Collaborative Quality Initiatives Fact Sheet
Value-Based Reimbursement 2028

Michigan Hospital Medicine Safety Consortium (HMS)

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% or 102%, of the standard fee schedule if they meet performance targets in one or more of those initiatives.

Participants can only receive VBR for one hospital/professional CQI, even if they are participating in more than one CQI, with the following exception. Practitioners that participate in one of the four population-health based CQIs - INHALE, MCT2D, MIMIND – can receive the related VBR 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 (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. Hospital scores are based on the average of all providers using an adjusted scoring methodology.

The collective average for each group of hospital-affiliated physicians must achieve either one of the following conditions to be eligible for 102% or 103% of the standard fee schedule:

VBR Eligibility Scale for CQIs offering up to 103%	Points Threshold
Points Threshold to Meet 102% VBR eligibility	> 60 - 79
Points Threshold to Meet 103% VBR eligibility	>= 80 - 100

VBR Measures

2028 CQI VBR Measure Scorecard **Hospital Medicine Safety (HMS) - Hospitalists & Infectious Diseases Physicians** **VBR Measurement Period:** **Sepsis & Antimicrobial Discharges: 05/06/2027 – 07/28/2027** **VBR Reimbursement Period:** **03/01/2028 - 02/28/2029**			
Measure #	Weight	Measure Description	Points
1	25%	**Measure:** Increase Use of Appropriate Antibiotic Treatment Duration (3 – 5 days) in Uncomplicated CAP (Community Acquired Pneumonia) Cases (i.e., reduce excess durations) **Aggregation level:** Collaborative level **Measurement period:** N/A	
		>= 75% collaborative-wide average of uncomplicated CAP cases receive appropriate duration of antibiotics	25
		70- 74% collaborative-wide average of uncomplicated CAP cases receive appropriate duration of antibiotics	15
		<=69% collaborative-wide average of uncomplicated CAP cases receive appropriate duration of antibiotics	0
2	25%	**Measure:** Reduce Use of Antibiotics in Patients with Asymptomatic Bacteriuria (ASB) **Aggregation level:** Hospital level **Measurement period:** N/A	
		<= 10% of positive urine culture cases treated with an antibiotic are ASB cases	25
		11 - 15% of positive urine culture cases treated with an antibiotic are ASB cases	15
		>=16% of positive urine culture cases treated with an antibiotic are ASB cases	0

3	25%	**Measure:** Increase Appropriate Antibiotic Treatment for Uncomplicated UTI **Aggregation level:** Hospital level **Measurement period:** N/A	
		>= 58% of uncomplicated UTI cases receive appropriate antibiotic treatment	25
		50 - 57% of uncomplicated UTI cases receive appropriate antibiotic treatment	15
		<= 49% of uncomplicated UTI cases receive appropriate antibiotic treatment	0
4	25%	**Measure:** Increase Discharge/Post-Discharge Coordination (2 of 4) of Care for High-Risk Sepsis Patients **Aggregation level:** Hospital level **Measurement period:** N/A	
		>= 74% of sepsis cases at high risk of readmission received at least 2 of 4 discharge/post-discharge coordination- of-care measures	25
		55 - 73% of sepsis cases at high risk of readmission received at least 2 of 4 discharge/post-discharge coordination-of-care measures	15
		<= 54% of sepsis cases at high risk of readmission received at least 2 of 4 discharge/post-discharge coordination-of-care measures	0
		Total Points Possible	100

Changes from 2027 VBR Measures - Hospitalists & Infectious Diseases Physicians

Measure Description (document same language as on the scorecard)	Was this measure an Addition or Removal	2028 CQI VBR	Rationale for Additional or Removal
Reduce Use of Antibiotics in Patients with Asymptomatic Bacteriuria (ASB)	Addition	X	New Measure for VBR – Consistent with P4P
Increase Appropriate Antibiotic Treatment for Uncomplicated UTI	Addition	X	New Measure - Consistent with National IDSA Guidelines
Increase Discharge/Post-Discharge Coordination (2 of 4) of Care for High-Risk Sepsis Patients	Addition	X	New Measure for VBR – Consistent with P4P

2028 CQI VBR Measure Scorecard
Hospital Medicine Safety (HMS) - Critical Care Physicians

VBR Measurement Period (unless specified otherwise in the measure):
05/06/2027 – 07/28/2027
VBR Reimbursement Period:
03/01/2028 - 02/28/2029

Measure #	Weight	Measure Description	Points
1	30%	**Measure:** Increase Use of Balanced Solutions in Patients with Sepsis **Aggregation level:** Hospital level **Measurement period:** N/A	
		>= 60% of sepsis cases who have >= 75% of their bolus and/or maintenance fluid as balanced solutions in the first 48 hours of hospital arrival	30
		40 – 59% of sepsis cases who have >= 75% of their bolus and/or maintenance fluid as balanced solutions in the first 48 hours of hospital arrival	20
		<=39% of sepsis cases who have >= 75% of their bolus and/or maintenance fluid as balanced solutions in the first 48 hours of hospital arrival	0
2	30%	**Measure:** Increase Use of IV Fluids at >=30 ml/kg within 6 Hours in Patients with Sepsis **Aggregation level:** Hospital level **Measurement period:** N/A	
		>= 65% of sepsis cases receive >=30 ml/kg intravenous fluid within 6 hours of hospital arrival	30
		60 – 64% of sepsis cases receive >=30 ml/kg intravenous fluid within 6 hours of hospital arrival	20
		<=59% of sepsis cases receive >=30 ml/kg intravenous fluid within 6 hours of hospital arrival	0
3	40%	**Measure:** Increase Transitions of Care Documentation - ICU to Floor Composite Measure 1) Temporary CVC removal or documentation of need to keep prior to transfer out of ICU, 2) Urinary catheter removal or documentation of need to keep prior to transfer out of ICU, 3) Communication of fluid volume status at ICU transfer, 4) Communication of antibiotic plan at ICU transfer **Aggregation level:** Hospital level **Measurement period:** N/A	
		=>72% of sepsis cases have appropriate documentation at ICU to Floor Transfer	40
		60-71% of sepsis cases have appropriate documentation at ICU to Floor Transfer	20
		<60% of sepsis cases have appropriate documentation at ICU to Floor Transfer	0
		Total Points Possible	100

Changes from 2027 VBR Measures - Critical Care Physicians

Measure Description (document same language as on the scorecard)	Was this measure an Addition or Removal	2028 CQI VBR	Rationale for Additional or Removal
Increase Use of Balanced Solutions in Patients with Sepsis	Addition	X	New Measure for VBR – Consistent with P4P
Increase Use of IV Fluids at >=30 ml/kg within 6 Hours in Patients with Sepsis	Addition	X	New Measure - Appropriate Fluid Administration is associated with decreased mortality

VBR selection process

To be eligible for 2028 CQI VBR, the practitioner must:

- Meet the performance targets set by the coordinating center
- Be on the PGIP winter 2027 and summer 2027 snapshots (as well as in PGIP as of February 2028)
- 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 does not collect provider specific data. Each Fall in the HMS semi-annual quality improvement (QI) survey hospital participants are asked 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, it is required 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.

Hospital CQIs, with the exception of HMS, collect practitioner NPI information through clinical data abstracted into the clinical data registry.
Population Health CQIs collect practitioner NPI information through claims data.

About the HMS CQI

The Michigan Hospital Medicine Safety Consortium (HMS) was established in 2010. HMS is a data-driven collaborative 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 focuses on 3 main initiatives including improving appropriate antimicrobial use, improving care and outcomes for patients hospitalized with Sepsis and care of critically ill patients.

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.