MVC Component of the BCBSM
Pay-for-Performance Program

# TECHNICAL DOCUMENT

Program Years
2022 and 2023

2022 | APRIL

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 MVC data. This metric measures hospital performance using price-standardized, risk-adjusted 30-day episode payments for BCBSM Preferred Provider Organization (PPO), Medicare Fee-For-Service (FFS), BCBSM Medicare Advantage, Blue Care Network (BCN) Health Maintenance Organization (HMO), and BCN Medicare Advantage.

## II. Earning Points

Each hospital's condition-specific total episode payment will be assessed for year-over-year improvement compared to its baseline year and its achievement respective to the appropriate MVC cohort. Hospitals must meet the minimum in-hospital mortality and readmission rate quality threshold for the selected condition in order to earn points. Provided the threshold is met, hospitals can earn 0 – 6 points for each selected condition for a total of 12 points. While 12 points can be achieved, the program will be scored out of 10 points. Points are earned based on the following criteria for each condition:

- Higher of improvement or achievement points (0-5 points)
- MVC questionnaire bonus point (0-1 points)

## III. Conditions

Each hospital previously chose two conditions for measurement. The available conditions for the 2022-2023 program years are shown below.

- Coronary artery bypass graft (CABG)
- Congestive heart failure (CHF)
- Colectomy (non-cancer)
- Chronic obstructive pulmonary disease (COPD)
- Joint replacement (Hip and knee)
- Pneumonia
- Spine surgery

## IV. Timeline

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 2023 and 2024, respectively.

# Introduction

## I. Purpose

The purpose of this document is to provide information on the Michigan Value Collaborative (MVC) BCBSM Hospital Pay-for-Performance Program (P4P) for Program Years 2022 and 2023. Information on past program years can be found in the previous Technical Documents (PY2018-2019) (PY2020-2021). Information regarding future program years will have separate documentation.

## II. Background

Blue Cross Blue Shield of Michigan's (BCBSM) Hospital Pay-for-Performance Program (P4P) recognizes hospitals that excel at care quality, cost-efficiency, and population health management. Beginning in 2018, BCBSM allocated 10% of its P4P program to an episode of care spending metric based on MVC data. The Michigan Value Collaborative (MVC) is a Collaborative Quality Initiative (CQI) funded by Blue Cross Blue Shield of Michigan's (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 shows where MVC falls in the breakdown of program components for the BCBSM Pay-for-Performance Program. To learn more about BCBSM's 2021 Hospital Pay-for-Performance Program, please refer to their documentation.

**Table 1: BCBSM Pay-for-Performance Program**

| 2021 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% of the incentive pot which is allocated 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:

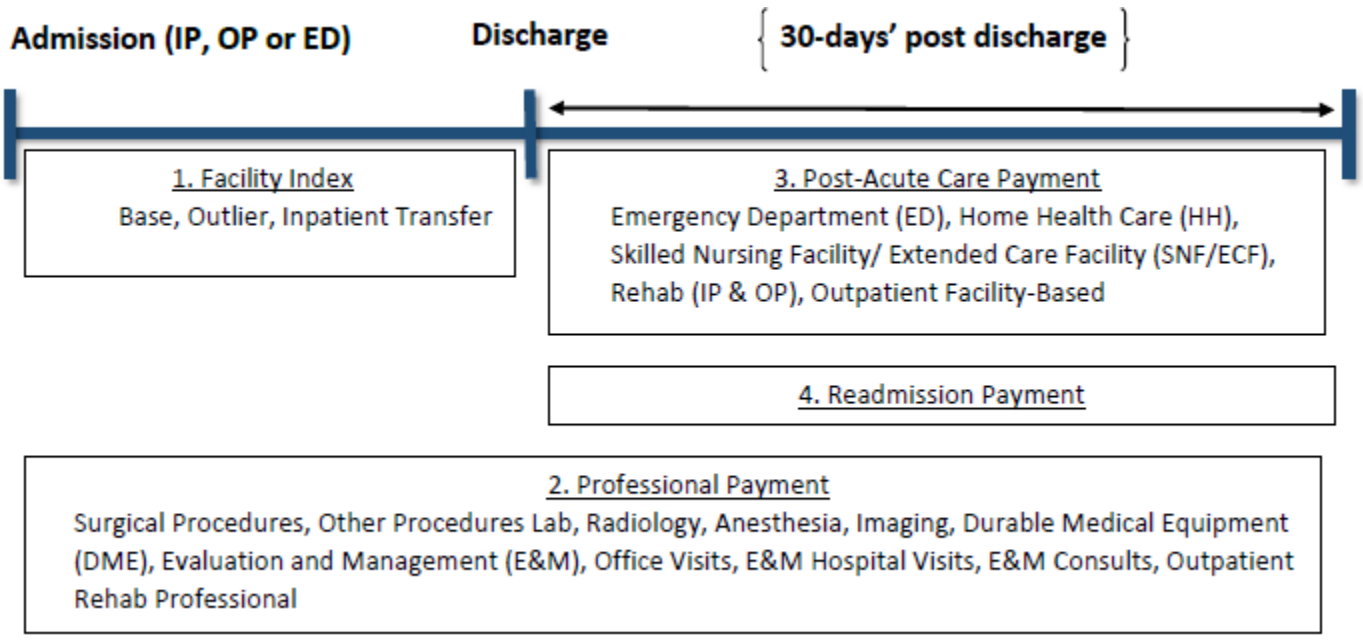
1. The measure will reflect the BCBSM Value Partnerships philosophy of using high-quality data to drive collaborative quality improvement.
2. The measure will be fair, valid, and transparent.
3. The measure will align with existing BCBSM and CMS hospital quality measures when possible and be consistent 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. MVC Measure

As part of the MVC Component of the BCBSM P4P Program, hospitals are evaluated on their average 30-day episode spending for selected conditions. This 30-day episode measure is price-standardized to the Medicare Fee-for-Service (FFS) schedule and risk-adjusted for age, gender, history of prior high spending, end-stage renal disease, as well as 79 comorbidities based on hierarchical condition categories and condition specific risk adjusters. Figure 1 below shows the components of the MVC episode. For more information regarding the MVC's price standardization and risk adjustment methodology, as well as the breakdown of the episode structure, please see the MVC Data Guide.

**Figure 1: Anatomy of an MVC Episode**



*Exclusions:*
Episodes will be excluded from the program 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 in patient or being discharged to hospice
- Patient has an ICD 10 diagnosis code of U07. 1 (COVID19, virus identified) on a facility claim during any inpatient setting during the 30-day episode. The first three diagnosis codes on the claim will be evaluated.

## II. Data Sources

The 2022 and 2023 program years utilize all available claims from the providers below:

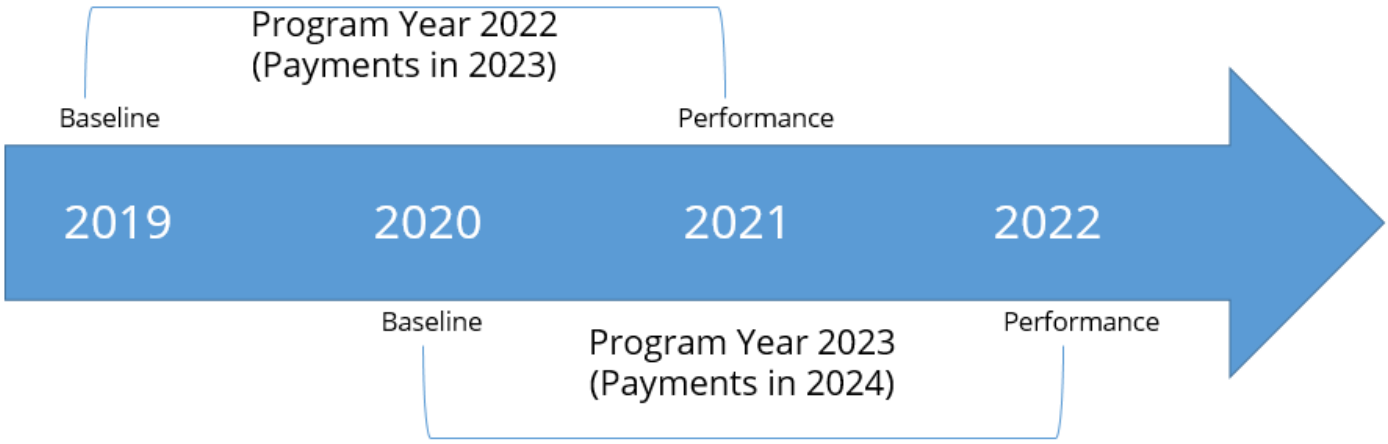
- Commercial BCBSM Preferred Provider Organization (PPO)
- BCBSM Medicare Advantage Preferred Provider Organization (PPO)
- Commercial Blue Care Network (BCN)
- Medicare Advantage Blue Care Network (BCN)
- Medicare Fee for Service (FFS)

As additional payers are added to the MVC registry, the Coordinating Center may incorporate them into the program with the permission of BCBSM and the Quarterly Hospital P4P Workgroup. Any changes that are made to the program will start at the beginning of the two-year reporting cycle.

## III. Program Timeline

Hospitals will be assessed on their average 30-day episode payment in 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 assessment year, and final scores on the MVC-based measure will be sent to BCBSM for payment during the payment year. Figure 2 outlines the timeline for each stage in program years 2022 and 2023.

**Figure 2: Timeline for Program Years 2022 and 2023**



## IV. MVC Cohorts

MVC cohorts are designed to compare hospitals with similar characteristics for specific conditions. Recognizing that episode spending may vary across cohorts, a participant's achievement is compared to hospitals within their assigned cohort. All hospitals are assigned to cohorts for each individual condition regardless of the hospital's condition 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*

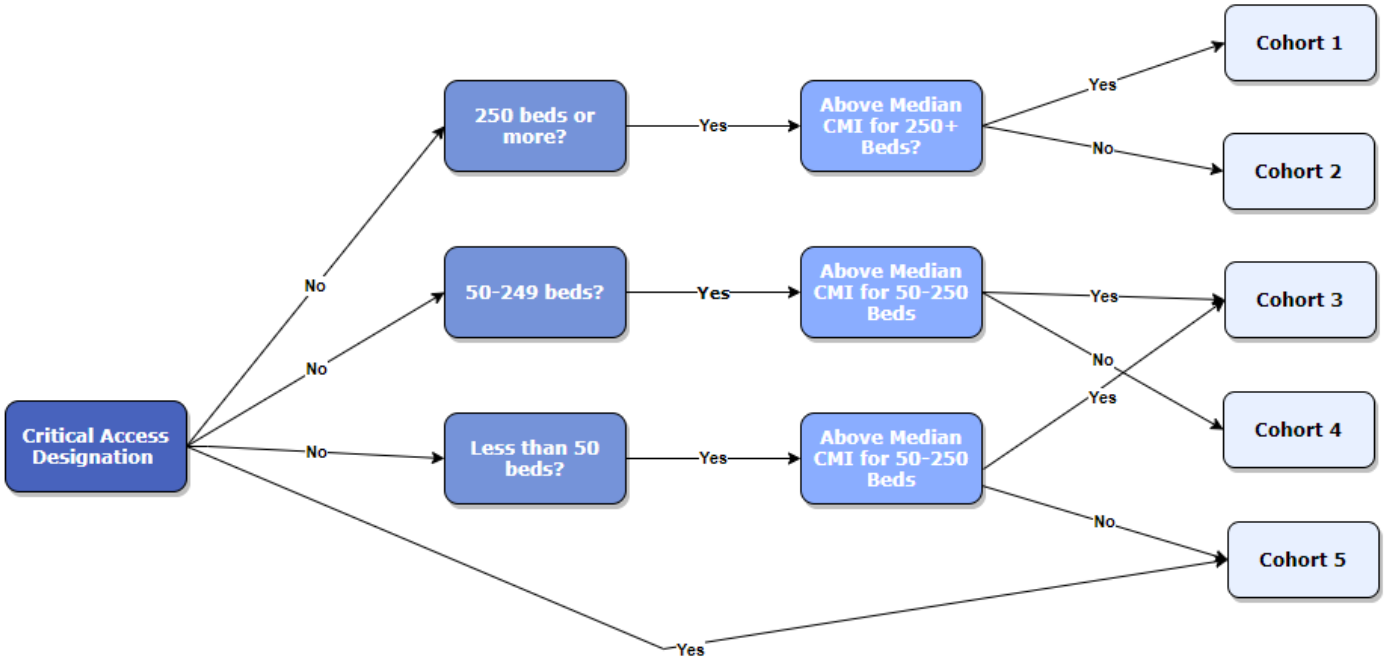
Cohorts were reassigned in June of 2021 to apply to the 2022 and 2023 program years. Cohort designations can be found in the resource section of the MVC website.

One set of cohorts is defined for CHF, Colectomy, COPD, Joint, and Pneumonia. Two additional sets of cohorts are defined separately for Spine and for CABG. Case mix index is defined based on hospital index admissions for the P4P conditions using all payers and includes patients with index admissions in 2018 and 2019. For the purposes of classification, episodes without a Medicare Severity-Diagnosis Related Group (MS-DRG) associated with the index admission are excluded. The Centers for Medicare and Medicaid Services (CMS) MS-DRG relative weights from the 2019 release are applied to all inpatient admissions to calculate the mean relative case mix index weight for each hospital.

*Joint, Pneumonia, CHF, COPD, and Colectomy*

The average case mix index for these five P4P conditions is calculated for all hospitals. Critical access hospitals are placed in cohort five, and the remaining hospitals are divided into three groups by bed size: 250 or more beds, between 50 and 249 beds, and less than 50 beds. The median case mix index for each of the two larger bed size groups is calculated and used to distinguish between cohorts 1-4. Hospitals in the group of 50 or less beds are included in cohort three if they had a case mix index above the median for the medium sized hospitals. Otherwise, the hospitals with less than 50 beds are placed in cohort 5. See Figure 3 below for a detailed breakdown of cohort designations.

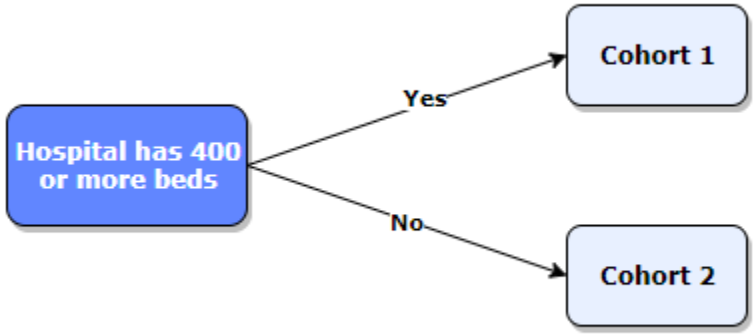
**Figure 3. Cohorts Designation CHF, Colectomy, COPD, Joint, and Pneumonia**




*CABG*

The CABG cohort is based solely upon bed size. This decision was made because nearly half of MVC hospitals do not offer CABG services, and the case mix index distributions did not produce distinct clusters of hospitals.

**Figure 4: CABG Cohort Designation**




*Spine*

The spine cohort groups are based upon the complexity of spine surgeries performed by a hospital (as determined by the case mix index for spine surgery), as well as bed size. The 75$^{th}$ percentile of spine case

mix index for hospitals is used as the initial branch point for the spine cohort. Bed size is used to further divide hospitals into cohorts 2 and 3.

**Figure 5. Spine Cohort Designation**

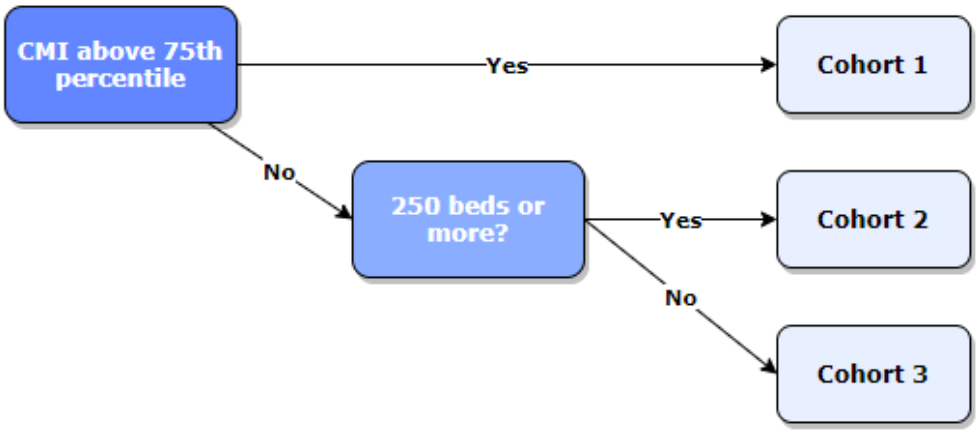



**Table 2. Number of MVC Hospitals by Cohort**

| Cohort | Main | CABG | Spine |
|---|---|---|---|
| **1** | 17 | 17 | 12 |
| **2** | 18 | 16 | 26 |
| **3** | 22 | | 15 |
| **4** | 17 | | |
| **5** | 23 | | |

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

## V. Conditions

*Selection of Conditions*

Hospitals are required to select two of seven condition options (Table 3). 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. Hospitals selected two conditions in 2021 on which they will be evaluated during the 2022 and 2023 program years.

**Table 3. Condition Options for the MVC Component of the BCBSM P4P Program**

| Program Year 2022 and 2023 |
|---|
| Coronary artery bypass graft (CABG) |
| Congestive heart failure (CHF) |
| Colectomy (non-cancer) |
| Chronic obstructive pulmonary disease (COPD) |
| Joint replacement (Hip and knee) |
| Pneumonia |
| Spine surgery |

*Minimum case requirements*

The Coordinating Center selected the minimum episode volume requirements of 20 cases based on several empirical analyses. Ultimately, we selected minimum case thresholds that simultaneously 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 count.

## Program Scoring

Hospitals can earn P4P points in three ways: (1) improvement (2) achievement, and (3) questionnaire bonus point. Hospitals will earn the higher of their improvement or achievement points. In order to be eligible for points, a hospital must first meet the quality thresholds.

### I. Quality Thresholds

Hospitals will not be eligible to receive P4P points for a condition if they are ranked in the bottom 10$^{th}$ percentile in the performance year for condition-specific in-hospital mortality and related readmissions. The Coordinating Center will evaluate discharge disposition to assess inpatient mortality and 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.

### II. Improvement

Hospitals can earn up to five points per condition by reducing spending in the performance period over their baseline spending. Points are scored based on Z-scores, which reflect the standardized percent reduction from the baseline payment. Z-scores are calculated by subtracting the hospitals mean performance payment from the mean baseline payment and dividing that difference by the winsorized MVC standard deviation. All payments are risk-adjusted and price-standardized.

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

The intent of the 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 cases, and the MVC standard deviation will be winsorized at the 99th percentile, meaning any values above the 99th percentile will be given the value of the 99th percentile. The utility of winsorization is to mitigate the impact of extreme outlier cases. The output of the improvement z-score formula will then be used to assign points, according to Table 4 below. The chosen z-score thresholds reflect improvement percentage thresholds used in previous Program Years.

**Table 4. Z-score Thresholds for Point Values**

| Z-score Threshold | Point Value |
|---|---|
| <0 | 0 Points |
| 0 - <0.05 | 1 Point |
| 0.05 - <0.1 | 2 Points |
| 0.1 - <0.15 | 3 Points |
| 0.15 - <0.2 | 4 Points |
| 0.2+ | 5 Points |

## III. Achievement

Hospitals can earn up to five points per condition by having an average episode cost that is lower than the cohort average. Achievement Z-scores will be calculated by subtracting the hospitals mean performance payment from the cohort's mean baseline payment and dividing the difference by the MVC winsorized standard deviation. The z-score thresholds will be the same for improvement and achievement points (see Table 4).

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

*Shifting Targets*

Over time, 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 doesn't freeze targets.

### IV. MVC Bonus Point

Participants are able to earn two bonus points by completing one questionnaire per selected condition and submitting these to the MVC Coordinating Center by November 1st of each Program Year. The purpose of this is to gather examples of quality improvement initiatives in operation at MVC member hospitals to share with the Collaborative. Moving forward, this will help support members in reducing costs through collaboration. Appendix G contains the bonus point questionnaire for use in PY22 and PY23.

## MVC Registry

The MVC registry has a series of P4P reports that allow hospitals to assess their improvement and achievement points throughout the program year. These reports show combined Medicare FFS and all BCBSM data and so reflect the patient population included in P4P. The reports can be found in the P4P menu. To request access to the registry, please contact the Coordinating Center or complete the Access Request Form.

### I. P4P Registry Reports

1. **Comparison with the MVC All:** This report shows how a hospital's rank compares to the whole collaborative. While this report does not show how a hospital is scoring, it allows benchmarking of episode payments and episode components of combined Medicare and BCBSM data.
2. **P4P Year-Over-Year Performance Comparison:** This report shows a hospital's improvement targets and current improvement points for all P4P conditions.
3. **P4P Achievement Comparison 30-Day Episodes:** This report currently shows hospitals rankings compared to their cohort to inform the achievement points for the 2020 and 2021 Program Years. The report will be updated to accommodate the change to Z-score methodology.

The Coordinating Center will continue to make improvements to the reports with the long term goal of having the registry reports contain all necessary scoring information. Until then, the Coordinating Center will send a mid-year scorecard and a final scorecard.

## 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 Pay-for-Performance Quarterly Workgroup.

### I. Program Year 2022 and 2023 Changes

The 2022-2023 P4P program has been updated to include the following changes:

- Move improvement and achievement scoring to z-scores

- Change achievement scoring from rankings to distance from cohort mean at baseline
- Modify improvement scoring equation to align with new achievement methodology
- Replace cohort reduction bonus point with questionnaire bonus point
- Remove COVID-19 patients from the measure
- Remove inpatient deaths and discharge to hospice from the measure

If you have suggestions for future changes to the program, please email them to michiganvaluecollaborative@gmail.com.

## MVC Coordinating Center Support

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 (POs) that meet to collaborate and share ideas related to various topics. Please email michiganvaluecollaborative@gmail.com to request workgroup details. The current workgroup topics are:
    - Congestive Heart Failure (CHF)
    - Chronic Disease Management
    - Chronic Obstructive Pulmonary Disease (COPD)
    - Diabetes
    - Joint Replacement
    - Sepsis
- **Site Visits**: The Coordinating Center offers virtual site visits to all collaborative members. During these visits, the MVC team delivers information on any requested topics, provides an overview of the data available on the registry, and summarizes the benefits of being part of MVC.
- **Semi-Annual Meetings:** MVC holds meetings twice a year to bring quality leaders across the state together. The Coordinating Center invites speakers to share their stories of success, challenges, and barriers related to specific topics of interest to MVC members.
- **Coffee, Chat and Collaborate Networking Events:** MVC hosts virtual networking events for different regions of Michigan to engage hospital and PO leaders in discussion and provide networking opportunities.

### II. Analytic Support

- **MVC Registry:** The MVC registry houses over 20 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 areas of interest. If you would like to receive reports for your hospital, please contact the MVC Coordinating Center.
- **Custom Support:** The MVC analytic team supports our members with custom analytic reports and requests. If you are interested in receiving a custom report, please contact the MVC Coordinating Center.

## III. Coordinating Center

- **Facilitating Connections:** The Coordinating Center helps to connect members with high performing hospitals and/or others in their cohort as well as POs and other requested connections.
- **Questions/Consultations:** The Coordinating Center is happy to help hospital with data requests or other questions. Please submit requests through michiganvaluecollaborative@gmail.com.

## Appendix A: Glossary

**MVC Measure:** 30-day risk adjusted, price standardized, hospital average episode payment used to evaluate hospital's P4P performance.

**Improvement Points:** Points earned by reducing performance payment over the baseline payment.

**Achievement Points:** Points earned by being less expensive than the baseline cohort average.

**Bonus Point**: Participants can earn a bonus point by completing two questionnaires (one per selected condition) and submitting these to the MVC Coordinating Center by November 1st of each Program Year.

**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 in in-hospital mortality or related readmissions will not be eligible to earn P4P points.

**Cohort**: Group of hospitals deemed to be similar in bed size, teaching status, and case mix.

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

**Program Year:** Year that the program is being evaluated.

**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 performance year where a hospital will receive its scores and payment from BCBSM.

**Condition:** A medical or surgical condition with a homogenous group of patients to be tracked in the MVC data. The current eligible P4P conditions are chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), pneumonia, joint replacement (Hip and knee), colectomy (non-cancer), coronary artery bypass graft (CABG), and spine surgery.

## Appendix B: Value-based incentive programs from the Centers for Medicare & Medicaid Services (CMS)

***Bundled Payment for Care Improvements Advanced (BPCI Advanced)***
BPCI Advanced is a voluntary program developed and implemented by CMS to test bundled payments for 90-day clinical episodes of care related to 32 conditions or procedures. The goals of the model are: Care Redesign, Health Care Provider Engagement, Patient and Caregiver Engagement, Data Analysis/Feedback and Financial Accountability. The first round of the model has 1,299 participants nationwide.

***Condition-specific episode payment measures for AMI, Heart Failure (HF), and Pneumonia***
CMS recently designed and released episode payment measures for three common medical diagnoses. The measure calculates risk-adjusted payments for 30-day episodes of care. At present, these measures are not tied to value-based payments, however, they are publically reported as part of the Hospital Compare program.

***Comprehensive Care for Joint Replacement (CCJR)***
The proposed CCJR model was developed by CMS to test episode-based bundled payments for joint replacement surgery. Unlike BPCI (which is a voluntary program), CMS selected 75 geographic regions (metropolitan statistical areas) to participate in in CCJR. The participants include a wide range of hospitals with varying baseline costs. In this model, CMS will establish "target episode prices" and provide year-end reconciliation payments for hospitals that provide joint replacement at a lower cost. Hospitals that exceed the target price will be required to pay the difference back. To be eligible for reconciliation payments, hospitals must simultaneously meet quality standards for complications, readmissions, and patient satisfaction.

The table below provides additional details for each program.

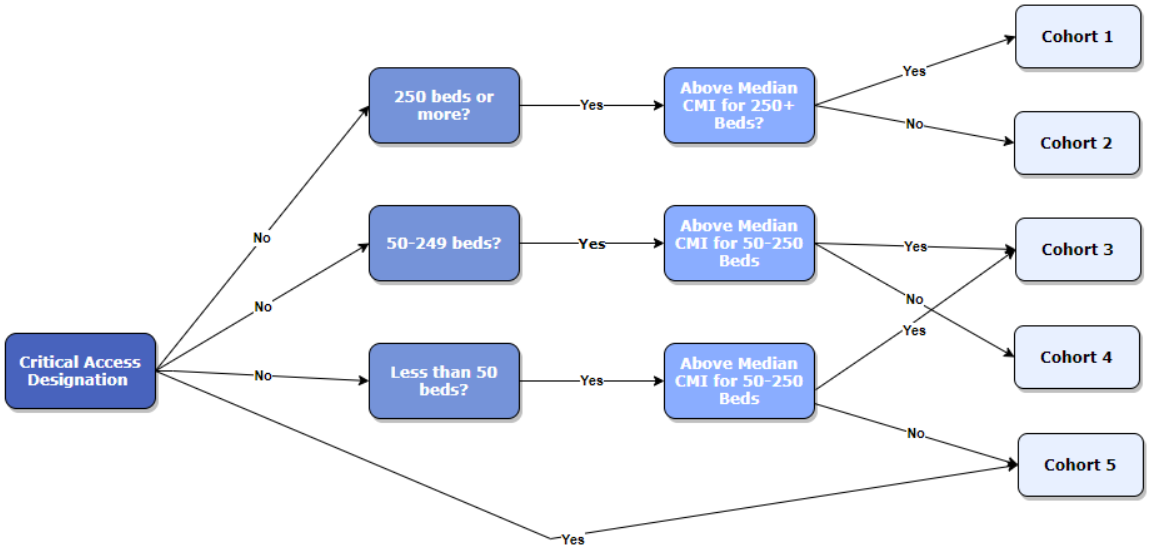
| | BPCI Advanced | AMI/HF/ Pneumonia Episode payment measure | CCJR |
|---|---|---|---|
| **Episode Length** | 90-days post discharge | 30-day episode of care beginning with a hospitalization | 90-day episode |
| **Episode Triggers** | Inpatient admission of eligible beneficiary to acute care hospital for one of the MS-DRGs or outpatient procedure identified by HCPCS code in a selected episode | Index admission for AMI/HF/Pneumonia | MS-DRG 469 or 470 |
| **Episode Inclusion** | Captures payments for all care covered under Medicare Part A and Part B within time of episode | Captures payments for all inpatient, outpatient and post-acute care claims | Captures payments for all inpatient, outpatient and post-acute care claims |
| **Medical/Surgical** | Both | Medical | Surgical |
| **Readmissions** | Included | Included | Included |

## Appendix C: Cohort Designation

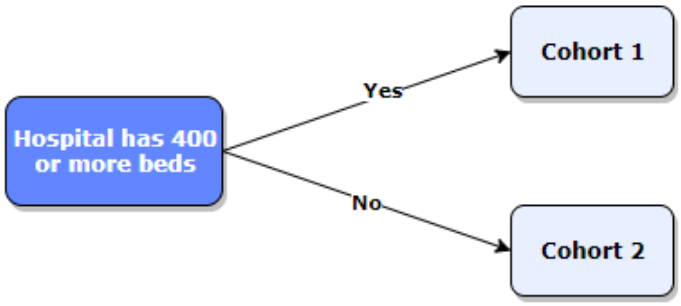
This appendix is meant to further illustrate how hospitals are assigned to cohorts. All hospitals will be assigned a cohort for each P4P condition regardless of the conditions the hospital selected. If a hospital does not perform a surgery, they will not be assigned a cohort for that condition. There is one main cohort methodology for the majority of the P4P conditions: CHF, colectomy, COPD, joint replacement, and pneumonia. This means that a hospital will be in the same cohort for all of these conditions. Spine and CABG have a different set of cohort criteria.

*Example 1:*

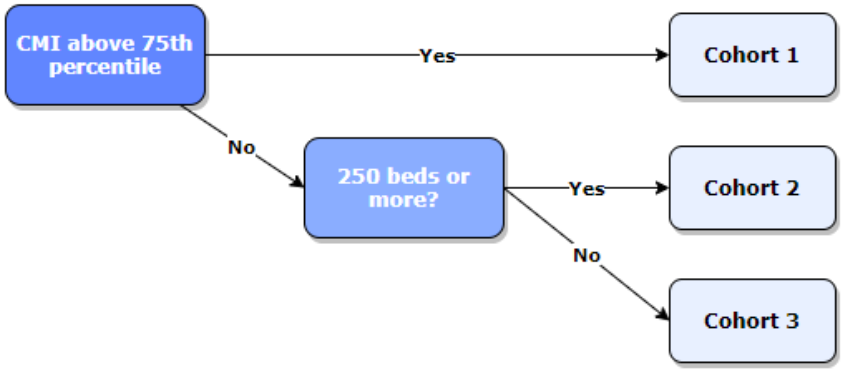
Hospital A is not a critical access hospital, has 300 beds, and a case mix index that is above the median in its bed size group. Following the map shown below, Hospital A will be put in cohort 1 for joint replacement, pneumonia, CHF, COPD, and colectomy.




Hospital A performs CABGs so they will be assigned to a CABG cohort. As Hospital A has less than 400 beds, they will be assigned to CABG cohort 2.



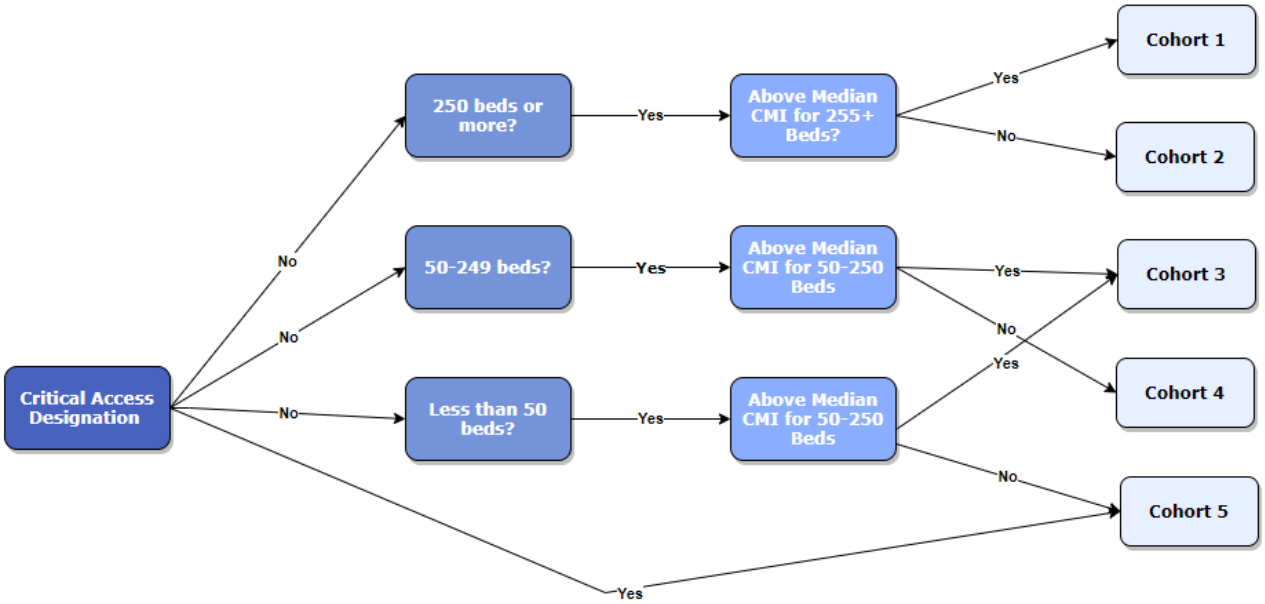
Hospital A also performs some spine surgeries and will be assigned to a spine cohort. Hospital A's case mix index for spine was below the 75th percentile. Hospital A has more than 250 beds, so they will fall into cohort 2 for spine.




| Hospital A's Cohort Designations | |
|---|---|
| **Condition** | **Cohort** |
| Chronic obstructive pulmonary disease (COPD) | 1 |
| Congestive heart failure (CHF) | 1 |
| Pneumonia | 1 |
| Joint replacement (Hip and knee) | 1 |
| Colectomy (non-cancer) | 1 |
| Coronary artery bypass graft (CABG) | 2 |
| Spine surgery | 2 |

*Example 2:*

Hospital B is not a critical access hospital with 45 beds, and their case mix index is above the median for the 50-249 beds group. They do not perform CABGs or spine surgeries. Following the map below, they will be assigned to cohort 3. While Hospital B has less than 50 beds, their case mix index puts them in cohort 3.




| Hospital B's Cohort Designations | |
|---|---|
| **Condition** | **Cohort** |
| Chronic obstructive pulmonary disease (COPD) | 3 |
| Congestive heart failure (CHF) | 3 |
| Pneumonia | 3 |
| Joint replacement (Hip and knee) | 3 |
| Colectomy (non-cancer) | 3 |
| Coronary artery bypass graft (CABG) | NA |
| Spine surgery | NA |

## 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 2022: Final Scorecard**
**Hospital A**

| Selected Condition | Baseline Payment (2019)[1] | Performance Payment (2021)[1] | Improvement | | Achievement | | Bonus Points | Quality Threshold Met | Points Per Line* | Total Points |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Z-Score | Improvement Points | Z-Score | Achievement Points | | | | |
| CHF | $18,158 | $17,800 | 0.12 | 3 | -0.18 | 0 | 1 | Yes | **4** | **10** |
| Joint | $19,405 | $18,524 | 0.18 | 4 | 0.23 | 5 | 1 | Yes | **6** | |

| Year-Over-Year Improvement Targets | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Selected Condition | Baseline Payment[1] | Performance Payment[1] | Z-Score | 1 Point (Z-Score: 0) | 2 Points (Z-Score: 0.05) | 3 Points (Z-Score: 0.10) | 4 Points (Z-Score: 0.15) | 5 Points (Z-Score: 0.20) | Point(s) |
| CHF | $18,158 | $17,800 | 0.12 | $18,158 | $18,003 | $17,848 | $17,963 | $17,538 | 3 |
| Joint | $19,405 | $18,524 | 0.18 | $19,405 | $19,164 | $18,924 | $18,683 | $18,443 | 4 |

| Achievement Ranking Targets | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Selected Condition | Cohort Baseline[1] | Performance Payment[1] | Z-Score | 1 Point (Z-Score: 0) | 2 Points (Z-Score: 0.05) | 3 Points (Z-Score: 0.10) | 4 Points (Z-Score: 0.15) | 5 Points (Z-Score: 0.20) | Point(s) |
| CHF | $17,240 | $17,800 | -0.18 | $17,240 | $17,085 | $16,930 | $16,775 | $16620 | 0 |
| COPD | $19,654 | $18,524 | 0.23 | $19,654 | $19,413 | $19,173 | $18,932 | $18,692 | 5 |

## Appendix E: Scoring Example

### Program Years 2022 and 2023

The following is an illustration of how the scoring system will be applied for program years 2022 and 2023. In this example, Hospital A selected CHF and joint replacement as their two conditions. All dollar amounts provided below are for illustrative purposes only. For program year 2022, the performance period is calendar year 2021, and the baseline year is calendar year 2019. In program year 2022, Hospital A meets the quality requirement by performing above the 10$^{th}$ 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 Joint Replacement:**

Hospital A's 30-day mean total episode costs for joint replacement in the performance year are shown on the line below ($18,524), along with their baseline year ($19,405), their cohort's baseline year ($19,654), and the MVC all standard deviation for this condition ($4,812).


From these four numbers, z-scores are calculated for both achievement and improvement.

$$Achievement = \frac{\$19,654 - \$18,524}{\$4,812} = 0.23 \text{ z-score value}$$

$$Improvement = \frac{\$19,405 - \$18,524}{\$4,812} = 0.18 \text{ z-score value}$$

Points are determined for each z-score value, and the higher of the two is awarded.

| Z-score threshold | Point value |
|---|---|
| <0 | 0 |
| 0 – <0.05 | 1 |
| 0.05 – <0.1 | 2 |
| 0.1 – <0.15 | 3 |
| 0.15 – <0.2 | 4 |
| 0.2+ | 5 |

*Achievement*

0.23 z-score value → 5 Achievement Points

*Improvement*

0.18 z-score value → 4 Improvement Points

**For the joint condition, Hospital A is awarded 5 achievement points.**

**Scoring for CHF:**

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).


From these four numbers, z-scores are calculated for both achievement and improvement.

$$Achievement = \frac{\$17,240 - \$17,800}{\$3,100} = \text{-0.18 z-score value}$$

$$Improvement = \frac{\$18,158 - \$17,800}{\$3,100} = 0.12 \text{ z-score value}$$

Points are determined for each z-score value, and the higher of the two is awarded.

| Z-score threshold | Point value |
|---|---|
| <0 | 0 |
| 0 – <0.05 | 1 |
| 0.05 – <0.1 | 2 |
| 0.1 – <0.15 | 3 |
| 0.15 – <0.2 | 4 |
| 0.2+ | 5 |

*Achievement*

-0.18 z-score value → 0 Achievement Points

*Improvement*

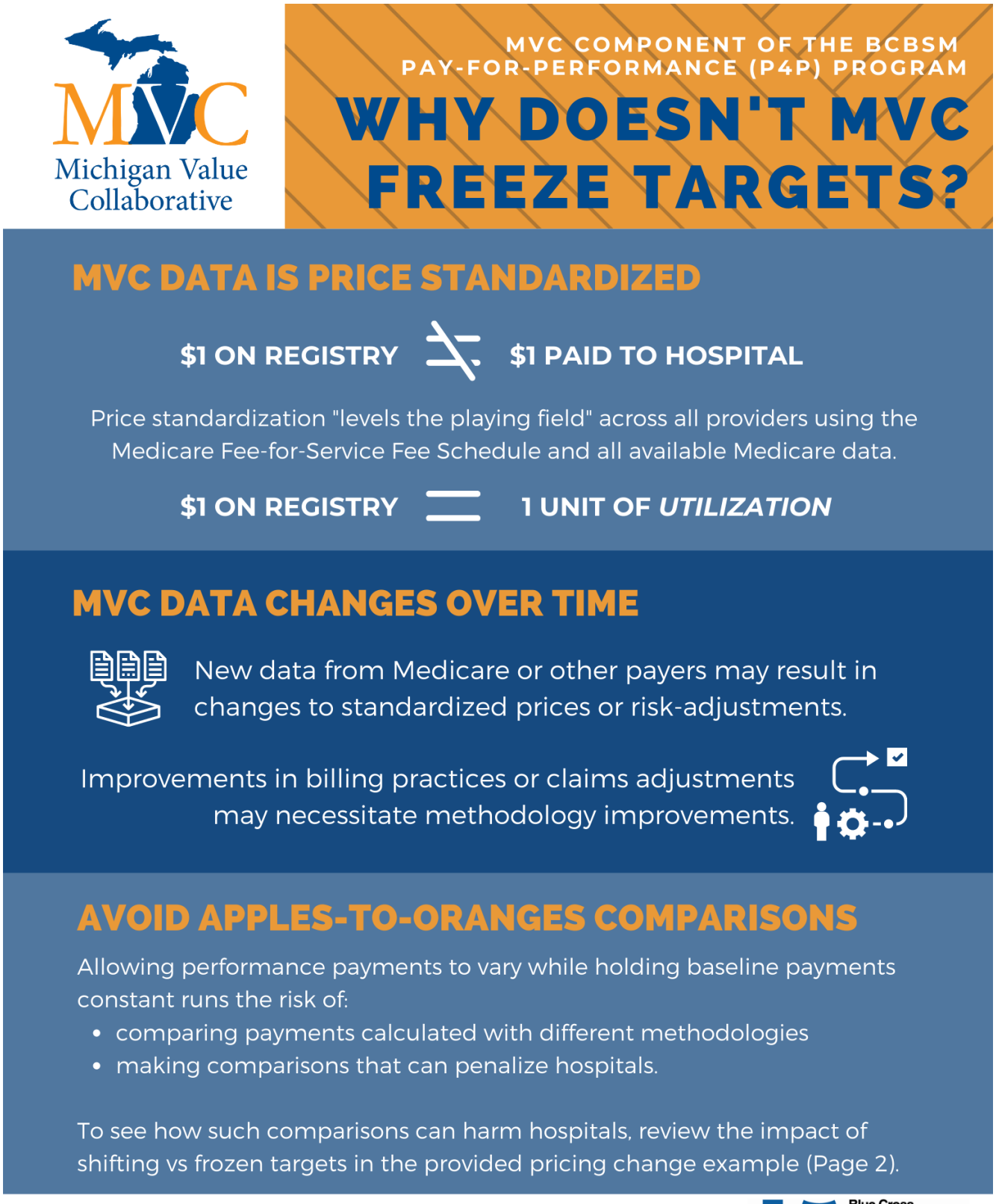
0.12 z-score value → 3 Improvement Points

**For the CHF condition, Hospital A is awarded 3 improvement points.**

Hospital A also completed the MVC questionnaire for both Joint Replacement and CHF conditions, earning them two bonus points. Therefore, their final score in the MVC Component of the BCBSM P4P Program would be 10 points.

| Selected Condition | Baseline Payment (2019)[1] | Performance Payment (2021)[1] | Improvement | | Achievement | | Bonus Points | Quality Threshold Met | Points Per Line* | Total Points |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Z-Score | Improvement Points | Z-Score | Achievement Points | | | | |
| CHF | $18,158 | $17,800 | 0.12 | 3 | -0.18 | 0 | 1 | Yes | **4** | **10** |
| Joint | $19,405 | $18,524 | 0.18 | 4 | 0.23 | 5 | 1 | Yes | **6** | |

**Appendix F: Why MVC Doesn't Freeze Targets**



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.

## Appendix G: Bonus Point Questionnaire

As part of the MVC Component of the BCBSM P4P Program, participating hospitals are able to earn a bonus point for each selected service line. To be eligible for this, the following questions must be completed in full for each selected service line at the end of both Program Years and returned to the MVC Coordinating Center by **November 1st of that year**. The purpose of this is to gather examples of quality improvement initiatives in operation at MVC member hospitals to share with the Collaborative. Moving forward, this will help support members in reducing costs through collaboration.

| | |
|---|---|
| Name of respondent: | |
| Respondent role: | |
| Hospital name: | |
| Service line: | |
| Points earned: | |

**Q1. What prompted you to select this service line?** *Please be specific. For example, what data or clinical insights led you to choose this condition as an opportunity for quality improvement?*

**Q2. How does the MVC Component of the BCBSM P4P Program align, compete or overlap with other performance-based incentives you are involved with?** *Was your decision to select this service line influenced by involvement in other programs?*

**Q3. How do you define and measure quality improvement within your organization?**

**Q4. What initiatives, programs, resources or tools have you implemented or plan to implement to try and improve performance in your selected service line? *Please provide examples and highlight the timeframe associated with these interventions.***

**Q5. Did these approaches have the desired impact?** *If yes, were there particular factors that contributed to this success? If no, what are some of the remaining barriers and what would you do differently to improve in this area?*

**Q6. How has the MVC Coordinating Center supported you in improving performance within your selected service line (e.g. MVC registry, push reports, custom analytics, regional networking, workgroups, semi-annual meetings)?**

**Q7. Would you be willing for this information to be shared openly with other collaborative members?** *To facilitate collaboration, would you also be willing for your contact details to be shared with collaborative members interested in learning more about your quality improvement efforts?*

**Q8. What, if anything, could be done differently by the MVC Coordinating Center to help support you in the future?**