



MVC Component of the BCBSM
Pay-for-Performance Program

TECHNICAL DOCUMENT

Program Years
2024 and 2025



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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, the BCBSM P4P Quarterly Workgroup approved changes to how hospitals are evaluated in future program cycles.

II. Timeline

The MVC Coordinating Center will assess claims from the performance years (encounters occurring in 2023 and 2024) during the program years (PYs) 2024 and 2025 and will provide a final score for the MVC-based measure to BCBSM for payment in 2025 and 2026, respectively.



III. Earning Points

Points From 30-Day Total Episode Payments

Each hospital will choose one of six conditions to be evaluated on using mean total 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 in order to earn points. Provided the threshold is met, hospitals will earn the higher of their improvement or achievement points for a total of 0 – 4 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.

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 2024 and 2025. Information on past cycles can be found in previous technical documents ([PY2020-2021](#), [PY2022-2023](#)). 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 an episode-of-care spending metric 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

2022 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.

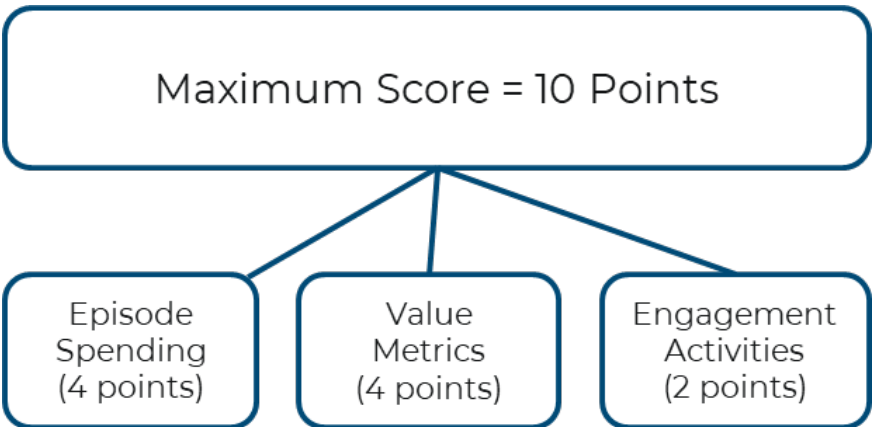


P4P Measure Methodology

I. Overall Structure

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

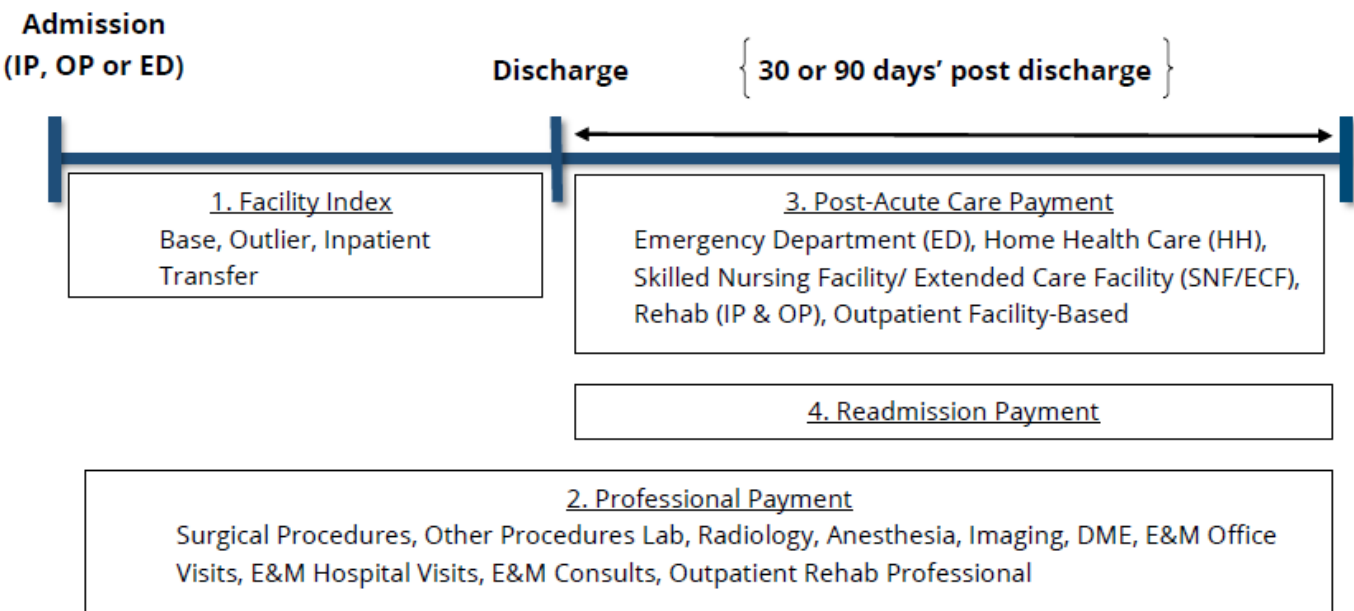
Figure 1: Point Breakdown



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 2024 and 2025 utilize all available claims from the payers below:

- BCBSM PPO
- BCBSM Medicare Advantage PPO
- BCN HMO
- BCN Medicare Advantage
- Medicare 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 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 assessment 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 2024 and 2025.

Figure 3: Timeline for PYs 2024 and 2025



IV. 30-Day Episode Spending

Hospitals can earn up to four points based on their average 30-day episode payments 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 eligible P4P population 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.
- 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.
- Index DRG is outside of the core DRGs for an inpatient episode for the given condition (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 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 took place in 2022 for evaluation in program years 2024 and 2025.

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

Episode Spending Condition Options for PYs 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

Minimum Case Requirements

The MVC Coordinating Center selected the minimum episode volume requirements of 20 cases 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 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. Winsorization is used to mitigate the impact of extreme outlier cases.

Figure 4. Improvement Z-score Equation

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

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 - <0.05	1 Point
0.05 - <0.1	2 Points
0.1 - <0.15	3 Points
>0.15	4 Points

Quality Thresholds

In order to earn points in the 30-day episode spending component, a hospital must first meet the quality thresholds. 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

List of Value Metrics and Definitions

After soliciting feedback from the BCBSM P4P workgroup and several clinicians, the value metric options were established for PYs 2024 and 2025 (Table 4). Hospitals must choose one of the seven value metrics for the PY24-25 two-year cycle. If preoperative testing is selected as a value metric, three low-risk surgeries (cholecystectomy, hernia repair, and lumpectomy) will be scored separately, and the surgery with the highest point value will be awarded.

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.
- Patient has an ICD 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.

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 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 a 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 admission, or a 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 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 Appendix C)	Low rates
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

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 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 year rate from the mean baseline rate and dividing that difference by the MVC standard deviation (Figure 5). 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
<p>Improvement Z-score</p> $\frac{\text{Hospital performance} - \text{Hospital baseline}}{\text{MVC All standard deviation from baseline}}$	<p>Improvement Z-score</p> $\frac{\text{Hospital baseline} - \text{Hospital performance}}{\text{MVC All standard deviation from baseline}}$
<p>Achievement Z-score</p> $\frac{\text{Hospital performance} - \text{Cohort baseline}}{\text{MVC All standard deviation from baseline}}$	<p>Achievement Z-score</p> $\frac{\text{Cohort baseline} - \text{Hospital performance}}{\text{MVC All standard deviation from baseline}}$

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 September 2022 for PYs 2024 and 2025. Cohort designations can be found in the [resource section of the MVC website](#).

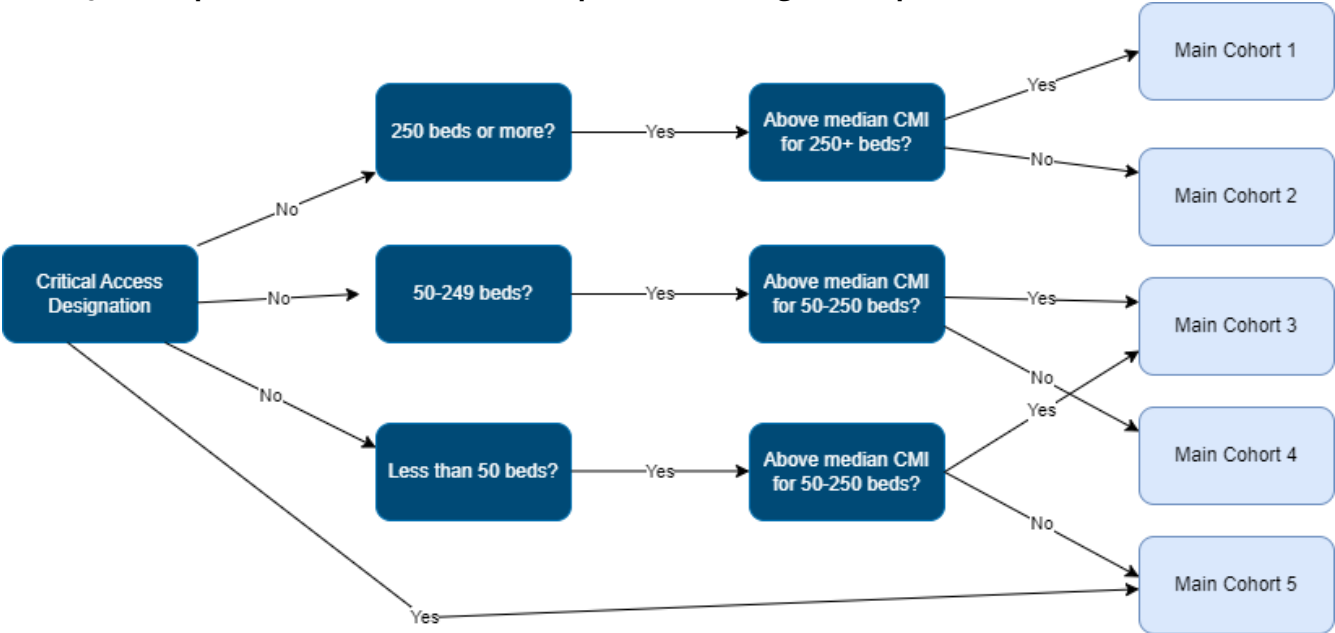
The main cohort is defined for the following episode payment conditions and value metrics: CHF, colectomy, COPD, joint replacement, pneumonia, preoperative testing, sepsis readmission, and outpatient follow-up. Additional sets of cohorts are defined separately for CABG and PCI. The CABG cohort is the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

CHF, Colectomy, COPD, Joint Replacement, Pneumonia, Preoperative Testing, and Sepsis

The average case mix index is calculated for all hospitals using all inpatient P4P conditions (CHF, colectomy, COPD, joint replacement, pneumonia, sepsis). The main cohort also covers value metrics related to preoperative testing, sepsis readmission, 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 2019 and 2020. 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, Colectomy, COPD, Joint Replacement, Pneumonia, Preoperative Testing, and Sepsis



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 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

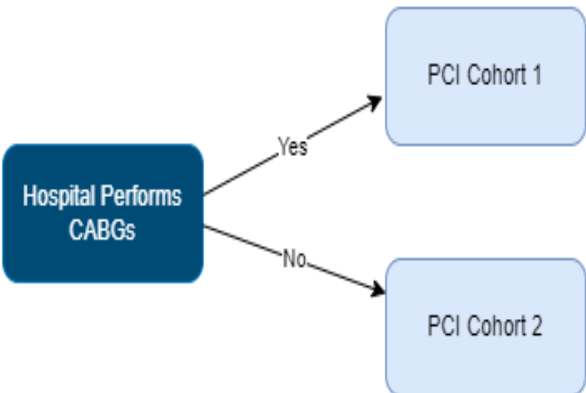


Table 6. Number of MVC Hospitals by Cohort

Cohort	Main	CABG	PCI
1	17	33	33
2	18		14
3	18		
4	16		
5	34		

**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. Engagement Activities

Hospitals can earn up to two points by performing a combination of engagement activities during the program year (the calendar year after the performance year). These points are intended to increase engagement with other hospitals and the MVC Coordinating Center. 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. The activities available to earn attendance and participation points will be offered in 2024 and 2025. 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

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 workgroups	0.25	Present at an MVC 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

**All engagement activities are described in more detail below.*



- **Attend MVC semi-annual meeting:** 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. In order to receive points, both semi-annual meetings need to be attended.
- **Present at an MVC semi-annual conference:** Collaborative members have always had an interest in hearing from local colleagues on a variety of topics. Presentations last approximately 20 minutes followed by a question-and-answer session. The MVC Coordinating Center extends an invitation to all collaborative members or a team from their facility to present on a past, current, or upcoming quality initiative at a semi-annual meeting. For more information and to share your ideas, please contact the Coordinating Center.
- **Attend five or more MVC workgroups:** Workgroups consist of a diverse group of representatives from Michigan hospitals and POs that meet virtually to collaborate and share ideas on various topics. The 2022 workgroup topics include chronic disease management, diabetes, health equity, health in action (ad hoc topics), joint replacement, and sepsis.
- **Attend a regional networking event:** The Coordinating Center organizes five regional networking events each year to bring collaborative members together in a relaxed environment to discuss healthcare issues.
- **Host a site visit:** Individual sites can host a virtual or in-person site visit with members of the Coordinating Center to discuss quality improvement efforts, data requests, and how MVC can assist sites in reducing costs and improving patient outcomes.
- **Request MVC custom analytics or share quality improvement initiative utilizing MVC data:** Members have the ability to request custom analytic reports that can be used to complement internal data to drive improvement. Working closely with members of the MVC Coordinating Center, sites can share information that can be developed into a case study for the benefit of fellow collaborative members or wider audiences.
- **MVC blog exclusive:** The MVC Coordinating Center posts a weekly blog to help inform members on a variety of topics. Sites can work closely with a member of the Coordinating Center to share stories about quality improvement projects within their facility and outcomes related to MVC data.

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 2024 and 2025 Changes

The PY 2024-2025 P4P program has been updated to include the following changes:



- Introduced value metric and engagement points
- Limited 30-day episode payment measure to core DRGs
- Removed bonus points from scoring

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 December 2022):

- Chronic disease management (e.g., CHF, COPD, etc.)
- Diabetes
- Health equity
- Health in action
- Joint replacement
- 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.

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, teaching status, and case mix.

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), pneumonia, joint replacement (hip and knee), colectomy (non-cancer), and coronary artery bypass graft (CABG).

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.

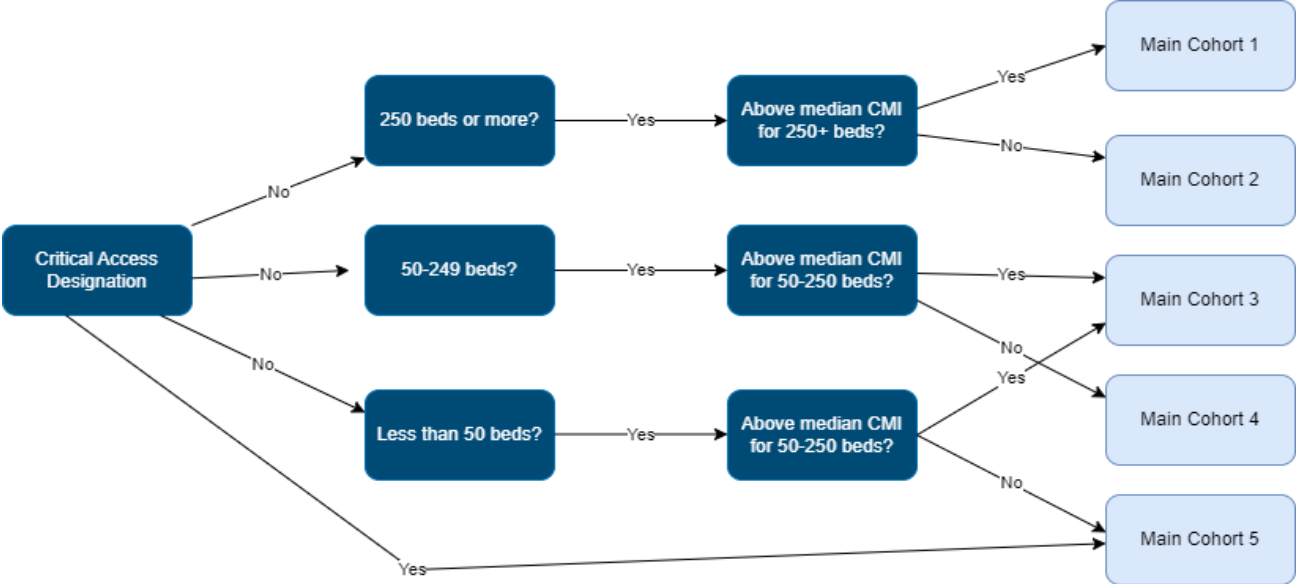


Appendix B: Cohort Designation

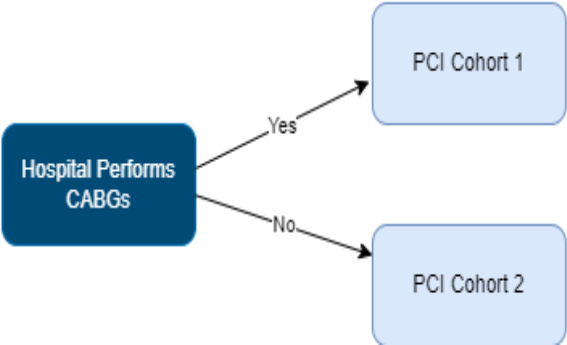
This appendix is meant to further illustrate how hospitals are assigned to cohorts. All hospitals will be assigned a cohort for each P4P condition regardless of the condition the hospital selected. If a hospital does not perform a surgery, they will not be assigned a cohort for that condition. There is one main cohort methodology for the majority of the inpatient P4P conditions: CHF, colectomy, COPD, joint replacement, and pneumonia. The main cohort also covers value metrics related to preoperative testing, sepsis readmission, and follow-up. 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.

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, colectomy, COPD, joint replacement, and pneumonia episode spending metrics, as well as preoperative testing, follow-up, and sepsis readmission 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
Colectomy (non-cancer)	1
Congestive heart failure (CHF)	1
Coronary artery bypass graft (CABG)	N/A
Joint replacement (hip and knee)	1
Pneumonia	1
Value Metric Component	
Cardiac rehabilitation after PCI	2
Cardiac rehabilitation after CABG	N/A
Preoperative testing rates	1
Sepsis readmission rates	1
Follow-up after CHF	1
Follow-up after COPD	1
Follow-up after pneumonia	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 Arrhythmias
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



P4P Program Year 2024: Final Scorecard Hospital A

Overall Summary			
Episode Spending Points	Value Metric Points	Engagement Points	Total Points
3	4	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	

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 2024 and 2025. 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 2024, the performance period is calendar year 2023, and the baseline year is calendar year 2021. In program year 2024, 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

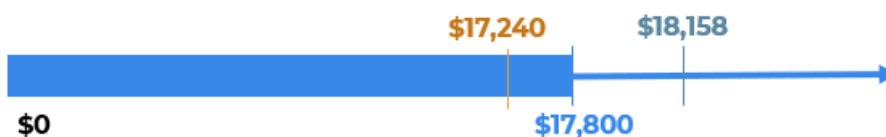
Hospital A's 30-day mean total episode costs for CHF in the performance year are shown on the line below (\$17,800), along with their baseline year (\$18,158), their cohort's baseline year (\$17,240), and the MVC all standard deviation for CHF (\$3,100).

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

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

Achievement Z-score

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

Step

3

Translate z-scores into points

Z-Score	Points
<0	0
0 - <0.05	1
0.05 - < 0.1	2
0.1 - < 0.15	3
0.15+	4

Improvement

0.12 z-score value

3 Improvement Points

Achievement

-0.18 z-score value

0 Achievement Points

Conclusion: Hospital A earns 3 points for their CHF episode payment.

Scoring for Value Metric

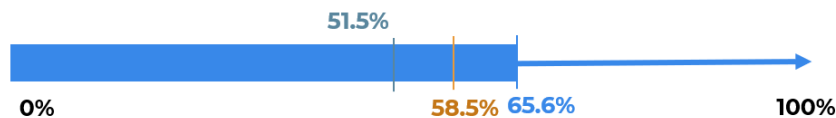
Hospital A's cardiac rehabilitation rate after CABG in the performance year was 65.6%. Two years before in the baseline year, their cardiac rehabilitation rate after CABG was 51.5%. Their cohort's baseline rate was 58.5%, and the MVC All standard deviation is 13.7%.

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

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

Achievement Z-score

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

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

Appendix F: Why MVC Doesn't Freeze Targets




MVC COMPONENT OF THE BCBSM
PAY-FOR-PERFORMANCE (P4P) PROGRAM

WHY DOESN'T MVC FREEZE TARGETS?

MVC DATA IS PRICE STANDARDIZED

\$1 ON REGISTRY  **\$1 PAID TO HOSPITAL**

Price standardization "levels the playing field" across all providers using the Medicare Fee-for-Service Fee Schedule and all available Medicare data.

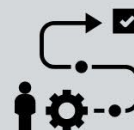
\$1 ON REGISTRY  **1 UNIT OF UTILIZATION**

MVC DATA CHANGES OVER TIME



New data from Medicare or other payers may result in changes to standardized prices or risk adjustments.

Improvements in billing practices or claims adjustments may necessitate methodology improvements.



AVOID APPLES-TO-ORANGES COMPARISONS

Allowing performance payments to vary while holding baseline payments constant runs the risk of:

- comparing payments calculated with different methodologies
- making comparisons that can penalize hospitals.

To see how such comparisons can harm hospitals, review the impact of shifting vs frozen targets in the provided pricing change example (Page 2).



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 UPDATE5-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 UPDATE5-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.