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

MVC Component of the Blue Cross Blue Shield of Michigan Pay-for-Performance Program

Frequently Asked Questions: Program Year 2026-2027

The Blue Cross Blue Shield of Michigan (BCBSM) P4P program includes three components based on MVC claims data, accounting for a portion of the overall incentive. The first component includes price-standardized, risk-adjusted 30-day total episode payments for four different episode spending conditions. The second component focuses on seven different value metrics, which are evidence-based, actionable measures that show variability across the state. Lastly, the third component is a new health equity component to the program. Claims data for these metrics now reflect all MVC payer sources: Commercial and Medicare Advantage beneficiaries with BCBSM preferred provider organization (PPO) or Blue Care Network (BCN) coverage, Medicare Fee-for-Service (FFS), and Michigan Medicaid patients. Below is a series of frequently asked questions related to the P4P measure. Additional information may be found in the MVC P4P Technical Document.

How will hospital performance be assessed?

Each hospital selects an episode spending condition and a value metric for measurement. Each hospital's condition-specific total episode payment or value metric rate will be assessed for year-over-year improvement compared to its baseline year or its achievement respective to the appropriate MVC cohort. Hospitals receive the higher of their improvement or achievement points for each condition or value metric. MVC's new health equity measure will also be assessed from an improvement and achievement perspective, but functions differently than episode spending conditions and value metrics (see below).

Which payers are being used to assess my performance?

The following payers are used to assess hospital performance:

- BCBCS PPO Commercial
- BCBSM PPO Medicare Advantage
- BCN HMO Commercial
- BCN HMO Medicare Advantage
- Medicare FFS
- Michigan Medicaid

Which Medicaid plans does MVC have data for that will be used in the P4P program?

MVC has data for all Medicaid beneficiaries across the state. Therefore, all Medicaid sub-payers are included in MVC data.

Which years are being used to assess my performance?

See Table 1 for the timeline of the 2026 and 2027 program years. The MVC Coordinating Center will assess the performance year data during the program year and will provide a final score for the MVC-based measure to BCBSM for payment in 2027 and 2028, respectively.

Table 1: Timeline for Program Years 2026 and 2027

	Baseline Year	Performance Year	Program Year	Payment Year
Program Year 2026	2023	2025	2026	2027
Program Year 2027	2024	2026	2027	2028

How are hospital year-over-year improvement and achievement targets calculated?

Points for both episode spending and value metrics are scored based on Z-scores, which reflect the standardized percent reduction from the baseline payment or value metric rate. Z-scores are calculated by subtracting the hospital's performance mean payment or value metric rate from the mean baseline payment or value metric rate and dividing that difference by the MVC standard deviation from the baseline year. For improvement targets the baseline is the hospital's baseline, whereas for achievement the baseline is the cohort's baseline.

Episode Spending Z-score Calculations:

Improvement Z-score

$$\frac{\text{Hospital baseline} - \text{Hospital performance}}{\text{MVC All standard deviation from baseline}}$$

Achievement Z-score

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

Value Metric Z-score Calculations:

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** $\frac{\text{Cohort baseline} - \text{Hospital performance}}{\text{MVC All standard deviation from baseline}}$

What is the new health equity measure?

Hospitals will be assessed on the spread of 30-day risk-adjusted all-cause readmission rates for medical conditions among different payer categories within their hospital. The measure that will be used for scoring is called an index of disparity.

Why might my registry baseline payments be slightly different compared to the previous report, and why might they continue to shift in the future?

As anticipated, two factors contribute to different values as data is updated:

1. *Improvements in pricing methodology and risk-adjustment*

In response to feedback from the Collaborative, MVC strives to continuously improve pricing methodology to better align with real world reimbursement practices. Additionally, MVC has updated the P4P methodology to better account for outlier cases by calculating the observed/expected ratio based on MVC-wide data for all years instead of at the patient level for one year. These updates make the data more reflective of real world payments and more stable from year to year.

2. *The addition of more recent data can affect both price standardization and risk-adjustment*

Standard prices are calculated based on all available Medicare data; therefore, new data will result in small changes to standardized prices. Risk-adjustment also takes into account all available data, and new data will update the risk-adjustment modeling. For more information on MVC risk adjustment, please refer to the MVC Data Guide.

How will shifts in baseline payments or value metric rates impact my score?

The MVC Coordinating Center will distribute a mid-year and a final P4P report in addition to the reports available on the registry. Hospitals will be evaluated using the baseline data shown on the registry when the full year of performance data is available. This data will be captured in the final P4P reports distributed to hospitals. Each report on the registry has a footnote indicating the dates of data that are currently shown on the registry. As more data is added, the current total payment will shift accordingly.

How will my score for the MVC-based measure impact my BCBSM P4P payment?

The MVC-based measure accounts for 10 percent of the BCBSM 2026 P4P program. Different from CMS value-based programs, hospitals participating in BCBSM's 2026 P4P program will not be penalized based on their performance scores, only rewarded. Any remaining, unearned incentive dollars will be redistributed differentially within each P4P program component. More information on BCBSM's P4P program and payment methodology may be accessed here.

What changes have been made to the 2026 and 2027 program years?

1. The payer mix now includes Michigan Medicaid, rounding out all MVC payer data sources.
2. The episode spending condition menu was revised, with colectomy, pneumonia, and joint replacement removed, and percutaneous coronary intervention (PCI) added. The new episode spending condition menu is coronary artery bypass graft (CABG), congestive heart failure (CHF), chronic obstructive pulmonary disorder (COPD) and PCI.
3. The sepsis value metric has been updated from a 30-day risk-adjusted readmission measure to a 14-day follow-up measure
4. The preoperative testing value metric will be based on testing in the 30 days prior to all three procedures combined (laparoscopic cholecystectomy, inguinal hernia repair, and lumpectomy) rather than calculated separately by procedure, and lab tests (i.e., urinalysis and blood tests) were added to the list of tests included in the numerator
5. A new health equity measure has been added to the program worth one point. With this addition, the points possible for episode spending has been reduced from 4 to 3.

What is an index of disparity measure?

The index of disparity is a summary measure that indicates the extent of differences in risk-adjusted all-cause readmission rates by payer within a hospital. The higher this number is, the higher the spread in payer-level readmission rates.

Which payers are included in the health equity component?

Five payer categories are included in the health equity component:

1. BCBSM and BCN Commercial
2. BCBSM and BCN Medicare Advantage

3. Medicare FFS
4. Medicaid
5. Dual-eligible (Medicare or Medicaid patients that are dual-eligible will be assessed separately)

How is the index of disparity calculated?

The index disparity measure is calculated using the following steps:

1. For each hospital, the overall (hospital) risk-adjusted readmission rate and payer-specific risk-adjusted readmission rates are calculated
2. Difference value is generated for each payer group by subtracting the hospital readmission rate from each payer-specific readmission rate
3. Absolute values of differences are multiplied by their respective payer-specific population, summed, and divided by the total population
4. This generates the final index of disparity that will be used for scoring

How are the rates risk-adjusted?

In addition to standard MVC risk-adjustment for demographic and comorbidity data, MVC implemented additional 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. 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

What might hospital success look like?

Hospitals can earn a point in the health equity component if they either reduce their index of disparity (improvement) or have a low index of disparity relative to the collaborative-wide median (achievement). Hospitals earn a maximum of one point in the health equity component.

<u>Improvement:</u>

Hospitals will earn a point in the health equity component via improvement if the index of disparity reduces by ten percent from baseline year to performance year.

<u>Achievement:</u>

Hospitals will earn a point in the health equity component via achievement if the performance year index of disparity is less than or equal to the median collaborative-wide index of disparity in the performance year.