Michigan Value Collaborative

Blue Cross Blue Shield Blue Care Network of Michigan
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MVC Component of the BCBSM P4P Program Changes for Program Years 2024 and 2025

Blue Cross Blue Shield of Michigan (BCBSM) includes a Pay-for-Performance (P4P) measure derived from MVC data in their Hospital P4P Program (hereafter referred to as the "MVC measure"). The MVC Coordinating Center has been guided by the following core principles when developing and recommending changes to the MVC measure:

- The measure will reflect the BCBSM Value Partnerships philosophy of using high quality data to drive collaborative quality improvement.
- The measure will be fair, simple, and transparent.
- The measure will align with existing BCBSM and CMS hospital quality measures when possible and be consistent with Value Partnerships CQI principles.
- The measure will encourage examination and use of MVC data to drive value improvement and reward those efforts.

In an effort to continually improve the MVC measure to align with these guiding principles, we have provided the BCBSM P4P Quarterly Workgroup with several recommended changes to the measure for Program Years (PYs) 2024 and 2025, which were approved on July 7, 2022. These changes will be implemented for the upcoming PY 2024, which is based on 2021 encounters for the baseline period and 2023 encounters for the performance period. These changes will not be retroactively applied to PYs 2022-2023. For more detail about PYs 2024-2025, please refer to the P4P Technical Document.

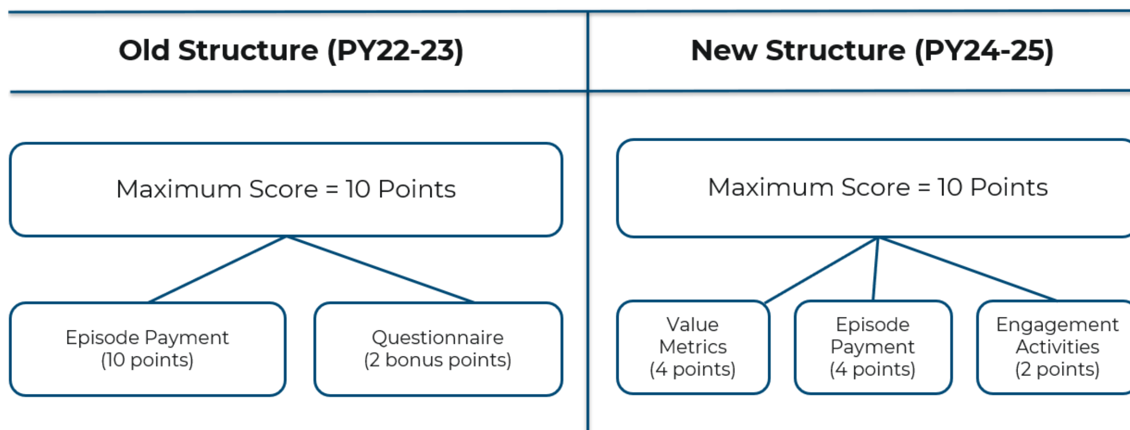
What is staying the same?

- The program will continue to be scored out of 10 points maximum.
- Improvement points will continue to be earned in comparison to a hospital's own past performance, and achievement points will continue to be earned in comparison to an MVC cohort. Each hospital will continue to be awarded the greater of the two scores, either improvement or achievement.
- Cohort designation will largely stay the same, based on bed size, critical access status, and case mix index.
- Hospitals will continue to be evaluated on their risk-adjusted, price-standardized total episode payment, though this will make up a smaller component of the overall program.
- Most condition options for the episode payment component will remain. Each participating hospital will choose **one of six** available conditions on which to be evaluated:
    - Chronic obstructive pulmonary disease (COPD)
    - Colectomy (non-cancer)
    - Congestive heart failure (CHF)
    - Coronary artery bypass grafting (CABG)
    - Joint replacement
    - Pneumonia

What is changing?

Program Structure

- The PY 2022-2023 program was scored out of 10 points, but 12 points could be earned (10 points from episode spending plus two bonus points). In PYs 2024-2025, the overall program structure will change so that the maximum score will be 10 points, made up of a maximum of four points from episode spending, a maximum of four points from value metrics (a new component), and a maximum of two points from engagement activities. No bonus points will be available for PYs 2024-2025.



New Scoring Component: Value Metrics

- Brand new in PYs 2024-2025 will be value metrics, which are measures of utilization in particular clinical 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 or low rates of low-value services.
- Hospitals will be eligible to earn **up to four points** for their performance on **one of seven** value metrics of their choosing:

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 coronary intervention (PCI)	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 PCI DRG (246, 247, 248, 249, 250, 251).	High rates

Follow-up after CHF	Episodes that included at least one outpatient follow-up visit (in-person or remote) within seven days of discharge. Follow-up that occurs after a readmission, inpatient procedure, emergency department visit, skilled nursing facility admission, or visit for inpatient rehabilitation is not included.	Includes all MVC-defined CHF episodes where the patient was discharged to home or home health.	High rates
Follow-up after COPD	Episodes that included at least one outpatient follow-up visit (in-person or remote) within 14 days of discharge. Follow-up that occurs after a readmission, inpatient procedure, emergency department visit, skilled nursing facility (SNF) admission, or visit for inpatient rehabilitation is not included.	Includes all MVC-defined COPD episodes where the patient was discharged to home or home health.	High rates
Follow-up after pneumonia	Episodes that included at least one outpatient follow-up visit (in-person or remote) within seven days of discharge. Follow-up that occurs after a readmission, an inpatient procedure, emergency department visit, skilled nursing facility (SNF) admission, or a visit for inpatient rehabilitation, is not included.	Includes all MVC-defined pneumonia episodes where the patient was discharged to home or home health.	High rates
Preoperative testing	Episodes where preoperative testing occurred in the 30 days prior to MVC-defined cholecystectomy, hernia repair, and lumpectomy procedures for any of the following test types: electrocardiography, echocardiogram, cardiac stress, x-ray, or pulmonary function.	Includes elective and outpatient MVC-defined cholecystectomy, hernia repair, and lumpectomy episodes. Episodes with certain comorbidities are excluded (see	Low rates

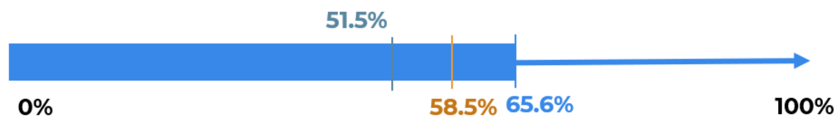
		Technical Document Appendix C).	
Risk-adjusted readmission after sepsis	Episodes that included at least one readmission within 30 days of discharge.	Includes all MVC-defined sepsis episodes. Episodes with index admissions containing a discharge disposition to a long-term acute care hospital (LTACH) are excluded.	Low rates

- Scoring for value metrics will be similar to the existing scoring methodology for episode payments. See scoring example below.
- 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

Episode Payment Component is Modified

- Three minor changes will apply to the episode payment component of the P4P Program.
  - The maximum possible points for the episode payment component of the program will **decrease from 5 to 4 points.** Participants will only be scored on a single condition as opposed to two different conditions, as in previous program cycles.
  - Spine surgery will no longer be an eligible condition. All other conditions will still be available to be selected.
  - An inpatient MVC episode will only be eligible to be scored in the program if it has a core DRG in alignment with existing CMS payment programs (see table below). This will not change the established MVC episode definitions, only exclude some episodes from P4P scoring. Outpatient episodes will be unaffected by this change.

Episode Spending Condition Options for Program Years 2024 and 2025	
Condition	**DRGs**
Chronic obstructive pulmonary disease (COPD)	190, 191, 192, 202, 203
Colectomy (non-cancer)	329, 330, 331
Congestive heart failure (CHF)	291, 292, 293
Coronary artery bypass graft (CABG)	231, 232, 233, 234, 235, 236
Joint replacement (Hip and knee)	469, 470, 483, 484
Pneumonia	177, 178, 179, 193, 194, 195

Engagement Points Incorporated into Program Structure

- Hospitals will be eligible to earn **up to two points** by completing various engagement activities throughout each program year. These points will be built into the structure of the program rather than being considered “bonus” points.
- Hospitals may select their own combination of activities but must include at least one activity from each of the *attendance* and *participation* categories to earn any points.

Attendance		**Participation**	
Description	**Point Value**	**Description**	**Point Value**
Attend both MVC Semi-Annual meetings	0.25	Present at an MVC Semi-Annual meeting	0.5
Attend 5+ MVC virtual workgroups	0.25	Present at an MVC virtual workgroup	0.5
Attend regional networking event	0.25	Host a virtual or in-person site visit	0.5
Submit a request for a custom analytic report	0.25	Participate in an MVC case study related to a QI project	0.5
Other TBD	0.25	Collaborate with MVC staff on an MVC blog post	0.5
Other TBD	0.25	Other TBD	0.5