatient P4P conditions (CHF, COPD, pneumonia, sepsis) that are not CABG or PCI episodes. The main cohort also includes value metrics related to preoperative testing and outpatient follow-up. This means that a hospital will be in the main cohort for all these conditions and metrics. However, preoperative testing procedures do not factor into the case mix index calculation, as they are outpatient and do not have an associated DRG.

Case mix index is defined based on hospital index admissions for the inpatient P4P conditions using all payers and includes patients with index admissions in 2022 and 2023. For the purposes of classification, episodes without a Medicare Severity-Diagnosis Related Group (MS-DRG) associated with the index admission are excluded. The CMS MS-DRG relative weights from the 2022 release are applied to all inpatient admissions to calculate the mean relative case mix index weight for each hospital. All critical access hospitals are placed in cohort five. The remaining hospitals are first divided into three groups by bed size: 250 or more beds, between 50 and 249 beds, and fewer than 50 beds. The median case mix index for the two largest bed size groups is then calculated and used to distinguish between cohorts 1-4. Hospitals in the group of 50 or fewer beds are included in cohort three if they had a case mix index above the median for medium-sized hospitals; otherwise, hospitals with fewer than 50 beds are placed in cohort 5 with critical access hospitals. See Figure 7 below for a detailed breakdown of cohort designations.

Figure 7. Cohort Designation for Episode Spending and Value Metrics Related to CHF, COPD, Preoperative Testing, and Outpatient Follow-Up Conditions



CABG
Only 33 hospitals in the state of Michigan perform CABG procedures. To align with the Michigan Society of Thoracic and Cardiovascular Surgeons (MSTCVS), all 33 hospitals that perform CABGs will be in one cohort.

PCI
The PCI cohort is based on 49 PCI-affiliated hospitals according to the Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2). Cohort 1 includes hospitals that perform PCI procedures in addition to CABG procedures. Cohort 2 includes hospitals that perform PCI procedures only.

Figure 8: PCI Cohort Designation

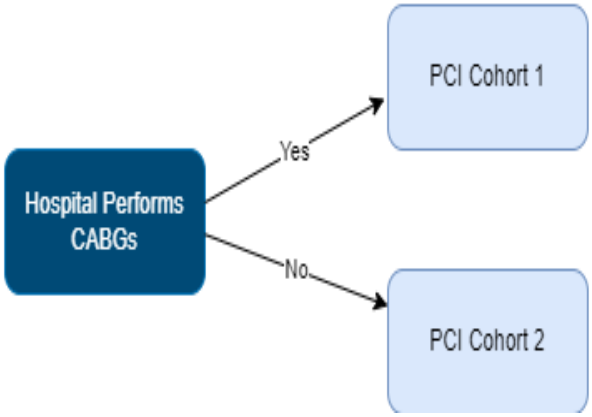


Table 6. Number of MVC Hospitals by Cohort

Cohort	Main	CABG	PCI
1	17	33	33
2	18		16
3	17		
4	17		
5	39		

**Cohort numbers may be subject to change as new hospitals join the collaborative. See Appendix B for examples of how hospitals were assigned cohorts.*

VII. Health Equity Measure

Hospitals can earn one point through a dedicated and newly introduced health equity measure. The development and introduction of this measure was informed by member feedback through MVC's recent health equity survey. As part of this survey, members were asked what barriers are preventing the effective development and implementation of health equity initiatives. The survey results revealed the top three barriers to be "insufficient financial investment," "insufficient data," and "no clear business case." Motivated by this, the MVC Coordinating Center developed a new health equity measure that was approved by the BCBSM P4P Hospital Quarterly Workgroup and introduced for implementation in PY26-27.

Risk-adjusted all-cause readmission rates will be calculated for each MVC hospital, as well as for five insurance payer groups at each hospital – BCBSM and BCN Commercial, BCBSM and BCN Medicare Advantage, Medicare FFS, Michigan Medicaid, and Dual-Eligible. If a patient's episode is originally assigned as Medicare or Medicaid but they are identified to be entitled to both Medicare and Medicaid, that patient's episode will be grouped into the dual-eligible category.

The spread of payer-specific risk-adjusted readmission rates will be assessed, and a measure will be calculated called an index of disparity. This is a summary measure that indicates the magnitude of payer-specific differences in risk-adjusted all-cause readmission rates within a hospital. The higher the index of disparity, the wider the spread of a hospital's payer-specific readmission rates. Hospitals can earn a point in this health equity component if they either reduce their index of disparity (improvement) or have an index of disparity in the performance year that is at or below the collaborative-wide median (achievement).

Exclusions

Episodes will be excluded from the health equity component if any of the following are true:

- Patient was transferred from the initial facility during the index event.
- Patient has a discharge disposition on the index event of having died inpatient or having been discharged to hospice.
- Episode is not a medical condition or endocarditis
- Episode occurred in the outpatient setting
- Episode index admission was considered potentially planned according to CMS algorithm

Risk-Adjustment

In addition to standard MVC risk adjustment for demographic and comorbidity data, MVC implemented further steps to risk-adjust the data for the health equity component. Social risk was accounted for by incorporating elements of the Distressed Communities Index and American Community Survey 2020 five-year estimates based on patient zip code. The impact of individual hospital quality was also removed, which does not impact the index of disparity and can be separately considered.

<u>The following variables are used for risk-adjusting this measure:</u>

- Hospital
- Payer type
- Condition
- Hierarchical Condition Categories
- Indication of high spending in the six months prior to the episode
- Gender
- Age
- Month the episode index admission occurred in
- Zip-code level social risk factors including:
    - Distressed community index distress score
    - Income
    - Education
    - Unemployment status
    - Percent of individuals living alone

Measure calculation

The index of disparity measure will be calculated using the following steps:

1. Hospital-level readmission rate is subtracted from each payer-level readmission rate, resulting in difference values for each payer group
2. Absolute values of differences are multiplied by the respective payer group populations, summed, and divided by the total population
3. The resulting value is multiplied by 100 to generate the final index of disparity used for scoring

Improvement, Achievement, and Point Allotment

Hospitals can earn one point in the health equity component by either improving (reducing) their index of disparity over time (improvement) or by comparing favorably against the collaborative (achievement). Hospitals will earn a maximum of one point. For the health equity measure, the hospital baseline year index of disparity, hospital performance year index of disparity, and the collaborative-wide median performance year index of disparity are considered.

One point in the health equity component will be earned via improvement if a hospital's index of disparity is reduced by ten percent of the baseline year value from baseline to performance year. For example, if a hospital has a baseline year index of disparity of 4.0, a point will be earned via improvement if the hospital's performance year index of disparity reflects a reduction by at least ten percent of 4.0, or 0.4; a performance year index of disparity of 3.6 or lower would earn the improvement point. Alternatively, one point will be earned via achievement if a hospital's performance year index of disparity is equal to or lower than the collaborative-wide median index of disparity in the performance year.

VIII. Engagement Activities

Hospitals can earn up to two points by performing a combination of engagement activities during the program year (engagement activities in calendar year 2026 count towards program year 2026). These points are intended to increase engagement with other hospitals and the MVC Coordinating Center. See Table 7 for an example of MVC engagement point offerings. Hospitals may select their own combination of activities, and the activities available will be offered in 2026 and 2027. The MVC Coordinating Center reserves the right to make changes to eligible activities and their point values in the future but will communicate all P4P-eligible engagement activities prior to and during both program years.

Table 7. P4P Engagement Point System

MVC Engagement Point Offerings	Points	Requirements & Tracking
Participate in **BOTH** of MVC's collaborative-wide meetings (May and October)	0.75	• Attendance by site representative(s) for entire meeting • Attendance will be tracked by check-in and completion of post-meeting surveys
Participate in **ONE** of MVC's collaborative-wide meetings (May and October)	0.25	• Attendance by site representative(s) for entire meeting • Attendance will be tracked by check-in and completion of post-meeting surveys
Presentation at an MVC virtual workgroup, virtual event, or in-person event • Single site presentation – 0.5 points	Varies	• Maximum of 1 point allowed per site per program year

• System-level best practicing sharing presentation involving multiple sites – 0.25 points for every participating site		• Spots are limited; final selection will be made at the discretion of the MVC coordinating center • Proposals submitted to MVC via 2025 presentation request form by **September 30**
Actively participate in an MVC virtual workgroup • MVC will host two workgroups per month with a guest presenter	0.1	• Active participation during the workgroup may include, but is not limited to, enabling video during virtual breakouts, responding to polls, and/or answering questions via chat • Completion of a post-workgroup survey is required to confirm attendance • Maximum of 1 point allowed per program year
Attend an MVC networking event • 1.5-hour Virtual networking event – 0.25 • 2.5- hour In-person networking event – 0.5 (limited spots)	Varies by setting	• Attendance by site representative(s) for entire event • Attendance will be tracked by check-in and completion of post-event survey • Maximum of 1 point allowed per program year
Complete MVC's custom analytic report process *Submit request, participate in planning meeting, participate in report review with MVC team, and complete feedback form*	0.25	• Maximum of .25 points allowed per program year; limited spots. • Sites may request additional custom reports; however, additional reports will not be eligible for engagement points.
Member hosts a site visit centered around QI initiatives: • Virtual site visit (1 hour) – 0.25 points • In person site visit (1.5 hours) – 0.5 points (limited spots) • In person multi-site visit for systems (2 hours) – 0.5 points awarded to every participating site (limited spots)	Varies by setting	• Submit 2025 site visit interest form, schedule site visit within MVC Team's availability, prepare meeting materials, and complete site visit • 2025 site visit interest form by **September 30**
Complete MVC quality improvement (QI) initiative survey about a recent QI success story from your organization	0.25	• Survey deadline: **September 30** • Maximum of 0.25 points per site per program year
Complete a one-hour virtual interview with MVC for use in MVC materials about member QI initiatives and successes	0.25	• Interview scheduling upon request • Questions will be provided in advance of recorded interview • Maximum of 0.25 points per site per program year

MVC Registry

The MVC registry can be utilized to help hospitals better understand their areas of opportunity in P4P conditions. The registry contains reports that can inform the episode payment component of the P4P program. These reports have combined payers and reflect the P4P population. To request access to the MVC registry, please contact the Coordinating Center or complete the Access Request Form. Push reports and custom analytics can be used to inform members of their progress and areas of opportunity for the value metrics.

Updates to P4P Program

The MVC Coordinating Center continues to look for ways to improve the MVC Component of the BCBSM P4P Program. Major changes to the program affect the two-year cycle and are required to be approved by the BCBSM Hospital P4P Quarterly Workgroup.

I. Program Year 2026 and 2027 Changes

The PY 2026-2027 P4P program has been updated to include the following changes:

- Introduction of Michigan Medicaid data to calculations and scoring
- Removal of colectomy, joint replacement, and pneumonia from the episode spending condition menu, and addition of percutaneous coronary intervention (PCI)
- Change of sepsis value metric from a 30-day risk-adjusted readmissions measure to a 14-day follow-up measure
- Change to preoperative testing value metric to score the three procedures collectively rather than separately, and adding lab tests (i.e., blood tests, urinalysis) to the list of eligible test types for the numerator
- Introduction of a new health equity measure worth one point
- Updated engagement point menu offerings

If you have suggestions for future changes to the program, please email them to Michigan-Value-Collaborative@med.umich.edu.

Support for Hospital Improvement

The MVC Coordinating Center provides a number of reports and resources to help hospitals improve patient care and reduce costs:

I. Engagement Events

Tailored Webinars

The MVC Coordinating Center provides customized webinars to individuals to provide an in-depth overview of the registry and breakdown of facility data. These webinars help to identify specific areas of opportunity.

Virtual Workgroups

Virtual workgroups consist of a diverse group of representatives from Michigan hospitals and physician organizations that meet to collaborate and share ideas related to various topics. Please email Michigan-Value-Collaborative@med.umich.edu to request workgroup details.

Workgroup topics currently include (as of September 2024):

- Cardiac Rehabilitation
- Follow-Up After CHF, COPD, and Pneumonia
- Health in Action
- Preoperative Testing
- Rural Health
- Sepsis

Site Visits

The Coordinating Center offers virtual and in-person site visits to all collaborative members. Site visits give MVC the opportunity to learn more about each collaborative member, its leadership team, and how their organization functions with regard to quality initiatives. During a site visit, the MVC team delivers information about MVC's latest activities and offerings, data requests, and how MVC can assist sites in reducing costs and improving patient outcomes. MVC will also share opportunities for collaboration with other hospitals and physician organizations.

Semi-Annual Meetings
MVC holds meetings twice per year to bring quality leaders, organizational leadership, and clinical professionals across the state together for MVC updates, practice sharing, networking, and topics of interest to MVC's membership.

Regional Networking Events
MVC hosts regional networking events for different regions of Michigan to engage hospital and physician organization leaders in discussion.

II. Analytic Support

MVC Registry
The MVC registry houses a variety of reports for hospitals to identify cost opportunities and track utilization. To request access to the registry, please contact the Coordinating Center or complete the Access Request Form.

MVC Push Reports
The Coordinating Center produces a series of reports to address specific MVC conditions. If you would like to receive reports for your hospital, please contact the MVC Coordinating Center.

Custom Support
The MVC analytic team supports its members with custom analytic reports by request. If you are interested in receiving a custom report, please contact the MVC Coordinating Center by submitting a custom request here.

III. Coordinating Center Support

Facilitating Connections
The Coordinating Center helps to connect members with high performing hospitals and/or others in their cohort as well as physician organizations and other requested connections.

Questions/Consultations
The Coordinating Center is happy to help hospitals with data requests or other questions. Please submit requests through Michigan-Value-Collaborative@med.umich.edu.

Appendix A: Glossary

Achievement Points: Points earned by comparing your hospital performance against other hospitals in your cohort.

Baseline Period: The calendar year three years prior to the program year or two years prior to the performance year. The claims from this period will be used to compare to the performance period for assessing hospital improvement.

Cohort: Group of hospitals deemed to be similar in bed size, case mix index, and critical access status.

Condition: A medical or surgical condition with a homogenous group of patients to be tracked in the MVC data. The current eligible P4P conditions for episode spending are chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery bypass graft (CABG), and percutaneous coronary intervention (PCI).

Index of Disparity: A summary measure that indicates the extent of differences in risk-adjusted all cause readmission rates by payer within a hospital

Improvement Points: Points earned by improving your hospital's own performance between the baseline year and performance year.

Program Year: Year that the program's episode spending and value metrics are being assessed, and the year that engagement points may be earned.

Performance Year: Calendar year of data that will be evaluated for improvement and achievement. This period is the year prior to the program year and two years after the baseline period.

Payment Year: The year after the assessment year where a hospital will receive its scores and payment from BCBSM.

Quality Threshold: A metric to ensure hospitals are not sacrificing the quality of care to reduce costs. Hospitals that are shown to be a statistical outlier for in-hospital mortality or related readmissions will not be eligible to earn P4P points.

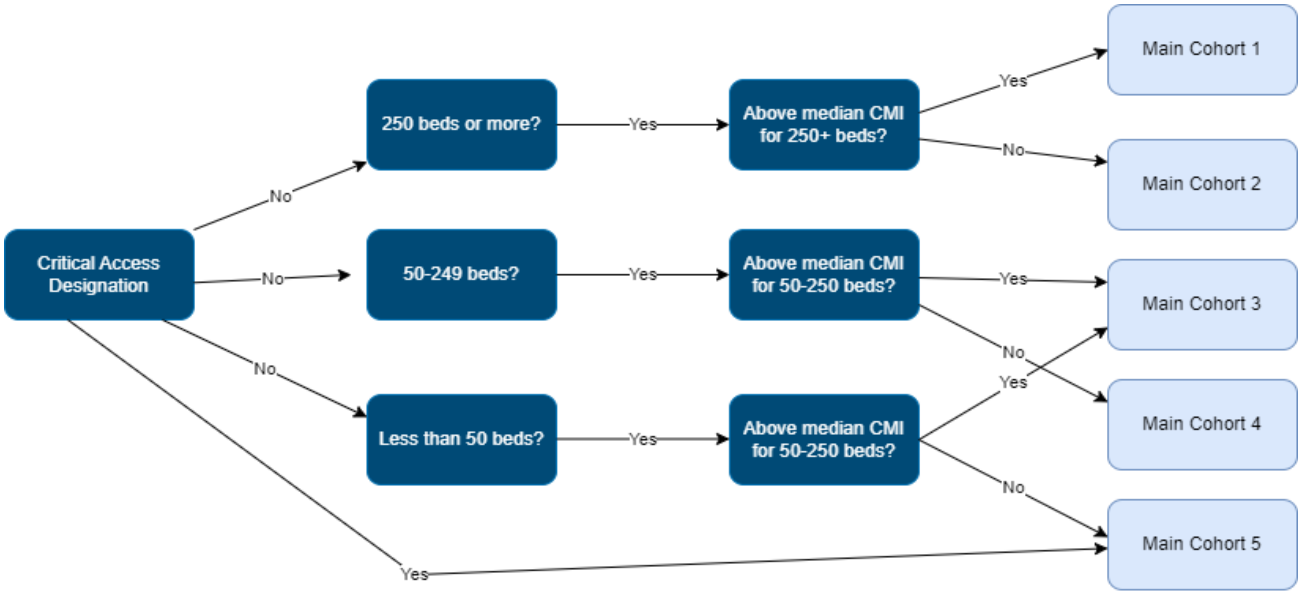
Value Metric: Measure of the rate of a service or event that is tied to both reducing payments and improving the value of care for patients.

Appendix B: Cohort Designations

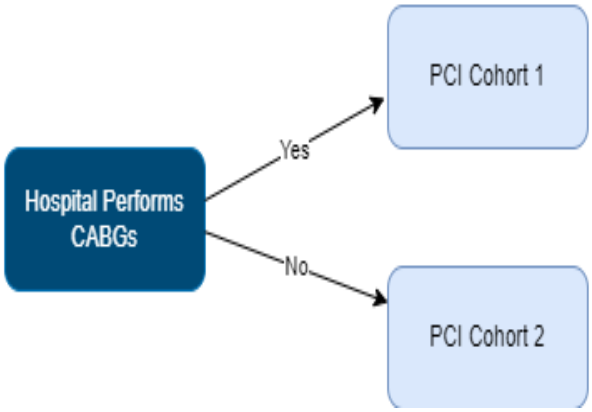
This appendix is meant to further illustrate how hospitals are assigned to cohorts. All hospitals will be assigned a cohort for each P4P condition regardless of the condition the hospital selected. There is one main cohort methodology for CHF and COPD as episode spending conditions, and also covers value metrics related to preoperative testing and outpatient follow-up conditions. This means that a hospital will be in the same cohort for all these conditions and metrics. CABG and PCI have a different set of cohort criteria for both episode spending and value metrics.

Example

Hospital A is not a critical access hospital, has 300 beds, and a case mix index that is above the median in its bed size group. Following the map shown below, Hospital A will be put in cohort 1 for CHF and COPD episode spending metrics, as well as for preoperative testing and outpatient follow-up value metrics.



Hospital A performs PCIs but not CABGs, so they will not be assigned a CABG cohort and will fall into PCI cohort 2 for the cardiac rehabilitation after PCI value metric.



Hospital A's Cohort Designations	
Condition	**Cohort**
30-Day Episode Payment Component	
Chronic obstructive pulmonary disease (COPD)	1
Congestive heart failure (CHF)	1
Coronary artery bypass graft (CABG)	N/A
PCI	2
Value Metric Component	
Cardiac rehabilitation after PCI	2
Cardiac rehabilitation after CABG	N/A
Preoperative testing rates	1
7-day follow-up after CHF	1
14-day follow-up after COPD	1
7-day follow-up after pneumonia	1
14-day follow-up after sepsis	1

Appendix C: Preoperative Testing Comorbidity Exclusions

Comorbidities are assessed in claims using Hierarchical Condition Categories (HCCs). The following HCCs will preclude episodes from being scored for the preoperative testing value metric:

Comorbidities	
Acute Myocardial Infarction	End-Stage Liver Disease
Acute Renal Failure	Opportunistic Infections
Angina Pectoris	Other Significant Endocrine and Metabolic Disorders
Cardio-Respiratory Failure and Shock	Pneumococcal Pneumonia, Empyema, Lung Abscess
Chronic Hepatitis	Protein-Calorie Malnutrition
Chronic Kidney Disease, Severe (Stage 4)	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
Chronic Kidney Disease, Stage 5	Specified Heart Arrythmias
Cirrhosis of Liver	Unstable Angina and Other Acute Ischemic Heart Disease
Coagulation Defects and Other Specified Hematological Disorders	Vascular Disease
Congestive Heart Failure	Vascular Disease with Complications

Appendix D: Sample Scorecard

Michigan Value Collaborative

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

P4P Program Year 2026: Final Scorecard
Hospital A

Overall Summary				
Episode Spending Points	Value Metric Points	Health Equity	Engagement Points	Total Points
3	4	1	2	9

Episode Spending Summary (Selected Condition = CHF)									
Dimension	Baseline Payment	Performance Payment	Z-Score	1 Point Target	2 Point Target	3 Point Target	4 Point Target	Potential Point(s)	Actual Point(s)
Improvement	$18,158	$17,800	0.12	$18,158	$18,003	$17,848	$17,963	3	3
Achievement	$17,240		-0.18	$17,240	$17,085	$16,960	$16,775	0	

Value Metric Summary (Selected Value Metric = Cardiac Rehab After CABG)									
Dimension	Baseline Rate	Performance Rate	Z-Score	1 Point Target	2 Point Target	3 Point Target	4 Point Target	Potential Point(s)	Actual Point(s)
Improvement	51.5%	65.6%	1.029	51.5%	54.93%	58.35%	61.78%	4	4
Achievement	52.5%		0.518	52.5%	61.93%	65.35%	68.78%	3	

Health Equity Summary										
Hospital Rate	Commercial BCBSM/BCN Rate	Medicare Advantage BCBSM/ BCN Rate	Medicare FFS Rate	Medicaid Rate	Dual Eligible Rate	Baseline IOD	Performance IOD	IOD Target - Improve	IOD Target - Achieve	Point Earned
11.2%	8.5%	12.5%	14.0%	11.5%	10.0%	2.37	1.56	2.13	2.0	Yes

Engagement Points Summary			
Attendance (worth 0.25 each)		Participation (worth 0.5 each)	
Activity	Earned Points	Activity	Earned Points
Attend both MVC Semi-Annual Conferences	0.25	Present at an MVC Semi-Annual Conference	0
Attend 5+ MVC Workgroups	0	Present at an MVC Workgroup	0.5
Attend Regional Networking Event	0.25	Host a Virtual or In-Person Site Visit	0
Submit a Request for a Custom Analytic Report	0	Participate in an MVC Case Study related to a QI Project	0.5
Other TBD	0	Collaborate with MVC Staff on a Blog Post	0.5
Other TBD	0.25	Other TBD	0.5
Total Attendance Points	0.75	Total Participation Points	2
Total Engagement Points (Maximum=2)			2

Appendix E: Scoring Example

The following is an illustration of how the scoring system will be applied for PYs 2026 and 2027. In this example, Hospital A selected CHF for their 30-day episode payment condition and cardiac rehabilitation after CABG as their value metric. All dollar amounts provided below are for illustrative purposes only. For PY 2026, the performance period is calendar year 2025, and the baseline year is calendar year 2023. In program year 2026, Hospital A meets the quality requirement by performing above the 10th percentile of in-hospital mortality and related readmissions. Meeting this requirement means the hospital is eligible to earn P4P points for the MVC Component of the BCBSM P4P Program.

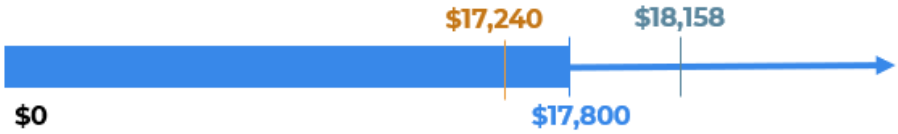
Scoring for Episode Spending Metric

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

Step 1

Calculate four numbers:

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



MVC All Standard Deviation = $3,100

Step 2

Plug into z-score equation

Improvement Z-score

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

Achievement Z-score

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

Step 3

Translate z-scores into points

Z-Score	Points
<0	0
0 - <0.1	1
0.1 - < 0.2	2
> 0.2	3

Improvement

0.12 z-score value

→ **2 Improvement Points**

Achievement

-0.18 z-score value

→ **0 Achievement Points**

Conclusion: Hospital A earns 2 points for their CHF episode payment.

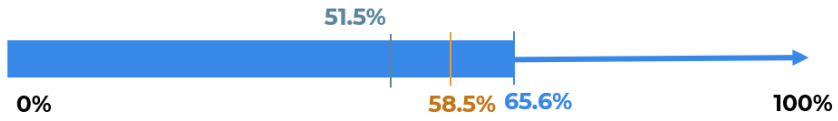
Scoring for Value Metric

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

Step 1

Calculate four numbers:

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



MVC All Standard Deviation = 13.7%

Step 2

Plug into z-score equations

Improvement Z-score

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

Achievement Z-score

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

Step 3

Translate z-scores into points

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

Improvement

1.029 z-score value

→ **4 Improvement Points**

Achievement

0.518 z-score value

→ **3 Achievement Points**

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

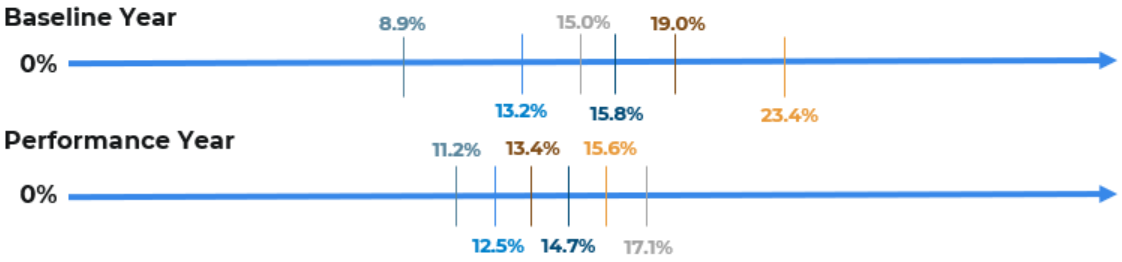
Scoring for Health Equity Component

Hospital A's performance year all-cause readmission rate index of disparity was 2.06. Two years before in the baseline year, their all-cause readmission rate index of disparity was 4.22. The MVC collaborative-wide median all-cause readmission rate index of disparity in the performance year was 2.02.

Step 1

Calculate 12 numbers, 6 in each the baseline and performance years:

- **Hospital Overall Risk-Adjusted Readmission Rate**
- **Commercial BCBSM/BCN Risk-Adjusted Readmission Rate**
- **Medicare Advantage BCBSM/BCN Risk-Adjusted Readmission Rate**
- **Medicare FFS Risk-Adjusted Readmission Rate**
- **Medicaid Risk-Adjusted Readmission Rate**
- **Dual-Eligible Risk-Adjusted Readmission Rate**



Step 2

Plug into Population Weighted Index of Disparity Formula

$$100 \times \left(\frac{\sum_{i=1}^{N} |Rate_i - Rate_{overall}| \times Population_i}{Population_{overall}} \right)$$

- First, take 5 differences
  - Commercial BCBSM/BCN Rate – Hospital Rate
  - Medicare Advantage Rate – Hospital Rate
  - Medicare FFS Rate – Hospital Rate
  - Medicaid Rate – Hospital Rate
  - Dual-Eligible Rate – Hospital Rate
- Then, take the absolute value of each of those differences, multiple by each respective subpopulation, and sum them
- Divide by the total population and multiply by 100 to achieve the population-weighted index of disparity

Step 3

Translate Index of Disparity Scores into Points

Improvement:

- Reduction by 10% of baseline score earns an improvement point
  - Check if performance value < baseline value – (0.10*baseline value)

2.06 < 3.80 ⟶ 1 Improvement Health Equity Point

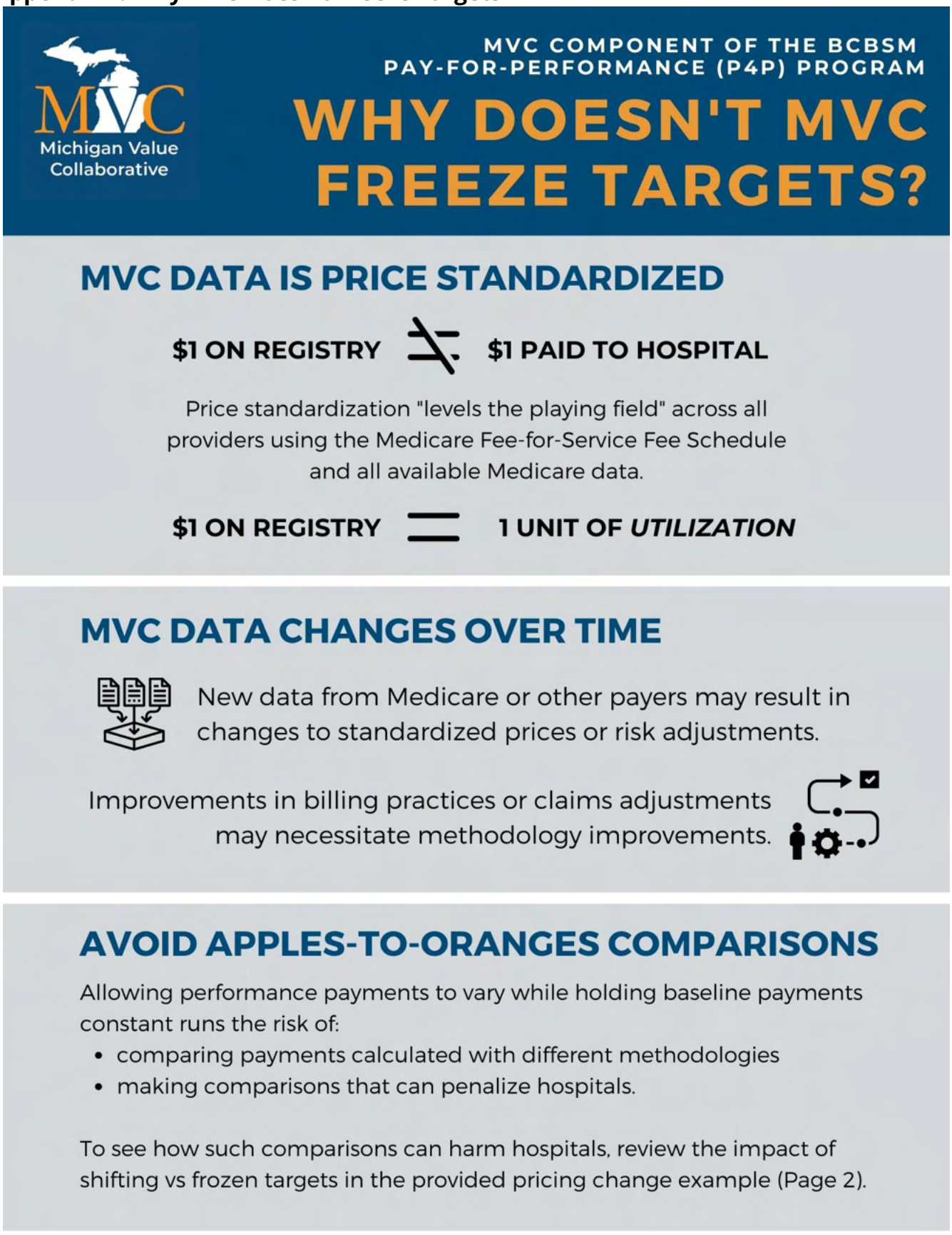
Achievement

- Hospitals earn an achievement point if the performance year index of disparity equal or below the collaborative-wide median index of disparity
  - Check if performance value ≤ collaborative-wide median value

2.06 < 2.02 ⟶ 0 Achievement Health Equity Points

Conclusion: Hospital A earns 1 point for the health equity component via improvement

Appendix F: Why MVC Doesn't Freeze Targets



Michigan Value Collaborative

MVC COMPONENT OF THE BCBSM P4P PROGRAM

EXAMPLE OF SHIFTING VS FROZEN TARGETS

HOSPITAL A

Baseline Total Episode Payment = $20,000
MVC All Standard Deviation (SD) from Baseline = $6,000

In order to earn 5 P4P improvement points, Hospital A needs a performance year total episode payment of $18,800 [BASELINE Total Episode Payment – (MVC All SD from Baseline*0.2)].

During the program year, MVC learns that CMS changed how skilled nursing facility claims are billed and has to alter its price standardization methodology to account for the CMS policy change, causing both the baseline payment and the performance payment to increase by $1,000.

SHIFTING TARGETS

BEFORE DATA UPDATE

5-pt Improvement Target = $*20,000* - ($6,000)(0.2) = **$18,800**
Performance Year Payment = **$18,500**

AFTER DATA UPDATE

5-pt Improvement Target = $*21,000* - ($6,000)(0.2) = **$19,800**
Performance Year Payment = **$19,500**

With shifting targets, Hospital A is **not penalized** because of this data update. Five improvement points are earned.

FROZEN TARGETS

BEFORE DATA UPDATE

5-pt Improvement Target = $*20,000* - ($6,000)(0.2) = **$18,800**
Performance Year Payment = **$18,500**

AFTER DATA UPDATE

5-pt Improvement Target = $*20,000* - ($6,000)(0.2) = **$18,800**
Performance Year Payment = **$19,500**

With frozen targets, the baseline stays the same, but the performance year is subject to the data update. Hospital A **must meet a greater reduction in utilization** and *does not* earn five improvement points.