



BlueCross BlueShield
of Texas



Medicaid

Value-Based Care Provider Manual

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Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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1 — INTRODUCTION

This value-based care provider manual outlines the Blue Cross and Blue Shield of Texas operations for its VBC models including the major components of the VBC model and how its methodology works. It is intended to be used as a reference guide to support the contractual arrangement between the VBC provider/administrator and us.

This manual is subject to the terms and conditions set forth in the VBC agreement, including but not limited to, obligations to maintain confidentiality of data and proprietary information and limitations on data use. In the event there is conflict between the explanations set forth in this VBC provider manual and the terms of the VBC agreement itself, the VBC agreement will govern. Failure to comply with any of the material terms of the agreement of this manual may be considered a breach that may result in termination of the VBC agreement.

We reserve the right to review and modify or change the explanations set forth in this manual. Any changes will be communicated to the provider/administrator in accordance with the terms of the VBC agreement. Following modification, we will distribute subsequent versions or addendums to this manual electronically with the intent to keep all information current and available on our [provider](#) site.

2 — VALUE-BASED CARE PROGRAMS

VBC programs redefine how we and providers collaborate. These models introduce new performance measurements and compensation methodologies, separate and apart from fee-for-service arrangements. Our VBC model seeks to partner with providers that deliver sustainable improvements to member care while better managing health care costs.

By shifting provider relationships towards VBC models, we increase the value of health care services through increased collaboration with providers. The VBC programs are supported by:

- Defining financial incentive models that align the interests of all parties around improving patient care and population health, and,
- Improving coordination between providers and us to reduce cost trends without reducing the level of benefit coverage or the options available to attributed members.

VBC programs consist of attribution, financial performance targets, quality improvement targets, financial incentive reconciliation, data exchange and reporting.

Provider team roles

- **Provider leadership:** Successful governance includes provider orientation and education regarding key components of the VBC model. This focus enables participating providers to be aligned with the objectives and understand how they are empowered to achieve those objectives based on the clinical and financial information available to them under this model. The provider leadership team is also responsible for sending provider roster updates. Refer to the **Provider Roster** section below for details.
- **Primary care physician role:** The PCP is a critical component in the success of the group. As part of the attribution process, members are attributed to providers based on the strength of the relationship between the member and the provider. Under the VBC model, members are attributed to PCPs or selected extenders practicing in a primary care role. The PCP is primarily responsible for treating and coordinating the Covered Person's health care needs
- **Medicaid** products require a member to choose a PCP.
- **Clinical team:** The provider's clinical team role does not fundamentally change. The clinical team remains a key resource for the members and should be versed in guiding principles and processes to facilitate patient coordination, scheduling, referral management and medication refill activity.
- **Quality team:** The provider group has designated team members who focus on Healthcare Effectiveness Data and Information Set (HEDIS®) quality measures and related guidelines from Medicaid or specific state requests. This includes gap closures, annual health visits and proper coding.
- **Finance team:** VBC provider financial team members ensure accurate financial management and reporting for value-based contracts. They track revenue, expenses and shared savings, while monitoring risk adjustment and performance-based payments. By providing analyses and forecasts, they support leadership in making informed decisions and help optimize financial outcomes under VBC models.

VBC model

This manual breaks down the VBC model into the following components:

1. Value contract models
2. Attribution logic and methodology
3. Electronic data exchange
4. Quality performance measurement and reports
5. Financial performance measurement and reports

To participate in VBC programs, Provider groups must have a direct Medicaid network participation agreement with BCBSTX and maintain current credentialing status. Medicaid products require members to have a PCP. PCPs must review their member roster and ensure patients receive annual well exams as well as other follow up visits, as needed. Specialists can participate with multiple provider groups. The performance year for value-based contracts is January 1 through December 31 each year. We will provide advance written notice ahead of the performance period of any changes to any program.

Types of VBC programs

- **Primary care quality improvement program:** This is an upside-only program that pays primary care groups incentives if certain quality activities are completed.
- **Home health QIP:** This program pays skilled home health groups incentives based on completion of certain quality activities.
- **Maternity QIP:** This program is an upside-only program that pays professional groups incentives if certain maternal care quality activities are completed.
- **Shared savings/shared losses program:** The SS/L program builds upon the QIPs and is designed to encourage providers to take on additional risk as their VBC maturity evolves.
- **Behavioral Health QIP:** This is an upside-only program that pays behavioral health specialist groups bonuses if certain quality activities are completed.
- **Dental QIP:** This program pays dental providers or co-located with a multi-specialty group, incentives based on completion of certain quality activities.

Providers may participate in multiple VBCs but only a single SS/L program.

Medicaid attribution logic

PCP attribution

All members are assigned to a Primary Care Provider, but members may change their PCP upon request to BCBSTX.

Specialty attribution

Specialty Attributions are claims based.

- Home health is attributed based on claims for the highest skilled provider for the member based on the final December claims report.
- Maternity is based on the delivering provider.

3 — PROVIDER ELECTRONIC DATA EXCHANGE

Data sharing requires shared responsibilities between the provider group and BCBSTX. Reports are available on [Availity® Essentials](#). Shared responsibilities include, but are not limited to:

- Availity data connectivity set up
- Sending and receiving standard file formats
- Testing activities
- Data validation

Availity registration

VBC providers who do not already have an Availity account will need to register their organization to receive data delivery.

VBC providers who already have a customer ID for other data exchange activities will need to provide the ID to their Network Consultant for data delivery.

Delays submitting the Availity registration may result in the provider not receiving data sharing files by the start of the contract period.

For step-by-step instructions, access the Availity Learning & Training Center:

Log in to Availity and go to the Blue Cross and Blue Shield of Texas-branded **Payer Spaces –Applications**.

You must be a registered Availity user to view the information in the training center. To register and get started at no cost, go to [Availity](#). For registration help, call Availity Client Services at **800-282-4548**.

Exchanging data process

The following are major activities required for electronic exchange of data:

1. We send data delivery documentation to the provider.
2. The provider registers for Availity, monitors application status, provides any required information to Availity for approval and provides their application ID to us.
3. We deliver sample files via Availity upon request after the provider is approved.
4. The provider, via their data vendor, will submit a fully executed Confidential Data Release Agreement to us.
5. We will then delivery monthly data files and daily authorization files based on the established cadence.
6. The provider can notify us if they need ongoing support with the process.

Provider roster

The provider or provider group is responsible for providing us with a roster of the physicians and other health care providers to include in the provider group on our roster form. The following information is required:

- Name
- Tax identification number
- National Provider Identifier
- Whether the professional provider is employed or affiliated with the provider or provider group

We conduct random provider roster audits to verify that the provider or provider group has a current executed agreement with a provider at the time of the roster submission. The provider or provider group may be subject to removal of attributed members, refund of the corresponding care coordination fees, and financial penalty, as appropriate, if the provider or provider group does not have a current executed agreement with a provider listed on

the roster.

Provider or provider groups that include facility or ancillary providers do not need to submit these provider types on the roster form. These facilities and ancillary providers are identified in underlying participation agreements.

For accurate attribution, it is important the provider roster is complete with no errors, omissions or duplicate providers. The provider or provider group will have an opportunity to review the physicians and health care providers we excluded from the provider or provider group roster.

Reasons for exclusion can include:

- *Participating within another provider or provider group (applicable to PCPs and extenders only)*
- *Participating in another value-based care program*
- *Located outside of the provider or provider group service area*
- *Not participating in the applicable networks for BCBSTX*

Provider inbound data

We will electronically transmit the minimum necessary data related to the attributed cohort to the provider or provider group in the file types listed below.

Medicaid VBC inbound data		
File type	Details	Frequency
Membership crosswalk	Contains historical subscriber ID and original BCBSTX membership start date for members found on the member file	Monthly
Membership attributed members	Contains list of attributed members and assigned PCP information	Monthly
Institutional claims	Contains approved institutional claims for eligible members found on the member file	Monthly
Professional claims	Contains approved professional claims for eligible members found on the member file	Monthly
National Council for Prescription Drug Programs Pharmacy	Contains pharmacy claims for eligible members found on the member file	Monthly
Payment detail	Contains member level payment detail	Monthly
Invoice summary	Contains deposit advice summary	Monthly
File summary	Provides a summary of files received	Monthly

Delivery Cadence:

- Monthly files are delivered each month between the 20th and 25th.
- The file summary is delivered on the last day of each month.
- Files for the contract year begin delivery a month prior to the start of the contract date.

We will provide a complete set of technical specifications, including data dictionaries defining the data elements for each file.

Provider outbound data

The provider or provider group may elect to electronically submit and share data, including supplemental clinical data. An outbound data kick-off session is available upon request for contracted VBC provider or

provider groups.

Medicaid Outbound Data		
Number	File type	Description of file
1	Supplemental File (Quality Data)	Pipe delimited text file prepared by the provider to contribute to gap closure and improve Star ratings*

For questions regarding Electronic Data Exchange, please email the [VBC Support Team](#).

4 — PROVIDER QUALITY PERFORMANCE MEASUREMENT AND REPORTS

HEDIS is a nationally recognized set of standardized performance measures developed and maintained by National Committee for Quality Assurance and is used to evaluate how health plans deliver clinical care, preventative services and chronic disease management.

HEDIS in Texas Medicaid

The Texas Health & Human Services Commission requires Medicaid managed care organization to report and meet performance standards based on HEDIS measures. HHSC uses HEDIS as a core component of its quality strategy to monitor clinical performance, evaluate MCO effectiveness and determine compliance with state and federal requirements. HEDIS results have a direct impact on quality improvement and value-based contracting.

What HEDIS measures

- *Preventive care: Immunizations, cancer screenings, well-child visits*
- *Chronic condition management: Diabetes, hypertension, asthma, behavioral health*
- *Medication management: Adherence measures, appropriate prescribing*
- *Access and utilization: Frequency of primary care visits, follow-ups after hospitalization*

Why HEDIS matters in value-based care

- *Aligns care delivery with quality benchmarks set at the national level*
- *Identifies care gaps to support targeted quality improvement initiatives*
- *Demonstrates clinical performance and outcomes used for incentive payments*
- *Improves patient outcomes by focusing on preventive care and chronic disease management*

5 — FINANCIAL PERFORMANCE MEASUREMENT AND REPORTS

Provider insight	Description
Attribution list	Contains the latest snapshot of members attributed to the VBC program.
Program overview	Provides an overview of your contracts including total measures, total programs, total patients and participating practitioners across HEDIS measures.
Measure performance	Provides an overview of current performance for the HEDIS quality measures applicable to the VBC contract. Only one measure can be viewed at a time, but includes information such as measure rate, patient adherence gaps, and performance targets (as applicable).
Provider performance	Provides an overview of current performance for the HEDIS quality measures applicable to the VBC program. Only one measure can be viewed at a time, but includes information such as measure rate, patient adherence gaps and performance targets, as applicable. This view is applicable for both table (e.g., Plan All Cause Readmission) and rate-based measures.
Patient detail	Provides current patient information by each VBC contract-applicable HEDIS quality measure, defining if adherent or non-adherent.
VBC cost and use	Displays the cost and utilization metrics giving insight into which members and services are most frequently utilized and driving cost or utilization metrics, inclusive of leakage analytics where applicable. These can help measure performance by VBC contract, physicians and services provided so you can more easily assess cost and use trends and target intervention opportunities when necessary. These dashboards allow you to further drill down on member details such as risk score, medical loss ratio and generate and export dynamic reports.
Visit level detail	Consists of five reports that provide population health and visit level detailed information about your current attributed member populations over a rolling period, such as 12 months. These reports are based on the most recently delivered membership and claims files. These reports include member level, inpatient admissions, emergency room visits and outpatient visits. You can search each report by member and export the full population.
Financial settlement	Provides insight into final VBC contract performance, including the resulting financial settlement results, with information at the provider and member level.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSTX. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by Availity.

HEDIS® is a registered trademark of National Committee for Quality Assurance.

The NCQA HEDIS® measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS. The adjusted measure specification may be used only for quality improvement purposes.



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