

# Collaborative Quality Initiatives Fact Sheets Value-Based Reimbursement 2025



## Fact Sheet Pack

CQIs and POs should feel free to use the following fact sheets in discussing value-based reimbursement with your practitioners. The following fact sheets are for Hospital and Professional CQI VBR effective dates of 03/01/2025 – 2/28/2026.

[Anesthesiology Performance and Improvement Reporting Exchange \(ASPIRE\)](#)

[BCBSM Cardiovascular Consortium \(BMC2\)](#)

[Michigan Anticoagulation Quality Improvement Initiative \(MAQII\)](#)

[Michigan Arthroplasty Registry Collaborative Quality Initiative \(MARCQI\)](#)

[Michigan Bariatric Surgery Collaborative \(MBSC\)](#)

[Michigan Emergency Department Improvement Collaborative \(MEDIC\)](#)

[Michigan Hospital Medicine Safety Consortium \(HMS\)](#)

[Michigan Oncology Quality Consortium \(MOQC\)](#)

[Michigan Radiation Oncology Quality Consortium \(MROQC\)](#)

[Michigan Society of Thoracic and Cardiovascular Surgery Quality Collaborative \(MSTCVS\)](#)

[Michigan Spine Surgery Improvement Collaborative \(MSSIC\)](#)

[Michigan Surgical Quality Collaborative \(MSQC\)](#)

[Michigan Trauma Quality Improvement Program \(MTQIP\)](#)

[Michigan Urological Surgery Improvement Collaborative \(MUSIC\)](#)

[CQI VBR Opportunity Summary Tables](#)

## Collaborative Quality Initiatives Fact Sheet Value-Based Reimbursement 2025



### Anesthesiology Performance and Improvement Reporting Exchange (ASPIRE)

The Value Partnerships program at Blue Cross Blue Shield of Michigan (BCBSM) develops and maintains quality programs to align practitioner reimbursement with quality of care standards, improve health outcomes and control health care costs. Practitioner reimbursement earned through these quality programs is called value-based reimbursement (VBR). The VBR Fee Schedule sets fees at greater than 100% of the Standard Fee Schedule. VBR opportunities are available to all practitioners who participate in the Anesthesiology Performance and Improvement Reporting Exchange (ASPIRE) regardless of PGIP enrollment. The coordinating center leaders, jointly with BCBSM, set quality and performance metrics for the VBR. Each Collaborative Quality Initiative, or CQI, uses unique measures and population-based scoring to receive BCBSM VBR. The CQI VBR is applied in addition to any other VBR the specialist may be eligible to receive. The CQI VBR applies only to reimbursement associated with commercial PPO BCBSM members. This is an annual incentive program.

#### Population-Based Scoring Methodology

The CQI coordinating center (*not* the physician organization) determines which practitioners have met the appropriate performance targets and notifies BCBSM. Each physician organization will notify practitioners who will receive CQI VBR, just as the PO does for other forms of specialist VBR.

Participants can only receive VBR for one CQI, even if they are participating in more than one CQI, with the following exceptions:

- 1) Practitioners that participate in one of the four population-health based CQIs - INHALE, MCT2D, MIBAC, MIMIND – can receive the related VBR in addition to other CQI VBR
- 2) Practitioners can receive 102% VBR for tobacco cessation in addition to other CQI VBR. The tobacco cessation VBR is limited to one reward per practitioner but can be earned in addition to other CQI VBR.

CQI VBR is not additive if the practitioner is contributing data to multiple CQIs. If a practitioner is eligible for rewards through multiple CQIs, the practitioner will be awarded the highest level of CQI VBR.

ASPIRE uses a hospital-affiliated scoring model to measure performance. ASPIRE practitioners are grouped by participating hospital level (physicians are assigned to the hospital where they have performed the most cases) then measured as a hospital collective average.

## VBR reward opportunities

Participants are scored on CQI performance measures according to the methodologies developed by each respective CQI and are eligible for CQI VBR of 102%, 103%, 105%, or 107% of the standard fee schedule if they meet performance targets in one or more of those initiatives.

ASPIRE practitioners are eligible for one of the following VBR combinations (102%, 103%, 105%, or 107%)

- a. **To be eligible for 103% VBR**, participants must achieve target on **2 of 3 measures** in the measures listed in Table 1 below.
- b. **To be eligible for 105% VBR**, participants must achieve target on **3 of 3 measures** in the measures listed in Table 1 below.
- c. **To be eligible for 102% VBR**, participants must achieve target on **2 of 2 measures** in the tobacco cessation measures listed in Table 2 below.
- d. **To be eligible for 107% VBR**, participants must achieve target on **3 of 3 measures** (Table 1) and **2 of 2 measures** (Table 2).

## VBR Measures

Table 1. VBR Measures	Measurement Period	Target Performance
Percentage of cases receiving general anesthesia that had at least one core temperature documented intraoperatively. <a href="#">TEMP-02</a>	10/01/2023 – 9/30/2024	≥80%
Percentage of cases where carbon dioxide equivalents normalized by hour for cases receiving halogenated agents and/or nitrous oxide is less than CO <sub>2</sub> eq. of 2% sevoflurane at 2L FGF = 2.83 kg CO <sub>2</sub> /hr during the maintenance period of anesthesia OR the total CO <sub>2</sub> equivalents is less than 2.83 kg CO <sub>2</sub> . <a href="#">SUS-02</a>	10/01/23 - 9/30/2024	≥40%
Percentage of patients who had a procedure requiring general anesthesia or cesarean delivery and received appropriate prophylaxis for postoperative nausea and vomiting. <a href="#">PONV-05</a>	10/01/23 - 9/30/2024	≥50%

Table 2. Tobacco Cessation VBR Measures	Measurement Period	Target Performance
Percentage of patients, ≥ 18 years of age, with tobacco status documented within 30 days prior to any procedure requiring anesthesia <a href="#">SMOK-01</a>	10/01/23 - 9/30/2024	≥75% (12-month average)
Percentage of patients ≥ 18 years of age, who are documented as current tobacco smokers and receive an approved tobacco cessation intervention from an anesthesia provider. <a href="#">SMOK-02</a>	10/01/23 - 9/30/2024	≥10% (12-month average)

## VBR selection process

To be eligible for 2025 CQI VBR, the practitioner must:

- Meet the performance targets set by the coordinating center
- Have contributed data to the CQI's clinical data registry for at least two years, including at least one year's worth of baseline data

## Are practitioners participating in CQIs eligible for other specialist VBR?

Yes. Specialists are eligible to receive additional VBR if they meet the stated criteria. See the *Specialist VBR fact sheets* for specialty-specific information.

## About ASPIRE

- Builds collaborative relationships between surgeons and anesthesiologists
- Aims to reduce variation in intraoperative anesthesia practices, resulting in reduced postoperative complications and costs, and better outcomes for patients. Collects data to measure, report, and decrease unwarranted variation across several anesthetic domains of care, including:
  - glycemic management
  - hemodynamic management
  - intraoperative ventilation
  - neuromuscular blockade
  - transfusion management

## About the coordinating center

Michigan Medicine serves as ASPIRE's coordinating center to collect and analyze comprehensive clinical data from participating hospitals to identify specific care components associated with better patient outcomes. It uses these analyses to examine practice patterns, generate new knowledge linking processes of care to outcomes, and identify best practices and opportunities to improve quality and efficiency. The center also supports participants in establishing quality improvement goals and in disseminating and implementing best practices. Center leadership:

Program Director:	Nirav Shah, MD
Administrative Program Manager:	Tory (Victoria) Lacca
Clinical Program Manager:	Kate Buehler, MS, RN

For more information on the CQI and measures, please contact Kate Buehler at [kjbucrek@med.umich.edu](mailto:kjbucrek@med.umich.edu).

## About the CQI Program

Collaborative Quality Initiatives and Collaborative Process initiatives bring together Michigan physicians and hospital partners to address common and costly areas of medical-surgical care, BCBSM and Blue Care Network supports this effort and funds each collaborative data registry, that include data on patient risk factors, processes, and outcomes of care. Collection, analysis, and dissemination of such data helps inform participants on best practices. This, in turn, helps increase efficiencies, improve outcomes, and enhance value. For more information, please contact Marc Cohen, Manager, Value Partnerships [mcohen@bcbsm.com](mailto:mcohen@bcbsm.com).

## About Value Partnerships

Value Partnerships is a collection of programs among physicians and hospitals across Michigan and Blue Cross, that make health care better for everyone. This unique, collaborative model enables robust data

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collection and sharing of best practices, so practitioners can improve patient outcomes. It is value and outcomes-based health care -- a movement away from fee-for-service that instead pays practitioners for successfully managing their patient's health. We invite you to visit us at [valuepartnerships.com](http://valuepartnerships.com).

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## Collaborative Quality Initiatives Fact Sheet Value-Based Reimbursement 2025



### Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2)

The Value Partnerships program at Blue Cross Blue Shield of Michigan (BCBSM) develops and maintains quality programs to align practitioner reimbursement with quality-of-care standards, improve health outcomes and control health care costs. Practitioner reimbursement earned through these quality programs is called value-based reimbursement (VBR). The VBR Fee Schedule sets fees at greater than 100% of the Standard Fee Schedule. VBR opportunities are available to PGP practitioners who participate in the Cardiovascular Consortium (BMC2), and that meet specific eligibility criteria. The coordinating center clinical leaders, jointly with Blue Cross, set quality and performance metrics for the VBR. Each Collaborative Quality Initiative, or CQI, uses unique measures and population-based scoring to receive BCBSM VBR. The CQI VBR is applied in addition to any other VBR the specialist may be eligible to receive. The CQI VBR applies only to reimbursement associated with commercial PPO BCBSM members. This is an annual incentive program.

#### Population-Based Scoring Methodology

The CQI coordinating center (*not* the physician organization) determines which practitioners have met the appropriate performance targets and notifies Blue Cross. Each physician organization will notify practitioners who will receive CQI VBR, just as the PO does for other forms of specialist VBR.

The BMC2 CQI has three different quality improvement initiatives that allow BMC2 practitioners to earn CQI VBR:

- Percutaneous Coronary Interventions (PCI),
- Vascular Surgery (VS), or the
- Michigan Structural Heart Consortium (MISHC).

Participants can only receive VBR for one CQI, even if they are participating in more than one CQI, with the following exceptions:

- 1) Practitioners that participate in one of the four population-health based CQIs - INHALE, MCT2D, MIBAC, MIMIND – can receive the related VBR in addition to other CQI VBR
- 2) Practitioners can receive 102% VBR for tobacco cessation (TC) in addition to other CQI VBR, but can only receive one tobacco cessation VBR, even if they are eligible for it through multiple CQIs. The tobacco cessation VBR is limited to one reward per practitioner, but can be earned in addition to other CQI VBR.

#### BMC2 VBR Scoring Methodology

Practitioners are grouped by the hospital according to which they perform the greatest number of procedures. All measurements are calculated at the hospital-level.

## VBR reward opportunities

Participants are scored on CQI performance measures according to the methodologies developed by each respective CQI and are eligible for CQI VBR of 102%, 103%, 105%, or 107% of the standard fee schedule if they meet performance targets in one or more of those initiatives. See summary table below:

VBR %	102%			104%	103%			105%			107%
Type of VBR (e.g., CQI, Tobacco Cessation)	Tobacco cessation (TC)	CQI Plus (VS)	Tobacco cessation + CQI Plus (VS)	CQI (PCI)	CQI (VS)	MISHC	CQI PCI + TC	CQI PCI + MISHC	CQI VS + CQI Plus (VS) or CQI VS + TC	CQI (PCI) + CQI (MISHC) + TC	CQI Plus (VS) + CQI (VS) + TC
Who It Applies to	Interventional cardiologists and vascular specialists	Vascular specialists	Vascular specialists	Interventional cardiologists	Vascular specialists	Interventional cardiologists	Interventional cardiologists	Interventional cardiologists	Vascular specialists	Interventional cardiologists	Vascular specialists
Criteria	Meets 1 of 1 measures	Meets 2 of 2 measures in CQI Plus VS	Meets TC measure AND 2 of 2 measures in CQI Plus VS	Meets 2 of 3 measures in CQI PCI 103%	Meets 2 of 3 measures in CQI VS 103%	Meets 2 of 3 measures in MISHC 103%	Meets 2 of 3 measures in CQI PCI AND meets TC measure	Meets 2 of 3 measures in CQI PCI 103% AND meets 2 of 3 measures in MISHC (separately can earn 103%, but not additive to 106%)	Meets 2 of 3 measures in CQI VS 103% AND meets 2 of 2 measures in CQI Plus 102% OR meets 2 of 3 measures in CQI VS 103% AND meets TC measure	Meets 2 of 3 measures in CQI PCI 103% AND meets 2 of 3 measures in CQI MISHC 103% AND meets TC measure	Meets 2 of 2 measures in CQI VS Plus 102% AND meets 2 of 3 measures in CQI VS 103% AND meets TC measure
Table	102% TC	CQI VS Plus 102%	102% TC + CQI VS Plus	CQI PCI 103%	CQI VS 103%	MISHC 103% in MISHC VBR Table	TC + CQI PCI 103%	CQI PCI 103% + CQI MISHC 103%	CQI VS 103% + CQI Plus VS 102% - OR - CQI VS 103% + TC	CQI PCI 103% + CQI MISHC 103% + TC	CQI VS 102% + CQI VS 103% + TC
Measurement Level - Hospital, Collaborative-Wide, Practice, Physician	Hospital level	Hospital level	Hospital level	Hospital level	Hospital level	Hospital level	Hospital level	Hospital level	Hospital level	Hospital level	Hospital level

BMC2 practitioners are eligible for one of the following VBR combinations (102%, 103%, 105%, or 107%):

- **To be eligible for 102% TC VBR**, practitioners must meet the singular target for the tobacco cessation measure (**Table 3**). This applies to BMC2 PCI and VS practitioners.
- **To be eligible for 102% VBR, VS practitioners** must achieve targets for **2 of 2 measures (Table 2, Additional Measures)**.
- **To be eligible for 103% VBR**, practitioners must achieve target on one of the following initiatives:
  - **PCI**: Practitioners must achieve target on **2 of 3 measures (Table 1)**
  - **VS**: Practitioners must achieve target on **2 of 3 performance measures (Table 2)**
  - **MISHC**: Practitioners must achieve target on **2 of 3 measures (Table 4)**
- **To be eligible for 105% VBR**, practitioners must achieve one of the following combinations:
  - **PCI**: achieve targets for PCI 103% (2 of 3 performance measures) *and* the TC 102% measure (**Tables 1 & 3, respectively**)
  - **PCI and MISHC dual participation**: achieve targets for PCI 103% (2 of 3 measures) *and* MISHC 103% s (2 of 3 measures) (**Tables 1 & 4, respectively**)
  - **VS**: achieve targets for VS 103% (2 of 3 performance measures) *and* VS 102% (2 of 2 additional measures) (**Table 2**) **OR** achieve targets for VS 103% (2 of 3 performance measures) *and* the TC 102% measure (**Tables 2 & 3, respectively**)
- **To be eligible for 107% VBR**, practitioners must achieve one of the following combinations:
  - **PCI**: Participants must achieve targets for PCI 103% *AND* MISHC 103% *AND* TC 102% (**Tables 1, 3, 4, respectively**)

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**VS:** Participants must achieve targets for VS 103% *AND* VS 102% *AND* TC 102%(Tables 2 & 3, respectively)

**VBR Measures**

**Table 1. Percutaneous Coronary Intervention (PCI) – 103%**

Measure	Measurement Period	Target Performance
1) Increase the appropriateness of PCI therapy, based on the BMC2 on-going peer review process	Peer review Feb-Mar 2024	>=90% of the reviewed cases with a decision to proceed to PCI within the two highest appropriateness categories
2) Improve the overall intervention quality as assessed in the BMC2 on-going peer review process		Fewer than 10% of reviewed cases should be rated as sub-optimal
3) Submit internal peer review cases and attest to discussing the internal review cases with colleagues		Submission of <u>≥</u> 80% of internal reviews and completion of attestation form

**Table 2. Vascular Surgery (VS)**

Measure	Measurement Period	Target Performance
Performance Measures (103%)		
1) Increase the rate of documentation of endovascular aneurysm repair (EVAR) imaging performed on the 1-year follow up form	1/01/2024 - 6/30/2024	<u>≥</u> 80%
2) Increase rate of duplex ultrasound completed prior to asymptomatic carotid endarterectomy	01/01/2024 - 6/30/2024	<u>≥</u> 50%
3) Increase the rate of vein mapping before elective lower extremity open bypass	01/01/2024 - 6/30/2024	<u>≥</u> 50%
Additional Measures (102%)		

1) Attest to attending a quality meeting using peer review data	01/01/2024 - 11/15/2024	100%
2) Attest to reports distributed and reviewed at your site per the Participation Agreement	01/01/2024 - 11/15/2024	100%

**Table 3. Tobacco Cessation (PCI and VS) – 102%**

Measure	Measurement Period	Target Performance
Proportion of smokers who receive tobacco cessation treatment  Current smokers (either documented at pre-procedure or discharge; excludes marijuana-only or vaping-only) receive 2/3 of the following: <ul style="list-style-type: none"> <li>• Physician-delivered advice</li> <li>• Nicotine replacement therapy</li> <li>• Referral to tobacco counseling services</li> </ul>	1/01/2024 - 6/30/2024	≥25%

**Table 4. Michigan Structural Heart Consortium (MISHC)\*\***

Measure	Measurement Period	Target Performance
1) Increase referral to cardiac rehabilitation after TAVR*	1/1/2024 – 6/30/2024	≥90%
2) Increase rate of mean gradient documentation at TAVR 1 year follow up	1/1/2024 – 6/30/2024	≥75%
3) Site-specific measure	1/1/2024 – 6/30/2024	Site-specific

\*TAVR = Transcatheter aortic valve replacement

\*\* = MSTCVS affiliated physicians also participate in this CQI and share the same CQI VBR measures/methodology

## VBR selection process

To be eligible for 2024 CQI VBR, the practitioner must:

- 1) Meet performance targets set by the coordinating center
- 2) Be enrolled in a PGIP physician organization by July 5, 2024
- 3) Have contributed data to registry for at least two years and at least one year baseline data

## Are practitioners participating in CQIs eligible for other specialist VBR?

Yes. Specialists are eligible to receive additional VBR if they meet the stated criteria. See the *Specialist VBR fact sheets* for specialty-specific information.

## About the CQI

BMC2 is a Collaborative Quality Initiative made up of three prospective, multicenter registries: Percutaneous Coronary Intervention (PCI), Vascular Surgery (VS), and Michigan Structural Health Consortium (MISHC). Each represents regional collaborative efforts to assess and improve care quality and outcomes:

- 1) **PCI:** The Percutaneous Coronary Intervention Quality Improvement Initiative (BMC2-PCI), launched in 1997 for patients with coronary artery disease undergoing percutaneous coronary intervention.
- 2) **VS:** The Vascular Surgery initiative was launched in 2012 as a multidisciplinary registry for patients with peripheral arterial disease having open abdominal aneurysm repair, endovascular abdominal aneurysm repair, and open bypass procedures of upper and lower extremities. Data is also collected on carotid artery procedures, including carotid artery stenting and carotid endarterectomy.
- 3) **MISHC** is a collaboration between the Michigan Society of Thoracic and Cardiovascular Surgeons CQI (“MSTCVS”) and BMC2 for patients having transcatheter valve procedures.

## About the coordinating center

Michigan Medicine serves as BMC2’s coordinating center to collect and analyze comprehensive clinical data from participating hospitals to identify specific care components associated with better patient outcomes. It uses these analyses to examine practice patterns, generate new knowledge linking processes of care to outcomes, and identify best practices and opportunities to improve quality and efficiency. The center also supports participants in establishing quality improvement goals and in disseminating and implementing best practices, from local to broader communities. Center leadership:

Program director, BMC2-PCI:	Hitinder S. Gurm, MD
Program director, BMC2-VS:	Nicholas H. Osborne, MD
Program co-directors, MISHC:	Stanley Chetcuti, MD, P. Michael Grossman, MD, Himanshu Patel, MD, and Raed Alnajjar MD
Program manager:	Annemarie Forrest, MS, MPH, RN

For more information on the BMC2 and VBR measures, please contact Annemarie Forrest at [avassalo@med.umich.edu](mailto:avassalo@med.umich.edu).

## About the CQI Program

Collaborative Quality Initiatives and Collaborative Process initiatives bring together Michigan physicians and hospital partners to address common and costly areas of medical-surgical care, BCBSM and Blue

Care Network supports this effort and funds each collaborative data registry, that include data on patient risk factors, processes, and outcomes of care. Collection, analysis, and dissemination of such data helps inform participants on best practices. This, in turn, helps increase efficiencies, improve outcomes, and enhance value. For more information, please contact Marc Cohen, Manager, Value Partnerships [mcohen@bcbsm.com](mailto:mcohen@bcbsm.com).

### **About Value Partnerships**

Value Partnerships is a collection of programs among physicians and hospitals across Michigan and Blue Cross, that make health care better for everyone. This unique, collaborative model enables robust data collection and sharing of best practices, so practitioners can improve patient outcomes. It is value and outcomes-based health care -- a movement away from fee-for-service that instead pays practitioners for successfully managing their patient's health. We invite you to visit us at [valuepartnerships.com](http://valuepartnerships.com).

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## Collaborative Quality Initiatives Fact Sheet Value-Based Reimbursement 2025



### Michigan Anticoagulation Quality Improvement Initiative (MAQI2)

The Value Partnerships program at Blue Cross Blue Shield of Michigan (BCBSM) develops and maintains quality programs to align practitioner reimbursement with quality-of-care standards, improve health outcomes and control health care costs. Practitioner reimbursement earned through these quality programs is called value-based reimbursement (VBR). The VBR Fee Schedule sets fees at greater than 100% of the Standard Fee Schedule. VBR opportunities are available to PGIP practitioners who participate in the Michigan Anticoagulation Quality Improvement Initiative (MAQI2), and that meet specific eligibility criteria. The coordinating center clinical leaders, jointly with Blue Cross, set quality and performance metrics for the VBR. Each Collaborative Quality Initiative, or CQI, uses unique measures and population-based scoring to receive BCBSM VBR. The CQI VBR is applied in addition to any other VBR the specialist may be eligible to receive. The CQI VBR applies only to reimbursement associated with commercial PPO BCBSM members. This is an annual incentive program.

#### Population-Based Scoring Methodology

The CQI coordinating center (*not* the physician organization) determines which practitioners have met the appropriate performance targets and notifies Blue Cross. Each physician organization will notify practitioners who will receive CQI VBR, just as the POs do with other forms of specialist VBR. MAQI2 uses an individual practitioner-based scoring model to measure performance, because of the limited number of eligible practitioners participating in this collaborative.

Participants can only receive VBR for one CQI, even if they are participating in more than one CQI, with the following exceptions:

- 1) Practitioners that participate in one of the four population-health based CQIs - INHALE, MCT2D, MIBAC, MIMIND – can receive the related VBR in addition to other CQI VBR
- 2) Practitioners can receive 102% VBR for tobacco cessation in addition to other CQI VBR, but can only receive one tobacco cessation VBR, even if they are eligible for it through multiple CQIs. The tobacco cessation VBR is limited to one reward per practitioner but can be earned in addition to other CQI VBR.

If a practitioner is eligible for rewards through multiple CQIs (those that are not one of the population-health CQIs), the practitioner will be awarded the highest level of CQI VBR.

#### VBR reward opportunities

MAQI2 practitioners are eligible to earn the CQI VBR equivalent to 102%, 103% or 105% of the standard fee schedule (all measured on the hospital level).

- **To be eligible for 102% VBR**, MAQI2 practitioners must achieve the tobacco cessation measure listed in **Table 2 below**.
- **To be eligible for 103% VBR**, MAQI2 practitioners must achieve target on 3 of 4 measures listed in **Table 1 below**.
- **To be eligible for 105% VBR**, MAQI2 practitioners must achieve target on 3 of 4 measures listed in **Table 1 below** *and* the tobacco cessation measure listed in **Table 2 below**.

**Table 1. MAQI2 VBR measures (103%)**

Measure	Measurement Period	Target Performance
Inappropriate aspirin use in warfarin patients	9/01/2023 - 8/31/2024	≤11%
Emergency Department (ED) visit rates for minor bleeds	9/01/2023 - 8/31/2024	<2.3 per 100 patient-year
Extended International Normalized Ratio (INR) testing intervals	9/01/2023 - 8/31/2024	≥80%
Time in Therapeutic Range (TTR)	9/01/2023 - 8/31/2024	≥68%

**Table 2. Tobacco Cessation VBR measure (102%)**

Population	Measure	Measurement Period	Target Performance
Patients enrolling in participating MAQI2 anticoagulation clinics	Smoking is associated with increased risk of blood clotting and can interfere with warfarin. Assess percentage of patients screened for smoking and have smoking status documented in the medical record upon anticoagulation clinic enrollment. Current smokers are asked if interested in quitting, and if so, referred to a smoking cessation program.	9/01/2023 - 8/31/2024	≥96%

### **CQI VBR selection process**

To be eligible for 2025 CQI VBR, the practitioner must:

- 1) Meet the performance targets set by the coordinating center
- 2) Be enrolled in a PGIP physician organization by July 5, 2024
- 3) Have contributed data to the CQI's clinical data registry for at least two years, including at least one year's worth of baseline data.

### **Are practitioners participating in CQIs eligible for other specialist VBR?**

Yes. Specialists are eligible to receive additional VBR if they meet the stated criteria. See the *Specialist VBR fact sheets* for specialty-specific information.

## About the CQI

MAQI2 aims to improve quality of care for patients undergoing anticoagulation therapy and to reduce associated adverse events. It includes a statewide consortium centered around a comprehensive clinical data registry. Such data is analyzed to generate performance reports. These reports reveal information that is used to improve the quality of care for patients receiving ongoing medical management under the guidance of anticoagulation services.

## About the coordinating center

Michigan Medicine serves as the coordinating center for MAQI2 and is responsible for collecting and analyzing comprehensive clinical data from the participating hospitals. It uses these analyses to examine practice patterns, to generate new knowledge linking processes of care to outcomes, and to identify best practices and opportunities to improve quality and efficiency. The Center further supports participants in establishing quality improvement goals and assists them in implementing best practices. MAQI2 leadership:

Program director: James B. Froehlich, MD  
Program director: Geoffrey D. Barnes, MD  
Program manager: Brian Haymart, MS, RN

For more information on MAQI2 and VBR measures, please contact Brian Haymart at [khaymart@umich.edu](mailto:khaymart@umich.edu)

## About the CQI Program

Collaborative Quality Initiatives and Collaborative Process initiatives bring together Michigan physicians and hospital partners to address common and costly areas of medical-surgical care, BCBSM and Blue Care Network supports this effort and funds each collaborative data registry, that include data on patient risk factors, processes, and outcomes of care. Collection, analysis, and dissemination of such data helps inform participants on best practices. This, in turn, helps increase efficiencies, improve outcomes, and enhance value. For more information, please contact Marc Cohen, Manager, Value Partnerships [mcohen@bcbsm.com](mailto:mcohen@bcbsm.com).

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### Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI)

The Value Partnerships program at Blue Cross Blue Shield of Michigan (BCBSM) develops and maintains quality programs to align practitioner reimbursement with quality of care standards, improve health outcomes and control health care costs. Practitioner reimbursement earned through these quality programs is called value-based reimbursement (VBR). The VBR Fee Schedule sets fees at greater than 100% of the Standard Fee Schedule. VBR opportunities are available to PGIP practitioners who participate in the Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI), and that meet specific eligibility criteria. The coordinating center clinical leaders, together with Blue Cross, set quality and performance metrics for the VBR. Each Collaborative Quality Initiative, or CQI, uses unique measures and population-based scoring to receive BCBSM VBR. The CQI VBR is applied in addition to any other VBR the specialist may be eligible to receive. The CQI VBR applies only to reimbursement associated with commercial PPO BCBSM members. This is an annual incentive program.

#### Population-Based Scoring Methodology

The CQI coordinating center (not the physician organization) determines which practitioners have met the appropriate performance targets and notifies Blue Cross. Each physician organization will notify practitioners who will receive CQI VBR, just as the POs do for other forms of specialist VBR.

Participants can only receive VBR for one CQI, even if they are participating in more than one CQI, with the following exceptions:

- 1) Practitioners that participate in one of the four population-health based CQIs - INHALE, MCT2D, MIBAC, MIMIND – can receive the related VBR in addition to other CQI VBR
- 2) Practitioners can receive 102% VBR for tobacco cessation in addition to other CQI VBR, but can only receive one tobacco cessation VBR, even if they are eligible for it through multiple CQIs. The tobacco cessation VBR is limited to one reward per practitioner but can be earned in addition to other CQI VBR.

If a practitioner is eligible for rewards through multiple CQIs (those that are not one of the population-health CQIs), the practitioner will be awarded the highest level of CQI VBR.

#### VBR reward opportunities

MARCQI practitioners are eligible to earn CQI VBR equivalent to 102%, 103%, or 105% of the standard fee schedule. MARCQI uses a hybrid collaborative-wide and individual practitioner methodology to score and reward practitioners.

To be eligible for MARCQI VBR, practitioners must be contributing data to the collaborative for at least 2 years and have at least 20 cases in the data registry while meeting the following scoring criteria:

- **To be eligible for the 102% VBR (see Table 1, 2 & 3 below), practitioners must meet:**
  - **All of the following (see Table 1 below):**
    - Individual surgeon target for measure 1, 2 & 3
  - **2 of 3 of the following (see Table 2 below):**
    - Individual surgeon target for measure 4, 5 & 6
  - **1 of 3 of the following (see Table 3 below):**
    - Collaborative-wide targets for measure 7, 8 & 9
- **To be eligible for 103% CQI VBR (see Table 1, 2 & 3 below), practitioners must meet:**
  - **All of the following (see Table 1 below):**
    - Individual surgeon target for measure 1, 2 & 3
  - **All of the following (see Table 2 below):**
    - Individual surgeon target for measure 4, 5 & 6
  - **2 of 3 of the following (see Table 3 below):**
    - Collaborative-wide targets for measure 7, 8 & 9
- **To be eligible for 105% VBR, MARCQI participating practitioners must meet scoring and performance criteria from ALL Tables listed below.**

## VBR measures

**Table 1. Primary Physician level VBR Measures**

Measure	Measurement Period	Target Performance
1) Surgeon attendance at 3 of 3 site-based quality improvement (QI) meetings	01/01/2024 - 11/15/2024	100%
2) Direct access to clinical office notes to abstract 90-day events for 99% of MARCQI surgeon cases	07/01/2023 - 06/30/2024	100%
3) Share and discuss 2024 MARCQI Individual surgeon level report after downloading from MARCQI data registry with 2 peer orthopaedic surgeons	01/01/2024 - 11/15/2024	100%

**Table 2. Secondary Physician level VBR Measures**

Measure	Measurement Period	Target Performance
4) PROS collection (pre-op & 2-16 weeks post op) completed in > 60% of all performed cases	07/01/2023-06/30/2024	≥60%

5) Surgical site attestation with MARCQI participation plan	01/01/2024 - 11/15/2024	100%
6) Identify quality improvement next steps following 2024 MARCQI Individual surgeon report review	01/01/2024 - 11/15/2024	100%

**Table 3. Collaborative-wide level VBR Measures**

Measure	Measurement Period	Target Performance
7) 90-day hip fracture following total hip arthroplasty (excluding conversions) is reduced by 10% to 1.05%	07/01/2023-06/30/2024	1.05%
8) Post-operative opioid prescribing patterns following total knee arthroplasty for opioid naïve patients at a rate of 85%	07/01/2023-06/30/2024	85%
9) Device utilization data: 92.5% of MARCQI site clinical champions will communicate device outcomes to their site c-suite leadership (and if relevant at the time, their purchasing group) as seen in the MARCQI 2023 Annual Report	01/01/2024 - 11/15/2024	92.5%

### VBR selection process

To be eligible for 2025 CQI VBR, the practitioner must:

- Meet the performance targets set by the coordinating center
- Be enrolled in a PGIP physician organization by July 5, 2024
- Have contributed data to the CQI's clinical data registry for at least two years, including at least one year's worth of baseline data

### Are practitioners participating in CQIs eligible for other specialist VBR?

Yes. Specialists are eligible to receive additional VBR if they meet the stated criteria. See the *Specialist VBR fact sheets* for specialty-specific information.

### About MARCQI

MARCQI is a statewide quality initiative which aims to engage Michigan hospitals and physicians in quality improvement activities for hip and knee joint replacement surgery procedures and reduction of unnecessary costs of this care in the state of Michigan.

### About the coordinating center

Michigan Medicine serves as the coordinating center for MARCQI and is responsible for collecting and analyzing comprehensive clinical data from the participating hospitals. It uses these analyses to examine

practice patterns, to generate new knowledge linking processes of care to outcomes, and to identify best practices and opportunities to improve quality and efficiency. The Center further supports participants in establishing quality improvement goals and assists them in implementing best practices, its leadership:

Program directors: Brian Hallstrom, MD  
Program manager: Tae Kim, MHSA

For more information on MARCQI and VBR measures, please contact Tae Kim at [taekk@med.umich.edu](mailto:taekk@med.umich.edu).

### **About the CQI Program**

Collaborative Quality Initiatives and Collaborative Process initiatives bring together Michigan physicians and hospital partners to address common and costly areas of medical-surgical care, BCBSM and Blue Care Network supports this effort and funds each collaborative data registry, that include data on patient risk factors, processes, and outcomes of care. Collection, analysis, and dissemination of such data helps inform participants on best practices. This, in turn, helps increase efficiencies, improve outcomes, and enhance value. For more information, please contact Marc Cohen, Manager, Value Partnerships [mcohen@bcbsm.com](mailto:mcohen@bcbsm.com).

### **About Value Partnerships**

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## Collaborative Quality Initiatives Fact Sheet Value-Based Reimbursement 2025



### Michigan Bariatric Surgery Collaborative (MBSC)

The Value Partnerships program at Blue Cross Blue Shield of Michigan (BCBSM) develops and maintains quality programs to align practitioner reimbursement with quality of care standards, and to improve health outcomes and control health care costs. Practitioner reimbursement earned in these quality programs is called value-based reimbursement (VBR). The VBR Fee Schedule sets fees at greater than 100% of the Standard Fee Schedule. VBR opportunities are available to PGIP practitioners who participate in the Michigan Bariatric Surgery Collaborative (MBSC), and that meet specific eligibility criteria. The coordinating center clinical leaders, together with Blue Cross, set quality and performance metrics for the VBR. Each Collaborative Quality Initiative, or CQI, uses unique measures and population-based scoring to receive BCBSM VBR. The CQI VBR is applied in addition to any other VBR the specialist may be eligible to receive. The CQI VBR applies only to reimbursement associated with commercial PPO BCBSM members. This is an annual incentive program.

#### Population-Based Scoring Methodology

The CQI coordinating center (not the physician organization) determines which practitioners have met the appropriate performance targets and notifies Blue Cross. Each physician organization will notify practitioners who will receive CQI VBR, just as the POs do for other forms of specialist VBR.

Participants can only receive VBR for one CQI, even if they are participating in more than one CQI, with the following exceptions:

- 1) Practitioners that participate in one of the four population-health based CQIs - INHALE, MCT2D, MIBAC, MIMIND – can receive the related VBR in addition to other CQI VBR
- 2) Practitioners can receive 102% VBR for tobacco cessation in addition to other CQI VBR, but can only receive one tobacco cessation VBR, even if they are eligible for it through multiple CQIs. The tobacco cessation VBR is limited to one reward per practitioner, but can be earned in addition to other CQI VBR.

If a practitioner is eligible for rewards through multiple CQIs (those that are not one of the population-health CQIs), the practitioner will be awarded the highest level of CQI VBR.

## VBR reward opportunities

MBSC practitioners can be eligible to earn CQI VBR equivalent to 102%, 103%, 104%, 105% or 107% of the standard fee schedule.

MBSC uses a combination of collaborative-wide and individual physician scoring to measure performance. To be eligible for MBSC VBR, practitioners must meet the following scoring criteria:

- **To be eligible for 102% CQI VBR, practitioners must meet one of the following:**
  - **Option 1:** Refer to **Table 2** below. Practitioners must achieve target on **2 of 2 measures**.
  - **Option 2:** Refer to **Table 3** below. Practitioners must achieve target on **1 of 1 measure**.
- **To be eligible for 103% CQI VBR** (refer to **Table 1** below), practitioners must achieve target on **3 of 3 measures**.
- **To be eligible for 104% CQI VBR, practitioners must meet both of the following:**
  - 102% CQI VBR from **Table 2** below **and**
  - 102% Tobacco cessation VBR from **Table 3** below
- **To be eligible for 105% CQI VBR practitioners must meet the following:**
  - **Option 1:** Refer to **Table 2** below. Practitioners must achieve target on **2 of 2 measures, or**
  - **Option 2:** Refer to **Table 3** below. Practitioners must achieve target on **1 of 1 measure, and**
  - Meet **3 of 3 measures** in **Table 1** below.
- **To be eligible for 107% CQI VBR practitioners must meet the following:**
  - Achieve **all** measures in **Tables 1, 2 & 3**

**Table 1. Primary VBR Measures (103% VBR)**

Measure	Measurement Period	Target Performance
Reduce 30-day ED visits for bariatric patients' post-surgery. ( <i>surgeon level</i> )	12/1/2023 - 11/30/2024	≤7.4%, or ≥ 5% relative reduction compared to prior year
Improve follow-up rates for Patient Reported Outcomes (PROs) 1-year post-surgery. ( <i>collaborative-wide</i> )	OR dates of 12/1/2022 - 11/30/2023	≥ 67%
Reduce new persistent opioid use to 1.2% ( <i>collaborative-wide</i> )	OR dates of 12/1/2022 – 11/30/2023	1.2%

**Table 2. Secondary VBR Measures (102% VBR)**

Measure	Measurement Period	Target Performance
Improve Post-Discharge VTE Compliance (according to MBSC VTE Calculator) ( <i>collaborative-wide</i> )	OR dates 12/1/2023 to 11/30/2024	≥70% VTE post-discharge compliance rate
Improve follow-up rates for Patient Reported Outcomes (PROs) 1-year post-surgery ( <i>surgeon level</i> )	OR dates of 12/1/2022 - 11/30/2023	≥ 65% in follow-up rate compared to prior year

**Table 3. Tobacco Cessation VBR Measure (102% VBR)**

Measure	Measurement Period	Target Performance
Increase the number of patients where tobacco cessation treatment is offered during a post-surgical visit (collaborative-wide)	OR dates of 12/1/2022- 11/30/2023	> 60% of patients who report tobacco use during first year post-bariatric surgery being offered cessation resources

### VBR selection process

To be eligible for 2025 CQI VBR, the practitioner must:

- Meet the performance targets set by the coordinating center
- Be enrolled in a PGIP physician organization by July 5, 2024
- Have contributed data to the CQI's clinical data registry for at least two years, including at least one year's worth of baseline data

### Are practitioners participating in CQIs eligible for other specialist VBR?

Yes. Specialists are eligible to receive additional VBR if they meet the stated criteria. See the *Specialist VBR fact sheets* for specialty-specific information.

### About MBSC

- Aims are to improve quality of care for patients undergoing bariatric surgery, and advance the science and practice of bariatric surgery, in Michigan and across the country.
- A unique partnership between BCBSM, surgery quality leaders and clinicians from the 41 bariatric surgery programs across the state
- Core pillars are collaborative quality improvement on the collection of detailed clinical data on outcomes and practice; timely, rigorous performance feedback to clinicians; and continuous improvement based on empirical analysis and collaborative learning.

### About the coordinating center

Michigan Medicine serves as the coordinating center for MBSC and is responsible for collecting and analyzing comprehensive clinical data from the participating hospitals. It uses these analyses to examine practice patterns, to generate new knowledge linking processes of care to outcomes, and to identify best practices and opportunities to improve quality and efficiency. The Center further supports participants in establishing quality improvement goals and assists them in implementing best practices. MBSC leadership:

Project directors: Arthur Carlin, MD  
Jonathan Finks, MD  
Program managers: Amanda Stricklen, MS, RN  
Rachel Ross, MS, RN

For more information on MBSC and VBR measures, please contact Amanda Stricklen [aoreilly@med.umich.edu](mailto:aoreilly@med.umich.edu) and Rachel Ross [rachacoo@med.umich.edu](mailto:rachacoo@med.umich.edu).

### **About the CQI Program**

Collaborative Quality Initiatives and Collaborative Process initiatives bring together Michigan physicians and hospital partners to address common and costly areas of medical-surgical care, BCBSM and Blue Care Network supports this effort and funds each collaborative data registry, that include data on patient risk factors, processes, and outcomes of care. Collection, analysis, and dissemination of such data helps inform participants on best practices. This, in turn, helps increase efficiencies, improve outcomes, and enhance value. For more information, please contact Marc Cohen, Manager, Value Partnerships [mcohen@bcbsm.com](mailto:mcohen@bcbsm.com).

### **About Value Partnerships**

Value Partnerships is a collection of programs among physicians and hospitals across Michigan and Blue Cross, that make health care better for everyone. This unique, collaborative model enables robust data collection and sharing of best practices, so practitioners can improve patient outcomes. It is value and outcomes-based health care -- a movement away from fee-for-service that instead pays practitioners for successfully managing their patient's health. We invite you to visit us at [valuepartnerships.com](http://valuepartnerships.com).

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## Collaborative Quality Initiatives Fact Sheet Value-Based Reimbursement 2025



### Michigan Emergency Department Improvement Collaborative (MEDIC)

The Value Partnerships program at Blue Cross Blue Shield of Michigan (BCBSM) develops and maintains quality programs to align practitioner reimbursement with quality of care standards, improve health outcomes and control health care costs. Practitioner reimbursement earned through these quality programs is called value-based reimbursement (VBR). The VBR Fee Schedule sets fees at greater than 100% of the Standard Fee Schedule. VBR opportunities are available to PGIP practitioners who participate in the Michigan Emergency Department Improvement Collaborative (MEDIC). The coordinating center clinical leaders, jointly with Blue Cross, set quality and performance metrics for the VBR. Each Collaborative Quality Initiative, or CQI, uses unique measures and population-based scoring to receive BCBSM VBR. The CQI VBR is applied in addition to any other VBR the specialist may be eligible to receive. The CQI VBR applies only to reimbursement associated with commercial PPO BCBSM members. This is an annual incentive program.

#### Population-Based Scoring Methodology

The CQI coordinating center (*not* the physician organization) determines which practitioners have met the appropriate performance targets and notifies Blue Cross. Each physician organization will notify practitioners who will receive CQI VBR, just as POs do for other forms of specialist VBR.

Participants can only receive VBR for one CQI, even if they are participating in more than one CQI, with the following exceptions:

- 1) Practitioners that participate in one of the four population-health based CQIs - INHALE, MCT2D, MIBAC, MIMIND – can receive the related VBR in addition to other CQI VBR
- 2) Practitioners can receive 102% VBR for tobacco cessation in addition to other CQI VBR, but can only receive one tobacco cessation VBR, even if they are eligible for it through multiple CQIs. The tobacco cessation VBR is limited to one reward per practitioner, but can be earned in addition to other CQI VBR.

If a practitioner is eligible for rewards through multiple CQIs (those that are not one of the population-health CQIs), the practitioner will be awarded the highest level of CQI VBR.

#### VBR reward opportunities

Practitioners can be eligible to earn CQI VBR equivalent to 102%, 103%, 104%, 105% or 107% of the standard fee schedule. To be eligible for MEDIC VBR, practitioners must meet the following scoring criteria:

- **To be eligible for 102% VBR**, practitioners must meet one of the following options:
  - Achieve targets at the **individual practitioner level** on the Secondary VBR measures (**see Table 2 below**), or

- Target at the **hospital level** on the Tobacco Cessation VBR measure (**see Table 3 below**)
- **To be eligible for 103% VBR**, practitioners must achieve target as a **collaborative-wide collective** average on **2 of 2 measures** listed in the Primary VBR measures (**see Table 1 below**).
- **To be eligible for 104% VBR**, practitioners must meet scoring and performance criteria for Secondary VBR (**Table 2**) and Tobacco Cessation VBR (**Table 3**) measures.
- **To be eligible for 105% VBR**, practitioners must meet scoring and performance criteria from Primary VBR measures (**Table 1**) and one of the following:
  - Achieve targets for Secondary VBR (**Table 2**) measures or
  - Achieve target for Tobacco Cessation VBR (**Table 3**) measures
- **To be eligible for 107% VBR**, practitioners must meet scoring criteria for all VBR measures listed below: Primary VBR (**Table 1**), Secondary VBR (**Table 2**), and Tobacco Cessation VBR (**Table 3**).

**Table 1. Primary VBR Measures (103% VBR) – Collaborative-wide performance**

Measure	Measurement Period	Target Performance
1) Utilization of appropriate use of head CT scans for adult minor head injury patients (wording is different from final VBR excel)	9/1/2023 – 8/31/2024	≥ 60%
2) Utilization of head CT scans for intermediate risk pediatric minor head injury patients	9/1/2023 – 8/31/2024	≤ 18%

**Table 2. Secondary VBR measure (102% VBR) – hospital (measure 1-4) and individual practitioner (measure 5) performance**

Measure Participating sites must choose 1 of 4 measures (from the first 4 measures) and meet measure #5	Measurement period	Target performance
1) Utilization of appropriate CT head scans for adult minor head injury	9/1/2023 – 8/31/2024	≥ 60%
2) Utilization of CT head scans for children with intermediate risk minor head injury	9/1/2023 – 8/31/2024	≤ 18%
3) Utilization of Chest X-ray for children with asthma, bronchiolitis, and croup	9/1/2023 – 8/31/2024	≤ 25%
4) Diagnostic yield of CTs for suspected pulmonary embolism in adult patients	9/1/2023 – 8/31/2024	≥ 8.5%
5) Individual Physician Engagement with MEDIC Registry – Physicians must complete both individual improvement tasks. 1 - register for a MEDIC Registry account. 2 - Submit their performance on the measure chosen by their site (3,4,5, or 6) once during the second half of the VBR performance period (3/1/2024 - 8/31/2024).	3/1/2024 – 8/31/2024	Complete tasks listed

**Table 3. Tobacco Cessation VBR measure (102% VBR) – Hospital level performance**

Measure	Measurement Period	Target Performance
Site Specific Tobacco Cessation Program*	9/1/2023 – 8/31/2024	> 10% Cessation offered on patients with COPD

\*Hospital sites must submit tobacco status and cessation counseling or referral status for all patients. Sites must also have one calendar month where they refer tobacco cessation counseling on more than 10% of COPD patients.

### **VBR selection process**

To be eligible for 2025 CQI VBR, the practitioner must:

- Meet the performance targets set by the coordinating center
- Be enrolled in a PGIP physician organization by July 5, 2024
- Have contributed data to the CQI's clinical data registry for at least two years, including at least one year's worth of baseline data.

### **Are practitioners participating in CQIs eligible for other specialist VBR?**

Yes. Specialists are eligible to receive additional VBR if they meet the stated criteria. See the *Specialist VBR fact sheets* for specialty-specific information.

### **About MEDIC:**

- An integrated adult and pediatric, emergency physician-led, hospital-based CQI advances the science to improve quality of care and patient outcomes in emergency room care across the
- Comprehensive as it encompasses the full spectrum of care across diverse emergency department settings;
- Dedicated to measuring, evaluating, and enhancing the quality and outcomes of patients seeking care in emergency departments;
- Effective in improving the quality and cost-efficiency of emergency care in the state of Michigan.

### **About the coordinating center**

Michigan Medicine serves as the coordinating center for MEDIC and is responsible for collecting and analyzing comprehensive clinical data from the participating hospitals. It uses these analyses to examine practice patterns, to generate new knowledge linking processes of care to outcomes, and to identify best practices and opportunities to improve quality and efficiency. The Center further supports participants in establishing quality improvement goals and assists them in implementing best practices. MEDIC leadership:

Project director: Keith Kocher, MD, MPH  
Project director, Pediatrics: Michele Nypaver, MD  
Program manager: Andy Scott, MHSA, MSE

For more information on MEDIC and VBR measures, contact Andy Scott at [afscott@med.umich.edu](mailto:afscott@med.umich.edu).

### **About the CQI Program**

Collaborative Quality Initiatives and Collaborative Process initiatives bring together Michigan physicians and hospital partners to address common and costly areas of medical-surgical care, BCBSM and Blue Care Network supports this effort and funds each collaborative data registry, that include data on patient risk factors, processes, and outcomes of care. Collection, analysis, and dissemination of such data helps inform participants on best practices. This, in turn, helps increase efficiencies, improve outcomes, and enhance value. For more information, please contact Marc Cohen, Manager, Value Partnerships [mcohen@bcbsm.com](mailto:mcohen@bcbsm.com).

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## Collaborative Quality Initiatives Fact Sheet Value-Based Reimbursement 2025



### Michigan Hospital Medicine Safety (HMS) Consortium

The Value Partnerships program at Blue Cross develops and maintains quality programs to align practitioner reimbursement with quality-of-care standards, improve health outcomes and control health care costs. Practitioner reimbursement earned through these quality programs is referred to as value-based reimbursement, (VBR). The VBR Fee Schedule sets fees at greater than 100% of the Standard Fee Schedule. VBR opportunities are available to PGIP practitioners who participate in the Michigan Hospital Medicine Safety Consortium, also known as HMS. The HMS collaborative, in collaboration with Blue Cross, developed quality and performance metrics for HMS's value-based reimbursement. Each participating CQI uses unique measures and population-based scoring methods to best fit their collaborative for value-based reimbursement. The CQI VBR is applied in addition to any other VBR the specialist may be eligible to receive. The CQI VBR applies only to reimbursement associated with commercial PPO BCBSM members. This is an annual incentive program.

#### Population-Based Scoring Methodology

The CQI coordinating center (*not* the physician organization) determines which practitioners have met the appropriate performance targets and notifies Blue Cross. Each physician organization will notify practitioners who will receive CQI VBR, just as the PO does for other forms of specialist VBR.

Participants are scored on CQI performance measures according to the methodologies developed by each respective CQI and are eligible for CQI VBR of 103%, of the standard fee schedule if they meet performance targets in one or more of those initiatives.

Participants can only receive VBR for one CQI, even if they are participating in more than one CQI, with the following exceptions:

- 1) Practitioners that participate in one of the four population-health based CQIs - INHALE, MCT2D, MIBAC, MIMIND – can receive the related VBR in addition to other CQI VBR
- 2) Practitioners can receive 102% VBR for tobacco cessation in addition to other CQI VBR, but can only receive one tobacco cessation VBR, even if they are eligible for it through multiple CQIs. The tobacco cessation VBR is limited to one reward per practitioner but can be earned in addition to other CQI VBR.

If a practitioner is eligible for rewards through multiple CQIs (those that are not one of the population-health CQIs), the practitioner will be awarded the highest level of CQI VBR.

## VBR Reward Opportunities

HMS will group physicians by their participating hospital and all physicians will be assessed based on the hospital score. There are two types of hospital measures, performance, and participation. Performance measures are based on the average of all providers using an adjusted scoring methodology. Participation measures are based on attendance at meetings. For 2025 VBR, one critical care physician from each hospital is required to attend the 3 special population workgroups during the 2024 calendar year to meet the performance target for the hospital.

Practitioners can be eligible to earn CQI VBR equivalent to 103% of the standard fee schedule. To be eligible for HMS VBR, practitioners must meet the following scoring criteria:

- **To be eligible for 103% VBR**, practitioners must meet one of the following:
  - Hospitalists and Infectious Diseases Physicians must achieve target on 1 of 1 measure in the table below
  - Critical Care Physicians must achieve target on 2 of 2 measures in the table below

The collective average for each group of hospital-affiliated physicians must achieve either one of the following conditions to be eligible for the 103% of the standard fee schedule:

## VBR Measures

Measure	Population Based Scoring Methodology	Measurement Period	Target Performance
<b>Specialty: Hospitalists and Infectious Diseases Physicians*</b>			
<small>*Infectious Diseases Physicians participating in Antimicrobial Stewardship Team</small>			
1. Increase Use of 5 Days of Antibiotic Treatment in Uncomplicated CAP (i.e. reduce excess durations)	Hospital	Q3 2023 Performance: 6/22/2024 - 9/13/2024  Patient Discharges: 5/9/2024 - 7/31/2024	≥70%
<b>Specialty: Critical Care Physicians</b>			
2. Participate in special population workgroup - Critical Care	Hospital	Calendar year 2023 - attendance at meetings	Critical Care Physician attends 3/3 special population workgroup meetings per year
3. Reduce triple lumen PICCs in Critical Care Patients	Hospital	Q1 - 3 2023 Performance: 12/23/2023 - 9/13/2024  PICC/Midline Placements 11/9/2023 - 7/31/2024	≤30%

## VBR selection process

To be eligible for 2025 CQI VBR, the practitioner must:

- Meet the performance targets set by the coordinating center
- Be enrolled in a PGIP physician organization by July 5, 2024
- Submit NPI number to the HMS Coordinating Center via the HMS Semi-Annual Fall QI Survey

## Are practitioners participating in CQIs eligible for other specialist VBR?

Yes. Specialists are eligible to receive additional VBR if they meet the stated criteria. See the *Specialist VBR fact sheets* for specialty-specific information.

*For more detailed information about PGIP, including VBR selection or the methodology, please contact your PGIP physician organization. If you have other questions, please contact your provider consultant.*

## How will the Physician NPI's for each provider specialty be obtained?

HMS collects data on a sample of patients at each hospital and therefore do not collect provider specific data. Each Fall in our HMS semi-annual quality improvement (QI) survey we will ask hospital participants to provide a list of physician NPI's for each specialty provider who have practiced (or billed) at your hospital within the measurement period. Additionally, we will require that the physician champion for each hospital attest to the list of names provided in the survey. If a hospital does not provide the NPI's, even if the hospital meets the measure, their affiliated practitioners will not be eligible for the VBR reward.

## About the HMS CQI

The Michigan Hospital Medicine Safety Consortium (HMS) was established in 2010. HMS is a data-driven collaborative is comprised of hospitals across Michigan. The goal of the consortium is to improve the quality of care for hospitalized medical patients who are at risk for adverse events. The Collaborative currently focused on 3 main initiatives including improving appropriate vascular device use, specifically peripherally inserted central catheters and midlines, appropriate antimicrobial use and improving care and outcomes for patients hospitalized with Sepsis.

Today, HMS encompasses 69 hospitals working in collaboration with multiple stakeholders responsible for the care of any given hospitalized medical patient. Currently, HMS is comprised of hospitalists, general internists, infectious diseases physicians, pharmacists, vascular access nursing teams, interventional radiologists, emergency medicine physicians, critical care physicians, infection preventionists, nursing, hospital leaders, and a patient advocate. This multidisciplinary approach ensures all relevant perspectives are incorporated into our improvement efforts and that our solutions are workable for all team members and thus sustainable across diverse care settings.

## About the Coordinating Center

Michigan Medicine serves as the Coordinating Center for HMS and is responsible for collecting and analyzing comprehensive clinical data from the participating hospitals. It uses these analyses to examine

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practice patterns, to generate new knowledge linking processes of care to outcomes, and to identify best practices and opportunities to improve quality and efficiency. The center also supports participants in establishing quality improvement goals and in disseminating and implementing best practices. Center leadership:

- Scott Flanders, MD, Chief Clinical Strategy Officer for Michigan Medicine, Vice Chair of External Relations in the Department of Internal Medicine, and hospitalist in the Division of Hospital Medicine serves as a Program Director.
- Elizabeth McLaughlin, MS, RN serves as Program Manager.
- Tawny Czilok, MHI, BSN, RN serves as Assistant Program Manager

For detailed information regarding the HMS CQI and specific details to the measures and methodology of HMS VBR, please contact Elizabeth McLaughlin, MS, RN at [emcnair@med.umich.edu](mailto:emcnair@med.umich.edu).

#### **About the CQI Program**

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## Collaborative Quality Initiatives Fact Sheet Value-Based Reimbursement 2025



### Michigan Oncology Quality Consortium (MOQC)

The Value Partnerships program at Blue Cross Blue Shield of Michigan (BCBSM) develops and maintains quality programs to align practitioner reimbursement with quality-of-care standards, improve health outcomes, and control health care costs. Practitioner reimbursement earned through these quality programs is called value-based reimbursement (VBR). The VBR Fee Schedule sets fees at greater than 100% of the Standard Fee Schedule. VBR opportunities are available to PGIP practitioners who participate in the Michigan Oncology Quality Consortium (MOQC), and that meet specific eligibility criteria. The coordinating center clinical leaders, jointly with Blue Cross, set quality and performance metrics for the VBR. Each Collaborative Quality Initiative, or CQI, uses unique measures and population-based scoring to receive BCBSM VBR. The CQI VBR is applied in addition to any other VBR the specialist may be eligible to receive. The CQI VBR applies only to reimbursement associated with commercial PPO BCBSM members. This is an annual incentive program.

#### Population-Based Scoring Methodology

The CQI coordinating center (*not* the physician organization) determines which practitioners have met the appropriate performance targets and notifies Blue Cross. Each physician organization will notify practitioners who will receive CQI VBR, just as the POs do for other forms of specialist VBR.

Participants can only receive VBR for one CQI, even if they are participating in more than one CQI, with the following exceptions:

- 1) Practitioners that participate in one of the four population-health based CQIs - INHALE, MCT2D, MIBAC, MIMIND – can receive the related VBR in addition to other CQI VBR
- 2) Practitioners can receive 102% VBR for tobacco cessation in addition to other CQI VBR, but can only receive one tobacco cessation VBR, even if they are eligible for it through multiple CQIs. The tobacco cessation VBR is limited to one reward per practitioner but can be earned in addition to other CQI VBR.

If a practitioner is eligible for rewards through multiple CQIs (those that are not one of the population-health CQIs), the practitioner will be awarded the highest level of CQI VBR.

MOQC applies a combination of collaborative-wide, regional, and practice-based scoring models to measure and reward VBR:

- Tobacco Cessation (TC) VBR measures, performance is measured at a collaborative-wide collective average
- Medical oncology VBR measures, performance is measured at the regional levels. These practitioners are grouped by their participating region as designated by the consortium and then measured as a regional collective average.
- Gynecologic oncology VBR measures, performance is measured collective-wide for gynecologic oncology practices in aggregate
- MOQC Certification VBR for medical oncology practices, measured at the practice level

There is one VBR opportunity open to both medical oncology and gynecologic oncology, using different criteria for each group, that is measured at the practice level.

### VBR reward opportunities

MOQC practitioners are scored on CQI performance measures and are eligible for CQI VBR for one of the following permutations if they meet performance targets in one or more MOQC initiatives: 102%, 103%, 104%, 105%, or 107% of the standard fee schedule.

In addition, oncology practices that are participating in POEM (Pharmacists Optimizing Oncology Care Excellence in Michigan), an embedded clinical pharmacy model in partnership with Michigan Institute for Care Management and Transformation (MICMT), may be eligible for an additional VBR equal to 115% (known as the POEM VBR) of the standard fee schedule. POEM practices must have identified a physician champion, confirmed a sufficient patient volume for the targeted population(s), signed the participation agreement with POEM, and begun recruitment of an embedded pharmacist to be eligible. MOQC participants can earn the POEM VBR in addition to one of the other VBR permutations listed above. The combined potential VBR earned for MOQC/POEM participants is up to 122% of the standard fee schedule.

MOQC practitioners are eligible for one of the following VBR combinations:

VBR %	102% TC	102%	102%	104%	103%		105%		107%	
<b>Type of VBR</b>	Tobacco Cessation	CQI VBR Additional	CQI VBR Additional	Tobacco Cessation + CQI VBR Additional	CQI VBR	CQI VBR	CQI VBR + CQI VBR Additional	CQI VBR + CQI VBR Additional	CQI VBR+CQI VBR Additional + Tobacco	CQI VBR + CQI VBR Additional + Tobacco
<b>Who It Applies to</b>	Med Oncs and Gyn Oncs	Med Oncs	Gyn Oncs	Med Oncs and Gyn Oncs	Med Oncs	Gyn Oncs	Med Oncs	Gyn Oncs	Med Oncs	Gyn Oncs
<b>Criteria</b>	Meet the 1 measure	Meet 5 of 5 measures	Meet 2 of 2 for gyn-onc measures in Table 3 AND meet complete family history measure	Meet tobacco cessation criteria AND CQI Additional criteria	Meet 4 of 5 measures	Meet 2 of 2 measures	Meet criteria for CQI 103% at (regional level) AND meet criteria for CQI 102% (at practice level)	Meet criteria for CQI 103% at (regional level) AND meet criteria for CQI 102% (at practice level) AND complete family history measure (at practice level)	Meet criteria for CQI 103% at (regional level) AND meet criteria for CQI 102% (at practice level) AND collaborative meets criteria for TC	Meet criteria for CQI 103% at (regional level) AND meet criteria for CQI 102% (at practice level) AND collaborative meets criteria for TC
<b>Table</b>	Table 4	Table 1a	Table 3	Tables 1a, 3 and 4	Table 1	Table 2	Table 1 and Table 1a	Table 2 + Table 3	Table 1 + Table 1a + Table 4	Table 2 + Table 3 + Table 4
<b>Measurement Level</b>	Collaborative-Wide	Practice	Practice	Both Collaborative-Wide and Practice	Regional	Gyn-Onc Collective-Wide	Both Regional and Practice	Both Collective-Wide and Practice	Collaborative-Wide, Regional and Practice	Gyn-Onc Collective-Wide, Collaborative-Wide and Practice

- **To be eligible for 115% POEM VBR**, the MOQC practitioners must participate in the POEM program.

- To be eligible for one of the following VBR permutations – 117%, 118%, 119%, 120%, or 122% - practitioners must be participating in the POEM (115% VBR) *and* achieve one of the VBR listed above (102%, 103%, 104%, 105%, 107%).

## VBR Measures

**Table 1. 103% VBR Medical oncology measures (at regional level)**

Measure	Measurement Period	Target
1. NK1RA and olanzapine administered with Cycle 1 high emetic risk chemotherapy	11/1/2023 - 10/31/2024	55%
2. NK1RA administered for low or moderate emetic risk Cycle 1 chemotherapy (lower score = better)	11/1/2023 - 10/31/2024	10%
3. Hospice enrollment	11/1/2023 - 10/31/2024	65%
4. Hospice enrollment more than 7 days before death	11/1/2023 - 10/31/2024	60%
5. Complete family history documented for patients with invasive cancer	11/1/2023 - 10/31/2024	40%

**Table 1a. Additional 102% VBR Medical Oncology measure (practice level)**

Measure	Measurement Period	Target
1. Medical oncology practices meet 5 of 5 measures on 103% table at <b>practice</b> level	11/1/2023 - 10/31/24	Targets in 103% table

**Table 2. 103% VBR Gynecologic oncology measures (collaborative-wide)**

Measure	Measurement Period	Target
1. Decrease outpatient prescribing of opioids after laparoscopic or open hysterectomy	11/1/2023 - 10/31/24	9 pills or fewer
2, Days from debulking surgery to chemotherapy start for ovarian cancer	11/1/2023 - 12/31/24	28 days or less

**Table 3. Additional 102% VBR Gynecologic oncology measures (practice level)**

Measure	Measurement Period	Target
Gynecologic oncology practices meet 2 of 2 measures in Table 2 <b>and</b> Complete family history documented for patients with invasive cancer at practice level	11/1/2023 - 10/31/24	Targets in 103% table

**Table 4. 102% VBR Tobacco Cessation medical & gynecologic oncology measure (collaborative-wide)**

Measure	Measurement Period	Target
Tobacco cessation counseling administered or patient referred in past year	11/1/2023 - 10/31/24	75%

## **MOQC Certification Pathway VBR**

Practices that meet measurement criteria and targets for MOQC Certification will be eligible to earn a VBR of 112%. The MOQC certification VBR would **replace** the standard MOQC VBR opportunities of either 102%, 103%, 104%, 105%, and 107% as described above.

Please note that If MOQC certification is not achieved, the oncologist still has the opportunity to be rewarded for the other standard MOQC VBR opportunities mentioned above.

MOQC participants that qualify for certification that also participate in POEM are eligible to receive a total maximum of **127% VBR** (MOQC Certification 112% VBR + POEM 115% VBR = 127% VBR) – in addition to other specialist VBR available to oncologists.

A practice pursuing MOQC certification must meet the following requirements:

- Meet targets for 80% or more of the measures in the set of MOQC Certification Measures in Table 5.
- Submit an equity action plan by 6/30/2024 (based on data provided from previous years)
- Schedule a site visit for evaluation on the Site Visit Criteria below or have current QOPI® certification

**Table 5. 112% MOQC Certification Medical Oncology Measures – Measured at Practice-Level**

<b>Measure</b>	<b>Measurement Period</b>	<b>Target</b>
1. Use of a 4-drug combination of antiemetic agents in patients on high emetic risk chemotherapy	1/1/2024-10/31/2024	55%
2. GCSF (Granulocyte colony stimulating factor) administered to patients who received chemotherapy for non-curative intent (lower score = better)	1/1/2024-10/31/2024	10%
3. Beginning a new anti-cancer regimen within 14 days of death (lower score = better)	1/1/2024-10/31/2024	30%
4. NK1 receptor antagonist administered for low or moderate emetic risk cycle 1 chemotherapy (lower score = better)	1/1/2024-10/31/2024	10%
5. Hospice enrollment more than 30 days before death	1/1/2024-10/31/2024	20%
6. Palliative care consultation more than 90 days before death	1/1/2024-10/31/2024	25%
7. Tobacco cessation counseling for tobacco users once a year	1/1/2024-10/31/2024	75%
8. Designated advocate documented on a legally recognized document in the inpatient or outpatient medical record	1/1/2024-10/31/2024	20%
9. Days from debulking surgery to chemotherapy (gynecologic oncology only)	1/1/2024-10/31/2024	28 or less
10. Median opioid prescribing (measured as oxycodone tablets, equivalent) following surgical procedure (gynecologic oncology only)	1/1/2024-10/31/2024	9 pills or less

## Certification Site Visit Criteria

Sources of data will include medical record review by MOQC abstractors of 20 randomly selected charts of patients who received chemotherapy, in person site visits, and preparatory surveys and documentation.

<b>Table 6. Certification Site Visit Criteria</b>		Preparatory to Site Visit		Site Visit	Medical record review
<b>Requirement</b>		Shared documents	Survey		
1)	The healthcare setting has policies to define the qualifications of clinical staff who order, prepare, and administer anticancer therapy.	x			
2)	Orders for chemotherapy are signed and scanned manually into the EMR or by using electronic approval by licensed independent practitioners who are determined to be qualified by the healthcare setting.				x
3)	Anticancer therapy is prepared by a licensed pharmacist, pharmacy technician, physician, or registered nurse with documented comprehensive treatment preparation education, initial training and annual continuing education and competency validation as required by the certifying agency.		x	x	
4)	Anticancer therapy is administered by a qualified physician, physician assistant, registered nurse or advanced practice nurse with documented comprehensive chemotherapy administration education, initial training, and annual continuing education as well as competency validation.		x	x	
5)	At least one clinical staff member (RN, MD, DO, APP) who maintains current certification from a nationally accredited course in (age appropriate) basic life support is present during anticancer therapy administration.	x			
6)	Pathologic confirmation or verification of initial diagnosis on a pathology report in the medical record				x
7)	Initial cancer stage or current cancer status				x
8)	Complete medical history and physical examination. An exception to the requirement for a physical examination will be made if the initial consultation is performed virtually.				x
9)	Pregnancy status for people who can become pregnant				x

<b>Table 6. Certification Site Visit Criteria</b>	Preparatory to Site Visit		Site Visit	Medical record review
10) Presence or absence of allergies and history of other hypersensitivity reactions				x
11) Assessment of the patient's and/or caregiver's comprehension of information regarding the disease and the treatment plan.				x
12) Initial psychosocial assessment using an instrument such as the NCCN distress thermometer, with action taken when indicated (based on the threshold for intervention of the assessment tool)				x
13) The anticancer therapy treatment plan includes the patient diagnosis, drugs, doses, anticipated duration, and goals of therapy				x
14) The planned frequency of office visits and patient monitoring are appropriate for the individual anticancer agents				x
<p><b>15) Before chemotherapy is given (no more than 4 days before each treatment), the following are documented.</b></p> <ol style="list-style-type: none"> <li>1. Functional status and/or performance status (ECOG, Karnofsky, WHO)</li> <li>2. Vital signs</li> <li>3. Weight is measured at least weekly when present in the healthcare setting</li> <li>4. Height is measured in the practice before starting treatment and yearly while on treatment. For children, height must be measured at least weekly when present in the healthcare setting</li> <li>5. For people who can become pregnant, negative qualitative pregnancy test completed on or before day 1 of each cycle of chemotherapy or at least monthly.</li> <li>6. Allergies, previous treatment related reactions</li> <li>7. Treatment toxicities</li> <li>8. Pain assessment</li> <li>9. Patient medications are updated and reviewed by a practitioner when a change occurs</li> <li>10. Staff assesses and documents psychosocial concerns and need for support with each cycle or more frequently with action taken when indicated.</li> </ol>	x	x		x
<p><b>16) Policy for obtaining consent</b></p> <p>The healthcare setting has a policy that documents a standardized process for obtaining and documenting consent or assent before beginning anticancer therapy. Informed consent and assent (optional) are documented before initiation of each regimen.</p>	x			
	x	x	x	

<b>Table 6. Certification Site Visit Criteria</b>	Preparatory to Site Visit		Site Visit	Medical record review
<p><b>17) Financial resources for patients and caregivers</b></p> <p>The healthcare setting provides information about financial resources and refers patients and caregivers to psychosocial and other cancer support services. MOQC will make financial navigators available for practices who wish to use the MOQC financial navigators.</p>				
<p><b>18) Emergency access</b></p> <p>The healthcare setting has a policy that identifies a process to provide 24/7 triage to a practitioner, for example, on-call practitioners or emergency department, to manage treatment-related toxicities and emergencies. If the patient's initial contact is not a practitioner from the treating healthcare setting, the person having initial patient contact must have continuous access to consultation from an experienced oncology practitioner and the opportunity for transfer of the patient to a facility with dedicated oncology services. Practices in rural low population areas should consult with MOQC Coordinating Center if unable to comply with the standard.</p>	x	x		
<p><b>19) Provision of information to patients and caregivers</b></p> <p>Patients and caregivers are provided with comprehensive verbal and written or electronic information as part of an education process before starting each treatment plan in the patient and caregiver language of care. The MOQC Coordinating Center will provide translated educational resources. The education process will be tailored to the patient's and caregiver's learning needs, abilities, preferences, and readiness to learn as assessed and documented prior to treatment. Education includes family, caregivers, or others based on the patient's ability to assume responsibility for managing therapy. Patient education materials should be appropriate for the patient's reading level/literacy and patient/caregiver understanding and given in the language of care of the patient/caregiver. As above, the MOQC Coordinating Center will provide educational materials in the languages of care in our MOQC practices. Documentation should include patient feedback reflecting understanding and engagement. Documentation that written or electronic educational materials were given to patients and/or caregivers.</p>			x	x
<p><b>20) Educational information includes all the following</b></p> <ol style="list-style-type: none"> <li>1. Diagnosis</li> <li>2. Goals of treatment (cure, prolong life, reduce symptoms)</li> <li>3. Planned duration of treatment, schedule of treatment administration</li> <li>4. Drug names and supportive medications, drug-drug and drug-food interactions, and plan for missed doses</li> <li>5. Potential long and short-term side effects of therapy, including infertility risks for appropriate patients</li> <li>6. Symptoms or adverse effects that require the patient to contact the healthcare setting or seek immediate attention</li> </ol>			x	x

<b>Table 6. Certification Site Visit Criteria</b>	Preparatory to Site Visit		Site Visit	Medical record review
7. Procedures for handling medications in the home, including storage, safe handling, and management of unused medication 8. Procedures for handling body secretions and waste in the home 9. Follow-up plans, including laboratory and provider visits 10. The healthcare setting's contact information with availability and instructions on when and whom to call 11. Expectations for rescheduling or cancelling appointments 12. Information about advance care directives and how to assign a legally recognized documented designated decision maker				
<b>21) Chemotherapy ordering, preparing, dispensing, and administering</b> Chemotherapy orders include the following elements: 1. Patient name 2. A second patient identifier 3. Date the order is written 4. Regimen or protocol name and number using full generic names 5. Cycle number and day, when applicable 6. Drug dose is written following standards for abbreviations, trailing zeros, and leading zeros 7. The dose calculation 8. Date of administration 9. Route of administration 10. Allergies 11. Supportive care treatments appropriate for the regimen (including premedications, hydration, growth factors, and hypersensitivity medications) 12. Parameters that would require holding or modifying the dose (e.g., lab values, diagnostic test results, and patient's clinical status) 13. Sequencing of drug administration when applicable 14. Rate of drug administration, when applicable 15. An explanation of time limitation, such as the number of cycles for which the order is valid 16. Name of prescribing provider				x
<b>22) Before preparation</b> , a second person – a practitioner or other personnel approved by the healthcare setting to prepare or administer anticancer therapy → <b>independently verifies the following</b> : 1. Two patient identifiers 2. Drug name 3. Drug dose 4. Route of administration 5. Rate of administration 6. The calculation for dosing, including the variables used in this calculation 7. Treatment cycle and day of cycle			x	

<b>Table 6. Certification Site Visit Criteria</b>	Preparatory to Site Visit		Site Visit	Medical record review
<p>23) <b>Upon preparation</b>, a second person approved by the healthcare setting to prepare parenteral chemotherapy <b>verifies</b></p> <ol style="list-style-type: none"> <li>1. The drug vial(s)</li> <li>2. Concentration</li> <li>3. Drug volume or weight</li> <li>4. Diluent type and volume, when applicable</li> <li>5. Administration fluid type, volume, and tubing</li> </ol>			x	
<p>24) <b>Anticancer agents are labeled immediately</b> upon preparation and labels include the following elements</p> <ol style="list-style-type: none"> <li>1. Patient's name</li> <li>2. A second patient identifier</li> <li>3. Full generic drug name</li> <li>4. Drug dose</li> <li>5. Drug administration route</li> <li>6. Total volume required to administer the drug</li> <li>7. Date the medication is to be administered</li> <li>8. Expiration dates/times</li> <li>9. When dose is divided, the total number of products to be given and the individual product sequence</li> <li>10. A warning or precautionary label or sticker, as applicable, to storage and handling; may be included within the label or on an auxiliary label</li> </ol>			x	
<p>25) <b>Intrathecal medications are:</b></p> <ol style="list-style-type: none"> <li>1. Prepared separately</li> <li>2. Stored in an isolated container or location after preparation</li> <li>3. Labeled with a uniquely identifiable intrathecal medication label</li> <li>4. Delivered to the patient only with other medication intended for administration into the CNS</li> <li>5. Administered immediately after a time out double check procedure involving two licensed practitioners or other personnel approved by the healthcare setting to prepare or administer anticancer therapy</li> <li>6. Intravenous vinca alkaloids are administered only by infusion</li> </ol>			x	
<p>26) <b>Before initiation of each anticancer therapy administration cycle</b>, the practitioner who is administering the therapy confirms the treatment with the patient</p> <p>Name of the drug</p> <ol style="list-style-type: none"> <li>1. Infusion time</li> <li>2. Route of administration</li> <li>3. Infusion-related symptoms to report—for example, but not limited to, hypersensitivity symptoms or pain during infusion</li> </ol>			x	
<p>27) <b>Before administration of anticancer therapy:</b> At least two individuals, in the presence of the patient, verify the patient identification using at least two identifiers</p>			x	

<b>Table 6. Certification Site Visit Criteria</b>	Preparatory to Site Visit		Site Visit	Medical record review
<p><b>28) Before each administration</b>, at least two practitioners approved by the healthcare setting to administer or prepare anticancer therapy verify and document the accuracy of the following elements:</p> <ol style="list-style-type: none"> <li>1. Drug name</li> <li>2. Drug dose</li> <li>3. Infusion volume or drug volume when prepared in a syringe</li> <li>4. Rate of administration</li> <li>5. Route of administration</li> <li>6. Expiration dates/times</li> <li>7. Appearance and physical integrity of the drugs</li> <li>8. Rate set on infusion pump, when used</li> <li>9. Sequencing of drug administration</li> <li>10. Documentation of the patient's clinical status during and upon completion of treatment</li> <li>11. Extravasation management procedures are defined and align with current literature and guidelines; antidote order sets and antidotes are accessible within the appropriate timeframe</li> </ol>			x	

## VBR selection process

To be eligible for 2025 CQI VBR, the practitioner must:

- 1) Meet the performance targets set by the coordinating center
- 2) Be enrolled in a PGIIP physician organization by July 5, 2024
- 3) Have contributed data to the CQI's clinical data registry for at least two years, including at least one year's worth of baseline data

## Are practitioners participating in CQIs eligible for other specialist VBR?

Yes. Specialists are eligible to receive additional VBR if they meet the stated criteria. See the *Specialist VBR fact sheets* for specialty-specific information.

## About MOQC

The goal of the Michigan Oncology Quality Consortium program is to promote high-quality, effective, and cost-efficient care for cancer patients through an oncologist-led, practice-based quality collaborative that promotes excellence in cancer care by helping practices create a culture of self-examination and improvement. MOQC's approach to improving cancer care includes measurement, feedback, and resources for medical oncology practices and the patients, families, and communities they serve. MOQC was launched in January 2010.

## About the coordinating center

Michigan Medicine serves as the coordinating center for MOQC and is responsible for collecting and analyzing comprehensive clinical data from the participating hospitals. It uses these analyses to examine practice patterns, to generate new knowledge linking processes of care to outcomes, and to identify best practices and opportunities to improve quality and efficiency. The Center further supports participants in establishing quality improvement goals and assists them in implementing best practices. MOQC Leaders:

Program Director:	Jennifer Griggs, MD, MPH
Program Manager:	Keli DeVries, LMSW

For more information on MOQC and VBR measures, contact the Coordinating Center at [moqc@moqc.org](mailto:moqc@moqc.org).

### About the CQI Program

Collaborative Quality Initiatives and Collaborative Process initiatives bring together Michigan physicians and hospital partners to address common and costly areas of medical-surgical care, BCBSM and Blue Care Network supports this effort and funds each collaborative data registry, that include data on patient risk factors, processes, and outcomes of care. Collection, analysis, and dissemination of such data helps inform participants on best practices. This, in turn, helps increase efficiencies, improve outcomes, and enhance value. For more information, please contact Marc Cohen, Manager, Value Partnerships [mcohen@bcbsm.com](mailto:mcohen@bcbsm.com).

### About Value Partnerships

Value Partnerships is a collection of programs among physicians and hospitals across Michigan and Blue Cross, that make health care better for everyone. This unique, collaborative model enables robust data collection and sharing of best practices, so practitioners can improve patient outcomes. It is value and outcomes-based health care -- a movement away from fee-for-service that instead pays practitioners for successfully managing their patient's health. We invite you to visit us at [valuepartnerships.com](http://valuepartnerships.com).

## Collaborative Quality Initiatives Fact Sheet Value-Based Reimbursement 2025



### Michigan Radiation Oncology Quality Consortium (MROQC)

The Value Partnerships program at Blue Cross Blue Shield of Michigan (BCBSM) develops and maintains quality programs to align practitioner reimbursement with quality of care standards, improve health outcomes and control health care costs. Practitioner reimbursement earned through these quality programs is called value-based reimbursement (VBR). The VBR Fee Schedule sets fees at greater than 100% of the Standard Fee Schedule. VBR opportunities are available to PGP practitioners who participate in the Michigan Radiation Oncology Quality Consortium (MROQC), and that meet specific eligibility criteria. The coordinating center clinical leaders, jointly with Blue Cross, set quality and performance metrics for the VBR. Each Collaborative Quality Initiative, or CQI, uses unique measures and population-based scoring to receive BCBSM VBR. The CQI VBR is applied in addition to any other VBR the specialist may be eligible to receive. The CQI VBR applies only to reimbursement associated with commercial PPO BCBSM members. This is an annual incentive program.

#### **Population-Based Scoring Methodology**

The CQI coordinating center (*not* the physician organization) determines which practitioners have met the appropriate performance targets and notifies BCBSM. Each physician organization will notify practitioners who will receive CQI VBR, just as the PO does for other forms of specialist VBR.

Participants can only receive VBR for one CQI, even if they are participating in more than one CQI, with the following exceptions:

- 1) Practitioners that participate in one of the four population-health based CQIs - INHALE, MCT2D, MIBAC, MIMIND – can receive the related VBR in addition to other CQI VBR
- 2) Practitioners can receive 102% VBR for tobacco cessation in addition to other CQI VBR, but can only receive one tobacco cessation VBR, even if they are eligible for it through multiple CQIs. The tobacco cessation VBR is limited to one reward per practitioner, but can be earned in addition to other CQI VBR.

If a practitioner is eligible for rewards through multiple CQIs (those that are not one of the population-health CQIs), the practitioner will be awarded the highest level of CQI VBR.

MROQC uses a scoring methodology grouping practitioners by their participating facility and measuring performance as a facility collective average. If a practitioner performs procedures at multiple facilities, the practitioner's performance will be aligned with the facility where they have most of their patients.

#### **VBR Reward Opportunities**

MROQC practitioners are scored on CQI performance measures and are eligible for CQI VBR of one of the following permutations 102%, 103%, 105%, 106%, 107%, 108%, or 110% of the standard fee schedule if they meet performance targets in one or more MROQC initiatives.

**Additional VBR for practitioners at free-standing independent radiation-oncology facilities**

- **CQI VBR for Independent free-standing Radiation Oncology facilities** (for facilities whose performance is not associated with a participating hospital and therefore not eligible for the hospital CQI pay-for-performance incentive). Practitioners assigned to these facilities will be eligible to earn MROQC VBR of 103% of the standard fee schedule for meeting the performance criteria

MROQC practitioners are eligible for one of the following VBR combinations:

- **To be eligible for 102% CQI VBR**, a participating facility must meet targets on **1 of 1 of the Tobacco Cessation VBR measure (Refer to Table 2 below)**
- **To be eligible for 103% CQI VBR**, a participating hospital must meet targets on **6 of 7 measures of the MROQC VBR measures (Refer to Table 1 below)**
- **To be eligible for 105% CQI VBR**, a participating hospital must meet targets on all **7 of 7 measures (Refer to Table 1 below)**
- **To be eligible for 106% CQI VBR**, a participating facility must be a free-standing independent radiation oncology facility and meet targets on **6 of 7 measures (Table 1 below)**.
- **To be eligible for 107% CQI VBR**, a participating hospital must meet targets for 105% CQI VBR and 102% Tobacco Cessation VBR measure (**Table 2 below**)
- **To be eligible for 108% CQI VBR**, a participating facility must be a free-standing independent radiation oncology facility and meet targets on all **7 of 7 measures (Table 1 below)**
- **To be eligible for 110% CQI VBR**, a participating facility must be a free-standing independent radiation oncology facility and meet the criteria mentioned above for 107% CQI VBR.

**Table 1. MROQC CQI VBR Measures – All are hospital-level measures with exception of measure 4A, which is collaborative wide**

Measure	Measurement Period	Target Performance
1. In ≥70% of node-positive breast cancer patients, the irradiated nodal group(s) is (are) contoured and named per TG-263 naming convention AND the dose to the supraclavicular (SCV), infraclavicular (ICV or Axillary Level 3), Axilla (Level 1 & 2) and/or internal mammary nodes (IMN) is reported.	January 1, 2024-September 30, 2024	≥70%
2. For lung cancer patients treated with conventional fractionation, the mean esophageal dose is <29 Gy AND the esophageal max dose (D2cc) is <61 Gy.	January 1, 2024-September 30, 2024	≥65%

Measure	Measurement Period	Target Performance
3. For SBRT treatment of lung cancer with a single PTV, the Paddick Conformity Index is $\geq 0.85$	January 1, 2024- September 30, 2024	$\geq 80\%$
4. Use of shorter course radiotherapy for bone metastasis treatment as shown by meeting BOTH: A: The MROQC consortium-wide rate of single fraction use is $\geq 45\%$ for uncomplicated patients B: Your site-level rate of $\leq 5$ fraction treatment is at least 75% for all patients	January 1, 2024- September 30, 2024	A & B are met
5. For treatment of bone metastasis using stereotactic body radiotherapy (SBRT), standardized dose constraints for organs at risk (OARs) are used, AND any violations of the standardized dose constraints are documented.	January 1, 2024- September 30, 2023	$\geq 80\%$
6. Percentage of patients with intermediate risk prostate cancer as defined by NCCN treated with EBRT or brachytherapy who received “high value radiotherapy”, defined as moderately hypofractionated EBRT (28 fractions or less) OR ultrahypofractionated EBRT/SBRT (7 fractions or less) OR brachytherapy monotherapy. Patients with unfavorable intermediate risk prostate cancer may also receive a brachytherapy boost.	January 1, 2024- September 30, 2024	$\geq 70\%$
7. Prostate Working Group Performance Goal: Completion of 12-month follow-up form (P6)	January 1, 2024- September 30, 2024	$\geq 60\%$

**Table 2. Tobacco Cessation VBR measure**

Measure	Measurement Period	Target Performance
Proportion of smokers who are counseled for tobacco cessation treatment (for MROQC patients receiving curative intent treatment for breast, lung, and prostate cancer)	January 1, 2024- September 30, 2024	80%

### VBR selection process

To be eligible for the 2025 CQI VBR, the practitioner must:

- Meet the performance targets set by the coordinating center
- Be enrolled in a PGIP physician organization by July 5, 2024
- Have contributed data to the CQI’s clinical data registry for at least two years, including at least one year’s worth of baseline data

### Are practitioners participating in CQIs eligible for other specialist VBR?

Yes, Specialists are eligible to receive additional VBR if they meet the stated criteria. See the *Specialist VBR fact sheets* for specialty-specific information.

## About MROQC

The Michigan Radiation Oncology Quality Consortium (MROQC) was established in 2011. In this first-of-its-kind initiative, MROQC has created a comprehensive clinical data registry of patients receiving radiation treatment for breast, lung, and prostate cancers and bone metastases. The registry data includes both patient-reported outcomes and physician assessments of toxicity as well as data on radiation treatment delivery and dose. Today, MROQC encompasses 22 hospital-based, 3 free-standing radiation oncology facilities, and over 100 Radiation Oncologists across the state of Michigan, working in collaboration to identify best practices in radiation therapy that minimize the side effects that patients may experience from radiation treatment.

## About the coordinating center

Michigan Medicine serves as the coordinating center for MROQC and is responsible for collecting and analyzing comprehensive clinical data from the participating hospitals. It uses these analyses to examine practice patterns, to generate new knowledge linking processes of care to outcomes, and to identify best practices and opportunities to improve quality and efficiency. The coordinating center further supports participants in establishing quality improvement goals and assists them in implementing best practices.

Program Director:	Lori Pierce, MD, FASTRO
Program Co-Director:	Robert Dess, MD
Program Co-Director:	Martha Matuszak, PhD
Program Manager:	Melissa Mietzel, MS

For more information on the MROQC CQI and specific details to the measures and methodology of MROQC VBR measures/methods, please contact Melissa Mietzel, MS at [hillmel@med.umich.edu](mailto:hillmel@med.umich.edu).

### About the CQI Program

Collaborative Quality Initiatives and Collaborative Process initiatives bring together Michigan physicians and hospital partners to address common and costly areas of medical-surgical care, BCBSM and Blue Care Network supports this effort and funds each collaborative data registry, that include data on patient risk factors, processes, and outcomes of care. Collection, analysis, and dissemination of such data helps inform participants on best practices. This, in turn, helps increase efficiencies, improve outcomes, and enhance value. For more information, please contact Marc Cohen, Manager, Value Partnerships [mcohen@bcbsm.com](mailto:mcohen@bcbsm.com).

### About Value Partnerships

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## Collaborative Quality Initiatives Fact Sheet Value-Based Reimbursement 2025



### Michigan Surgical Quality Collaborative (MSQC)

The Value Partnerships program at Blue Cross Blue Shield of Michigan (BCBSM) develops and maintains quality programs to align practitioner reimbursement with quality of care standards, improve health outcomes and control health care costs. Practitioner reimbursement earned through these quality programs is called value-based reimbursement (VBR). The VBR Fee Schedule sets fees at greater than 100% of the Standard Fee Schedule. VBR opportunities are available PGIP practitioners who participate in the Michigan Surgical Quality Collaborative (MSQC), and that meet specific eligibility criteria. The coordinating center clinical leaders, jointly with Blue Cross, set quality and performance metrics for the VBR. Each Collaborative Quality Initiative, or CQI, uses unique measures and population-based scoring to receive BCBSM VBR. The CQI VBR is applied in addition to any other VBR the specialist may be eligible to receive. The CQI VBR applies only to reimbursement associated with commercial PPO BCBSM members. This is an annual incentive program.

#### Population-Based Scoring Methodology

The CQI coordinating center (*not* the physician organization) determines which practitioners have met the appropriate performance targets and notifies Blue Cross. Each physician organization will notify practitioners who will receive CQI VBR, just as the POs do for other types of specialist VBR.

Participants can only receive VBR for one CQI, even if they are participating in more than one CQI, with the following exceptions:

- 1) Practitioners that participate in one of the four population-health based CQIs - INHALE, MCT2D, MIBAC, MIMIND – can receive the related VBR in addition to other CQI VBR
- 2) Practitioners can receive 102% VBR for tobacco cessation in addition to other CQI VBR, but can only receive one tobacco cessation VBR, even if they are eligible for it through multiple CQIs. The tobacco cessation VBR is limited to one reward per practitioner but can be earned in addition to other CQI VBR.

If a practitioner is eligible for rewards through multiple CQIs (those that are not one of the population-health CQIs), the practitioner will be awarded the highest level of CQI VBR.

#### VBR Reward Opportunities

MSQC Practitioners can be eligible to earn CQI VBR equivalent to 102%, 103% or 105% of the standard fee schedule.

- To be eligible for **102%** CQI VBR, practitioners must **achieve all targets in Table 2** below at the **PO level**.

- To be eligible for **103% CQI VBR**, practitioners must achieve target on **2 of 2 measures** listed in **Table 1** below at the **collaborative-wide level**. To be eligible for **105% CQI VBR**, practitioners must **achieve all targets in both Tables 1 and 2** below.

## VBR measures

**Table 1. 103% VBR measures – PGIP Physician Organization level**

Measure	Measurement Period	Target Performance
Hernia documentation (size and location of the hernia) are documented correctly	7/1/2023 - 6/30/2024	≥90%
Increasing the proportion of abdominal hernia patients with BMI >40 who receive weight loss education/counseling before their elective procedure	7/1/2023 - 6/30/2024	≥60%

The MSQC CQI also participates in tobacco cessation incentive. Those measure are detailed below:

**Table 2. 102% Tobacco Cessation Measures – PGIP Physician Organization level**

Measure	Measurement Period	Target Performance
Decreasing the number of patients who are smoking at the time of their (elective) procedure	7/1/2023 - 6/30/2024	Reduce rate to 14.0% or less
Intervention - Increase the number of patients who report that they are smoking tobacco "0 days per week" in the 30 days following their surgery. This information is based on patient report collected in PROs survey.	7/1/2023- 6/30/2024	40%

Both measures must be met in order for a PO to receive the 2% VBR for tobacco measures.

## VBR selection process

To be eligible for 2025 CQI VBR, the provider must:

- Be enrolled in a PGIP physician organization by July 5, 2024
- Has a PGIP Combined Specialty Type listed as one of the following:
  - General Surgery
  - Vascular Surgery
  - Colon/Rectal Surgery
  - Gynecologic Oncology
  - Obstetrics/Gynecology
- Be affiliated with a PO which met the performance scoring methodology set by the MSQC Coordinating Center.

- 4) As well as meet one of the following criteria:
- a. Have at least an abstracted case in the MSQC database during BOTH periods:
    - i. 7/1/2023-6/30/24
    - ii. 7/1/2023-6/30/24
  - b. Have at least four BCBSM claims for MSQC abstracted procedures (refer to list of CPT codes), during the periods mentioned above, establishing that the surgeon is doing the same work as those colleagues found in the MSQC database.

### **Are practitioners participating in CQIs eligible for other specialist VBR?**

Yes. Specialists are eligible to receive additional VBR if they meet the stated criteria. See the *Specialist VBR fact sheets* for specialty-specific information.

### **About MSQC**

MSQC is comprised of surgeons and hospitals throughout Michigan dedicated to collection and analysis of data to improve the quality of care for patients undergoing surgery in Michigan.

Most recently their quality improvement goals have focused on:

- Reducing morbidity rates
- Reducing sepsis rates
- Reducing surgical site infection rates
- Reducing readmissions
- Reducing ED visits
- Reducing length of stay in hospital
- Reducing opioid prescribing

### **About the coordinating center**

Michigan Medicine serves as MSQC coordinating center to collect and analyze comprehensive clinical data from participating hospitals to identify specific care components associated with better patient outcomes. It uses these analyses to examine practice patterns, generate new knowledge linking processes of care to outcomes, and identify best practices and opportunities to improve quality and efficiency. The center also supports participants in establishing quality improvement goals and in disseminating and implementing best practices. MSQC leadership:

Program director:	Michael Englesbe, MD
Program associate director:	Samantha Hendren, MD
Program manager:	Amanda Stricklen, MS, RN Rachel Ross, MS, RN

For more information on MSQC and VBR measures, please contact Amanda Stricklen [aoreilly@med.umich.edu](mailto:aoreilly@med.umich.edu) and Rachel Ross [rachacoo@med.umich.edu](mailto:rachacoo@med.umich.edu).

### **About the CQI Program**

Collaborative Quality Initiatives and Collaborative Process initiatives bring together Michigan physicians and hospital partners to address common and costly areas of medical-surgical care, BCBSM and Blue Care Network supports this effort and funds each collaborative data registry, that include data on patient risk factors, processes, and outcomes of care. Collection, analysis, and dissemination of such data helps inform participants on best practices. This, in turn, helps increase efficiencies, improve outcomes, and enhance value. For more information, please contact Marc Cohen, Manager, Value Partnerships [mcohen@bcbsm.com](mailto:mcohen@bcbsm.com).

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## Collaborative Quality Initiatives Fact Sheet Value-Based Reimbursement 2025



### Michigan Spine Surgery Improvement Collaborative (MSSIC)

The Value Partnerships program at Blue Cross Blue Shield of Michigan (BCBSM) develops and maintains quality programs to align practitioner reimbursement with quality of care standards, and to improve health outcomes and control health care costs. Practitioner reimbursement earned in these quality programs is called value-based reimbursement (VBR). The VBR Fee Schedule sets fees at greater than 100% of the Standard Fee Schedule. VBR opportunities are available to PGIP practitioners who participate in the Michigan Spine Surgery Improvement Collaborative (MSSIC), and that meet specific eligibility criteria. The coordinating center clinical leaders, together with Blue Cross, set quality and performance metrics for the VBR. Each Collaborative Quality Initiative, or CQI, uses unique measures and population-based scoring to receive BCBSM VBR. The CQI VBR is applied in addition to any other VBR the specialist may be eligible to receive. The CQI VBR applies only to reimbursement associated with commercial PPO BCBSM members. This is an annual incentive program.

#### Population-Based Scoring Methodology

The CQI coordinating center (not the physician organization) determines which practitioners have met the appropriate performance targets and notifies Blue Cross. Each physician organization will notify practitioners who will receive CQI VBR, just as the POs do for other forms of specialist VBR.

Participants can only receive VBR for one CQI, even if they are participating in more than one CQI, with the following exceptions:

- 1) Practitioners that participate in one of the four population-health based CQIs - INHALE, MCT2D, MIBAC, MIMIND – can receive the related VBR in addition to other CQI VBR
- 2) Practitioners can receive 102% VBR for tobacco cessation in addition to other CQI VBR, but can only receive one tobacco cessation VBR, even if they are eligible for it through multiple CQIs. The tobacco cessation VBR is limited to one reward per practitioner, but can be earned in addition to other CQI VBR.

If a practitioner is eligible for rewards through multiple CQIs (those that are not one of the population-health CQIs), the practitioner will be awarded the highest level of CQI VBR.

**VBR Reward Opportunities**

MSSIC Practitioners can be eligible to earn CQI VBR equivalent to 102%, 103%, 105% or 107% of the standard fee schedule.

- To be eligible for **102% CQI VBR**, practitioners must meet one of the following:
  - **Option 1:** achieve target on **2 of 2 measures** listed in **Table 2** below at the collaborative-wide level and individual surgeon level.
  - **Option 2:** achieve target on **one measure** listed for Tobacco Cessation (TC) VBR in **Table 3** below at the collaborative-wide level.
- To be eligible for **103% CQI VBR**, practitioners must achieve target on **3 of 4 measures** listed in **Table 1** below at the collaborative-wide level.
- To be eligible for **105% CQI VBR**, the practitioner must meet the following:
  - Achieve targets above in both **Table 1 (3 of 4 measures) and Table 2 (2 of 2 measures) or**
  - Achieve targets mentioned above in both **Table 1 (3 of 4 measures) and Table 3 (one TC measure)** at their respective population levels (i.e., collaborative-wide and individual surgeon)
- To be eligible for **107% CQI VBR**, the practitioner must achieve targets on **Table 1(3 of 4 measures) and Table 2 (2 of 2 measures) and Table 3 (one TC measure)**

To be eligible for MSSIC VBR, practitioners must meet the following scoring criteria:

**Table 1. VBR 103% – Meet 3 out of 4 measures, scored at the Collaborative-wide level**

Measure	Measurement Period	Target Performance
Percent of patients ambulating within 8 hours of surgery	Surgery Dates: 10/1/23-7/31/24	≥ 80%
Percent of Opioid-naïve, 2 level lumbar decompression surgeries with discharge prescription ≤ 225 MME	Surgery Dates: 10/1/23-7/31/24	≥ 90%
Percent of opioid-naïve, 1-2 level anterior cervical surgeries with discharge prescription ≤ 225MME	Surgery Dates: 10/1/23-7/31/24	≥ 80%
Percent of patients reporting satisfaction with outcome at 1 yr.	Patients with a 1 year questionnaire due: 1/1/2024-10/31/2024	≥ 82%

**Table 2. Secondary VBR 102% - Meet 2 out of 2 measures- Surgeon & Collaborative-wide level**

Measure	Measurement Period	Target Performance
Sign up for push reporting ( <i>surgeon level</i> )	1/1/2024-10/31/2024	Yes
Opioid naïve 1-2 level lumbar fusions discharged with a total prescribed ≤ 320 MME ( <i>Collaborative-wide level</i> )	1/1/2024-10/31/2024	≥ 80%

**Table 3. VBR 102% Tobacco Cessation measure - Collaborative-wide level**

Measure	Measurement Period	Target Performance
Percentage of smokers that received smoking cessation counseling before surgery	1/1/2024-10/31/2024	≥ 80%

To be eligible for 2025 CQI VBR, the practitioner must:

- Meet the performance targets set by the coordinating center
- Be enrolled in a PGIP physician organization by July 5, 2024
- A MSSIC Surgeon must have at least 1 case in the MSSIC registry for each of the last 2 years and allow abstractors free access to his/her clinic medical records for MSSIC chart abstraction purposes.

### **Are practitioners participating in CQIs eligible for other specialist VBR?**

Yes. Specialists are eligible to receive additional VBR if they meet the stated criteria. See the *Specialist VBR fact sheets* for specialty-specific information.

### **About MSSIC**

MSSIC aims to improve the quality of care of spine surgery by:

- Reducing surgical complications,
- Identifying ways to improve patient functional outcomes, and
- Reducing the need for repeat surgeries.

### **About the coordinating center**

The Henry Ford Health System serves as the coordinating center for MSSIC and is responsible for collecting and analyzing comprehensive clinical data from the participating hospitals. It uses these analyses to examine practice patterns, to generate new knowledge linking processes of care to outcomes, and to identify best practices and opportunities to improve quality and efficiency. The center further supports participants in establishing quality improvement goals and assists them in implementing best practices. Center leadership:

Program Director: Muwaffak Abdulhak, MD  
 Program Co-Directors: Jason Schwalb, MD, Victor Chang, MD, and David Nerenz, PhD  
 Program manager: Jamie Myers, BSN, RN

For more information on MSSIC CQI and VBR measures/methods, contact Jamie Myers at [JMyers8@hfhs.org](mailto:JMyers8@hfhs.org)

### **About the CQI Program**

Collaborative Quality Initiatives and Collaborative Process initiatives bring together Michigan physicians and hospital partners to address common and costly areas of medical-surgical care, BCBSM and Blue Cross Network supports this effort and funds each collaborative data registry, that include data on patient risk factors, processes, and outcomes of care. Collection, analysis, and dissemination of such data helps inform participants on best practices. This, in turn, helps increase efficiencies, improve outcomes, and enhance value. For more information, please contact Marc Cohen, Manager, Value Partnerships [mcohen@bcbsm.com](mailto:mcohen@bcbsm.com).

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## Collaborative Quality Initiatives Fact Sheet Value-Based Reimbursement 2025



### Michigan Society of Thoracic and Cardiovascular Surgery Quality Collaborative (MSTCVS)

The Value Partnerships program at Blue Cross Blue Shield of Michigan (BCBSM) develops and maintains quality programs to align practitioner reimbursement with quality of care standards, improve health outcomes and control health care costs. Practitioner reimbursement earned through these quality programs is called value-based reimbursement (VBR). The VBR Fee Schedule sets fees at greater than 100% of the Standard Fee Schedule. VBR opportunities are available to PGIP practitioners who participate in the Michigan Society of Thoracic and Cardiovascular Surgery Quality Collaborative (MSTCVS), and that meet specific eligibility criteria. The coordinating center clinical leaders, jointly with Blue Cross, set quality and performance metrics for the VBR. Each Collaborative Quality Initiative, or CQI, uses unique measures and population-based scoring to receive BCBSM VBR. The CQI VBR is applied in addition to any other VBR the specialist may be eligible to receive. The CQI VBR applies only to reimbursement associated with commercial PPO BCBSM members. This is an annual incentive program.

#### Population-Based Scoring Methodology

The CQI coordinating center (*not* the physician organization) determines which practitioners have met the appropriate performance targets and notifies Blue Cross. Each physician organization will notify practitioners who will receive CQI VBR, just as the POs do for other types of specialist VBR. MSTCVS applies a combination of collaborative-wide and hospital-level scoring models to measure and reward VBR:

- **Cardiac surgery:** Practitioners are measured at the hospital level.
- **General thoracic surgery:** Practitioners are measured at the collaborative-wide level.
- **Michigan Structural Heart Collaborative (MISHC):** Practitioners are measured at the hospital level.

Participants can only receive VBR for one CQI, even if they are participating in more than one CQI, with the following exceptions:

- 1) Practitioners that participate in one of the four population-health based CQIs - INHALE, MCT2D, MIBAC, MIMIND – can receive the related VBR in addition to other CQI VBR.
- 2) Practitioners can receive 102% VBR for tobacco cessation in addition to other CQI VBR, but can only receive one tobacco cessation VBR, even if they are eligible for it through multiple CQIs. The tobacco cessation VBR is limited to one reward per practitioner but can be earned in addition to other CQI VBR.

If a practitioner is eligible for rewards through multiple CQIs (those that are not one of the population-health CQIs), the practitioner will be awarded the highest level of CQI VBR.

## VBR Reward Opportunities

MSTCVS practitioners are scored on CQI performance measures and are eligible for CQI VBR for one of the following permutations: 103%, 105%, or 107% of the standard fee schedule, if they meet performance targets in one or more MSTCVS initiatives listed above.

- **To be eligible for 103% VBR**, one of the following performance conditions must be met:
  - **Cardiac Surgery initiative**: Target must be achieved at the hospital level in **2 of 3 measures** (see Table 1).
  - **General Thoracic Surgery initiative**: Target must be achieved as a collaborative-wide collective average in **2 of 3 measures** (see Table 2).
  - **MISHC**: Target must be achieved at the hospital-level in **2 of 3 measures** (see Table 3).
- **To be eligible for 105% VBR**, one of the following performance conditions must be met:
  - **Cardiac Surgery initiative and MISHC initiative *dual participation***
    - Meet performance for both initiatives at the 103% eligibility level
  - **Cardiac Surgery initiative and General Thoracic initiative *dual participation***
    - Meet performance for both initiatives at the 103% eligibility level
  - **General Thoracic Surgery initiative (This applies to surgeons that only participate in the General Thoracic initiative)**:
    - Target must be achieved for 3 of 3 measures (see Table 2) at the collaborative-wide level **and**
    - Attend 2 of 3 quarterly meetings at the participating hospital level (both surgeon and data manager must attend).
- **To be eligible for 107% VBR**, the following conditions must be met:
  - **Cardiac Surgery initiative, MISHC initiative, AND General Thoracic Surgery initiative *triple participation***
  - Participants met performance for all three **105% VBR** conditions listed above.

## VBR measures

**Table 1. Cardiac Surgery**

#	Measure	Measurement Period	Hospital Level Target Performance
1	Increase Isolated CABG patients less than 70 years old who receive Multiple Artery Grafting	1/01/2024 - 9/30/2024	40% or 5% higher than CY 2023
2	Increase percentage of risk-adjusted procedure patients who have highest intraoperative glucose <180 mg/dL	1/01/2024 - 9/30/2024	80%
3	Assessment and documentation of Clinical Frailty Score for all non-emergent cardiac surgery patients	1/01/2024 - 9/30/2024	50%

**Table 2. General Thoracic Surgery (#1-3 are collaborative-wide and #4 is hospital level)**

	Measure	Measurement Period	Collaborative Level Target Performance Measures 1-3
1	Pathologic sampling of 3 mediastinal and 1 hilar lymph node station at the time of lung cancer resection (Lobectomy, segmentectomy, pneumonectomy, therapeutic wedge resection)	1/01/2024 - 9/30/2024	82%
2	Decrease number of days from surgeon consult to therapeutic lung resection (Lobectomy, segmentectomy, pneumonectomy, therapeutic wedge resection)	1/01/2024 - 9/30/2024	32 Days
3	Capture of postoperative referral to medical oncology for patients with pathologic stage IB-III A (Lobectomy, segmentectomy and pneumonectomy, therapeutic wedge resection)	1/01/2024 - 9/30/2024	80%
4	Surgeon and Data Manager participation in quarterly Collaborative meetings <i>*site-specific opportunity</i>	1/01/2024 - 9/30/2024	Site Level: Attendance at 2/3 quarterly meetings

**Table 3. MISHC**

	Measure	Measurement Period	Hospital Level Target Performance
1	Increase referral to cardiac rehabilitation after TAVR	01/01/2024- 6/30/2024	90%
2	Increase rate of mean gradient documentation at 1 year follow-up after TAVR	01/01/2024- 6/30/2024	75%
3	Site Specific Measure	01/01/2024- 6/30/2024	Site Specific

## VBR selection process

To be eligible for 2024 CQI VBR, the practitioner must:

- Meet the performance targets set by the coordinating center
- Be enrolled in a PGIP physician organization by July 5, 2024
- Have contributed data to the CQI's clinical data registry for at least two years, including at least one year's worth of baseline data

## Are practitioners participating in CQIs eligible for other specialist VBR?

Yes. Specialists are eligible to receive additional VBR if they meet the stated criteria. See the *Specialist VBR fact sheets* for specialty-specific information.

## About MSTCVS

MSTCVS is a statewide quality initiative that:

- Aims to reduce the risk of complications and improve treatment methods for patients undergoing:
  - cardiac surgery,
  - general thoracic surgery,
  - transcatheter aortic valve replacement surgery (MISHC initiative), and
  - perfusion related procedures
- Collects clinical data for its registries.
- Analyzes structure, process and outcomes measures related to thoracic and cardiovascular surgery among participation sites.
- Shares best practices and care approaches to create optimal care at every institution.

## About the coordinating center

Michigan Medicine serves as the coordinating center for MSTCVS and is responsible for collecting and analyzing comprehensive clinical data from the participating hospitals. It uses these analyses to examine practice patterns, to generate new knowledge linking processes of care to outcomes, and to identify best practices and opportunities to improve quality and efficiency. The Center further supports participants in establishing quality improvement goals and assists them in implementing best practices. MSTCVS Leaders:

Program Director: Andrew Pruitt, MD  
Program Co-Director: Frank Pagani, MD, PhD  
Program Co-Director: Rishindra Reddy, MD  
Program Manager: Patty Theurer, MSN, RN

For more information on MSTCVS and VBR measures/methods, contact Patty Theurer at [ptheurer@umich.edu](mailto:ptheurer@umich.edu).

### **About the CQI Program**

Collaborative Quality Initiatives and Collaborative Process initiatives bring together Michigan physicians and hospital partners to address common and costly areas of medical-surgical care, BCBSM and Blue Care Network supports this effort and funds each collaborative data registry, that include data on patient risk factors, processes, and outcomes of care. Collection, analysis, and dissemination of such data helps inform participants on best practices. This, in turn, helps increase efficiencies, improve outcomes, and enhance value. For more information, please contact Marc Cohen, Manager, Value Partnerships [mcohen@bcbsm.com](mailto:mcohen@bcbsm.com).

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## Collaborative Quality Initiatives Fact Sheet Value-Based Reimbursement 2025



### Michigan Trauma Quality Improvement Program (MTQIP)

The Value Partnerships program at Blue Cross Blue Shield of Michigan (BCBSM) develops and maintains quality programs to align practitioner reimbursement with quality-of-care standards, improve health outcomes and control health care costs. Practitioner reimbursement earned through these quality programs is called value-based reimbursement (VBR). The VBR Fee Schedule sets fees at greater than 100% of the Standard Fee Schedule. VBR opportunities include PGIP practitioners who participate in the Michigan Trauma Quality Improvement Program (MTQIP) and meet specific eligibility criteria. The coordinating center clinical leaders, jointly with Blue Cross, set quality and performance metrics for the VBR. Each Collaborative Quality Initiative, or CQI, uses unique measures and population-based scoring to receive BCBSM VBR. The CQI VBR is applied in addition to any other VBR the specialist may be eligible to receive. The CQI VBR applies only to reimbursement associated with commercial PPO BCBSM members. This is an annual incentive program.

#### Population-Based Scoring Methodology

The CQI coordinating center (*not* the physician organization) determines which practitioners have met the appropriate performance targets and notifies Blue Cross. Each physician organization will notify practitioners who will receive CQI VBR, just as the POs do for other types of specialist VBR.

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- 1) Practitioners that participate in one of the four population-health based CQIs - INHALE, MCT2D, MIBAC, MIMIND – can receive the related VBR in addition to other CQI VBR
- 2) Practitioners can receive 102% VBR for tobacco cessation in addition to other CQI VBR, but can only receive one tobacco cessation VBR, even if they are eligible for it through multiple CQIs. The tobacco cessation VBR is limited to one reward per practitioner, but can be earned in addition to other CQI VBR.

If a practitioner is eligible for rewards through multiple CQIs (those that are not one of the population-health CQIs), the practitioner will be awarded the highest level of CQI VBR.

## **VBR Reward Opportunities**

MTQIP Practitioners can be eligible to earn CQI VBR equivalent to 103%, or 105% of the standard fee schedule.

MTQIP practitioners are measured by the affiliated trauma center where the practitioner admits the most patients. The collective average for each group of hospital-affiliated physicians must achieve either one of the following conditions to be eligible for either 103% or 105% VBR:

- **To be eligible for 103% VBR**, participants must achieve target on **2 of 3 measures** in the Table below
  - Note: The 3rd measure in the Table below is a collaborative-wide measure, so practitioners must achieve the target as a collective average to be eligible for VBR.
- **To be eligible for 105% VBR**, participants must achieve target on **3 of 3 measures** in the Table below

## **VBR measures**

Measure	Measurement Period	Target Performance
Trauma center collective level. Timely LMWH VTE Prophylaxis (≥52.5% of patients within 48 hours)	7/1/23-6/30/24	≥ 52.5%
Trauma center collective level. Timely operative repair in geriatric hip fractures (≥92% of patients within 42 hours)	7/1/23-6/30/24	≥ 92%
Collaborative-wide level. Timely antibiotic in femur/tibia open fractures (≥85% of patients within 90 mins)	7/1/23-6/30/24	≥ 85%

## **CQI VBR selection process**

To be eligible for 2025 CQI VBR, the provider must:

- Meet the performance targets set by the coordinating center
- Be enrolled in a PGIP physician organization by July 5, 2024
- Have contributed data to the CQI's clinical data registry for at least two years, including at least one year's worth of baseline data

## **Are practitioners participating in CQIs eligible for other specialist VBR?**

Yes. Specialists are eligible to receive additional VBR if they meet the stated criteria. See the *Specialist VBR fact sheets* for specialty-specific information.

## **About MTQIP**

The Michigan Trauma Quality Improvement Program Collaborative Quality Initiative aims to address inconsistencies and variations in patient outcomes related to trauma-based care. The goals of MTQIP are to create a quality improvement infrastructure for trauma care that will improve the quality of care for trauma patients and reduce the costs of this care in the State of Michigan.

## About the coordinating center

Michigan Medicine serves as the coordinating center for MTQIP and is responsible for collecting and analyzing comprehensive clinical data from the participating hospitals. It uses these analyses to examine practice patterns, generate new knowledge linking processes of care to outcomes, and identify best practices and opportunities to improve quality and efficiency. The center further supports participants in establishing quality improvement goals and assists them in implementing best practices. MTQIP Leaders:

Project Director: Mark Hemmila, MD  
Program Manager: Judy Mikhail, PhD, MBA, RN

For more information on MTQIP and VBR measures/methods, contact Judy Mikhail at [jmikhail@umich.edu](mailto:jmikhail@umich.edu).

### About the CQI Program

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## Collaborative Quality Initiatives Fact Sheet Value-Based Reimbursement 2025



### Michigan Urological Surgery Improvement Collaborative (MUSIC)

The Value Partnerships program at Blue Cross Blue Shield of Michigan (BCBSM) develops and maintains quality programs to align practitioner reimbursement with quality of care standards, improve health outcomes and control health care costs. Practitioner reimbursement earned through these quality programs is called value-based reimbursement (VBR). The VBR Fee Schedule sets fees at greater than 100% of the Standard Fee Schedule. VBR opportunities include PGIP practitioners who participate in the Michigan Urological Surgery Improvement Collaborative (MUSIC) and that meet specific eligibility criteria. The coordinating center clinical leadership, jointly with Blue Cross, set quality and performance metrics for its VBR. Each Collaborative Quality Initiative, or CQI, uses unique measures and population-based scoring to receive BCBSM VBR.

#### Population-Based Scoring Methodology

The CQI coordinating center (*not* the physician organization) determines which practitioners have met the appropriate performance targets and notifies Blue Cross. Each physician organization will notify practitioners who will receive CQI VBR, just as the POs do for other types of specialist VBR.

Participants can only receive VBR for one CQI, even if they are participating in more than one CQI, with the following exceptions:

- 1) Practitioners that participate in one of the four population-health based CQIs - INHALE, MCT2D, MIBAC, MIMIND – can receive the related VBR in addition to other CQI VBR
  
- 2) Practitioners can receive 102% VBR for tobacco cessation in addition to other CQI VBR, but can only receive one tobacco cessation VBR, even if they are eligible for it through multiple CQIs. The tobacco cessation VBR is limited to one reward per practitioner, but can be earned in addition to other CQI VBR.

If a practitioner is eligible for rewards through multiple CQIs (those that are not one of the population-health CQIs), the practitioner will be awarded the highest level of CQI VBR.

#### VBR Reward Opportunities

MUSIC Practitioners can be eligible to earn CQI VBR equivalent to 102%, 103%, 104%, 105% or 107% of the standard fee schedule. To be eligible for MUSIC VBR, practitioners must meet the following scoring criteria:

- To be eligible for **103% VBR**, practitioners must achieve targets at collaborative level for **2 of 2** measures in **Table 1** below. Participants must achieve the targets as a collaborative-wide average.
- To be eligible for **102% VBR**, practitioners must achieve targets for **2 of 3** measures in **Table 2** below or **2 of 2** measures in **Table 3**.
- To be eligible for **104% VBR**, practitioners should achieve targets for **2 of 3** measures in **Table 2** below **AND** meet **2 of 2** Tobacco Cessation measures in **Table 3** below.

- To be eligible for **105% VBR combination**, practitioners must meet targets for 103% VBR and for 102% targets for either Secondary VBR or Tobacco Cessation measures:
  - Meet criteria for **103% VBR** for **2 of 2** measures at collaborative level in **Table 1 AND**
  - Meet criteria for **102% VBR** for **2 of 3** measures in **Table 2 OR**
  - Meet criteria for **102% TC VBR** for **2 of 2** measures in **Table 3**.
- To be eligible for **107% VBR combination**, practitioners must meet all of the following targets:
  - Meet criteria for **103% VBR** for **2 of 2** measures at collaborative level in **Table 1 AND**
  - Meet criteria for **102% VBR** for **2 of 3** measures in **Table 2 AND**
  - Meet criteria for **102% TC VBR** for **2 of 2** measures in **Table 3**.

**Table 1. Primary VBR measures (103% VBR)**

Performance Measure	Measurement Period	Target Performance
PSA testing within 90 days of radical prostatectomy	4/1/2023-3/1/2024 (surgery date)	≥95%
Opioid-limited partial and radical nephrectomy	4/1/2023-3/1/2024 (surgery date)	≥ 60%

**Table 2. Secondary VBR measures (102% VBR)**

Performance Measure	Measurement Period	Target Performance
Ureteral stent omission following ureteroscopy in pre-stented patients	7/1/2023 - 6/30/2024 (surgery date)	≤ 62%
Radical nephrectomy for benign renal masses	4/1/2023 – 3/31/2024 (surgery date)	≤ 6%
Renal mass surveillance follow-up	4/1/2023 - 3/31/2024 (16-month follow-up date)	≥ 50%

**Table 3 Tobacco Cessation measures (102% VBR)**

Performance Measure	Measurement Period	Target Performance
Maintain the proportion of smokers who receive smoking cessation counselling/treatment	10/01/2023 - 6/30/2024 (Baseline survey date)	≥ 85%
Maintain the proportion of smokers who quit smoking at 3 months after surgery	10/01/2023 - 6/30/2024 (3-month survey date)	≥ 30%

### VBR selection process

To be eligible for 2025 CQI VBR, the practitioner must:

- Meet performance targets set by the coordinating center at the collaborative level
- Be enrolled in a PGIP physician organization by July 5, 2024
- Have contributed data to registry for at least two years and at least one year baseline data

### Are practitioners participating in CQIs eligible for other specialist VBR?

Yes. Specialists are eligible to receive additional VBR if they meet the stated criteria. See the *Specialist VBR fact sheets* for specialty-specific information.

## About MUSIC

- Professional CQI launched January 2012 with an all-payer Michigan registry
- Original purpose: to improve quality of care for men with prostate cancer
- Collects data on:
  - cancer severity (including pathology from needle biopsies),
  - radiographic staging studies utilization and outcomes
  - local (e.g., radical prostatectomy, radiation therapy) and systemic androgen deprivation therapy patterns of care
  - radical prostatectomy patient reported outcomes
- Collects newly added data on other urologic diseases to reduce complications after kidney stone surgery and improve quality of care for patients diagnosed with small renal mass.
- Data analysis compares performance of participating Michigan urology practices to its peers.

## About the coordinating center

Michigan Medicine serves as MUSIC's coordinating center to collect and analyze comprehensive clinical data from participating hospitals to identify specific care components associated with better patient outcomes. It uses these analyses to examine practice patterns, generate new knowledge linking processes of care to outcomes, and identify best practices and opportunities to improve quality and efficiency. The center also supports participants in establishing quality improvement goals and in disseminating and implementing best practices, from local to broader communities. MUSIC leadership:

Program director: Khurshid Ghani, MD, MS  
Administrative Officer: Susan Linsell, MHSA  
Program manager: Anna Johnson, MS

For more information on the CQI and measures, please contact Anna Johnson at [rayam@med.umich.edu](mailto:rayam@med.umich.edu).

### About the CQI Program

Collaborative Quality Initiatives and Collaborative Process initiatives bring together Michigan physicians and hospital partners to address common and costly areas of medical-surgical care, BCBSM and Blue Care Network supports this effort and funds each collaborative data registry, that include data on patient risk factors, processes, and outcomes of care. Collection, analysis, and dissemination of such data helps inform participants on best practices. This, in turn, helps increase efficiencies, improve outcomes, and enhance value. For more information, please contact Marc Cohen, Manager, Value Partnerships [mcohen@bcbsm.com](mailto:mcohen@bcbsm.com).

### About Value Partnerships

Value Partnerships is a collection of programs among physicians and hospitals across Michigan and Blue Cross, that make health care better for everyone. This unique, collaborative model enables robust data collection and sharing of best practices, so practitioners can improve patient outcomes. It is value and outcomes-based health care -- a movement away from fee-for-service that instead pays practitioners for successfully managing their patient's health. We invite you to visit us at [valuepartnerships.com](http://valuepartnerships.com).

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**2025 Hospital and Practice-based CQI VBR Opportunities**  
**Specialist ONLY VBR Effective 03/01/2025 - 02/28/2026**

CQI Abbreviation	CQI Name	Eligible Specialties	2% CQI VBR	3% CQI VBR	2% Tobacco Cessation (TC) VBR	3% Ambulatory Radiation Oncology VBR (MROQC only)	15% Oncology Pharmacy (POEM) VBR <sup>§</sup>	Maximum Earnable CQI VBR
ASPIRE	Anesthesiology Performance Improvement and Reporting Exchange	Anesthesiology	✓	✓	✓			7%
BMC2	Blue Cross Blue Shield of Michigan Cardiovascular Consortium	Interventional Cardiology Vascular Surgery	✓*	✓	✓			7%
HMS	Hospital Medicine Safety	Hospitalist Interventional Radiology Critical Care		✓				3%
MAQI2	Michigan Anti-Coagulation Quality Improvement Initiative	Cardiology		✓	✓			5%
MARCQI	Michigan Arthroplasty Registry Collaborative	Orthopedic Surgery	✓*	✓				5%
MBSC	Michigan Bariatric Surgery Collaborative	General Surgery	✓*	✓	✓			7%
MEDIC	Michigan Emergency Department Improvement Collaborative	Emergency Medicine	✓*	✓	✓			7%
MOQC	Michigan Oncology Quality Consortium	Medical Oncology	✓*	✓	✓		✓	22%
MROQC	Michigan Radiation Oncology Quality Collaborative	Radiation Oncology	✓	✓	✓	✓ <sup>†</sup>		10% <sup>†</sup>
MSQC	Michigan Surgical Quality Collaborative	General Surgery Vascular Surgery Colorectal Surgery Gynecologic Oncology Obstetrics/Gynecology		✓	✓			5%
MSSIC	Michigan Spine Surgery Improvement Collaborative	Neurosurgery Orthopedic Surgery	✓*	✓	✓			7%
MSTCVS	Michigan Society of Thoracic and Cardiovascular Surgeons Quality Collaborative	Cardiothoracic Surgery	✓	✓	✓			7%
MTQIP	Michigan Trauma Quality Improvement Program	General Surgery	✓	✓				5%
MUSIC	Michigan Urological Surgery Improvement Collaborative	Urology	✓*	✓	✓			7%

\* Indicates that 2% CQI VBR is available alone and in addition to the 3% CQI VBR

\*\* Indicates that smoking cessation is embedded in CQI VBR measure

§ POEM VBR is available for MOQC participants only

†Only independent free-standing radiation oncology facilities that achieve the 10% (all other have the potential to earn 7%)

Note: physicians that participate in multiple hospital or practice-based CQIs are only eligible for one permutation of any of the percentages listed above

Updated 12-22-2023

**These are the potential 2025 CQI VBR Reward Permutations for Hospital and Professional CQIs**  
**For practitioners that achieve targets set by the individual coordinating centers**  
**Specialist ONLY VBR Effective 03/01/2025 - 02/28/2026**  
**Note: Does not include the Population Health CQI details**

% VBR (% is the percentage above the standard fee schedule)										
CQI Name	102%	103%	104% (only 2% and 2% TC)	105%	106%	107%	108%	110%	115%	Comments
ASPIRE		103%		105%		107%				
BMC2	102%	103%	104%	105%		107%				
HMS		103%								
MAQII	102%	103%		105%						102% is from tobacco cessation
MARCQI	102%	103%		105%						
MBSC	102%	103%	104%	105%		107%				
MEDIC	102%	103%	104%	105%		107%				
MOQC (includes POEM)	102%	103%	104%	105%		107%			115%	the POEM VBR is an additional 115% across any of the permutations listed (MOQC+POEM practitioners could earn any of the following permutations in MOQC VBR 117%, 118%, 119%, 120%, 122%)
MROQC	102%	103%		105%	106%	107%	108%	110%		106%, 108%, or 110% is only for free-standing rad-onc facilities (103% VBR)
MSQC	102%	103%		105%						
MSSIC	102%	103%		105%		107%				
MSTCVS		103%		105%		107%				
MTQIP		103%		105%						
MUSIC	102%	103%	104%	105%		107%				