Michigan Value Collaborative

MVC Component of the BCBSM P4P Program PY20/21: Member Evaluation

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 payment metric based on Michigan Value Collaborative (MVC) data. This metric measures hospital performance using price-standardized, risk-adjusted 30-day episode payments for Commercial BCBSM Preferred Provider Organization (PPO) and Medicare Fee-for-Service (FFS) patients. Each hospital's condition-specific total episode payments were assessed for year-over-year improvement compared to their baseline year. Hospitals were also able to earn achievement points by being less expensive than the other hospitals in their cohort. The MVC cohorts are groups of hospitals determined to be peers based on bed size and case mix index.

Hospitals earned the greater of their improvement or achievement points plus a bonus point if their cohort reduced payments by five percent or more during the program. Hospitals could have earned 0-6 points for each selected condition. Hospitals had to meet a quality threshold minimum for both in-hospital mortality and readmission rates for the selected conditions in order to earn any points.

In light of the COVID-19 pandemic and its effect on 2020 hospital admissions, the MVC Coordinating Center elected to add two additional bonus points for the 2021 program year only. One point could be earned by having a representative attend both MVC semi-annual meetings, and a second point could be earned by completing a site visit with the Coordinating Center in 2021. This brought the total possible points in program year (PY) 2021 to 14 points, though the program was scored out of 10 points. **Table 1** shows the 2020/2021 timeline for the program.

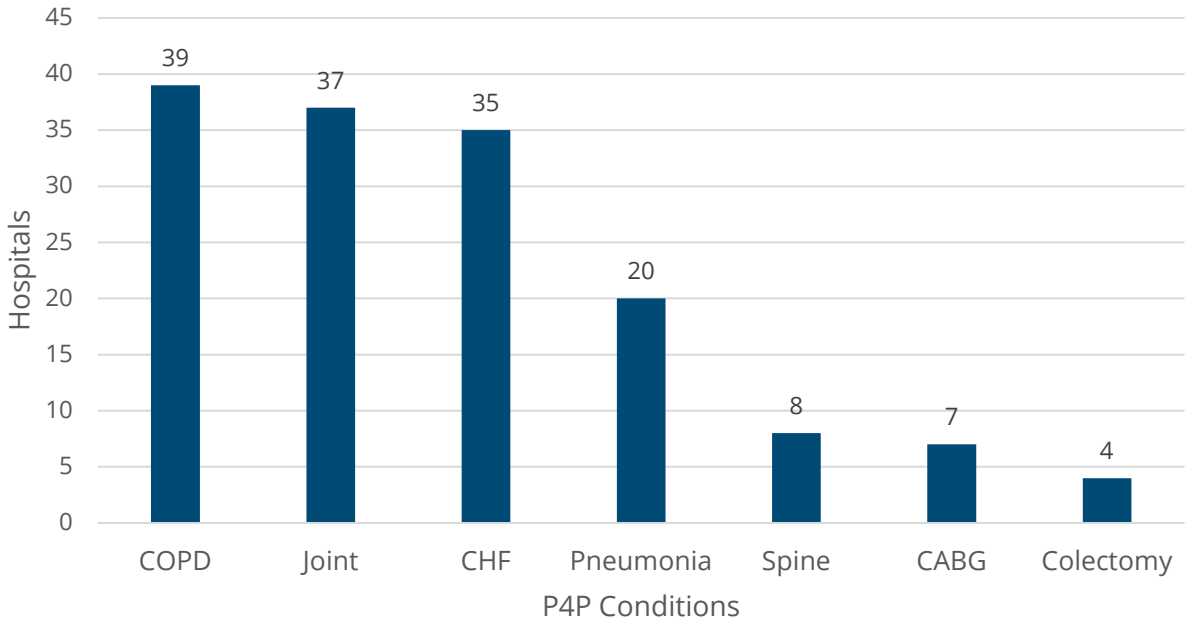
Table 1. MVC Component of the BCBSM P4P Program: PY 2020/2021 Timeline

	Baseline Year	Performance Year	Scoring Year	Payment Year
Program Year 2020	2017	2019	2020	2021
Program Year 2021	2018	2020	2021	2022

Condition Selection

Hospitals selected two of seven conditions before the two-year scoring cycle began. The seven conditions to choose from included chronic obstructive pulmonary disease (COPD), coronary artery bypass graft (CABG), congestive heart failure (CHF), colectomy, joint replacement, spine surgery, and pneumonia. Hospitals were eligible to select a given condition if they had at least 20 episodes in 2019. **Figure 1** shows the distribution of conditions selected by participants. These conditions were evaluated for both PY 2020 and 2021.

Figure 1. Distribution of Selected Conditions at MVC Hospitals for PY2020/2021



The two most common selections were COPD and joint replacement. In contrast, CABG and colectomy were the least selected options. The medical options represented nearly two-thirds (63%) of the selected conditions, with the remaining 37% of selections made up of surgical options. This is likely explained by fewer hospitals being eligible to select the more specialized surgical options.

Payments

Hospitals were evaluated on their average 30-day risk-adjusted, price-standardized episode payment for their selected conditions. Episode payments were standardized to the Medicare fee schedule, meaning that the dollars shown throughout this report are measures of utilization rather than true dollar amounts.

Hospitals could earn improvement points based on the absolute reduction in payment from their performance year compared to their baseline year. The analysis that follows show the change in average episode payment over time among hospitals that selected each condition.

Figure 2 shows the full payment trend across the four years. Of the seven P4P conditions, joint replacement showed the most consistent decrease over time. Pneumonia, CHF, and COPD had relatively flat trends over time, while CABG, spine, and colectomy fluctuated from year to year. Colectomy decreased in 2018 but increased for 2019 and 2020. Spine surgery payments declined slightly from 2017 to 2019 but increased in 2020. CABG showed the inverse trend with payments increasing slightly until 2019 and decreasing in 2020.

Figure 2. Average Episode Payment Trends for P4P Conditions (2017-2020)

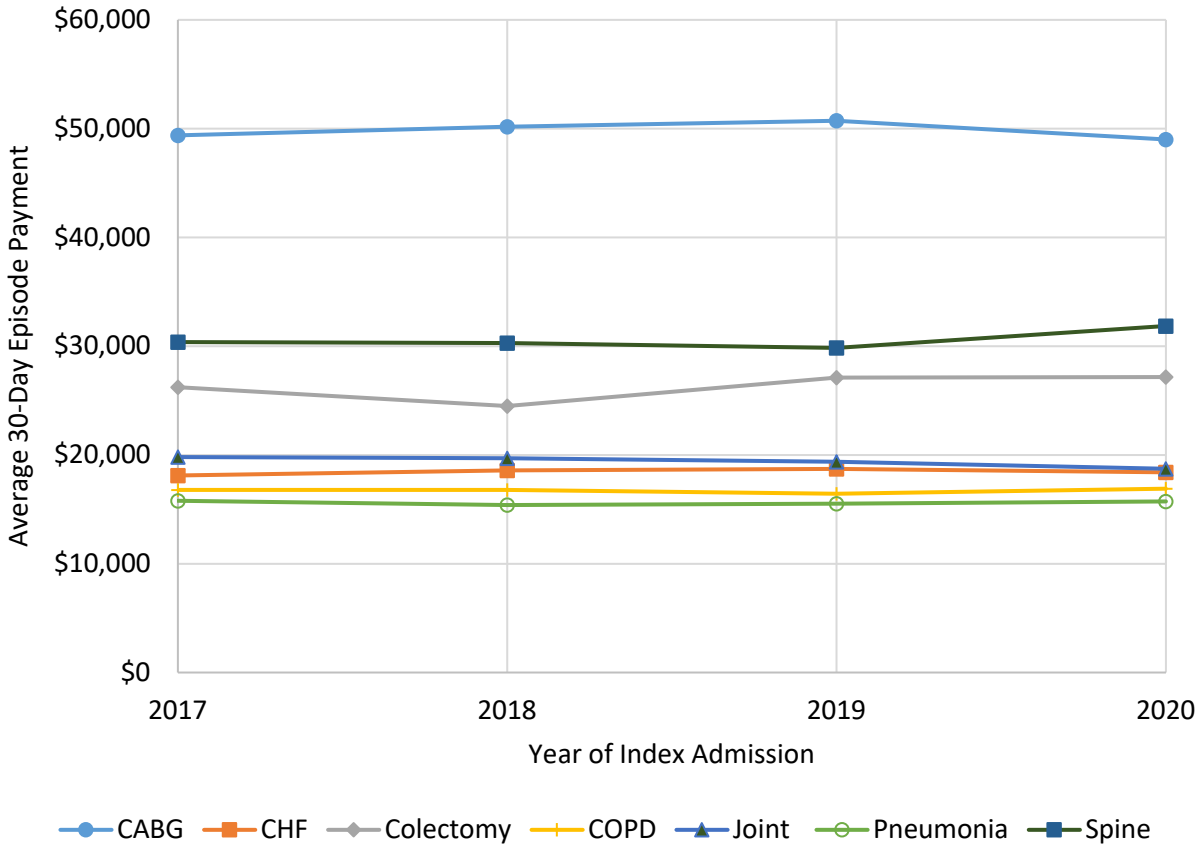


Table 2 shows the average payment change for each condition as well as the price-standardized cost savings for each PY. Standardized cost savings were calculated using the change in 30-day episode payment and the performance year case counts. Joint replacement had the largest reduction in cumulative payments for both PYs and it was the only condition that showed an average decrease in payments across both years. Conversely, colectomy was the only condition in which payments increased in both PYs, though it was the least common condition selection.

Table 2. Average 30-Day Episode Payment Changes for P4P Conditions

P4P Condition	PY 2020 Average Payment Change	PY 2021 Average Payment Change	PY 2020 Cumulative Payment Change	PY 2021 Cumulative Payment Change
CABG	$1,330	-$1,186	$1,324,959	-$1,138,733
CHF	$604	-$176	$4,785,175	-$1,359,629
Colectomy	$882	$2,664	$190,445	$623,427
COPD	-$365	$118	-$3,299,098	$784,220
Joint Replacement	-$428	-$962	-$4,656,618	-$9,119,243
Pneumonia	-$270	$341	-$509,126	$699,506
Spine	-$544	$1,569	-$870,272	$1,788,614
		Total	**-$3,034,534**	**-$7,721,838**

The collective price-standardized cost savings for PY 2020 and 2021 were approximately $3 million and $7.7 million, respectively. Joint replacement was the largest contributor to these cost savings with a decrease of $4.7 million for PY 2020 and $9.1 million for PY 2021. PY 2020 saw an average decrease in payments among four of the seven conditions, whereas PY 2021 saw decreases in three of the seven. **Over the two PYs, the collective risk-adjusted, price-standardized cost savings were $10.8 million.**

Figures 3 and **4** demonstrate the change in episode component payments over PYs 2020 and 2021, respectively. Bars above the horizontal axis represent increases in payment, and bars below the horizontal axis signify decreases in payment. For an explanation of the episode components included in Figures 3 and 4, please refer to the MVC Data Guide.

Figure 3. Change in Average Episode Components in PY 2020

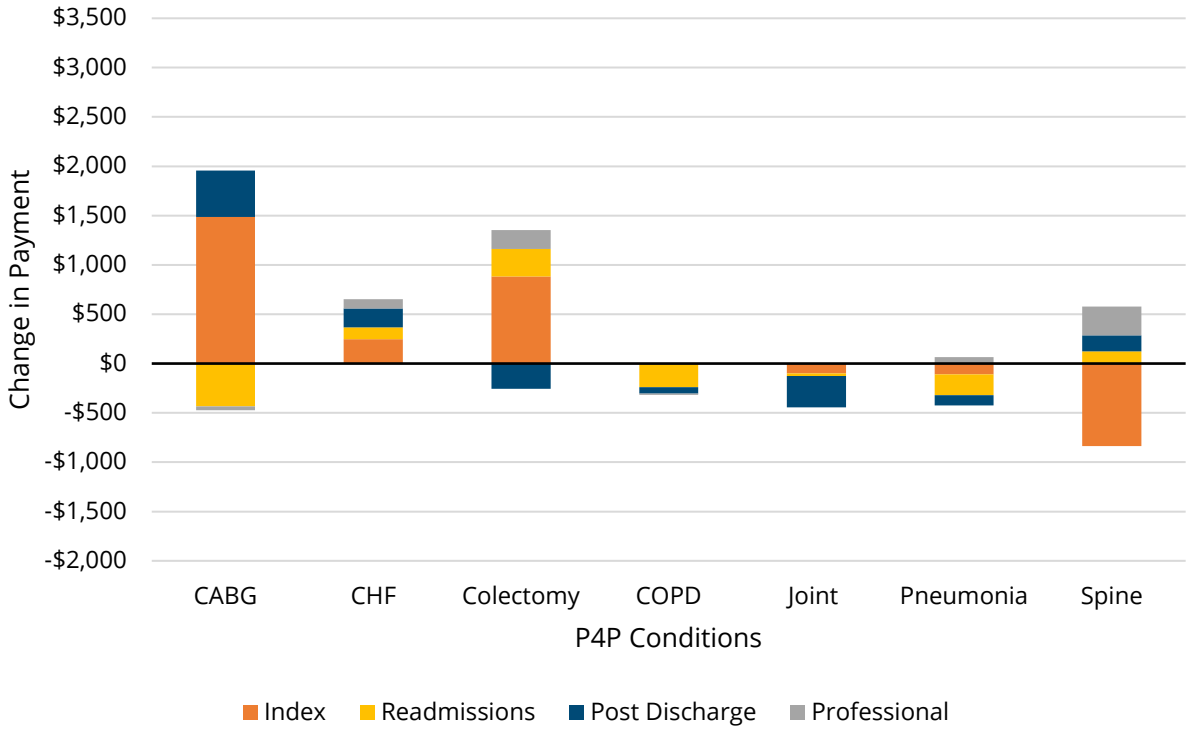


Figure 4. Change in Average Episode Components in PY 2021

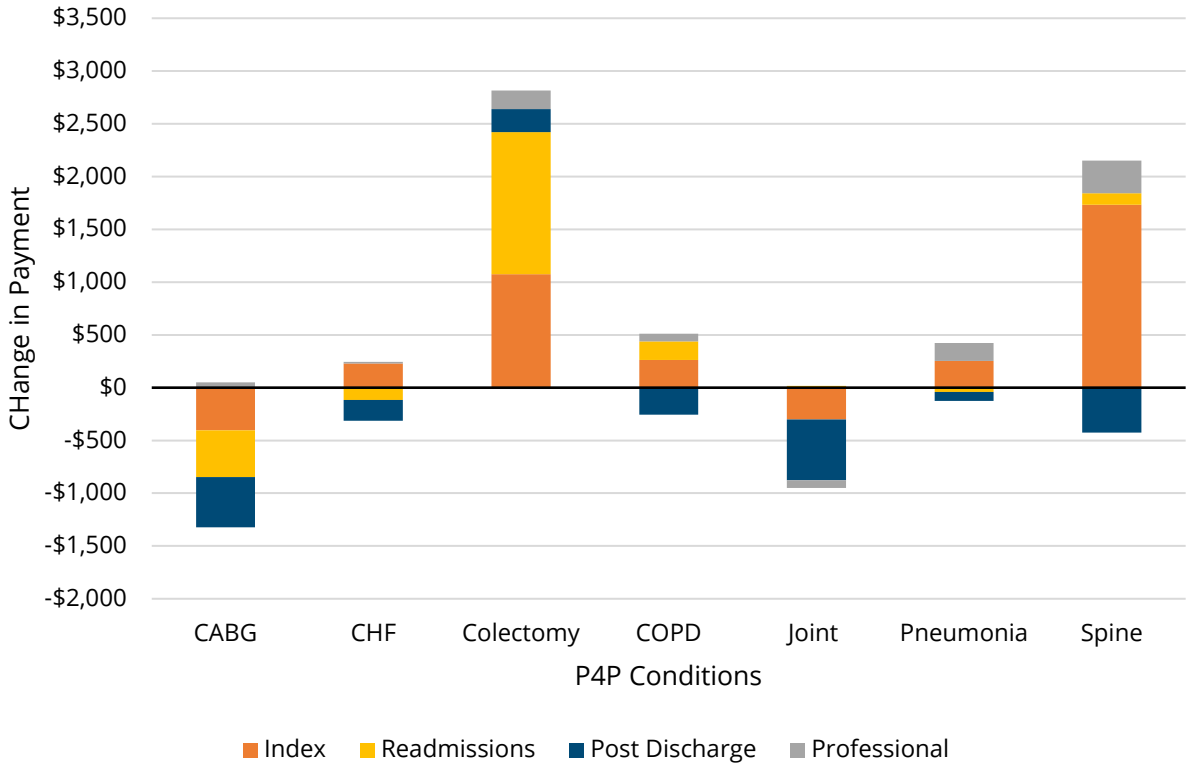


Figure 3 shows that COPD, joint replacement, and pneumonia decreased across the majority of episode components, while CHF increased across all components. The majority of the increase in payments for CABG and colectomy were due to the index component, and both conditions decreased in other parts of the episode that were masked by the increase in the index. Spine surgery showed the inverse, where the decrease in payments was driven by the index component while the other episode components increased.

Figure 4 shows both joint replacement and CABG decreasing across the majority of components while colectomy increased across all components. CHF, COPD, pneumonia, and spine all saw decreases in post-discharge payments despite increases in other parts of the episode. **Figures 3 and 4** show that the substantial decrease in joint replacement payments in both program years took place across all components of the episode with post discharge being the most prominent. Increases in colectomy payments were largely driven by the index and the readmission components across both PYs. The fluctuation in spine payments between PYs was due largely to the index component. Overall, there is little consistency between PYs.

Points

Figure 5 shows that more overall points were distributed in PY 2021 compared to PY 2020. Part of this change was due to additional bonus points being awarded for PY 2021 in light of the COVID-19 pandemic and its effects on the performance year 2020 data; hospitals were able to earn two additional bonus points in PY 2021 (see above). For example, 83% of hospitals earned a point for attending the semiannual meetings and 77% earned a point for completing a site visit. Almost all (88%) participating hospitals earned at least one extra bonus point, with 72% earning both additional bonus points.

Figure 5. PY 2020 and 2021 Total Point Distribution

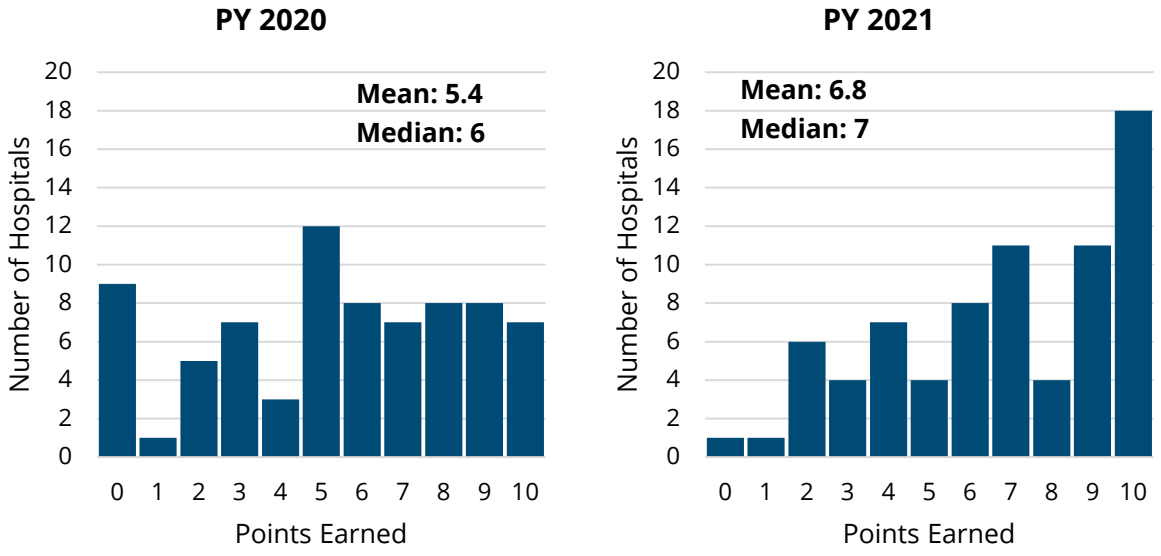


Figure 6. PY 2020 and 2021 Improvement Point Distribution

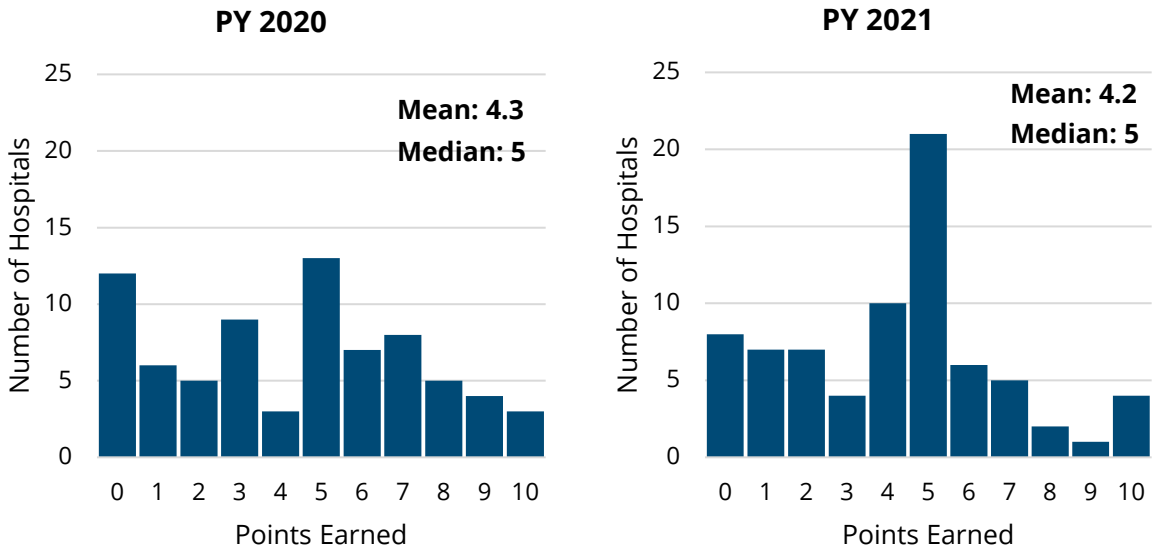
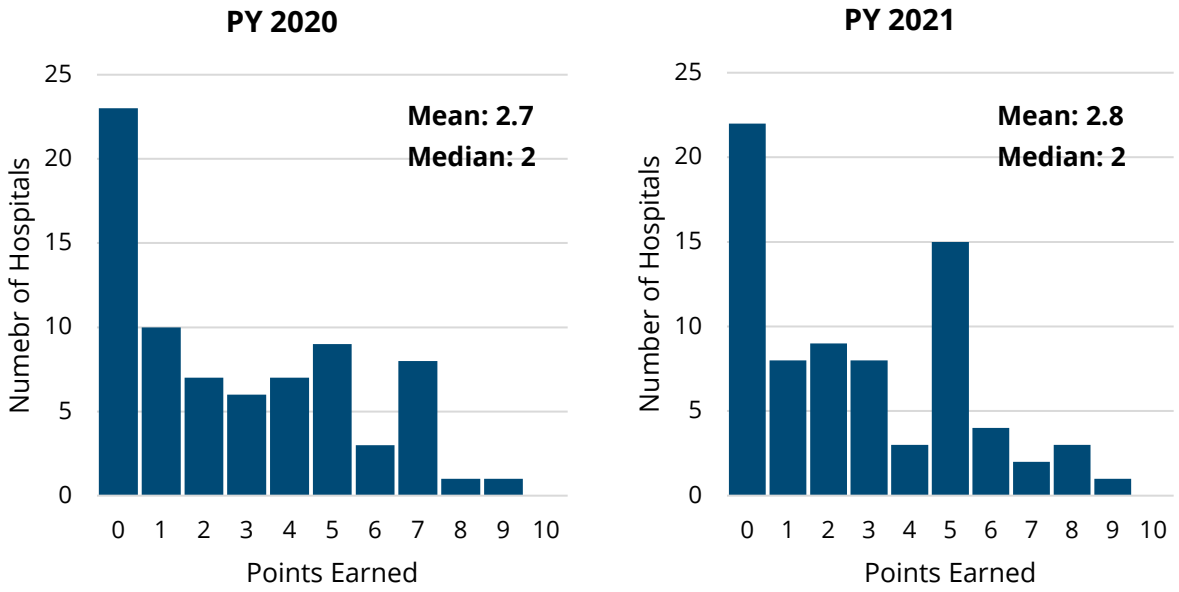


Figure 7. PY 2020 and 2021 Achievement Point Distribution



Figures 6 and 7 show very little change between PYs in the average points scored for improvement and achievement.

Cohort Bonus Point

Hospitals earned a bonus point if all hospitals in their cohort that selected the same condition reduced the collective payment by five percent or more. In PY 2020, two COPD cohorts, one colectomy cohort, two joint replacement cohorts, and one pneumonia cohort earned the bonus point. This represented a total of 33 individual bonus points. In PY 2021, one CHF cohort, one COPD cohort, and two joint replacement cohorts earned the bonus point, representing a total of 31 individual bonus points.

Quality Threshold

In order to earn any P4P points, hospitals were required to meet the quality thresholds for both readmissions and inpatient mortality. Of the 75 evaluated hospitals, all met both quality thresholds in both PYs.

Hospital Characteristics

Table 3 shows the point distribution by hospital characteristics including teaching status, bed size, and the type of geographic location. MVC used the American Hospital Association (AHA) 2020 survey to identify hospital teaching status, bed size, and urban/rural classification. Teaching status and urban/rural designation was defined using the AHA guidelines described below.

Teaching Status
Major teaching hospitals were determined to be hospitals that had the Council of Teaching Hospitals designation and minor teaching hospitals had any one of the following accreditations:

- Participating site recognized for one or more Accreditation Council for Graduate Medical Education accredited programs
- Medical school affiliation reported to the American Medical Association
- Internship approved by American Osteopathic Association
- Residency approved by American Osteopathic Association

Urban/Rural Designation

- Rural hospitals were those located outside a Core-Based Statistical Area (CBSA), as designated by the U.S. Office of Management and Budget (OMB), effective June 6, 2003
- Urban hospitals were inside a CBSA
- Micropolitan areas, which were new to the OMB June 6, 2003 definitions, continue to be classified as "rural" in AHA data offerings
- Further information on urban and rural designations in Michigan is available here

Table 3. Average Point Totals by Hospital Characteristics

	PY 2020 Mean (SD)	PY 2021 Mean (SD)
Teaching status		
Major-teaching (N=6)	5.5 (2.3)	5.8 (1.9)
Minor-teaching (N=46)	5.3 (3.1)	6.2 (3)
Non-teaching (N=22)	5.5 (3.4)	8.2 (2.2)
Bed Size		
Fewer than 100 (N=20)	5.6 (3.3)	7.6 (2.3)
100-199 (N=15)	6.5 (3.5)	8 (2.4)
200-299 (N=12)	5.3 (3.3)	5.6 (3.6)
300-399 (N=11)	5.2 (2.4)	5.8 (3.5)
400-499 (N=5)	2.6 (1.8)	5.8 (1.3)
500 or more (N=11)	5.1 (2.8)	6.3 (2.5)
Location		
Metro (N=56)	5.5 (3)	6.4 (2.9)
Micro (N=12)	5.1 (3.3)	7.8 (2.2)
Rural (N=6)	4.8 (4.3)	8.3 (2.7)

Table 3 shows that the point distribution was fairly even across teaching status and bed size, though smaller hospitals and non-teaching hospitals seemed to score higher in PY 2021.

Looking Forward

The MVC Coordinating Center will continue to evaluate the mechanisms by which hospitals were successful in the P4P program in order to share best practices with members. Additionally, the Coordinating Center will work to modify the program as necessary to ensure it is as fair and transparent as possible. For details regarding PY 2022 and 2023, please see the MVC P4P Technical Document. MVC hosts a series of workgroups for physician organizations and hospitals to share best practices on several P4P conditions and learn from high-performing peers. The times and dates of all MVC workgroups can be found here. You can also contact the Coordinating Center at MichiganValueCollaborative@gmail.com to receive the event reminders and registration details.