Primary care pay-for-value hybrid payment model manual

2024
Blue Shield of California

blue california

Contents

Blue Shield is committed to supporting our primary care providers in maintaining a vibrant and sustainable practice that's personally and professionally rewarding for you, which translates to optimal care for our members.

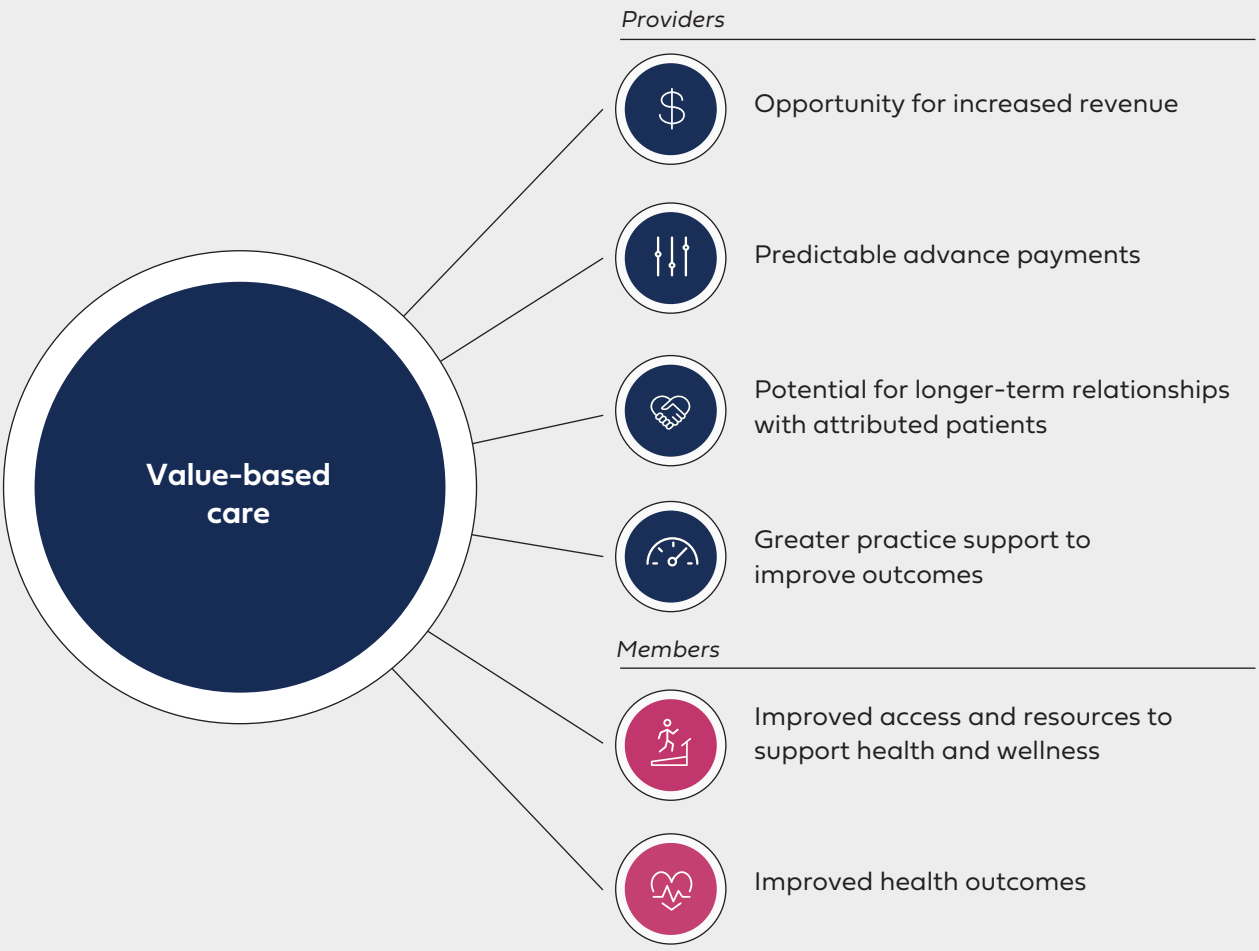
This guide is intended to orient you to the Primary care pay-for-value hybrid payment model and provides detailed information about incentive opportunities, what services are eligible for the per member per month payment, and how patients are attributed to your practice. It also provides an overview of an analytical tool you can use to retrieve key information about attributed members and track performance.

If you have any questions, please email us at: primarycarereimagined@blueshieldca.com.

Why value-based care?

In recent years, there has been a shift away from traditional fee-for-service (FFS) to value-based care. The 'value' in value-based care is derived from greater emphasis on patient outcomes and overall quality of care.

Under value-based payment models, practice reimbursement is tied to both outcomes and quality of care, not to quantity of care. Value-based care offers myriad benefits to practices and Blue Shield members.



Model overview

The primary care pay-for-value hybrid payment model reimburses providers for services through a mix of traditional FFS and PMPM payments.

The goal of the PMPM payments is to support providers like you with a predictable payment each month so that they can focus on patient relationships and overall care management.

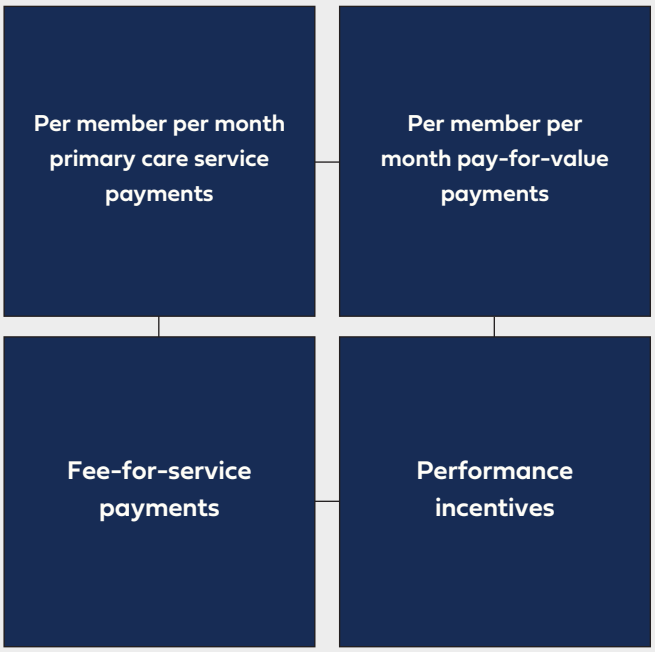
Blue Shield uses medical claims history to identify with which physician a member is most closely affiliated/identified. This method is known as attribution.

Payment model payments

Payments for delivery of primary care services

Monthly advance payments to cover a portion of primary care services.

Payments for services not included in monthly advance payments.



Payments for pay-for-value services and performance outcomes

Where applicable, monthly advanced payments to support traditional and/or new approaches to care delivery and coordination.

Revenue opportunity tied to performance against targets in a minimum set of HEDIS quality measures, resource utilization measures, and member satisfaction scores. Paid bi-annually.

Practices receive a PMPM payment for each attributed member, regardless of whether those members are seen by the practice that month or if the practice does/does not meet minimum performance metrics.

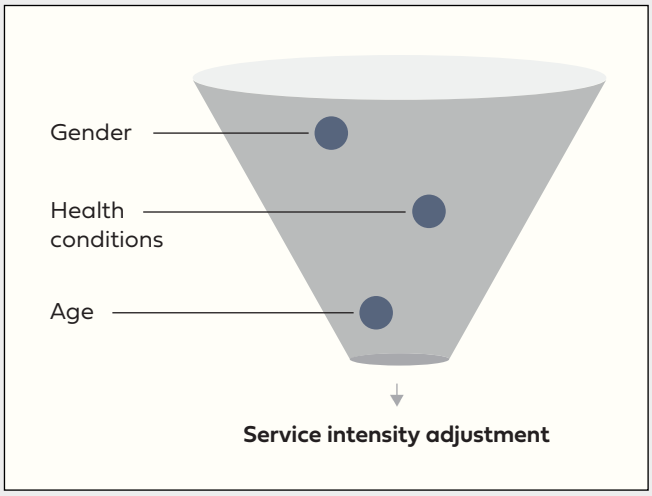
Traditional FFS will remain for a variety of services such as annual well visits, immunizations, and high-cost drugs (see page 41 for table of codes).

What's included

Clinicians	Family practice, general practice, internal medicine, and pediatric physicians
Practices	Outpatient only
Lines of business	Fully insured Commercial PPO members only
Services rendered in an eligible place of service	Clinic (includes independent, walk-in, retail health, public health, and rural health), Federally Qualified Health Center, home, in-office visit, mobile unit, school, and telehealth (provided in home or other than patient's home)
Services rendered	Page 41 includes a detailed list of services covered by the PMPM vs. paid as FFS

How are payments calculated?

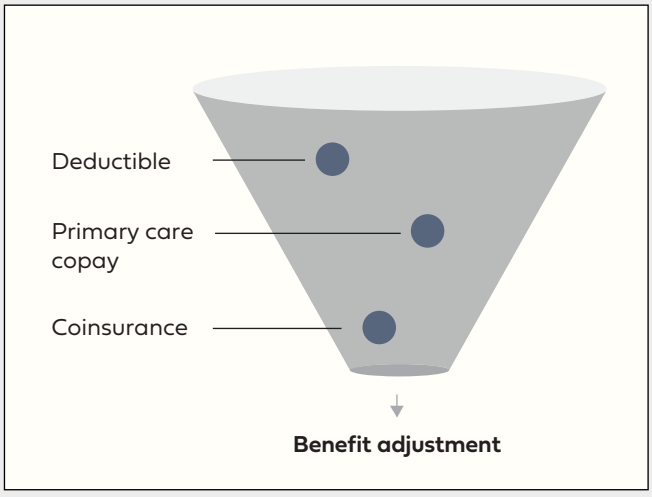
Per member per month fees are based on expected service patterns and utilization for an average population, adjusted for your contracted fee schedule at the time of the signing of the Primary Care Hybrid Model Contract. The base PMPM is adjusted monthly based on service intensity and benefits to account for expected utilization deviation of your member population compared to the average population.



Service intensity adjustment

The PMPM is adjusted monthly to account for variation in expected utilization and intensity of services needed by your attributed members based on their gender, age, and health conditions.

See page 44 for a detailed list of service intensity factors.



Benefit adjustment

The benefit design of a member's plan will determine what level of the member cost share is collected by the practice. Each practice will have a different mix of member benefits that may shift over time, so the PMPM is adjusted to account for this.

See page 49 for more detailed information about benefit adjustment factors.

Pay-for-value payments

Where applicable, an additional pay-for-value payment is added to the adjusted base PMPM to support care coordination activities outside patient visits as shown below. Check your provider contract agreement to verify whether your practice is eligible for this type of payment.

Identification

Regular member identification (i.e., members with complex needs or patients with chronic conditions)

Coordination

Referral, test, and follow-up care coordination and tracking

Outreach

Proactive outreach to other clinical, home, and community-based service providers for diagnosis and treatment coordination

Home health

Home health oversight, consultation, and management

Resources

Connecting with health advocates / care coordinators / care navigator resources

Transitions

Transitions of care support and management

Assessments

Medication reconciliation and adherence assessments

Influence

Proactive outreach to encourage tests; visit specialists to establish accurate diagnoses; or make follow-up visits based on test results

Communicate

Enhanced communication and outreach (i.e., email)

Payment example

PMPM will be calculated monthly to reflect changes in the age, gender, health condition, and benefit mix of the attributed patient population, as shown in the example on the right.

$16.00

Base per member per month
Found in provider contract agreement and may vary for different lines of business.

x0.95

Benefit adjustment*

x1.10

Service intensity adjustment*

= $16.72

Adjusted PMPM

+ $4.00

Pay-for-Value PMPM payment
Found in eligible provider contract agreements and varies for adult vs. pediatric members.

$20.72

PMPM payment

**See appendix for detailed information about benefit and service intensity adjustment*

Reconciliation

To provide practices predictable advance payments, Blue Shield will make PMPM payments on or before the 15th of the month. This is before final eligibility, benefit, and health condition status of members are known and may lead to a need for payment adjustments.

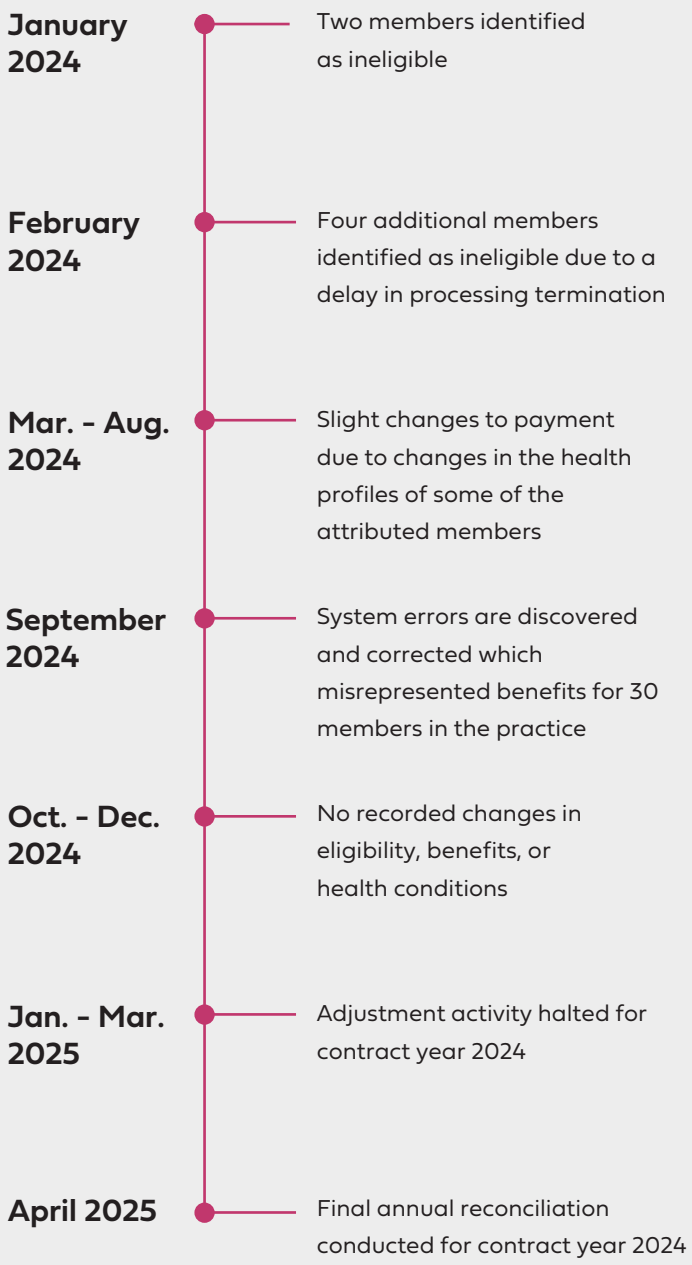
Examples include a PMPM payment for a member who is no longer eligible, a payment too high because the member switched to a plan with higher cost sharing, or a payment too low because a member was diagnosed with a health condition linked to higher utilization.

To ensure that PMPM payments accurately reflect the underlying patient population, Blue Shield will conduct monthly and annual reconciliations to true-up member eligibility, benefits, and health conditions.

Reconciliation example

In this example, a practice is paid an initial PMPM payment of $2,000 for its 100 attributed members in January 2024.

This number is based on known membership as of December 2023. Subsequent to December 2023, the following changes occurred to membership.



Payment adjustment example

As of	Attributed members	Benefit adjustment	Service intensity adjustment	PMPM payments	Reconciliation adjustments
Dec 2023	100	1.00	1.00	$2,000	-
Jan 2024	98	0.99	1.02	$1,979	($21)
Feb 2024	94	1.00	1.02	$1,915	($65)
Mar 2024	94	1.00	1.01	$1,897	($18)
Apr 2024	94	1.00	1.01	$1,897	$0
May 2024	94	1.00	1.00	$1,878	($18)
Jun 2024	94	1.00	1.01	$1,897	$18
Jul 2024	94	1.00	1.02	$1,915	$18
Aug 2024	94	1.00	1.03	$1,933	$18
Sep 2024	94	1.05	1.03	$2,030	$97
Oct 2024	94	1.05	1.03	$2,030	$0
Nov 2024	94	1.05	1.03	$2,030	$0
Dec 2024	94	1.05	1.03	$2,030	$0
Jan – Mar 2025	*No monthly adjustment for 2024*				
Apr 2025	94	1.05	1.05	$2,068	$38

2024 updates

Updates effective 1/1/2024

Performance measures

Adult performance measures

- Asthma Medication Ratio (ages 19-50 and 51-64) is no longer included in the measure set.
- HbA1C >9.0% (poor control) is no longer included in the measure set.
- HbA1C <8.0% (good control) is new to the measure set. See page 32 for more information about this measure.

Pediatric performance measures

- Asthma medication ratio metric (ages 5-11 and 12-18) is no longer be included in the measure set.

Incentive PMPMs

- While the maximum incentive per member per month (PMPM) for adult and pediatric attributed members did not change, incentive amounts for individual measures have been updated where appropriate as shown on pages 14 and 15.

Updates effective 4/1/2024

PMPM procedure code inclusions and exclusions

- Behavioral health collaborative care procedure codes will be paid FFS going forward. Further, updates have been made as required to reflect the addition of new codes, removal of retired codes, and any changes to codes for procedures requiring prior authorization and injectable medications covered by Section 1375.8 of the California Health and Safety code (commonly referred to as the Richman Bill). See page 43 for more information.

Service intensity adjustment

- Service intensity and condition tiers and factors have been updated to reflect more recent healthcare utilization patterns. Further, condition tiers and factors now include a more granular list of conditions in each tier. "Unknown or Not Disclosed" has been added to age and gender factors to better reflect members' self-reported gender. These changes are detailed on pages 44 to 48.

Incentives

Practices may receive an additional incentive payment for each attributed member based on meeting targets for clinical quality, resource utilization, and patient experience metrics. Our model includes measure sets for both adults and pediatric patients.

Incentives are calculated based on measurement year performance (such as January 1 through December 31). Members must be attributed to the practice for 11 out of 12 months of a calendar measurement year in order to be included in the performance rate calculation.

Adult incentive measures

Defined as an individual member who is eighteen (18) years of age or older.

Type	Name	Min denominator	Max PMPM per attributed member
Resource utilization	Emergency room (ER) visits per 1,000 members	30 members	$1.30
	Inpatient admits (IA) per 1,000 members	150 members	$1.30
Clinical quality	Diabetes: Hemoglobin A1c (HbA1c) good control (<8.0%)*	1 member	$0.8125
	Controlling high blood pressure	1 member	$0.8125
	Breast cancer screening	1 member	$0.8125
	Colorectal cancer screening	1 member	$0.8125
Patient experience	Patient experience survey	1 member	$0.65
Maximum incentive per attributed member			**$6.50**

*New in 2024

Pediatric incentive measures

Defined as an Individual member who is under eighteen (18) years of age as of Dec. 31.

Type	Name	Min denominator	Max PMPM per attributed member
Resource utilization	Emergency room (ER) visits per 1,000 members	30 members	$0.75
Clinical quality	Childhood immunization status: combo 10	1 member	$1.25
	Immunizations for adolescent immunizations: combo 2	1 member	$1.25
	Weight assessment & counseling for nutrition and physical activity - BMI percentile documentation	1 member	$0.4166
	Weight assessment & counseling for nutrition and physical activity - counseling for nutrition	1 member	$0.4166
	Weight assessment & counseling for nutrition and physical activity - counseling for physical activity	1 member	$0.4166
Patient experience	Patient experience survey	1 member	$0.50
Maximum incentive per attributed member			**$5.00**

How are targets set?

Targets for each of the incentive measures are set by utilizing internal and industry-wide data. Each are updated on an annual basis. See page 39 for detailed measure specifications, as well as thresholds for adult and pediatric clinical quality and resource use measures.

How performance data are collected and reported

Supplemental data

Supplemental data refers to additional clinical data about a member, beyond claims data, received by a health plan. Examples include use of procedure codes for reporting a clinical result, such as blood pressure. Supplemental data saves money and time as it eliminates the need for chasing individual charts, simplifies data attainment, and improves the data available for Healthcare Effectiveness Data Information Set® (HEDIS) reporting and patient analytics.

While not required, practices are encouraged to submit supplemental data to enhance performance rates for measures. Please reach out to the Blue Shield supplemental data team to request help with setting up supplemental data feeds or ask questions regarding supplemental data submissions at HEDISSUPPDATA@blueshieldca.com.

Survey data

Blue Shield will administer a patient experience survey to attributed members who have a visit with your practice. A copy of the survey is in the appendix on page 35.

Claims data

Claims data are used to calculate clinical quality and resource utilization performance.

Clinical quality and patient experience calculation

1. If provider performance is lower than the minimum threshold for each measure, provider is not eligible to receive any incentive for that measure.

2. If provider performance is equal to the minimum threshold, provider will receive 50% of the incentive amount for that measure.

3. If provider performance is between the minimum and the target threshold, provider will receive an additional, pro-rated incremental incentive.

4. If provider performance is greater than or equal to the target threshold, provider will receive the full incentive amount for that measure.

Note: This does not apply to Diabetes Hemoglobin A1c (HbA1c) Control (<8.0%), where a lower rate indicates better performance.

The example below is for the colorectal cancer screening measure.

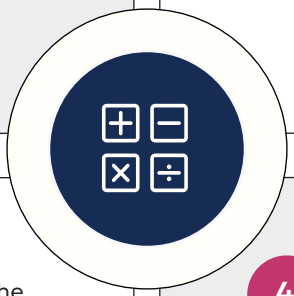
Colorectal cancer screening measure example

Max incentive PMPM	$0.8125
Min threshold	56.0%
Target threshold	62.0%
Performance rate	59.82%
PMPM earned	$0.66
Attributed member months	6021
Annual incentive earned	$3,973.86

Resource utilization incentive calculation

1. If provider performance is below the minimum threshold (i.e., higher rate), provider is not eligible to receive any incentive for that measure.

2. If provider performance is equal to the minimum threshold, provider will receive 50% of the incentive amount for that measure.



3. If provider performance is between the minimum and the target threshold, provider will receive a pro-rated incremental incentive.

4. If provider performance is above the target threshold (i.e., lower rate), provider will receive the full incentive amount for that measure.

Note: For resource utilization measures, a lower rate indicates better performance.

Example: Adult ER utilization measure

Max incentive PMPM	$1.30
Min threshold	200
Target threshold	110
Performance rate	124
PMPM earned	$1.12
Attributed member months	6021
Annual incentive earned	$6,743.52

Incentive opportunity payment example

Using adults only, this example shows how incentive payments are paid based on performance and number of continuously attributed members.

Number of attributed members*
(not impacted by continuous enrollment criteria for performance measures)

January **500**	February **505**	March **510**	April **500**
May **490**	June **500**	July **501**	August **510**
September **495**	October **500**	November **500**	December **510**

x

Annual incentive earned PMPM amount

$5.85

=

Total annual incentive opportunity
(Earned PMPM annual member months)

$35,222.85
(6021 x $5.85)

**Total member months are calculated by adding January through December's attributed members – the number of members eligible for each measure's denominator (which includes continuous attribution criteria) does not affect the number of member months for the calculation of the incentive*

Adult incentive opportunity payment example

Measure	Member denominator	Max PMPM opportunity	PMPM earned (base performance rate)†	Attributed member months (measurement year)§	Total incentive earned#
Diabetes: Hemoglobin A1c (HbA1c) good control (<8.0%)*	250	$0.8125	$0.55	6021	$3,311.55
Controlling high blood pressure*	300	$0.8125	$0.60	6021	$3,612.60
Breast cancer screening*	200	$0.8125	$0.65	6021	$3,913.65
Colorectal cancer screening*	375	$0.8125	$0.50	6021	$3,010.50
Emergency room (ER) visits per 1,000 members*	400	$1.30	$0.75	6021	$4,515.75
Inpatient admits (IA) per 1,000 members*	400	$1.30	$1.00	6021	$6,021.00
Rating of provider	150	$0.13	$0.10	6021	$602.10
Someone at office gave test results	150	$0.13	$0.05	6021	$301.05
Discussed prescription medications	150	$0.13	$0.11	6021	$662.31
Getting care quickly composite	150	$0.13	$0.13	6021	$782.73
Provider explained things in an easily understandable way	150	$0.13	$0.13	6021	$782.73
TOTALS	n/a	$6.50	$4.57	6,021	$27,516.97 ($4.57 * 6,021)

** For these measures, members must meet measure eligibility and continuous attribution requirements (be attributed for 11 of the 12 months of the measurement year) to be included in the performance rate*

† PMPM earned is based on performance ratings

§ Attributed member months is sum of number of members attributed each month of the membership year

Re-weighting incentive calculations

Practices have an opportunity to earn an incentive in the domains of resource utilization, clinical quality, and patient experience. The annual PMPM incentive calculation uses a re-weighting methodology when a practice is ineligible for either: 1) a measure or measures within a domain, or 2) the entire domain. A measure is ineligible if it does not meet the minimum denominator (i.e., number of members) requirement. A domain is ineligible if all measures in the domain are ineligible. When either is the case, the PMPM is re-distributed to eligible measures or domains.

Re-weighting the incentive PMPM within a domain

If a domain contains an ineligible measure, the PMPM of that measure will be re-distributed evenly to the remaining eligible measures.

The table below shows an example of re-weighting within a domain when a single measure is ineligible.

Adult clinical quality	Original PMPM	Measure eligibility	Re-distributed PMPM
Diabetes: Hemoglobin A1c (HbA1c) good control (<8.0%)	$0.8125	Yes	$1.083
Controlling high blood pressure	$0.8125	Yes	$1.083
Breast cancer screening	$0.8125	Ineligible	$0.00
Colorectal cancer screening	$0.8125	Yes	$1.083
Total	$3.25		$3.25

Re-weighting across domains

The following rules are used to re-weight PMPM when an entire domain is ineligible.

A. Clinical quality domain ineligible – PMPM re-distributed to resource use domain.

B. Resource use domain ineligible – PMPM re-distributed to clinical quality domain.

C. Patient experience domain ineligible – PMPM re-distributed equally to clinical quality and resource use domains.

D. Any two domains ineligible – Entire PMPM is re-distributed to eligible domain.

The table below shows examples for each re-weighting rule.

Adult domains	Domain PMPM	Scenario A	Scenario B	Scenario C	Scenario D
Clinical quality	$3.25	Ineligible	$5.85	$3.575	$6.50
Resource use	$2.60	$5.85	Ineligible	$2.925	Ineligible
Patient experience	$0.65	$0.65	$0.65	Ineligible	Ineligible
Total PMPM	$6.50	$6.50	$6.50	$6.50	$6.50

Member impact

The primary care pay-for-value hybrid payment model is on agreement to enhance reimbursement at the practice level. As noted previously, this model applies to Commercial PPO members only. Practices will continue to collect cost shares, consistent with PPO members' benefit structure.

Attribution

Blue Shield's approach to attribution considers medical claim history for the previous 18 months and associates members with the primary care doctor they are most closely affiliated/identified with.

Blue Shield will provide you with a list of attributed patients each month with key, personalized information. With this information, you can view your panel through the lenses of quality care metrics and patient experience, enabling you to build stronger relationships with your patients through effective continuity of care.

Attribution lists can be retrieved via an online analytical tool. Refer to page 30 to learn more about this tool.

Attribution methodology

To determine the attributed members for a provider in an attribution period, Blue Shield will apply our methodology using these steps:

Note: Attributed members can only be attributed to one PCP in a given attribution period and must be currently eligible for covered services with Blue Shield and residing in the general geographical area of the provider's location in order to be included in the attribution process for PCPs.

1. Blue Shield will match PCP visits to each member utilizing specific E&M codes, which must have been billed by an eligible PCP in a twelve-month claim period prior to the attribution period (the "Look-Back Period"). This period will be extended to 18 months in the event there is no PCP linked to the patient. The term "PCP" means a contracted Blue Shield physician who provides covered services in the specialties of general practice, family practice, pediatrics, or internal medicine to Commercial PPO Members. Blue Shield will then move to Step 2.

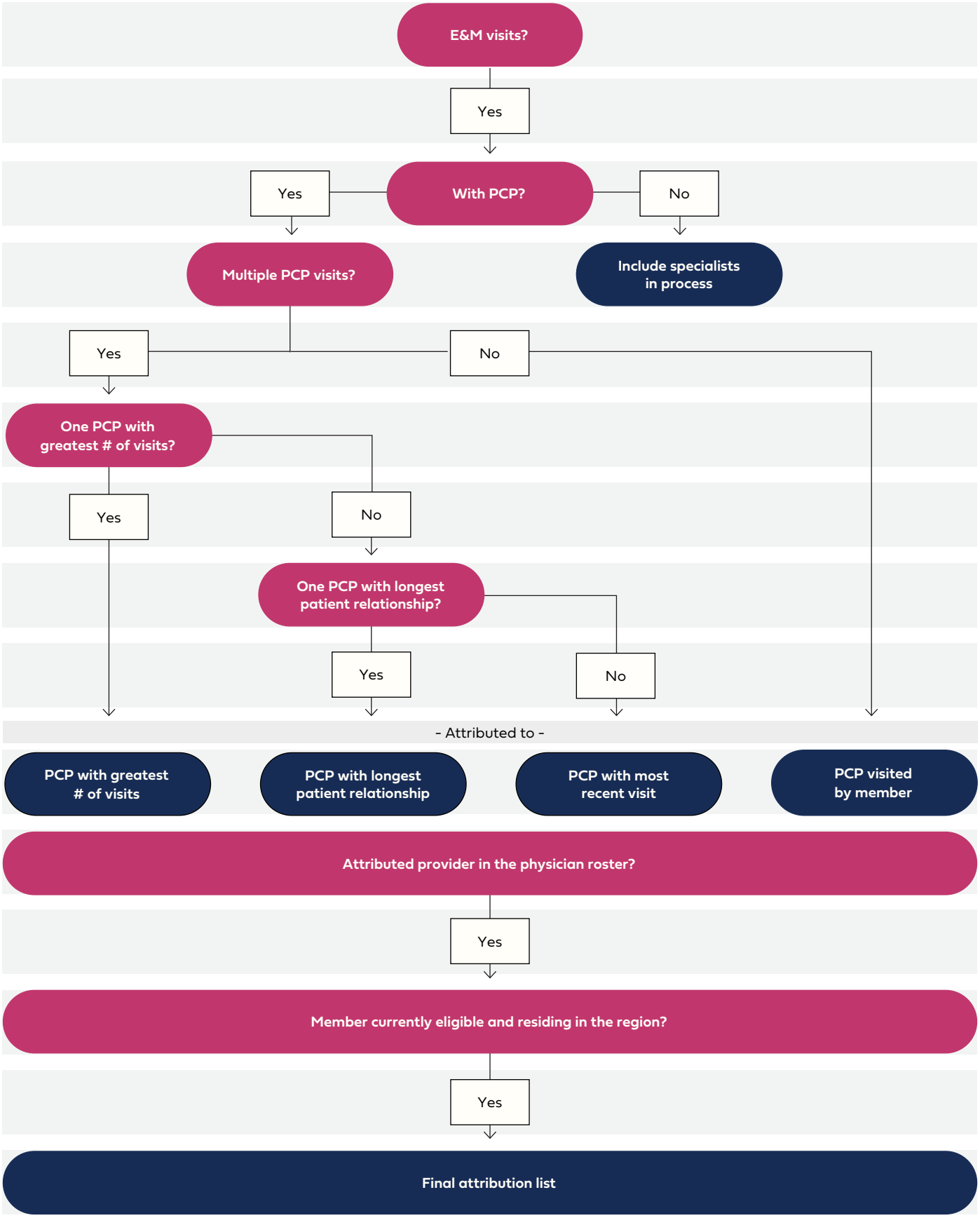
2. If Blue Shield determines that a member had one or more visits with a single PCP during the Look-Back Period, the member will be attributed to that PCP. If a member had visits with more than one PCP during the Look-Back Period, Blue Shield will move to Step 3.

3. If a member had visits with more than one PCP during the Look-Back Period, Blue Shield will determine the PCP with whom the member had the most visits. If one PCP has more visits than any other PCP, the member will be attributed to that PCP. If no PCP had more visits than any other PCP during the Look-Back Period, Blue Shield moves to Step 4.

4. If no PCP had more visits with a member than any other PCPs during the Look-Back Period, Blue Shield would determine which PCP has had the longest relationship with that member based on the duration of the member's relationship with each PCP as evidenced by the member's PCP visits during the Look-Back Period. If one PCP has the longest established relationship with the member, the member will be attributed to that PCP. If no PCP has the longest established relationship with the member, Blue Shield will move to Step 5.

5. If no PCP has the longest established relationship with the member, Blue Shield will determine which PCP saw the patient most recently for a visit. The member will then be attributed to the PCP who most recently saw the patient.

Attribution method flow chart



Payment

Claims submission

There is no change to the way practices submit claims for attributed members. Blue Shield will identify claims for which the PMPM vs. FFS applies and issue payment accordingly based on procedure codes submitted in each claim.

It's essential to submit accurately coded claims to Blue Shield in a timely manner to ensure the correct member benefits are processed and to continue to have members attributed to your practice. It is also important to note there is no change to claims submissions for members who are not included in the primary care value-based hybrid payment model.

PMPM

Blue Shield will make prospective PMPM payments on or before the 15th of the month. Practices will receive a PMPM payment for each attributed member, regardless of whether those members are seen by the practice in a given month or if the practice does/does not meet minimum performance thresholds described on page 39. Payments will be made via electronic transfer to a bank account designated by the practice. Practices can view payment history using the online analytical tool described on page 30.

FFS

Services that qualify as FFS will continue to be reimbursed as such. There is no change to the way FFS claims are submitted. FFS payments are made separately from PMPM payments.

Incentive payment

The number and timing of incentive payments is linked to practices' contract effective date. Incentive payments are based on practices' performance against resource utilization, clinical quality, and the patient experience metrics described on page 39. Partial advance incentive payments are paid in Q3. These payments will be made on an estimated basis and will be equal to practices' actual performance on the incentive measures in the previous measurement year, multiplied by the total number of attributed members in the current year. Annual performance incentive payments are paid in Q2 of a given year and are based on actual performance in the prior measurement year. Where applicable, this annual payment is reconciled against the partial advance incentive payment made in Q3 of the previous year. All incentive payments will be made via electronic transfer to a bank account designated by the practice.

Payment schedule example

The table below describes the payment schedule based on the practice's primary care pay-for-value hybrid payment model contract effective date. Please refer to this agreement to confirm this date.

Contract effective month	Payment schedule

January	• First year quality performance results will be paid:
	  ○ Partial advance payment: Q3 of 1st year
	  ○ Annual performance incentive payment: Q2 of 2nd year
	• Second year quality performance results will be paid:
	  ○ Partial advance payment: Q3 of 2nd year
	  ○ Annual performance incentive payment: Q2 of 3rd year

February to July	• First year quality performance results will be paid:
	  ○ Annual performance incentive payment: Q2 of 2nd year
	• Second year quality performance results will be paid:
	  ○ Partial advance payment: Q3 of 2nd year
	  ○ Annual performance incentive payment: Q2 of 3rd year

August to December	• First year quality performance results will not be paid
	• Second year quality performance results will be paid:
	  ○ Partial advance payment: Q3 of 2nd year
	  ○ Annual performance incentive payment: Q2 of 3rd year

2024 incentive payment schedule

Contract effective month	Payment schedule

January 2024 contract effective date	• Measurement year 2024 quality performance results paid:
	  ○ Partial advance payment: Q3 of 2024 for measurement year 2024
	  ○ Annual incentive payment: Q2 of 2025 for measurement year 2024
	• Measurement year 2025 quality performance results paid:
	  ○ Partial advance payment: Q3 of 2025 for measurement year 2025
	  ○ Annual incentive payment: Q2 of 2026 for measurement year 2025

February thru July 2024 contract effective date	• Measurement year 2024 quality performance results paid:
	  ○ Annual incentive payment: Q2 of 2025 for measurement year 2024
	• Measurement year 2025 quality performance results paid:
	  ○ Partial advance payment: Q3 of 2025 for measurement year 2025
	  ○ Annual incentive payment: Q2 of 2026 for measurement year 2025

August thru December 2024 contract effective date	• Measurement year 2024 quality performance results will not be paid
	• Measurement year 2025 quality performance results paid:
	  ○ Partial advance payment: Q3 of 2025 for measurement year 2025
	  ○ Annual incentive payment: Q2 of 2026 for measurement year 2025

Tools and tips

Online resources

You can access the value-based reporting and analytics tool to retrieve key information about their attributed Commercial PPO members and track performance.

The tool is free (i.e., no license is required) and is compatible with Google Chrome and Microsoft Edge web browsers. Practices will automatically have access to it via Blue Shield's Provider Connection website once their pay-for-value hybrid payment model contract becomes effective. Contact primarycarereimagined@blueshieldca.com if you have trouble accessing this tool. Practices will also receive training to orient staff and providers on how to use these features:

Attribution lists

Retrieve detailed member-level information for attributed Commercial PPO members

Care gap reports

Identity members for whom outreach and/or tailored interventions may be appropriate based on their current health status

Payment history

View PMPM and incentive payment history

Performance dashboards

View practice-level performance against resource utilization, clinical quality, and patient experience metrics

Tips for success

Keep an eye out for gaps in care prior to member arrival to avoid missed opportunities

Understand requirements for meeting or exceeding performance metrics

Where appropriate, provide clearly documented supplemental data

Code claims correctly to ensure correct member benefits are processed and continue to have members attributed to your practice

Use online analytical tools to identify attributed members, develop outreach strategies to address their healthcare-related needs, and track practice performance

These operational guidelines will be updated periodically. Practices will be notified at least 45 working days prior to the effective date of any change to the Provider Manual or these operational guidelines.

If you have questions about the primary care pay-for-value hybrid payment model, please email primarycarereimagined@blueshieldca.com.

Appendix

Performance measures

Adult	
Resource use measures	
Emergency room visits	• Emergency room (ER) visits per 1,000 members • Measure must meet minimum denominator size of 30 members to be included for payment
Inpatient admits	• Inpatient admits per 1,000 members • Risk adjustment using concurrent DxCG risk score • Measure must meet minimum denominator size of 150 members to be included for payment
Clinical quality measures	
Diabetes: Hemoglobin A1c (HbA1c) good control (<8.0%)	• Percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had Hemoglobin A1c (HbA1c) good control (<8.0%)
Controlling high blood pressure	• Percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year
Breast cancer screening	• Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer
Colorectal cancer screening	• Percentage of members 45-75 years of age who had appropriate screening for colorectal cancer

Pediatric	
Resource use measures	
Emergency room visits	Individual member who is under eighteen (18) years of age as of Dec. 31 of measurement year who had an emergency room (ER) visit per 1,000 members. • Measure must meet minimum denominator size of 30 members to be included in incentive payment
Clinical quality measures	

Childhood immunization status: Combination 10	• Percentage of children 2 years of age who, by their second birthday, received all vaccinations in the combination 10 vaccination set. This vaccination set includes:
	  • 4 diphtheria, tetanus, and acellular pertussis (DTaP) vaccinations
	  • 3 polio (IPV) vaccinations
	  • 1 measles, mumps, and rubella (MMR) vaccination
	  • 3 haemophilus influenza type B (HiB) vaccinations
	  • 3 hepatitis B (HepB) vaccinations
	  • 1 chicken pox (VZV) vaccination
	  • 4 pneumococcal conjugate (PCV) vaccinations
	  • 1 hepatitis A (HepA) vaccination
	  • 2 or 3 rotavirus (RV) vaccination
	  • 2 influenza (flu) vaccines

Immunizations for adolescents: Combination 2	• Percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

Weight assessment & counseling for nutrition and physical activity for children/adolescents	• Percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year.
	  • Rate 1: BMI percentile documentation
	  • Rate 2: Counseling for nutrition
	  • Rate 3: Counseling for physical activity

Adult and Pediatric	
Patient experience	
Rating of provider	• As measured by respondents answering: • "Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate your provider?"
Someone at office gave test results	• As measured by respondents answering: • "In the last 6 months, when your provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?"
Discussed prescription medications	• As measured by respondents answering: • "In the last 6 months, how often did you and your provider talk about all the prescription medicines you were taking?"

Getting care quickly composite	• As measured by respondents answering:
	  • "In the last 6 months, when you contacted your provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?"
	  • "In the last 6 months, when you made an appointment for a check-up or routine care with your provider, how often did you get an appointment as soon as you needed?"

Provider explained things in an easily understandable way	• As measured by respondents answering: • "In the last 6 months, how often did your provider explain things in a way that was easy to understand?"

* Only the questions noted above are utilized for incentive measures in patient experience. See full patient experience survey on pages 35 to 38.

Patient experience survey

Blue Shield will administer a patient experience survey to your attributed members who have a visit with your practice. Members will be contacted by mail, email, or phone and asked to complete/return the survey. All responses are anonymous. Results will be collated and made available via the online analytical tool described on page 30. At this time, the survey is available in English and Spanish only. A copy of the survey is included on the following pages.

Blue Shield patient experience survey (adult)

INSTRUCTIONS

Answer each question by marking the box to the left of your answer.

You are sometimes told to skip over some questions in this survey. When this happens, you will see an arrow with a note that tells you what question to answer next, like this:

☐ Yes ➔ **If Yes, go to question 1**
☒ No

Personally identifiable information will not be made public and will only be released in accordance with federal laws and regulations.

You may choose to answer this survey or not. If you choose not to, this will not affect the benefits you get. You may notice a number on the back of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

If you want to know more about this study, please call 1-877-866-2460.

YOUR PROVIDER

A. Our records show that you got care from the provider named below in the last 6 months. This may have included an appointment in the office, over the telephone or by video.

<UDEF10>

Is that right?

☐ Yes
☐ No ➔ **If No, go to question 15**

The questions in this survey will refer to the provider named in Question A as "your provider." Please think of that person as you answer the survey.

1. In the last 6 months, when you contacted your provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?

☐ Never
☐ Sometimes
☐ Usually
☐ Always
☐ Does not apply

2. In the last 6 months, when you made an appointment for a check-up or routine care with your provider, how often did you get an appointment as soon as you needed?

☐ Never
☐ Sometimes
☐ Usually
☐ Always
☐ Does not apply

3. Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see your provider within 15 minutes of your appointment time?

☐ Never
☐ Sometimes
☐ Usually
☐ Always
☐ Does not apply

4. In the last 6 months, how often did your provider explain things in a way that was easy to understand?

☐ Never
☐ Sometimes
☐ Usually
☐ Always
☐ Does not apply

5. In the last 6 months, how often did your provider show respect for what you had to say?

☐ Never
☐ Sometimes
☐ Usually
☐ Always
☐ Does not apply

6. In the last 6 months, how often were the clerks and receptionists at your provider's office helpful and courteous?

☐ Never
☐ Sometimes
☐ Usually
☐ Always
☐ Does not apply

7. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed from your provider?

☐ Never
☐ Sometimes
☐ Usually
☐ Always
☐ Does not apply

8. In the last 6 months, when your provider ordered a blood test, x-ray or other test for you, how often did someone from your provider's office follow up to give you those results as soon as you needed them?

☐ Never
☐ Sometimes
☐ Usually
☐ Always
☐ Does not apply

9. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ Does not apply

10. In the last 6 months, how often did your provider seem informed and up-to-date about the care you got from specialists?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ Does not apply

11. In the last 6 months, how often did you and your provider talk about all the prescription medicines you were taking?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ Does not apply

12. In the last 6 months, how often was it easy to use your prescription drug plan to get the medicines your provider prescribed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ Does not apply

13. Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate your *provider*?

Worst provider possible — Best provider possible

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

14. Using any number from 0 to 10 where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your *health care* in the last 6 months?

Worst health care possible — Best health care possible

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

ABOUT YOU

15. In general, how would you rate your overall health?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

16. In general, how would you rate your overall mental or emotional health?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

17. What is your age?

- ☐ 24 or under
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 to 74
- ☐ 75 or older

18. What is your Gender?

- ☐ Male
- ☐ Female
- ☐ Non-binary/non-conforming
- ☐ Prefer not to respond

19. What is the highest grade or level of school that you have completed?

- ☐ 8th grade or less
- ☐ Some high school, but did not graduate
- ☐ High school graduate or GED
- ☐ Some college or 2-year degree
- ☐ 4-year college graduate
- ☐ More than 4-year college degree

20. Are you of Hispanic or Latino origin or descent?

- ☐ Yes, Hispanic or Latino
- ☐ No, not Hispanic or Latino

21. What is your race? Mark one or more.

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ American Indian or Alaska Native
- ☐ Other

22. Please provide your email address:

_____

Thank you.

Please return the completed survey in the postage-paid envelope.

Blue Shield patient experience survey (pediatric)

INSTRUCTIONS

Answer each question by marking the box to the left of your answer.

You are sometimes told to skip over some questions in this survey. When this happens, you will see an arrow with a note that tells you what question to answer next, like this:

- ☐ Yes ➔ **If Yes, go to question 1**
- ☒ No

Personally identifiable information will not be made public and will only be released in accordance with federal laws and regulations.

You may choose to answer this survey or not. If you choose not to, this will not affect the benefits you get. You may notice a number on the back of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

If you want to know more about this study, please call 1-877-866-2460.

YOUR CHILD'S PROVIDER

A. Our records show that your child got care from the provider named below in the last 6 months. This may have included an appointment in the office, over the telephone or by video.

<UDEF10>

Is that right?

- ☐ Yes
- ☐ No ➔ **If No, go to question 15**

The questions in this survey will refer to the provider named in Question A as "your child's provider." Please think of that person as you answer the survey.

1. In the last 6 months, when you contacted your child's provider's office to get an appointment for care your child needed right away, how often did you get an appointment as soon as your child needed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ Does not apply

2. In the last 6 months, when you made an appointment for a check-up or routine care with your child's provider, how often did you get an appointment as soon as your child needed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ Does not apply

3. Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see your child's provider within 15 minutes of your child's appointment time?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ Does not apply

4. In the last 6 months, how often did your child's provider explain things in a way that was easy to understand?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ Does not apply

5. In the last 6 months, how often did your child's provider show respect for what you had to say?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ Does not apply

6. In the last 6 months, how often were the clerks and receptionists at your child's provider's office helpful and courteous?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ Does not apply

7. In the last 6 months, how often was it easy for your child to get the care, tests, or treatment you needed from your child's provider?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ Does not apply

8. In the last 6 months, when your child's provider ordered a blood test, x-ray or other test for your child, how often did someone from your child's provider's office follow up to give you those results as soon as you needed them?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ Does not apply

9. In the last 6 months, how often did you get an appointment to see a specialist as soon as your child needed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ Does not apply

10. In the last 6 months, how often did your child's provider seem informed and up-to-date about the care your child got from specialists?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ Does not apply

11. In the last 6 months, how often did you and your child's provider talk about all the prescription medicines your child was taking?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ Does not apply

12. In the last 6 months, how often was it easy to use your child's prescription drug plan to get the medicines your child's provider prescribed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ Does not apply

13. Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate your child's *provider*?

Worst provider possible — Best provider possible

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

14. Using any number from 0 to 10 where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your child's *health care* in the last 6 months?

Worst health care possible — Best health care possible

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

ABOUT YOUR CHILD

15. In general, how would you rate your child's overall health?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

16. In general, how would you rate your child's overall mental or emotional health?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

17. What is your child's age?

- ☐ Less than one year old
- ☐ _____ YEARS OLD

18. What is your child's Gender?

- ☐ Male
- ☐ Female
- ☐ Non-binary/non-conforming
- ☐ Prefer not to respond

19. What is the highest grade or level of school that you have completed?

- ☐ 8th grade or less
- ☐ Some high school, but did not graduate
- ☐ High school graduate or GED
- ☐ Some college or 2-year degree
- ☐ 4-year college graduate
- ☐ More than 4-year college degree

20. Is your child of Hispanic or Latino origin or descent?

- ☐ Yes, Hispanic or Latino
- ☐ No, not Hispanic or Latino

21. What is your child's race? Mark one or more.

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ American Indian or Alaska Native
- ☐ Other

22. Please provide your email address:

_____

Thank you.

Please return the completed survey in the postage-paid envelope.

Measurement year 2024 thresholds

The table below shows thresholds for 2024.

Adult

Type	Name	Min threshold	Target threshold	Max incentive PMPM
Resource utilization	Emergency room (ER) visits per 1,000 members	50th percentile	75th percentile	$1.30
	Inpatient admits (IA) per 1,000 members	50th percentile	75th percentile	$1.30
Clinical quality	Diabetes: Hemoglobin A1c (HbA1c) good control (<8.0%)*	58.0%	62.0%	$0.8125
	Controlling high blood pressure	60.0%	66.0%	$0.8125
	Breast cancer screening	73.0%	79.0%	$0.8125
	Colorectal cancer screening	56.0%	62.0%	$0.8125
Patient experience	Rating of provider	79.0%	82.0%	$0.13
	Someone at office gave test results	80.0%	85.0%	$0.13
	Discussed prescription medications	83.0%	89.0%	$0.13
	Getting care quickly composite	69.0%	76.0%	$0.13
	Provider explained things in an easily understandable way	91.0%	93.0%	$0.13
Maximum incentive per attributed member				**$6.50**

* New measure in 2024. Lower rate indicates better performance for these measures

Pediatric

Type	Name	Min threshold	Target threshold	Max incentive PMPM
Resource Utilization	Pediatric ER visits/1000 members	50th percentile	75th percentile	$0.75
Clinical quality	Childhood immunizations – Combo 10	53.0%	61.0%	$1.25
	Adolescent immunizations – Combo 2	31.0%	41.0%	$1.25
	Weight assessment & counseling for nutrition and physical activity:			
	i. BMI percentile documentation	69.0%	86.0%	$0.4166
	ii. Counseling for nutrition	61.0%	80.0%	$0.4166
	iii. Physical activity	60.0%	78.0%	$0.4166
Patient experience	Rating of provider	79.0%	82.0%	$0.10
	Someone at office gave test results	80.0%	85.0%	$0.10
	Discussed prescription medications	83.0%	89.0%	$0.10
	Getting care quickly composite	69.0%	76.0%	$0.10
	Provider explained things in an easily understandable way	91.0%	93.0%	$0.10
Maximum incentive per attributed member				**$5.00**

Blue Shield uses National Committee for Quality Assurance (NCQA) guidelines for HEDIS clinical quality measures. Blue Shield updates thresholds annually for each performance measure. Updates are retroactive to 1/1 of the year in which they are made.

Procedure code inclusions and exclusions

The table on the following page shows a list of included and excluded procedure codes by group in 2024. Codes that do not appear on this list or are specified otherwise will continue to be paid on an FFS basis based on the standard fee schedule.

Blue Shield complies with state and federal laws and regulatory requirements regarding coding additions, subtractions, inclusions, and exclusions. If a new procedure code is created during a measurement year, Blue Shield will pay for services under that procedure code on an FFS basis at least until the end of the measurement year.

Blue Shield will provide practices with advance written notice if Blue Shield subsequently includes those new procedure codes in PMPM payments.

Included in PMPM

Columns A and B in the table below represent codes that are covered by the PMPM. Column C shows exceptions to these codes; these exceptions will continue to be paid FFS.

A	B	C
Included code categories	**Procedure codes in included code categories**	**Exceptions to the included category: Codes excluded from the PMPM and paid as FFS**
E&M	992xx	None
Other E&M	99300-99499	• Home visits • Rest home visits • Skilled Nursing Facility (SNF) • Behavioral Health Collaborative Care
Medicine services	90757-99756 HCPCS - S & Q codes	• Echocardiograms • Specimen handling • Inhalation treatment • Filing of inflatable pump • COVID testing • Flu vaccines • IV tubing • IV infusion • Pap smear • IUDs • Abortion
Temporary HCPCS	HCPCS - G & C codes	• COVID testing
Drugs, non-oral and chemo	HCPCS - J codes	• Ceftriaxone • Progesterone • Asthma-related • Nausea-related • IV fluid • IUDs • Estradiol • Cortisone • Chemo
Category III	Codes ending in T	None

Excluded from PMPM

Procedures requiring prior authorization and injectable medications covered by Section 1375.8 of the California Health and Safety Code (commonly referred to as the Richman Bill) will be excluded from the PMPM and thus continue to be paid as FFS.

The table below shows codes that are included in the PMPM vs. paid as FFS. Columns D and E represent codes that continue to be paid FFS. Column F shows codes for which the PMPM applies and thus services for these codes will be covered in the PMPM.

D	E	F
Excluded code categories	**Procedure codes in excluded code categories (to be paid FFS)**	**Exceptions to excluded code categories (to be covered by the PMPM and not paid FFS)**
Immunizations	90281–90756 G0008–G0010	None
Annual well visits	99381–99387 99391–99397	None
Transportation and supplies	HCPCS – A codes	None
DME	HCPCS – E codes	None
Surgery	10004–69990	• Cerumen removal • Collection of capillary blood • Dermatologic (removals, not including biopsies) • Injection of trigger points
Radiology	70010–79999	• Ultrasounds (other than for pregnant uterus)
Pathology and lab	80047-89398 HCPCS - P codes	• IV tubing • IV infusion

Service intensity adjustment methodology and factors

The service intensity adjustment modifies the PMPM payment made to your practice based on the age, gender, and health conditions of your attributed patient population.

For each attributed member, the service intensity adjustment is equal to the age/gender factor multiplied by the condition factor. Condition factors vary for adult and pediatric patients. Factors will be updated periodically.

Condition tier and factors: Adult

Condition tier	Conditions included*	Condition factor
1A	Acquired cognitive disorders Bone marrow transplant and complications Cardiac arrest Dialysis and kidney transplant GI transplant Lung congestion and effusion Malnutrition Medical and radiation oncology Myoneural conditions Other lung conditions Paralysis and coma Respiratory insufficiency (acute and chronic) Severe developmental disability	2.121
2A	Congestive heart failure Coronary artery disease Disorders of immunity Drug abuse Eating disorders Hyperlipidemia Inflammatory musculoskeletal conditions Liver failure Lung fibrosis Musculoskeletal infection (unspecified location) Other transplant status and complications Peptic ulcer and related conditions Personality disorders Poisoning Post-stroke paralysis Traumatic amputation Type I diabetes	1.6313

Condition tier	Conditions included*	Condition factor
3A**	Artificial openings Atherosclerosis Biliary and gallbladder conditions Blood and lymph neoplasm Chronic kidney disease Hepatitis Liver transplant Lung transplant Miscellaneous Significant Infections Other nutritional and metabolic conditions Other sequelae of cerebrovascular events Other vascular conditions Pancreatic disorders	1.3623
4A	Artificial/transplant heart or valve replacement Cardiac arrhythmias Cerebro-vascular impairment Chromosomal and developmental disorders Congenital heart conditions Diabetes Implant and device complications Inflammatory bowel disease Lung infection Neurological trauma Other complications Psychoses Skin ulcers Stroke Suicide attempts	1.2000
5A	Alcohol abuse Alcoholic liver, cirrhosis, and infarct Anemia Back disorders and injuries Bladder and other urinary conditions Carcinoma in situ COPD and asthma Degenerative neurological conditions Head injury Heart valve and pericardial conditions Hypertension Malignancy Other heart conditions Other neurological conditions Post-procedural conditions Seizure disorders Significant ENT disorders	1.0181
6A**	All others	0.5513

* Effective 4/1/2024, condition tiers and factors include a more granular list of conditions in each tier.

** Effective 8/1/2024, Miscellaneous Significant Infections will be removed from tier 6A and added to tier 3A.

Condition tier and factors: Pediatric

Condition Tier	Conditions Included*	Condition Factor
1P	Anemia Artificial openings Coronary artery disease Disorders of immunity Inflammatory bowel disease Liver transplant Lung fibrosis Lung transplant Malnutrition Medical and radiation oncology Myoneural conditions Other transplant status and complications Type I diabetes	2.5271
2P	Acquired cognitive disorders Biliary and gallbladder conditions Bone marrow transplant and complications Cardiac arrhythmias Chronic kidney disease Completed/terminated pregnancy Congestive heart failure Eating disorders Hepatitis Hypertension Inflammatory musculoskeletal conditions Other machine dependence Other vascular conditions Peptic ulcer and related conditions Respiratory insufficiency (acute and chronic) Significant ENT disorders Stroke	1.9858
3P	Atherosclerosis COPD and asthma Degenerative neurological conditions Diabetes Drug abuse Endocrine conditions Heart valve and pericardial conditions Lung congestion and effusion Lung infection Musculoskeletal infection (unspecified location) Neurological trauma Other neurological conditions Other nutritional and metabolic conditions Pancreatic disorders Paralysis and coma Personality disorders Poisoning Seizure disorders Social determinants of health Suicide attempts Urinary system infection	1.5784

Condition tier and factors: Pediatric

Condition Tier	Conditions Included*	Condition Factor
4P	Artificial/transplant heart or valve replacement Chromosomal and developmental disorders Excess weight Eye infection and inflammation Head injury Hemorrhagic conditions Hyperlipidemia Implant and device complications Malignancy Mood and anxiety disorders Other complications Other gastrointestinal conditions Other lung conditions Other screening & high-risk medication Other screening and history Other sequelae of cerebrovascular events Severe developmental disability Skin ulcers	1.2625
5P	Blood and lymph neoplasm Congenital heart conditions Headache Knee disorders Miscellaneous signifcant infections Orthopedic hip/pelvic disorders Other ENT disorders Other heart conditions Other mental conditions Post-procedural conditions Post-stroke paralysis Serious perinatal conditions Shoulder & upper arm disorders*	1.0347
6P	All others	0.5539

*Effective 4/1/2024, condition tiers and factors include a more granular list of conditions in each tier.

Age and gender factors

Age	Female	Male	Unknown or Not Disclosed*
Under 2	1.2169	1.3273	1.2721
2 to 5	0.9539	1.0363	0.9951
6 to 17	0.6673	0.6815	0.6744
18 to 24	0.7072	0.5180	0.6126
25 to 29	0.8752	0.7227	0.7989
30 to 34	0.9232	0.8043	0.8637
35 to 39	0.9758	0.8214	0.8986
40 to 44	1.0358	0.8777	0.9568
45 to 49	1.1309	0.9370	1.0339
50 to 54	1.2196	1.0251	1.1224
55 to 59	1.2702	1.1465	1.2084
60 to 64	1.3670	1.2617	1.3143
Over 65	1.6814	1.5546	1.6180

*Unknown or Not Disclosed is new effective 4/1/2024.

Benefit adjustments

Benefit adjustments modify the PMPM payment made to your practice based on the benefit design of plans for your attributed patient population. For each attributed member in 2024, the benefit adjustment is based on the table below.

Benefit adjustment factors

Deductible Low	High	Coinsurance Low	High	Copay Low	High	Benefit adjustment
0	0	0	4.9	0	4	2.1915
0	0	5	14.9	0	4	1.7015
0	0	15	24.9	0	4	1.3430
0	0	25	34.9	0	4	1.0778
0	0	35	44.9	0	4	0.8808
0	0	45	100	0	4	0.7337
0	0	0	100	5	9	1.9964
0	0	0	100	10	14	1.8014
0	0	0	100	15	19	1.6063
0	0	0	100	20	24	1.4112
0	0	0	100	25	29	1.2969
0	0	0	100	30	34	1.1826
0	0	0	100	35	39	1.0683
0	0	0	100	40	44	0.9540
0	0	0	100	45	49	0.8897
0	0	0	100	50	54	0.8253
0	0	0	100	55	59	0.7610
0	0	0	100	60	64	0.6966
0	0	0	100	65	69	0.6633
0	0	0	100	70	74	0.6300
0	0	0	100	75	79	0.5966

Deductible Low	High	Coinsurance Low	High	Copay Low	High	Benefit adjustment
0	0	0	100	80	84	0.5633
0	0	0	100	85	89	0.5484
0	0	0	100	90	999999	0.5334
1	999	0	4.9	0	4	1.9972
1	999	5	14.9	0	4	1.5646
1	999	15	24.9	0	4	1.2462
1	999	25	34.9	0	4	1.0099
1	999	35	44.9	0	4	0.8335
1	999	45	100	0	4	0.7013
1	999	0	100	5	9	1.8237
1	999	0	100	10	14	1.6503
1	999	0	100	15	19	1.4769
1	999	0	100	20	24	1.3034
1	999	0	100	25	29	1.2015
1	999	0	100	30	34	1.0995
1	999	0	100	35	39	0.9976
1	999	0	100	40	44	0.8957
1	999	0	100	45	49	0.8380
1	999	0	100	50	54	0.7803
1	999	0	100	55	59	0.7227
1	999	0	100	60	64	0.6650
1	999	0	100	65	69	0.6350
1	999	0	100	70	74	0.6050
1	999	0	100	75	79	0.5749
1	999	0	100	80	84	0.5449
1	999	0	100	85	89	0.5314
1	999	0	100	90	999999	0.5178
1000	2999	0	4.9	0	4	1.4122
1000	2999	5	14.9	0	4	1.1451
1000	2999	15	24.9	0	4	0.9400
1000	2999	25	34.9	0	4	0.7844
1000	2999	35	44.9	0	4	0.6667
1000	2999	45	100	0	4	0.5778

Deductible Low	High	Coinsurance Low	High	Copay Low	High	Benefit adjustment
1000	2999	0	100	5	9	1.3021
1000	2999	0	100	10	14	1.1921
1000	2999	0	100	15	19	1.0820
1000	2999	0	100	20	24	0.9720
1000	2999	0	100	25	29	0.9060
1000	2999	0	100	30	34	0.8401
1000	2999	0	100	35	39	0.7741
1000	2999	0	100	40	44	0.7081
1000	2999	0	100	45	49	0.6701
1000	2999	0	100	50	54	0.6320
1000	2999	0	100	55	59	0.5940
1000	2999	0	100	60	64	0.5560
1000	2999	0	100	65	69	0.5359
1000	2999	0	100	70	74	0.5158
1000	2999	0	100	75	79	0.4957
1000	2999	0	100	80	84	0.4756
1000	2999	0	100	85	89	0.4664
1000	2999	0	100	90	999999	0.4572
3000	5999	0	4.9	0	4	1.1318
3000	5999	5	14.9	0	4	0.9352
3000	5999	15	24.9	0	4	0.7828
3000	5999	25	34.9	0	4	0.6656
3000	5999	35	44.9	0	4	0.5761
3000	5999	45	100	0	4	0.5082
3000	5999	0	100	5	9	1.0504
3000	5999	0	100	10	14	0.9691
3000	5999	0	100	15	19	0.8878
3000	5999	0	100	20	24	0.8065
3000	5999	0	100	25	29	0.7572
3000	5999	0	100	30	34	0.7080
3000	5999	0	100	35	39	0.6587
3000	5999	0	100	40	44	0.6094
3000	5999	0	100	45	49	0.5809

Deductible Low	High	Coinsurance Low	High	Copay Low	High	Benefit adjustment
3000	5999	0	100	50	54	0.5523
3000	5999	0	100	55	59	0.5237
3000	5999	0	100	60	64	0.4951
3000	5999	0	100	65	69	0.4800
3000	5999	0	100	70	74	0.4649
3000	5999	0	100	75	79	0.4498
3000	5999	0	100	80	84	0.4347
3000	5999	0	100	85	89	0.4277
3000	5999	0	100	90	999999	0.4208
6000	999999	0	4.9	0	4	0.9089
6000	999999	5	14.9	0	4	0.7791
6000	999999	15	24.9	0	4	0.6760
6000	999999	25	34.9	0	4	0.5945
6000	999999	35	44.9	0	4	0.5299
6000	999999	45	100	0	4	0.4792
6000	999999	0	100	5	9	0.8571
6000	999999	0	100	10	14	0.8052
6000	999999	0	100	15	19	0.7534
6000	999999	0	100	20	24	0.7015
6000	999999	0	100	25	29	0.6672
6000	999999	0	100	30	34	0.6329
6000	999999	0	100	35	39	0.5987
6000	999999	0	100	40	44	0.5644
6000	999999	0	100	45	49	0.5428
6000	999999	0	100	50	54	0.5211
6000	999999	0	100	55	59	0.4995
6000	999999	0	100	60	64	0.4779
6000	999999	0	100	65	69	0.4656
6000	999999	0	100	70	74	0.4533
6000	999999	0	100	75	79	0.4410
6000	999999	0	100	80	84	0.4287
6000	999999	0	100	85	89	0.4228
6000	999999	0	100	90	999999	0.4168

Glossary of terms

01 **Adult member**
An individual member who is eighteen (18) years of age or older.

02 **Attribution**
Blue Shield's approach to attribution considers medical claim history for the previous 18 months and associates the member with the primary care doctor most closely affiliated.

03 **Benefit adjustment**
Modifies the PMPM payment made to your practice based on the benefit design of plans for your attributed patient population.

04 **Denominator**
Minimum number of eligible attributed members included in a given performance metric.

05 **Domain**
Practices may earn an incentive based on performance in three categories of quality of care and/or health outcomes measures. In the Primary Care Pay-for-Value Hybrid Payment Model, these categories – resource utilization, clinical quality, and patient experience – are known as "domains".

06 **Member eligibility**
Commercial PPO members (adult and pediatric).

07 **Numerator**
Actual number of attributed members included in a given performance metric (e.g., number of members with clinical diagnosis of diabetes).

08 **Patient experience**
Blue Shield will administer a survey to assess attributed members' experience with accessing services in the practice.

09 **Pay-for-value PMPM payment**
Monthly advance payments to support traditional and/or new approaches to care delivery and coordination.

10 **Pediatric member**
An individual member who is under eighteen (18) years of age as of 12/31.

11 **Performance incentive**
Practices may receive an additional incentive payment for each attributed member based on meeting targets for clinical quality, resource utilization, and patient experience metrics.

12 **Primary care pay-for-value hybrid payment model**
Reimburses providers for services with a mix of traditional fee for service (FFS) and per member per month (PMPM) payments.

13 **Per member per month (PMPM)**
Monthly advance payments for majority of codes used for standard primary care delivery, service intensity and benefit adjusted.

14 **Reconciliation**
To ensure that PMPM payments accurately reflect the underlying patient population, Blue Shield will conduct monthly and annual reconciliations to true-up member eligibility, benefits, and health conditions.

15 **Re-weighting**
Process of redistributing the PMPM of an ineligible individual measure weight to other measures within a domain, or to an entire domain if all measures in that domain are ineligible.

16 **Service intensity adjustment**
The service intensity adjustment modifies the PMPM payment made to your practice based on the age, gender, and health conditions of your attributed patient population.

17 **Supplemental data**
Additional clinical data about a member, beyond claims data, received by a health plan. Example: use of procedure codes for reporting a clinical result, such as blood pressure.

Resources

Questions about financial data or attribution

The current process for formal appeals and grievances will be used to address practices' concerns regarding calculations or data. This process is detailed in your agreement with Blue Shield, as well as the Blue Shield Provider Manual.

Contacts

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