BlueCross BlueShield of Texas

Medicare Advantage

Value-Based Care Provider Manual

Updated January 2026

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1 — INTRODUCTION

This value-based care provider manual outlines the Blue Cross and Blue Shield of Texas operations for our VBC models, including the major components of the VBC model and how our methodology works. It's intended to be 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. If there is conflict between the explanations set forth in this VBC provider manual and the terms of the VBC agreement, 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 could 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 on our provider website with the intent to keep all information current.

Provider groups who participate in VBC must have a Medicare Advantage network participation agreement with us and maintain current credentialing status. Medicare HMO products require members to have a primary care provider. Therefore, PCPs may only participate in one BCBSTX Medicare value-based contract. Specialists can participate with multiple provider groups. Value-based contracts have a performance year from Jan. 1-Dec. 31 each year. All new or modifications to existing VBC contract will need to be completed by Sept. 1 prior to the new performance year.

Throughout this manual, references to “provider” refers to the provider groups contracted with us.

2 — VALUE-BASED CARE PROGRAMS

Value-based care programs redefine how we collaborate with providers. These models introduce new performance measurements and compensation methodologies separate from fee-for-service arrangements. Our VBC model seeks to partner with providers who deliver sustainable improvements to member care and manage health care costs.

By shifting provider relationships towards VBC models, we increase the value of health care services through increased collaboration with participating 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.

Some 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.
- **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 provider. Under the VBC model, members are attributed to PCPs or selected extenders practicing in a primary care role. The PCP or extender plays a key role in fostering engagement and is responsible for outcomes of treatment.
- **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 quality team focuses on members' quality measures based on Healthcare Effectiveness Data and Information Set (HEDIS®) from Medicare or specific state requests. This includes gap closures, annual health visits and proper coding.
- **Coding team**: The coding team is responsible for accurate and compliance (with ICD official coding guidelines of diagnoses), especially Hierarchical Condition Categories, so patient risk is properly reflected in VBC measurements. They perform chart reviews, audits and provider education to improve documentation and coding accuracy. By monitoring patterns and collaborating with quality and clinical teams, they help optimize risk adjustment factor scores, revenue and overall VBC performance.
- **Finance team**: VBC provider financial teams ensure accurate financial management and reporting for VBC financial targets. They track revenue, expenses and shared savings while monitoring risk adjustment and performance-based payments. By providing analyses and forecasts, they help VBC leadership make informed decisions and optimize financial outcomes under VBC models.

VBC model

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

1. VBC contracts models
2. Attribution logic and methodology
3. Electronic data exchange
4. Quality performance measurement and reports
5. Medicare financial terminology

VBC contract model continuum

Enhanced Fee-For-Service

This model is designed to introduce our Fee-For-Service providers to value-based contracting. It provides bonus incentives for meeting quality measures and incentives for closing out annual health assessments. This model allows the provider group to grow their membership and increase the quality measures which may allow them to move to more advanced VBC models in the future.

Partial Risk Models

Shared Savings/Shared Loss

Shared Saving model is designed for provider groups to earn a greater incentive after they meet an agreed upon membership, STARS and medical loss ratio thresholds. The shared savings rate paid to the provider group is the percentage of any estimated savings (compared with to the benchmark) that is paid to the provider group, subject to meeting set benchmarks in the VBC agreement.

For the shared loss component, providers performing below their benchmark must repay the payer a portion of the financial loss. Providers who fail to meet MLR target, STAR rating and membership requirements must cover downside percentage should their group perform in a deficit as indicated in their agreement.

Global risk/full risk

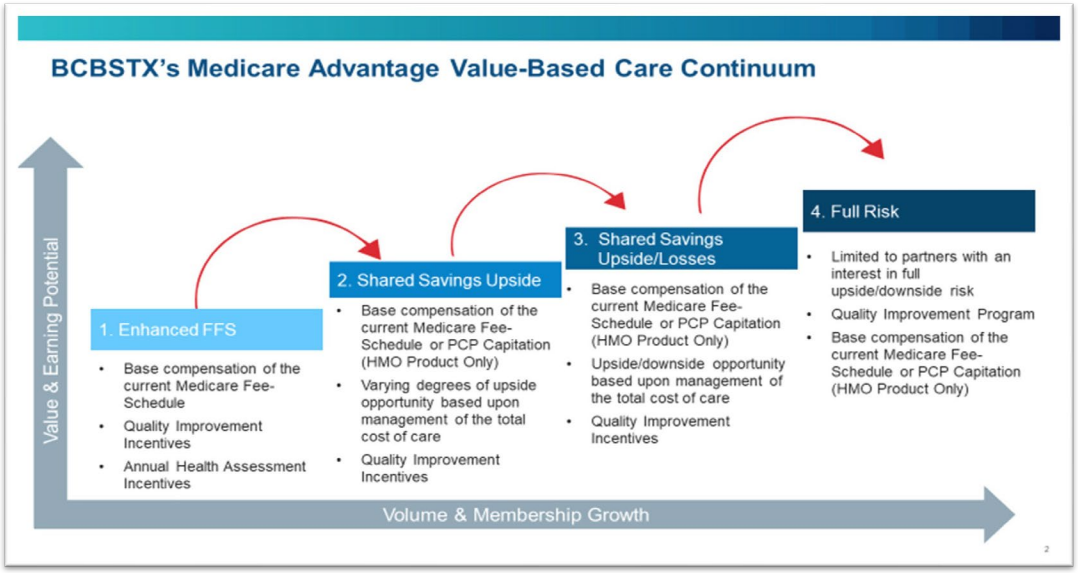
Global and full risk mean the provider takes financial responsibility for the total cost of care for a defined population.

- Global risk means the provider is responsible for all healthcare cost up to a limit, across the continuum such as inpatient, outpatient and physician services. Provider keeps savings but also absorbs losses.
- Full risk usually means the provider assumes 100% downside financial risk if the total cost of care exceeds the VBC contract thresholds.

Capitation

Capitation is a healthcare payment system in which a provider or practice is paid a fixed amount per patient over a defined period (e.g., monthly) by a payer inclusive of all covered healthcare services the provider is responsible for within the capitation model. The payment amount received is based on the average expected health care utilization and cost of each member in a defined group for a set period (e.g., a performance year). This per member per month is usually calculated in advance of a performance year and is based on historical, local, regional or national cost and utilization data. Furthermore, higher utilization and costs are assigned to groups with greater medical needs or higher acuity. A provider can be capped and also participate in shared savings shared loss or global phase in their contract.

See example in chart below.



3 — ATTRIBUTION LOGIC AND METHODOLOGY FOR PPO

Primary care provider attribution is the process of aligning members with the provider responsible for delivering and coordinating care. The provider will be held accountable for the cost and quality of that care. For HMO populations, members are required to elect a PCP. In the PPO population, we run a claims-based attribution methodology to determine the link between a member and provider.

1. **PCP Selection**
   PPO members are encouraged to select a PCP prior to running the claims-based attribution. After this step, the claims-based attribution is run which includes a series of provider types and HCPCS/CPT codes to identify primary care services provided to members by a primary care provider.

2. **PCP Selection for PPO members without a selected PCP**
   The PCP 1, PCP 2 and PCP 3 attribution methods are stacked, with the highest preference given to the first algorithm. The results of PCP 1 are given preference over PCP 2 and PCP 3. PCP 2 is given preference over PCP 3. PCP 2 will be considered for PCP attribution only when there are no claims for a member meeting PCP 1 criteria. PCP 3 will be considered only when there are no claims for a member that meet the criteria for either PCP 1 or 2. The order of selection preference is as follows: PCP 1, PCP 2 and PCP 3. The details of each of these steps are detailed below.

   PCP 1

Identified by the following HCPCS/CPT® codes:	
99201 through 99215 or	99304 through 99340 or
99341 through 99350 or	G0402, G0438, G0439 99381 through 99387 or
99391 through 99397or	G0402, G0438, G0439

Type of provider specialty:	
001 – General practice	058 – Rural health clinics
008 – Family practice	346 – Endocrinology, diabetes and metabolism
009 – Gynecology	354 – Maternal and fetal medicine
011 – Internal medicine	388 – Federally qualified health clinic
015 – Obstetrics	518 – Developmental-behavioral pediatrics
016 – Obstetrics-gynecology	519 – Gynecologic oncology
035 – Pediatrics	522 – Neonatal-perinatal medicine
043 – Obstetrics	546 – Family practice (obstetrics Only)
044 – Gynecology	547 – Family practice including obstetrics
051 – General practice (osteopaths only)	549 – Internal medicine – pediatrics
052 – Internal medicine (osteopaths only)	700 – Rural health facility
054 – Pediatrics (osteopaths only)	

The combination of evaluation and management codes identified above with the provider specialty codes above are used in determining PCPs under grouping identified as **PCP 1**.

PCP 2

Identified by the following HCPCS/CPT codes:	
99201 through 99215 or	99304 through 99340 or
99341 through 99350 or	99381 through 99387 or
99391 through 99397 or	G0402, G0438, G0439

Type of provider specialty:	
006 – Cardiovascular disease	012 – Manipulative therapy (osteopaths only)
013 – Neurology	025 – Physical medicine and rehabilitation
026 – Psychiatry	027 – Psychiatry, neurology (osteopaths only)
029 – Pulmonary disease	037 – Pediatric cardiology
038 – Child psychiatry	048 – Preventive medicine
074 – Certified nurse midwife	079 – Mixed specialties clinic
083 – Physical therapy	102 – Physician assistant
161 – Osteopathic manipulative	274 – Psychiatry and neurology, forensic psychiatry
304 – Osteopathic/general acute	333 – Nephrology
335 – Osteopathic manipulative medicine	344 – Pulmonary diseases
348 – Hematology	357 – Pediatric cardiology
358 – Pediatric pulmonology	359 – Pediatric medical oncology
360 – Pediatric endocrinology	361 – Pediatric psychiatry
364 – Pediatric nephrology	367 – Pediatric hematology
404 – Neuropsychiatry	406 – Oncology
473 – Psychiatry and neurology, addiction Psychiatry	505 – Pediatric hematology-oncology
506 – Reproductive endocrinology and infertility	510 – Pediatric endocrinology
512 – Pedatric nephrology	513 – Pediatric pulmonology
516 – Sports medicine	520 – Interventional cardiology
530 – Pediatric sports medicine	531 – Pediatric transplant hepatology
535 – Child abuse pediatrics	536 – Addiction medicine
539 – Child and adolescent psychiatry	548 – Hematology and oncology
551 – Neuromusculoskeletal medicine	552 – Neuropathology
553 – Osteopathic manipulative medicine	554 – Osteopathic manipulative therapy
556 – Pediatric genetics	557 – Pediatric neurology
559 – Pediatric rehabilitation medicine	560 – Pulmonary disease and critical care
583 – Orthopaedic sports medicine	749 – Licensed addiction counselor
778 – Physician assistant primary Care	779 – Physician assistant specialist
788 – Sleep psychiatrist	AZ – Osteopath group

The combination of E&M codes identified above with the provider specialty codes above are used in determining PCPs under grouping identified as **PCP 2**.

Based on the Medicare Shared Savings Program guidance, we expect those providers with an internal medicine subspecialty such as nephrology, oncology, rheumatology, endocrinology, pulmonology and cardiology would frequently provide primary care to their patients. Especially for those with certain chronic conditions (e.g., certain heart conditions, cancer, diabetes) but who are otherwise healthy, specialist providers are often expected to take on the role of PCPs in the overall treatment of the members if there is no family practitioner or other PCP serving in that role.

PCP 3

Identified by the following HCPCS/CPT codes:	
99201 through 99215 or	99304 through 99340 or
99341 through 99350 or	99381 through 99387 or
99391 through 99397 or	G0402, G0438, G0439

AND
All other remaining specialty codes.

The combination of E&M codes identified above with all other provider specialty codes are used in determining PCPs under grouping identified as **PCP 3**.

3. **PCP Selection Example**
   Using the stacked PCP methodology, if a member has only one visit with that meets criteria 1, but has two visits with criteria 2, three visits with criteria 3, the attribution logic will apply the results of PCP 1 and given preference.

4. **Tie breaking criteria**
   When a member has the same number of visits with multiple providers within the same criteria, the provider with the most recent visit will be designated their PCP.

5. **Frequency and time periods**
   PCP attribution runs prospectively and will be refreshed every month for all months beginning from January of the performance period. Prospective attribution runs the month prior to the impact month.

The attribution uses a 24-month look back period of claims with zero months runout starting from January of the performance period to the current month.

For example, for the members in January 2026, attribution will run in December 2025 and will use claims with service dates from Dec. 1, 2023, through Nov. 3, 2025. Similarly, for the members in October 2026, attribution will run in September 2026 and will use claims with service dates from Oct. 1, 2025, to Aug. 30, 2026.

4 — PROVIDER ELECTRONIC DATA EXCHANGE

To support the VBC provider success with population health management activities, we share our confidential and proprietary attributed membership information, medical and pharmacy claims, and pre-authorization information with the VBC provider on a limited-use basis subject to restrictions, terms and conditions set forth in the Confidential Data Release Agreement between the provider and us.
Reports are available on Availity® Essentials.

Availity registration

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

VBC providers who already have an Availity customer ID for other data exchange activities, please provide the ID to your Network Consultant for data delivery.

For step-by-step instructions, access the Availity Learning & Training Center:
Log in to Availity and go to the BCBSTX-branded **Payer Spaces – Applications**.

You must be a registered Availity user to view the information in the training center. If you haven't registered yet, go to Availity and get started today at no cost. For registration help, call Availity Client Services at **800-282-4548**.

Provider team electronic roles and responsibilities

The VBC Provider must identify people meeting the following criteria to facilitate discussions in connectivity, data integration, testing & validation and CDRA signing:

Role	Responsibilities
Availity administrator	• An office manager or other employee primarily responsible for overseeing implementation • Person with legal authority to sign agreements for the organization. Will need to sign and return the Organizational Access Agreement to complete registration with Availity if one is not already established. • Adds users to Availity.
Integration Expert	• Load data into the provider's data warehouse • Reviews technical specifications and other support documentation to understand the delivered files
Data Testing and Quality Assurance	• Review data received and ask questions

Confidential data release agreement

We will provide our standard CDRA to VBC provider and its data vendor (if applicable). The CDRA must be executed prior to the exchange of any data associated with the attributed population to ensure providers and their data vendors do not misuse our proprietary and
confidential information.

Data sharing files with production data cannot be delivered until the CDRA is signed.
However, electronic connectivity data setup can begin prior to CDRA execution (see next section).

Exchanging data process

Data sharing requires shared responsibilities between the provider and us. Shared responsibilities include but are not limited to:

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

The following are required for electronic data exchange:

1. We send data delivery documentation to provider.
2. Provider registers for Availity, monitors application status and 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. Provider submits fully executed CDRA to us.
5. We will deliver monthly data files and daily authorization files based on the established cadence.
6. The provider can notify us if they need ongoing support on the process.

Provider inbound data

We'll electronically transmit the minimum necessary data related to the attributed cohort to the provider via the files listed below.

Inbound Data			
File type	**File description**	**Details**	**Frequency**
Member attribution file	List of attributed prospective and retrospective members for each month during the current calendar year	Provides a full view for the months a member is active, has a PCP change, and/or has termed all business lines are included that are applicable to the site/vendor: HMO and/or PPO	Monthly
Claims file	Claims for members attributed to site, vendor, provider group or community based partner	File includes paid and denied Medical Part C claims (e.g. inpatient, outpatient and professional) and Part D claims (prescription); Dental claims are excluded.	Monthly
HEDIS file	HEDIS measures and PCP data for historical reporting periods	Reports results for up to 16 HEDIS quality measures	Monthly
Census file	Identifies inpatient/hospital facility admissions for attributed members	Populates daily to understand inpatient medical treatment on an ongoing basis.	Daily
Readmissions file	Identifies hospital readmissions for attributed members	Information used improve member communication to reduce avoidable readmissions.	Daily
Authorization file	Pre-authorization data for attributed members	Includes authorization, services requested, and outcomes (three service years - up to 35 months) for each member.	Monthly

Inbound Data			
File type	**File description**	**Details**	**Frequency**
Emergency room file	Identifies emergency room visits for attributed members and information used to understand conditions associated with emergency room visits	Identifies attributed members who utilized the emergency room for the current month. Reflects a subset of members from authorizations file, showing authorized members who did not need to be admitted.	Monthly
Lab results file	Lab data for attributed members	Includes both lab requests and results from major lab vendors (3 service years - up to 35 months) for each member.	Monthly
C gaps file	Hierarchical condition category member updates	Suspected HCC (closed and open) gaps for acute/chronic conditions on members in the attribution file for the current payment year based on BCBSTX's predictive model.	Monthly
Provider files	Provider demographic information	Demographic information for all providers included in claims extracts (e.g. the provider tax ID, PFIN, etc.). Providers from claims, labs, member PCP.	Monthly
Member month records file	CMS MMR records for attributed members	All MMRs for the member and eligibility date spans, including adjustments.	Monthly
Model output records file	CMS Monthly Model Output Records for members in attribution file	All MMR records for the member and eligibility date spans including adjustments. Generated by risk adjustment system and reports the HCC, which is used to calculate each member's risk adjustment classification within each model run.	Monthly
MAO 002 file Star	Availity Star records for attributed members	Report provides information on the disposition status (accepted or rejected) on all records submitted through Availity.	Monthly
MAO 004 file	Availity	Informs which diagnoses are accepted for risk adjustment. CMS allowed diagnosis records for electronic data processing system encounter submissions, with allowed/disallowed reason code.	Monthly
Annual health assessment gaps file	Report on AHA for provider group	Includes AHA completion status for members in the attribution file for the current payment year.	Monthly

Inbound Data			
File type	**File description**	**Details**	**Frequency**
PCP cap	Identifies cap, AHA and care management fee payments for attributed membership	Includes provider NPI and Tax ID, helpful for dispersing funds.	Monthly
File Summary	Itemizes monthly files delivered to providers, includes record counts	Provides file names and record counts for file download reconciliation.	Monthly

Delivery cadence

- Monthly files (except PCP Cap & File Summary) are delivered each month between the 20th and 25th.
- PCP cap (if applicable) are delivered each month between the 26th and 30th.
- 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 VBC agreement effective date.

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

Provider outbound data

The 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 the contracted VBC provider group.

Outbound Data		
#	**File type**	**Description on file**
1	Supplemental File (Quality Data)	Pipe delimited text file prepared by provider to contribute to gap closure and improve Star ratings*.

* Additional information regarding Star ratings is discussed in the Quality Performance Measurement and Reports section of this manual.

For questions regarding electronic data exchange and coding of the supplemental file a provider can reach out to the Supplemental Data team.

5 — MEDICARE QUALITY INTRODUCTION

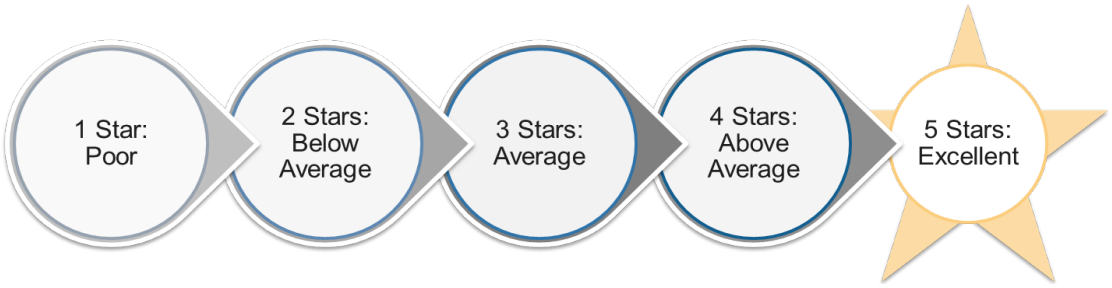
HEDIS® (Healthcare Effectiveness Data and Information Set) is a set of performance measures used to assess the quality of care provided by health plans and healthcare providers in the United States. HEDIS measures cover various aspects of healthcare including preventive care, chronic disease management and patient satisfaction.

In relation to Medicare Advantage, HEDIS is often used by the CMS to evaluate and compare the quality of care provided by different Medicare Advantage plans. These measures help members make informed choices when selecting a Medicare Advantage plan, by measuring how well each plan performs in terms of providing high-quality care.

Health plans, including Medicare Advantage plans, are incentivized to perform well on HEDIS measures as it impacts their reimbursement and reputation. Plans consistently achieving high HEDIS scores are more likely to attract members and receive financial bonuses from CMS. The specific HEDIS measures and their importance in Medicare Advantage can evolve over time due to changes in healthcare policy and regulations, so it is essential to check the latest information from CMS or your specific health plan for the most up-to-date details.

Medicare Star ratings

The CMS Five-Star Rating Quality System is used to assess and compare the overall performance of Medicare Advantage and Medicare Part D prescription drug plans. This system assigns star ratings ranging from 1 to 5 stars, with 5 stars being the highest rating, to help Medicare members make informed choices when selecting their healthcare plans.

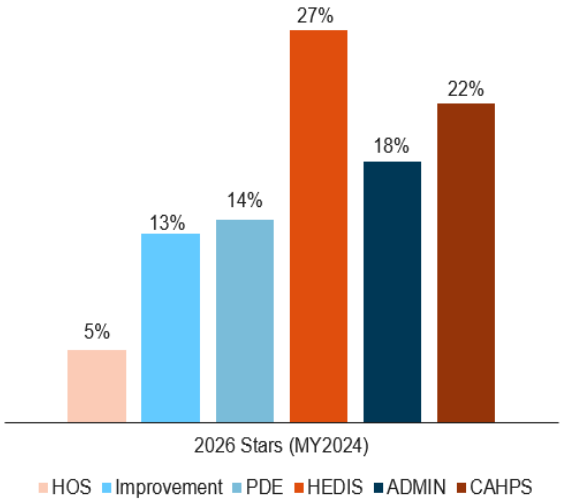


Medicare star domains

The Medicare Advantage star domains for Medicare Advantage apply to specific evaluation categories for determining the plan's overall quality rating.

Star quality rating

System uses these Star Domains to assess and rate plan performance.



Star Measure Domain	Description
CAHPS	Consumer Assessment of Healthcare Providers and Systems survey; administered annually to understand member experience
Admin	Measures controlled/owned by the Plan; no provider or member impact
HEDIS	Healthcare Effectiveness Data and Information Set; designed to provide consumers with reliable plan comparisons
PDE	Prescription Drug Event; summary of prescription fills for Part D
HOS	Health Outcome Survey is mailed to a random sample of members by CMS
Improvement	Indicates measures that must improve year over year

Medicare Star Timeline

Data collection
January through June of the calendar year is the period when MA plans and their contracted healthcare providers collect and submit data based on the prior year's dates of service January through June of each calendar year.

Data analysis and calculation
CMS begins the process of analyzing the data collected from the prior year's dates of service from June through August.

Preliminary Star ratings released
In September, CMS releases preliminary star ratings for Medicare Advantage plans. This provides an initial assessment of plan performance to both the plans themselves and the public.

Review and correction period
Medicare Advantage plans review their preliminary star ratings and can submit corrections or additional information to CMS if they identify discrepancies or errors from September through October.

Final star ratings calculated
In October, CMS calculates the final star ratings for Medicare Advantage plans for the prior year's dates of services. These ratings incorporate any corrections or updates made during the review and correction period. The final star rating is released to the public in October, typically before the start of the Medicare annual open enrollment period (October 15 – December 7).

Quality bonus payment determinations
In January of the following year, CMS determines which high-performing Medicare Advantage plans with four- or five-star ratings are eligible for quality bonus payments.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

CAHPS is an essential part of the Medicare Advantage Stars Program. The CAHPS Survey measures patients' experiences with their healthcare services and providers. Medicare Advantage plans and prescription drug plans must conduct the CAHPS survey annually, which typically occurs between January and June. Results are collected by CMS and survey respondents are confidential. Specific domains are included in Star Ratings. Domains and weights are identified by CMS and published annually. CAHPS results are calculated as part of the star ratings. Which are released in the fall of each year and impact the subsequent year's payments and plan ratings.

The Medicare CAHPS *MA-PD questionnaire* includes the following domains: Your healthcare in the Last six Months, Your Personal Doctor, Getting Healthcare from Specialists, Your Health Plan, Your Prescription Drug Plan, and About You. The *PDP questionnaire* includes the following domains: Your Prescription Drug Plan, and About You.

For scoring and reporting purposes, some questions are combined into the following composite measures for Star ratings:

- Getting needed care
- Getting appointments and care quickly
- Customer service
- Getting needed prescription drugs (MA-PD and PDP)
- Care coordination

In addition to the publicly reported composite measures listed above, the survey questionnaires include several publicly reported **member overall** ratings based on a 0–10 scale, where 0 is the lowest rating and 10 is the highest:

- Rating of health plan

- Rating of health care quality
- Rating of drug plan (MA-PD and PDP)

The MA and PDP CAHPS Survey also includes the following single item measure, which is publicly reported:

- Annual flu vaccine

CAHPS sample survey questions

- Have you had a flu shot since MM/DD/YYYY?
- In the last six months, how often did you get an appointment to see a specialist as you needed?
- In the last six months, how often was it easy to get the care, test or treatment you needed?
- In the last six months when you needed care right away, how often did you get care as soon as you needed?
- In the last six months, how often did you get an appointment for a check-up or routine care as soon as you needed?
- In the last six months, how often did you see the person you came to see within 15 minutes of your appointment time?
- In the last six month, how often did your health plan's customer service give you the information or help you needed?
- In the last six months, how often were the forms from your health plan easy to fill out?
- Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate your health care in last six months?
- Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?
- In the last six months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
- In the last six months, when your personal doctor ordered a blood test, X-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
- In the last six months, when your personal doctor ordered a blood test, X-ray or other test for you, how often did you get those results as soon as you needed them?
- In the last six months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
- In the last six months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
- In the last six months, how often did your personal doctor seem informed and *up to date* about the care you got from specialists?
- Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your prescription drug plan?
- In the last six months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?
- In the last six months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?
- In the last six months, how often was it easy to use your prescription drug plan to fill a prescription by mail?

Medicare HEDIS metrics and cut points

The quality metrics are defined in the VBC agreement. To understand the details for each metric, the provider should obtain the latest set of HEDIS specifications which can be found on the National Committee for Quality Assurance site.

In addition, as a secondary resource, our quality team provides a quality Handbook for HEDIS which is available under Quality Improvement on the Availity portal. It provides a high-level overview for each HEDIS measure along with gap closure information and corresponding CPT codes. Lastly, each year CMS releases cut-points in October via its site. These cut-points define the level or standard that healthcare providers or organizations need to meet to achieve a specific rating. Find the most recent release on cms.gov by entering **Medicare Star Rating Fact Sheet**.

Medicare Quality Improvement Program

The Medicare QIP provides monetary compensation to PCPs who work with designated members to address certain HEDIS measures. The three primary QIP categories are improving diabetic care, controlling hypertension and increasing preventive screenings. Below is an example of a QIP. QIP's structures, metrics and pay can vary by provider. In addition, the plan may adjust the measurements to accommodate changes in CMS measures/requirements. The plan may add or omit metrics as CMS adjusts requirements under each category.

Type of Service	Payment Determination and Criteria	Measure	Pass Threshold
Improving diabetic care	A certain PMPM of effective Revenue for three out of four measures at or above the pass threshold	Kidney Health Evaluation	≥ 73%
		Blood Sugar Controlled	≥ 90%
		Diabetes Medication Adherence	≥ 91%
		Statin use for Patients with Diabetes	≥ 92%
Controlling hypertension and cholesterol	A certain PMPM of effective Revenue for three out of four measures at or above the pass threshold	Controlling Blood Pressure	≥ 85%
		Statin use for Patients with Cardiovascular Disease	≥ 90%
		Hypertension Medication Adherence (RAS Antagonists)	≥ 92%
		Cholesterol Medication Adherence (Statins)	≥ 92%
Increasing preventive screenings	A certain PMPM or of effective revenue for at or above the pass threshold	Brease Cancer Screenings	≥ 83%
		Colorectal Screenings	≥ 77%

Data sources for quality measurement

To measure quality performance, we leverage data from various sources, including but not limited to, medical and pharmacy claims and lab results. The provider can submit supplemental clinical data for some of the metrics using standard (automated) electronic files, as defined in the **Provider Outbound Data** section of this manual. We'll provide the file format required for supplemental data transmission as dictated by the HEDIS certified engine requirements.

Quality Measured Population

The population used to measure our quality performance includes:

- Members attributed by the fourth month of the performance period
- Members attributed during the last month of the performance period
- Members attributed at least nine months during the performance period (attribution does not have to be continuous)
- Member must have program eligible coverage as defined by HEDIS and NCQA

BlueCard® members are excluded from the quality measured population.

All HEDIS-specific metrics rules must have a denominator of 30 or more attributed members. If the denominator is less than 30 members, we don't consider the metric for purposes of calculating quality performance. However, the results will still appear on the quality reports for informational purposes.

6 — MEDICARE VBC FINANCIAL TERMINOLOGY

Value	Description
Attribution	The method used to assign members to a provider for cost and quality measurement. Attribution can be prospective (assigned ahead of time) or retrospective (based on visits). It impacts membership, payments and benchmarks
Expenses	The following amounts are calculated by BCBSTX for any claims incurred in the Performance Period: • Payments for Medicare Part A and Part B services provided to the attributed covered persons during the performance period, whether paid for by us on a fee-for-service, capitated, care coordinator fee or some other basis • All ourincentive or bonus payments, including the quality incentive payment, paid by us that are allocated by us to attributed covered persons for performance during the performance period (shared savings and shared losses are not considered incentive or bonus payments for purposes of this definition) • Payments by us to third-party vendors engaged by us to assist us or a medical group in the successful implementation of the Medicare Advantage partial capitation attachment during the performance period.
Medical loss ratio	The percentage of revenues received by health plan that are spent on Part C healthcare, defined in this agreement to be the ratio between the actual cost of medical care to attributed covered persons and the calculated revenue provided to us.
Capitation	A fixed PMPM paid in advance to manage a population's care. The provider is responsible for delivering necessary services within that payment.
PMPM	The dollar amount paid for each enrolled patient every month. It is the basic unit used to calculate capitation payments and budget projections. PMPM helps providers understand revenue trends and cost control needs.
Upside/shared savings	A contract structure where providers can earn shared savings if they reduce costs below the benchmark. There is no penalty if they overspend. It encourages improvement without exposing providers to financial loss.
Downside risk	Providers are financially responsible if spending exceeds the benchmark. This means the provider may have to repay a portion of the loss. It increases accountability but requires strong cost controls and reserves.
Shared risk	A model with both upside savings and downside losses. Providers can earn more, but they can also lose more. It is considered full financial risk and requires mature infrastructure.
Full risk/global risk	A payment model where the provider or independent practice association is financially responsible for almost all medical costs for their members, including inpatient, outpatient, ER, skilled nursing facility, and pharmacy. They keep savings if total spending is below the budget and absorb losses if costs exceed it. This represents the highest level of financial accountability in VBC. A payment model where the provider or IPA is financially responsible for almost all medical costs for their members, including inpatient, outpatient, ER, SNF and pharmacy. They keep savings if total spending is below the budget and absorb losses if costs exceed it.
Risk score/RAF score	A numeric score representing how complex or sick a patient population is. Accurate, annual coding is essential for fair reimbursement.
Hierarchical condition category	A diagnosis category used to determine risk scores for Medicare Advantage and ACA patients. Chronic conditions must be documented every year to count. Missing HCCs results in reduced payments from CMS.

Value	Description
Suspect gaps	Conditions that likely exist (based on claims or pharmacy data) but haven't been coded by the provider. Closing suspect gaps improves risk accuracy and care management. They help identify overlooked chronic conditions.
Reconciliation	The final financial comparison of actual costs versus the benchmark for a contract period. It determines the provider's shared savings or shared losses.
Stop-loss/reinsurance	Financial protection that caps exposure to extremely high-cost cases. If a patient's cost exceed the stop-loss threshold, the insurance pays the remainder. It stabilizes risk for provider groups. Stop-loss is required at full-risk phase.
Incurred but not reported	These are medical claims that have occurred but have not yet been submitted or processed. IBNR ensures financial reports reflect the true cost of care, not just paid claims. It is essential for accurate reconciliations, forecasting, and determining whether a provider is achieving savings or overspending
Premium dollars	This is the total amount of money the health plan receives per member each month from CMS. All medical spending, administrative costs, and provider payments come out of this pool.
Total cost of care	Primary care capitation rate, care coordination fee, Part C medical claims, outlier protection adjustments and outlier expenses

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