Michigan Value Collaborative

MVC Component of the BCBSM
Pay-for-Performance Program

TECHNICAL DOCUMENT

Program Years
2028 - 2029



2026 | NOVEMBER

MICHIGAN VALUE COLLABORATIVE

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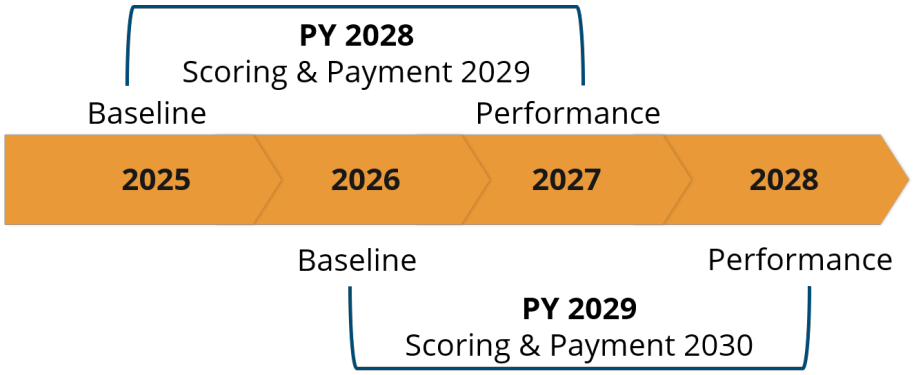
Executive Summary

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 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, BCBSM approved the addition of claims-based value metrics in program years (PYs) 2024 and 2025. These value metrics are evidence-based, actionable measures that show variability across the state. In 2024, BCBSM approved changes to how hospitals are evaluated in the PY26-27 cycle, including the addition of Michigan Medicaid claims and the introduction of a health outcome variation metric. This document outlines evaluated components in the PY28-29 cycle.

II. Timeline

The MVC Coordinating Center will assess claims from the performance years (encounters occurring in 2027 and 2028) during PY 2028 and PY 2029 and will provide a final score for the MVC-based measure to BCBSM for payment in 2029 and 2030, respectively.



III. Earning Points

Points From 30-Day Total Episode Payments

Each hospital will choose one of five conditions to be evaluated on using mean total risk-adjusted, price-standardized 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 to earn points.

Provided the threshold is met, hospitals will earn the higher of their improvement or achievement points for a total of 0-3 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 achievement based on its performance relative to prospective thresholds established by the MVC Coordinating Center. Hospitals will earn the higher of their improvement or achievement points for a total of 0 – 4 points.

Points From Health Outcome Variation Measure
Variation in payer-specific unplanned readmissions will be evaluated for each hospital through the calculation of a population-weighted, risk-adjusted index of variation. Each hospital's index of variation 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 maximum of 1 point.

Engagement Points
Hospitals can earn 0-2 points by completing certain engagement activities during each PY.

Introduction

I. Purpose

The purpose of this document is to provide information on the MVC Component of the BCBSM P4P Program for PYs 2028 and 2029. Information on the previous cycle can be found in the PY2026-2027 technical document. 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 a performance evaluation 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 2026 Hospital P4P Program, please refer to the BCBSM P4P Program documentation.

Table 1: BCBSM P4P Program

2028 Program Component	Weight
Collaborative Quality Initiatives	40%
Michigan Value Collaborative	**10%***
P4P Readmissions Measure	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:

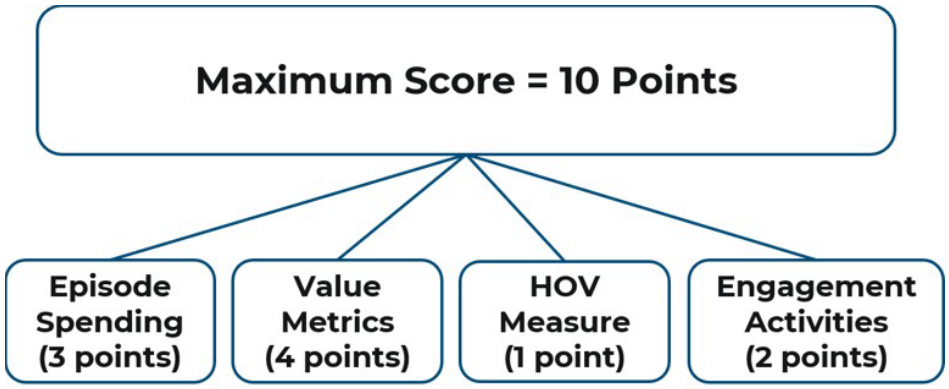
- The measure will reflect the BCBSM Value Partnerships philosophy of using high-quality data to drive collaborative quality improvement.
- The measure will be fair, valid, and transparent.
- The measure, where possible, will align with existing BCBSM and Centers for Medicare and Medicaid Services (CMS) hospital quality measures and be consistent with Value Partnerships' CQI principles.
- The measure, where possible, will align with other CQI initiatives and seek to support site- and system-level priorities.
- 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 four different elements: 30-day total episode spending (worth up to three points), value metric (worth up to four points), a health outcome variation measure (worth one point), and engagement activities (worth up to two points).

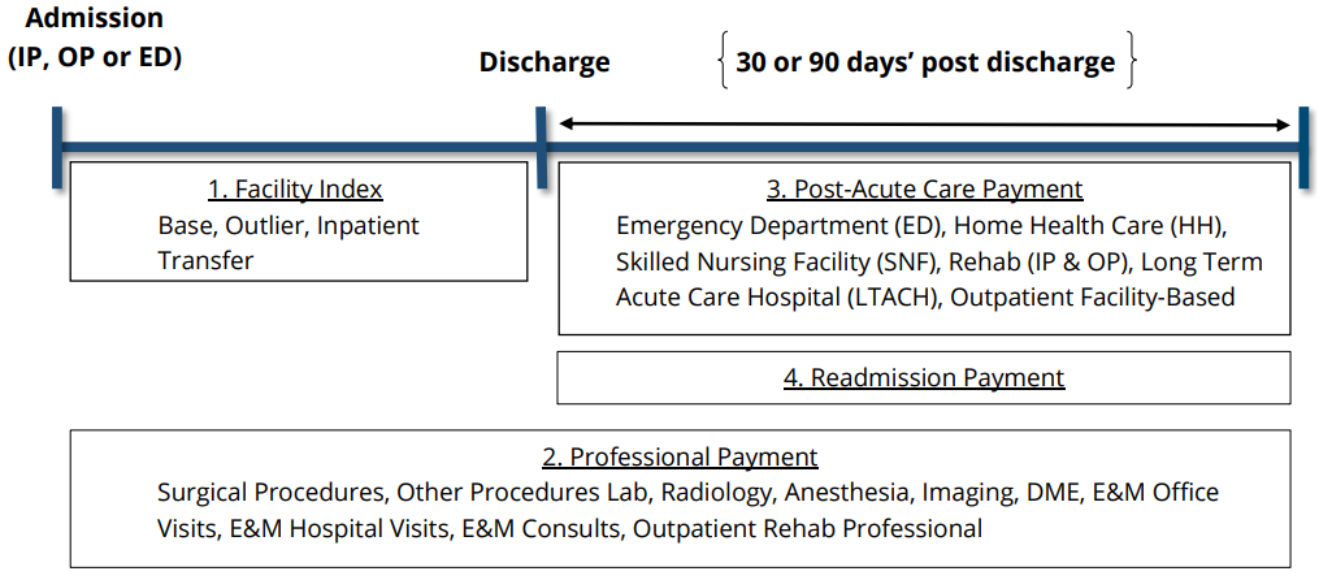
Figure 1: Point Breakdown



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 2028 and 2029 utilize all available claims from the payers below:

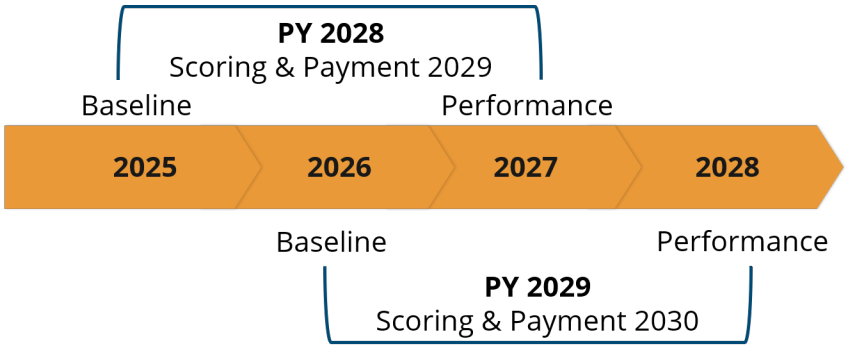
- BCBSM PPO
- BCBSM Medicare Advantage PPO
- BCN HMO
- BCN Medicare Advantage HMO
- Medicare FFS
- Michigan Medicaid

With the addition of Michigan Medicaid beginning in PY 26-27, the MVC Component of the BCBSM P4P Program now includes all payers in MVC's data portfolio, representing approximately 84% of Michigan's insured population.

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 program 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 2028 and 2029.

Figure 3: Timeline for PYs 2028 and 2029



IV. 30-Day Episode Spending

Hospitals can earn up to three points based on their average 30-day episode payment for their selected condition. This 30-day episode measure is price standardized to the Medicare FFS schedule and risk adjusted for patient characteristics, including age, gender, history of prior high spending, payer, 79 comorbidities based on hierarchical condition categories, and condition-specific risk factors. 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 episode spending 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, being discharged to hospice or being discharged against medical advice.
- Index DRG is outside of the core DRGs for an inpatient episode for the given condition (with the exception of outpatient PCI procedures, which do not have a DRG) (Table 2).
- Patient was admitted for stroke and has a discharge disposition to long term acute care hospital

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 PCI episode spending condition includes both outpatient (MVC PCI episodes without a DRG) and inpatient (PCI and AMI episodes with a core PCI DRG) episodes. 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 will take place in 2026 for evaluation in program years 2028 and 2029.

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

Episode Spending Condition Options	DRGs
Chronic obstructive pulmonary disease (COPD)	190, 191, 192, 202, 203
Congestive heart failure (CHF)	291, 292, 293
Coronary artery bypass graft (CABG)	231, 232, 233, 234, 235, 236
Percutaneous Coronary Intervention (PCI)	246, 247, 248, 249, 250, 251, 321, 322, 323, 324, 325
Stroke	061, 062, 063, 064, 065, 066

Minimum Case Requirements

The MVC Coordinating Center selected the minimum episode volume requirement of 20 cases per year based on several empirical analyses. Minimum case thresholds were set to balance 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 used in 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 eligible episodes, and the average payment 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 payments.

Figure 4. Improvement Z-score Equation

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

Figure 5. Achievement Z-Score Equation

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

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. 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 - <0.1	1 Point
0.1 - <0.2	2 Points
≥0.2	3 Points

Quality Thresholds

In order to earn points in the 30-day episode spending component, a hospital must first meet the quality threshold. Hospitals will not be eligible to receive 30-day episode spending points for a condition if they rank 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 database yields small changes to standardized prices, which are calculated based on all available Medicare data. Second, every data update incorporates not only newly available claims, but also historical claims that have since been adjudicated that might alter the baseline payments and corresponding z-score thresholds. Third, methodological improvements may be required 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.

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

MVC 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
- Alignment where possible with other CQI, BCBSM and CMS measures and initiatives

List of Value Metrics and Definitions

After soliciting feedback from the BCBSM Hospital P4P Measurement Workgroup and clinician advisors, MVC's value metric options were originally established for PYs 2024 and 2025, modified for PYs 2026 and 2027, and have been updated for PYs 2028 and 2029. To leverage existing resources and support alignment with the MiCR network and RITE-Size initiative, MVC will assess the Main 5 cardiac conditions collectively under the cardiac rehab value metric and expand the list of low-risk procedures included in the preoperative testing value metric for PY28-29. Unlike episode spending conditions, MVC episodes evaluated for value metrics are not restricted based on index DRG inclusion

in the core DRGs for a given condition (Table 2). Hospitals must choose one of the six value metrics for the PY28-29 two-year cycle (Table 4).

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, having been discharged to hospice or against medical advice.

Table 4. Value Metric Definitions

Value Metric	Numerator	Denominator	Goal
Cardiac rehab after Main 5 cardiac conditions	Episodes that included one cardiac rehabilitation visit within 90 days of discharge.	Includes all MVC-defined CABG, AMI, PCI, SAVR and TAVR episodes.	High rates
7-day follow-up after CHF	Episodes that included at least one outpatient follow-up visit (in-person or remote) within seven days of discharge. Visits that occur after a readmission or emergency department visit are not considered follow-up.	Includes MVC-defined CHF episodes where the patient was discharged to home or home health and did not utilize SNF, inpatient rehab, or LTACH within seven days of discharge.	High rates
14-day follow-up after COPD	Episodes that included at least one outpatient follow-up visit (in-person or remote) within 14 days of discharge. Visits that occur after a readmission or emergency department visit are not considered follow-up.	Includes all MVC-defined COPD episodes where the patient was discharged to home or home health and did not utilize SNF, inpatient rehab, or LTACH within seven days of discharge.	High rates
7-day follow-up after pneumonia	Episodes that included at least one outpatient follow-up visit (in-person or remote) within seven days of discharge. Visits that occur after a readmission or emergency department visit are not considered follow-up.	Includes all MVC-defined pneumonia episodes where the patient was discharged to home or home health and did not utilize SNF, inpatient rehab, or LTACH within seven days of discharge.	High rates

Value Metric	Numerator	Denominator	Goal
14-day follow-up after sepsis	Episodes that included at least one outpatient follow-up visit (in-person or remote) within 14 days of discharge. Visits that occur after a readmission or emergency department visit are not considered follow-up.	Includes all MVC-defined sepsis episodes where the patient was discharged to home or home health and did not utilize SNF, inpatient rehab, or LTACH within seven days of discharge.	High rates
Preoperative testing	Episodes where preoperative testing occurred in the 30 days prior to MVC-defined low-risk procedures (Appendix C) for any of the following test types: urinalysis, pulmonary function, chest x-ray, electrocardiography, blood tests (complete blood count, coagulation tests, basic metabolic panel, and comprehensive metabolic panel), and cardiac tests (transthoracic echocardiogram and cardiac stress tests). Please note that urinalysis is counted toward the testing rate for all procedures except cystourethroscopy.	Includes elective and outpatient low-risk procedures with a length of stay between 0 and 2 days. Episodes with certain comorbidities are excluded (see Appendix C). Episodes with an emergency department revenue code during the index event are excluded.	Low rates

Minimum Case Requirements

The MVC Coordinating Center selected the minimum episode volume requirements of 20 cases in the baseline year to be eligible to select a value metric. This minimum episode volume was set based on several empirical analyses, and minimum case thresholds help to balance the reliability of the value metric and the number of eligible hospitals for each value metric.

Value Metric Scoring

Hospitals can earn points in the value metric component by either improving their own rates over time (improvement) or by meeting rate thresholds set prospectively by the coordinating center (achievement). Hospitals will earn the higher of their improvement or achievement points.

Improvement and Z-Scores

For the improvement component of value metrics, the hospital's baseline and performance rate are entered into the relevant equation, which yields a Z-score, a statistical value describing the distance from the mean of a distribution. Points are assigned based on the improvement Z-score, which reflects the standardized percent difference from the baseline period. Value metric improvement scores are calculated using the standard deviation of the average rate across all MVC hospitals with at least 20 cases in the baseline year for a given value metric (the MVC standard deviation). Improvement Z-scores are calculated by dividing the difference between the hospital's mean baseline and performance year rates by the MVC standard deviation. The order of subtraction depends on whether the metric falls under high-value or low-value (Figure 6).

Figure 6. Improvement Z-score Equations for High and Low Value Metrics

High Value Metrics	Low Value Metrics
Improvement Z-score $\frac{Hospital\ performance - Hospital\ baseline}{MVC\ All\ standard\ deviation\ from\ baseline}$	Improvement Z-score $\frac{Hospital\ baseline - Hospital\ performance}{MVC\ All\ standard\ deviation\ from\ baseline}$

The output of the improvement Z-score formula will be used to assign improvement points according to Table 5 below. The Z-score thresholds will be the same for all value metrics 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 becomes available in order to maintain a fair program.

Achievement and Prospective Thresholds

For the achievement component of value metrics, scores are calculated by comparing the hospital's performance rate against prospective rate thresholds set by the Coordinating Center. These thresholds are specific to each value metric and are informed by historical distributions and relevant clinical guidelines. They remain fixed throughout the two-year program cycle, providing hospitals with clear and actionable targets before the program cycle begins.

Table 5. Improvement and Achievement Thresholds for 7-Day Follow Up Value Metrics (CHF and Pneumonia)

Point Value	Improvement Z-score Threshold	Achievement Rate Threshold
0 Points	<0	<45%
1 Point	0 - <0.25	45% to <50%
2 Points	0.25 - <0.50	50% to <55%
3 Points	0.50 - <0.75	55% to <60%
4 Points	>0.75	≥60%

Table 6. Improvement and Achievement Thresholds for 14-Day Follow Up Value Metrics (COPD and Sepsis)

Point Value	Improvement Z-score Threshold	Achievement Rate Threshold
0 Points	<0	<55%
1 Point	0 - <0.25	55% to <60%
2 Points	0.25 - <0.50	60% to <65%
3 Points	0.50 - <0.75	65% to <70%
4 Points	>0.75	≥70%

Table 7. Improvement and Achievement Thresholds for Cardiac Rehabilitation Value Metric

Point Value	Improvement Z-score Threshold	Achievement Rate Threshold
0 Points	<0	<40%
1 Point	0 - <0.25	40% to <50%
2 Points	0.25 - <0.50	50% to <60%
3 Points	0.50 - <0.75	60% to <70%
4 Points	>0.75	≥70%

Table 8. Improvement and Achievement Thresholds for Preoperative Testing Value Metric

Point Value	Improvement Z-score Threshold	Achievement Rate Threshold
0 Points	<0	≥25%
1 Point	0 - <0.25	22% to <25%
2 Points	0.25 - <0.50	19% to <22%
3 Points	0.50 - <0.75	15% to <19%
4 Points	>0.75	<15%

VI. MVC Cohorts

MVC cohorts are designed to compare hospitals with similar characteristics for specific episode spending conditions. Cohort assignments are not applicable for value metrics in PY 2028-2029. Recognizing that episode payments may vary across cohorts, a participant's achievement is compared to hospitals within their assigned cohort. All hospitals are assigned to cohorts for each episode spending condition 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

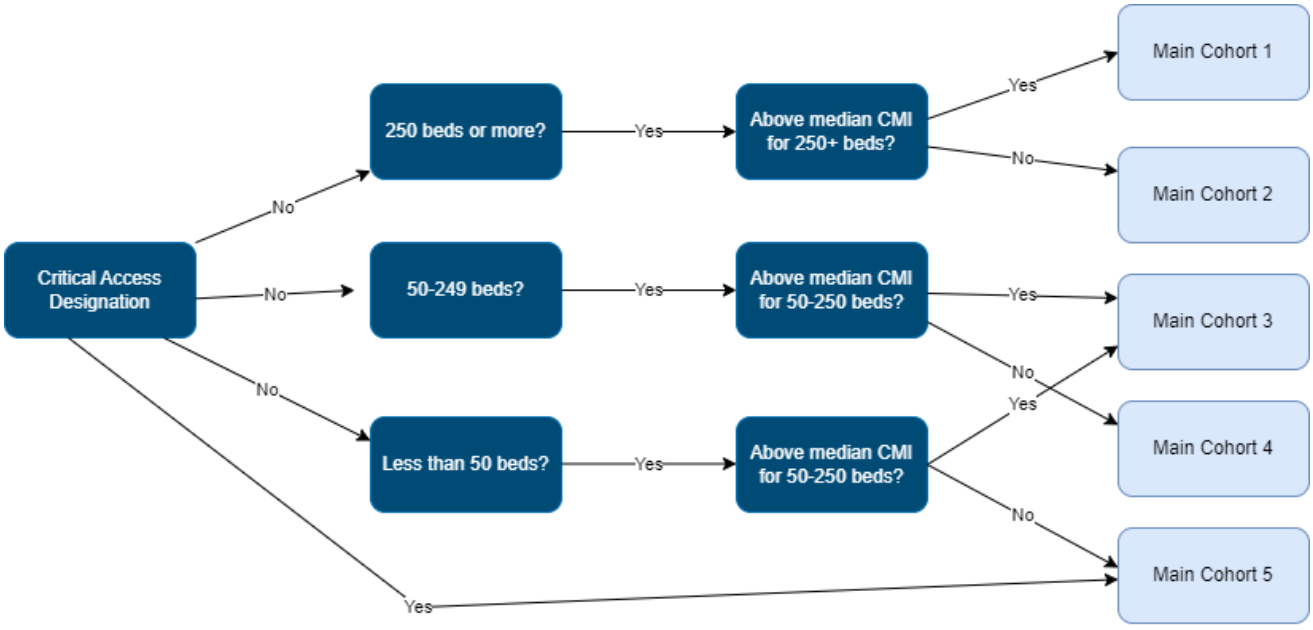
Cohorts were reassigned in October 2026 for PYs 2028 and 2029. Cohort designations can be found in the P4P program section of the MVC website. The main cohort is referenced to evaluate achievement for the following episode payment conditions: CHF, COPD, and stroke. Additional sets of cohorts are defined separately for CABG and PCI.

CHF, COPD and Stroke

The average case mix index is calculated for all hospitals using episodes from inpatient P4P conditions (CHF, COPD, stroke) that are not CABG or PCI episodes. This means that a hospital will be in the main cohort for all these episode spending conditions.

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 2024 and 2025. 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 2026 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, COPD, and Stroke



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 49 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

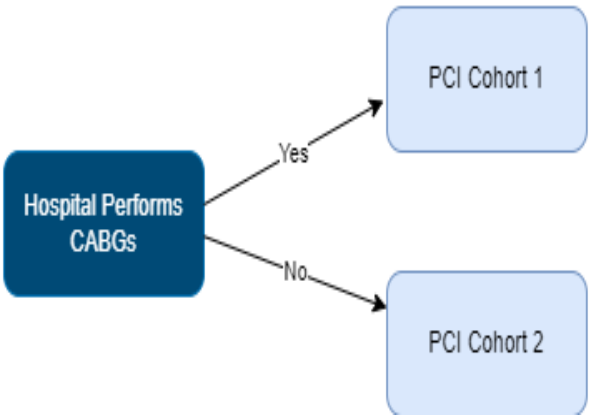


Table 9. Number of MVC Hospitals by Cohort

Cohort	Main	CABG	PCI
1	17	33	33
2	17		16
3	16		
4	16		
5	41		

**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. Health Outcome Variation Measure

Hospitals can earn one point through a dedicated health outcome variation measure in PY28-29. For this measure, overall risk-adjusted unplanned readmission rates will be calculated for each MVC hospital, as well as for five insurance payer groups at each hospital – BCBSM and BCN Commercial, BCBSM and BCN Medicare Advantage, Medicare FFS, Michigan Medicaid, and Dual-Eligible. If a patient's episode is originally assigned as Medicare or Medicaid but they are identified to be entitled to both Medicare and Medicaid, that patient's episode will be grouped into the dual-eligible category.

The spread of payer-specific risk-adjusted readmission rates will be assessed, and a measure will be calculated called an index of variation. This is a summary measure that indicates the magnitude of payer-specific differences in risk-adjusted unplanned readmission rates within a hospital. The higher the index of variation, the wider the spread of a hospital's payer-specific readmission rates. Hospitals can earn a point in this measure if they either reduce their index of variation (improvement) or have an index of variation in the performance year that is at or below the collaborative-wide median (achievement).

Exclusions

Episodes will be excluded from the health outcome variation component 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 or against medical advice.
- Episode is not a medical condition or endocarditis
- Episode occurred in the outpatient setting

Measure calculation

The health outcome variation measure will be calculated using the following steps:

1. Overall hospital-level readmission rate is subtracted from each payer-level readmission rate, resulting in difference values for each payer group
2. Absolute values of differences are multiplied by the respective payer group population proportions, summed, and divided by the total population
3. The resulting value is multiplied by 100 to generate the final index of variation used for scoring

Improvement, Achievement, and Point Allotment

Hospitals can earn one point in the health outcome variation component by either reducing their index of variation over time (improvement) or by comparing favorably against the collaborative (achievement). Hospitals will earn a maximum of one point. For the health outcome variation measure, the hospital baseline year index of variation, hospital performance year index of variation, and the collaborative-wide median performance year index of variation are considered.

One point in the health outcome variation component will be earned via improvement if your hospital's index of variation is reduced by 10 percent from baseline year to performance year. For

example, if a hospital has a baseline year index of variation of 4.0, a point will be earned via improvement if the hospital's performance year index of variation reflects a reduction by at least 10 percent of 4.0, or 0.4; a performance year index of variation of 3.6 or lower would earn the improvement point. Alternatively, one point can be earned via achievement if a hospital's performance year index of variation is equal to or lower than the target achievement index for that performance year, which is determined using the collaborative-wide median index.

VIII. Engagement Activities

Hospitals can earn up to two points by performing a combination of engagement activities during the program year (engagement activities in calendar year 2028 count towards program year 2028). These points are intended to increase engagement with other hospitals and the MVC Coordinating Center. See Table 10 for an *example* of MVC engagement point offerings. Hospitals may select their own combination of activities, and the activities available will be offered in 2028 and 2029. 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 both program years.

Table 10. P4P Engagement Point System *(Example)*

MVC Engagement Point Offerings	Points	Requirements & Tracking
Participate in **BOTH** of MVC's collaborative-wide meetings (May and October)	1.0	• Attendance by site representative(s) for entire meeting • Attendance will be tracked by check-in and completion of post-meeting surveys
Participate in **ONE** of MVC's collaborative-wide meetings (May and October)	0.4	• Attendance by site representative(s) for entire meeting • Attendance will be tracked by check-in and completion of post-meeting surveys
Presentation at an MVC virtual workgroup, virtual event, or in-person event • Single site presentation – 0.5 points • System-level best practicing sharing presentation involving multiple sites – 0.25 points for every participating site	Varies	• Maximum of 1 point allowed per site per program year • Spots are limited; final selection will be made at the discretion of the MVC coordinating center • Proposals submitted to MVC via presentation request form by **September 30**
Site coordinator education modules	0.25 per module	• Maximum of 1 point per program year
Actively participate in an MVC virtual workgroup • MVC will host up to two workgroups per month with a guest presenter	0.1	• Active participation during the workgroup may include, but is not limited to, enabling video during virtual breakouts, responding to polls, and/or answering questions via chat • Completion of a post-workgroup survey is required to confirm attendance • Maximum of 1 point allowed per program year
Attend an MVC networking event • 1.5-hour virtual event – 0.15 • 2.5- hour in-person event – 0.25 (limited spots)	Varies by setting	• Attendance by site representative(s) for entire event • Attendance will be tracked by check-in and completion of post-event survey • Maximum of 1 point allowed per program year
Complete MVC's custom analytic report process *(Submit request, participate in planning meeting, participate in report review with MVC team, and complete feedback form)*	0.1 for completing custom report process 0.1 for sharing lessons learned	• Maximum of .2 points allowed per program year; limited spots. • Sites may request additional custom reports; however, additional reports will not be eligible for engagement points.

MVC Engagement Point Offerings	Points	Requirements & Tracking
Member hosts a site visit centered around QI initiatives: • Virtual site visit (1.5 hours) – 0.25 points • In person site visit (2 hours) – 0.5 points (limited spots) • In person multi-site visit for systems (2 hours) – 0.5 points awarded to every participating site (limited spots)	Varies by setting	• Submit site visit interest form, schedule site visit within MVC Team's availability, prepare meeting materials, and complete site visit • Submit site visit interest form by **September 30**
Complete MVC quality improvement (QI) initiative survey about a recent QI success story from your organization	0.2	• Survey deadline: **September 30** • Maximum of 0.2 points per site per program year

MVC Registry

The MVC registry can be utilized to help hospitals better understand their areas of opportunity in P4P conditions. The registry contains reports specific to the P4P program that provide scoring information, historical trends, and episode spending component breakdowns. 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 discussed and reviewed by the BCBSM Hospital P4P Measurement Workgroup.

I. Program Year 2028 and 2029 Changes

The PY 2028-2029 P4P program has been updated to include the following changes:

- Addition of stroke to the episode spending condition menu
- Replacement of existing cardiac rehab value metrics in PCI and CABG with a new cardiac rehab metric for all main five cardiac conditions combined (AMI, CABG, PCI, SAVR, TAVR)
- Expansion of conditions included under the preoperative testing value metric
- Introduction of new prospective rate thresholds for value metric achievement 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

Registry Training

The MVC Coordinating Center provides customized one-on-one training to review members' specific facility or hospital data on the registry with any registry access request. The engagement team can also provide customized training to individuals or designated groups to help navigate data resources and identify specific areas of opportunity. Designated site coordinators also have an opportunity to enroll in MVC's four-module Site Coordinator Education Program designed to provide tailored trainings to hospital quality leaders so they may fully leverage MVC offerings to support quality improvement goals.

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 October 2026):

- Cardiac Rehabilitation
- Care Coordination
- Health in Action
- Preoperative Testing
- Rural Health
- Sepsis
- System Alignment

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.

Collaborative-Wide 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 by submitting a custom request here.

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 or by meeting prospectively set threshold for episode spending conditions and value metrics, respectively.

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, case mix index, and critical access status.

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), coronary artery bypass graft (CABG), and percutaneous coronary intervention (PCI) and stroke.

Index of Variation: A summary measure that indicates the extent of differences in risk-adjusted unplanned readmission rates by payer within a hospital.

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.

Prospective Rate Thresholds: Predetermined targets established before the program cycle that hospitals must meet to earn points via achievement in the value metric component.

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.

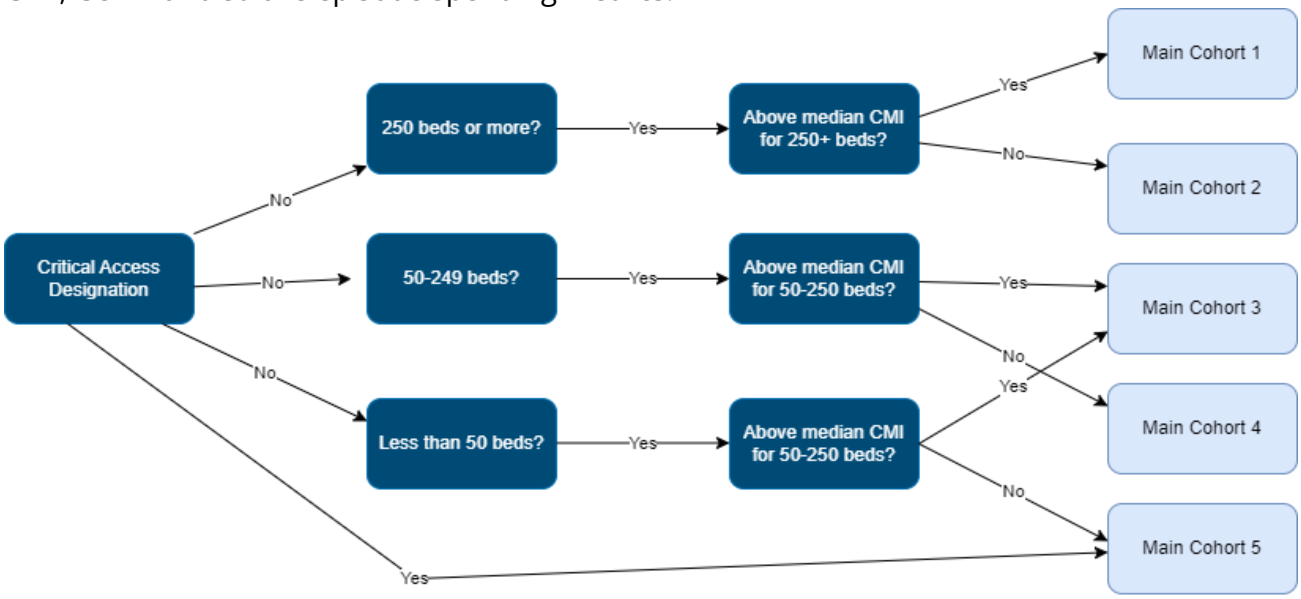
Value Metric: Measure of the rate of a service or event that is tied to both reducing payments and improving the value of care for patients.

Appendix B: Cohort Designations

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. There is one main cohort methodology for CHF, COPD and stroke as episode spending conditions. 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 for both episode spending and value metrics.

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, COPD and stroke episode spending 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 PCI episode spending metric.

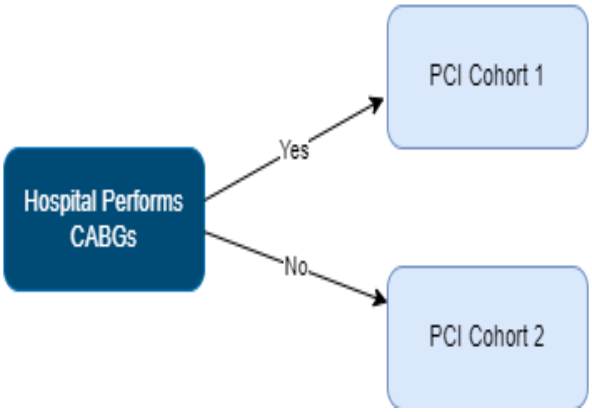


Table 11. Hospital A's Cohort Designations

Episode Spending Condition	Cohort
Chronic obstructive pulmonary disease (COPD)	1
Congestive heart failure (CHF)	1
Stroke	1
Coronary artery bypass graft (CABG)	N/A
PCI	2

Appendix C: List of Expanded Conditions Included Under Preoperative Testing in PY28-29 and Comorbidity Exclusions

Preoperative testing value metric includes a set of expanded conditions for PY28-29. The list of conditions being evaluated for this metric is included below:

Service Line	Procedures Included
Breast Resection	Excision Lumpectomy Simple mastectomy
Cholecystectomy	Laparoscopic cholecystectomy only
ENT	Sinus surgery
Gastroenterology	Diagnostic colonoscopy Screening colonoscopy Other colonoscopy Upper endoscopy
Hernia Repair	Inguinal hernia repair only
Ophthalmology	Cataract
Orthopedics	Arthroscopy, knee ACL/PCL repair Rotator cuff Carpal tunnel release Bursa injections SI joint procedures
Skin	Trunk, arm, legs Scalp, neck, hands, feet, genitalia Face, ears, eyelids, nose, lips
Urology	Cystourethroscopy

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:

- Acute Myocardial Infarction
- Acute Renal Failure
- Angina Pectoris

- Cardio-Respiratory Failure and Shock
- Chronic Hepatitis
- Chronic Kidney Disease, Severe (Stage 4)
- Chronic Kidney Disease, Stage 5
- Cirrhosis of Liver
- Coagulation Defects and Other Specified Hematological Disorders
- Congestive Heart Failure
- End-Stage Liver Disease
- Opportunistic Infections
- Other Significant Endocrine and Metabolic Disorders
- Pneumococcal Pneumonia, Empyema, Lung Abscess
- Protein-Calorie Malnutrition
- Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
- Specified Heart Arrythmias
- Unstable Angina and Other Acute Ischemic Heart Disease
- Vascular Disease
- Vascular Disease with Complications

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

The MVC Component of the BCBSM Pay-for-Performance Program
Program Year 2028 Final Scorecard
Hospital A

Scoring Summary

Episode Spending Points (Out of 3)	Value Metric Points (Out of 4)	Health Outcome Variation Points (Out of 1)	Engagement Points (Out of 2)	Total Points (Out of 10)
0	2	1	1.9	4.9

Scoring Summary by Component

Type	Baseline (2023)	Performance (2025)	Achievement Z-Score / Rate / Target*	Achievement Points	Improvement Z-Score / Target*	Improvement Points	Points Scored
Episode Spending (PCI)	$18,754	$19,873	-0.004	0	-0.128	0	0
Value Metric (14-Day Follow-Up After COPD)	43.5%	49.7%	49.7%	0	0.472	2	2
Health Outcome Variation Measure	1.39	3.03	3.24	1	1.25	0	1

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

The MVC Component of the BCBSM Pay-for-Performance Program
Program Year 2028 Final Scorecard
Hospital A

30-Day Episode Spending Metric Summary

Selection	Assessment	Baseline (2023)	Performance (2025)	Z-Score	1 Point Threshold	2 Points Threshold	3 Points Threshold	Quality Threshold Met	Points Scored
PCI	Achievement	$19,832	$19,873	-0.004	$19,832	$18,959	$18,086	Yes	0
PCI	Improvement	$18,754	$19,873	-0.128	$18,754	$17,881	$17,008	Yes	0

Value Metric Summary

Selection	Assessment	Baseline (2023)	Performance (2025)	Z-Score / Rate	1 Point Threshold	2 Points Threshold	3 Points Threshold	4 Points Threshold	Points Scored
14-Day Follow-Up After COPD	Achievement	53.4%	49.7%	49.7%	55%	60%	65%	70%	0
14-Day Follow-Up After COPD	Improvement	43.5%	49.7%	0.472	43.5%	46.8%	50.1%	53.3%	2

Health Outcome Variation Measure Summary*

BCBSM/BCN Comm (2025)	BCBSM/ BCN MA (2025)	Medicaid (2025)	Medicare FFS (2025)	Dual-Eligible (2025)	Overall (2025)	Baseline Index (2023)	Performance Index (2025)	Improvement Target	Achievement Target**	Points Scored
18.8%	13.6%	18.7%	18.5%	18.4%	17.1%	1.39	3.03	1.25	3.24	1

Appendix E: Scoring Example

The following is an illustration of how the scoring system will be applied for PYs 2028 and 2029. 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 2028, the performance period is calendar year 2027, and the baseline year is calendar year 2025. In program year 2028, 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.

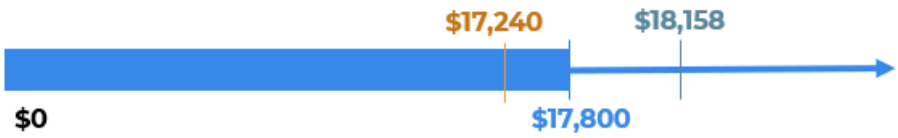
Scoring for Episode Spending Metric

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

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

Achievement Z-score

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

Step 3

Translate z-scores into points

Z-Score	Points
<0	0
0 - <0.1	1
0.1 - < 0.2	2
> 0.2	3

Improvement

0.12 z-score value

→ **2 Improvement Points**

Achievement

-0.18 z-score value

→ **0 Achievement Points**

Conclusion: Hospital A earns 2 points for their CHF episode payment.

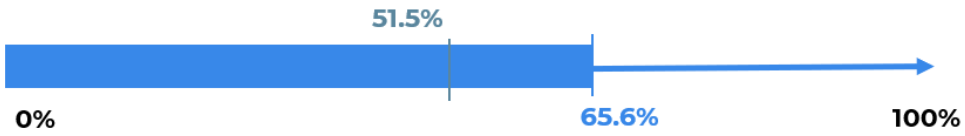
Scoring for Value Metric

Hospital A's cardiac rehabilitation rate after Main 5 cardiac conditions 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 three numbers:

- Hospital Performance Year Rate
- Hospital Baseline Year Rate
- MVC All Standard Deviation for CR after Main 5 (Baseline Year)



MVC All Standard Deviation = 13.7%

Step 2

Plug into high-value improvement z-score equations

Improvement Z-score

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

Step 3

Calculate scores for achievement & improvement component

Z-Score (Improvement)	Rate Thresholds (Achievement)	Points
<0	<40%	0
0 - <0.25	40% to <50%	1
0.25 - <0.50	50% to <60%	2
0.50 - <0.75	60% to <70%	3
0.75+	≥70%	4

Improvement

1.029 z-score value

→ **4 Improvement Points**

Achievement

65.6% CR rate

→ **3 Achievement Points**

Conclusion: Hospital A earns 4 points for the Cardiac Rehab After Main 5 Value Metric

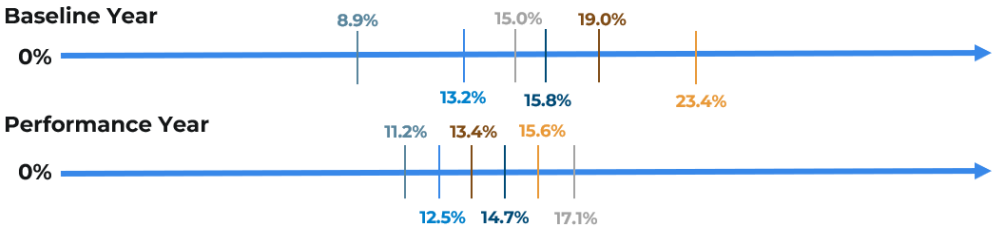
Scoring for Health Outcome Variation Component

Hospital A's performance year readmission rate index of variation was 2.06. Two years before in the baseline year, their readmission rate index of variation was 4.22. The MVC collaborative-wide median readmission rate index of variation in the performance year was 2.02.

Step 1

Calculate 12 numbers, 6 in each the baseline and performance years:

- **Hospital Overall Risk-Adjusted Readmission Rate**
- **Commercial BCBSM/BCN Risk-Adjusted Readmission Rate**
- **Medicare Advantage BCBSM/BCN Risk-Adjusted Readmission Rate**
- **Medicare FFS Risk-Adjusted Readmission Rate**
- **Medicaid Risk-Adjusted Readmission Rate**
- **Dual-Eligible Risk-Adjusted Readmission Rate**



Step 2

Plug into Population Weighted Index of Variation Formula

$$100 \times \left(\frac{\sum_{i=1}^{N} |Rate_i - Rate_{overall}| \times Population_i}{Population_{overall}} \right)$$

- First, take 5 differences
  - Commercial BCBSM/BCN Rate – Hospital Rate
  - Medicare Advantage Rate – Hospital Rate
  - Medicare FFS Rate – Hospital Rate
  - Medicaid Rate – Hospital Rate
  - Dual-Eligible Rate – Hospital Rate
- Then, take the absolute value of each of those differences, multiple by each respective subpopulation, and sum them
- Divide by the total population and multiply by 100 to achieve the population-weighted index of variation

Step 3

Translate Index of Variation Scores into Points

Improvement:

- Reduction by 10% of baseline score earns an improvement point
  - Check if performance value < baseline value – (0.10*baseline value)

2.06 < 3.80 ⟶ 1 Improvement Point

Achievement

- Hospitals earn an achievement point if the performance year index of variation equal or below the collaborative-wide median index of variation
  - Check if performance value ≤ collaborative-wide median value

2.06 > 2.02 ⟶ 0 Achievement Point

Conclusion: Hospital A earns 1 point for the health outcome variation component via improvement