2025 Pay for Performance (P4P) & 2026 Value Based Reimbursement (VBR) Frequently Asked Questions (FAQ)

Background

HMS offers two incentive programs: the Performance Index, also known as Pay for Performance (P4P), and an optional Value-Based Reimbursement (VBR) program for specialty physicians. The VBR funding is separate from the P4P program and is distributed through physician billing. In October 2024, the HMS Program Manager conducted several drop-in sessions to answer questions related to the upcoming P4P and VBR incentive programs. This document is a collection of questions from those sessions and other received inquiries. This document will be updated on an as-needed basis during the performance year. The questions have been grouped into categories below.

Pay for Performance (P4P)

Question: For optional 5 points, can you only receive these points if you are lacking in another area? Meaning, you cannot exceed 100% on the scorecard, correct?
Answer: You are correct; the optional 5 bonus points would take the place of an area where your site is behind in points. Sites cannot receive above 100%.

Question: If the Sepsis Abstractor and also the antimicrobial abstractor present at our meetings, would they be capped at just 2 points even though it would be two separate presentations?
Answer: Yes, it is capped at 1 presentation per performance year.

Question: Do attempts to reach the patient count as success even if the patient doesn't answer the call or complete the PROs?
Answer: The measure is successful contact of the patient via phone, email, or text. Below are the details of how this measure is assessed:
Cases ineligible for PRO data collection include:

- Transferred to the intensive care unit (antimicrobial only)
- Transferred to another hospital (antimicrobial only)
- Inpatient or home hospice
- Deceased
- Prison
- Extended Care Facility
- In the hospital at time of patient contact
- No contact information available
- Patient or caregiver refuses to answer questions

Successful phone call = “Yes” to “Were you able to obtain information about the patient?”
Successful electronic PROs = email or text response received

Question: How are we expected to make a difference in how many patients respond to PROs?
Answer: At the HMS 11/13/23 Sepsis Abstractor Conference Call, we reviewed several resources to improve successful contact with patients. Below is an overview of strategies:

- The Coordinating Center developed a phone call script that should be used when speaking with patients. This helps to provide context for the phone call and encourages responses.
- If the patient does not answer the phone, leave a voicemail and provide a callback number. Sites that left voicemails had ~10% higher success rates than those hospitals that didn't. There is no difference in success rates between leaving a voicemail after each attempt or after the last attempt. Sites that leave a callback number increased their follow-up success rate by ~6%.
- If requesting a call back from patients, provide a timeframe for the patient to call back when you will be available, or suggest a time that you will be calling in your voicemail.
- Utilize phone services that don't provide personal phone numbers. Examples include Cisco Jabber, Google Voice app, etc.
- Speaking to the patient is the most preferred contact. If they are unable to speak, speaking with a caregiver or spouse is acceptable if consistent with your hospital policies.
- To limit patients hanging up, let them know the approximate amount of time the survey will take.
- For language barriers, send an email/text using their preferred language. If there is a common language you are seeing in your patient population that we don't currently have available, please let us know so we can consider adding it.
- Review demographic information to assess employment status and make calls at times outside of typical working hours.
- Share who you are from the start and explain you are not calling to discuss bills, etc.
- Explain upfront that they have the option to answer the questions at their own comfort level to keep the interview going.
- An abstractor stated that calling younger patients in the afternoon and older patients in the morning has led to increased success.
- Ask your hospital for your own direct line (not tied to your personal phone).
- Vary the time of day you call the patient on phone call attempts.

Example #1 from an Abstractor: I just started leaving voicemails after the 2nd unsuccessful attempt & Include:

- My name
- The department/hospital I work at (I include that I am a nurse).
- The reason for my call (I keep it vague, so I don't include any PHI, but I explain that the questions will help us learn about what happened after discharge and gather information on how they are doing now).
- If there is no answer after the 2nd attempt: I leave my name, number, and a time they can call me back. I also let them know that I will try to call them again tomorrow if I don't hear from them.
- If there is no answer after the 3rd attempt: I share the information about the PRO email/text. I suggest they check their junk mail if they don't see it in their inbox.

Example #2 from an Abstractor:
"Hi, can I please speak with _____? My name is _____, and I am a Registered Nurse from _____Hospital. I work here at the hospital in our quality department, working to improve the care of our hospitalized medical patients. Part of my job is to call our patients that have been hospitalized with a diagnosis of (target this with whatever their discharge diagnosis was i.e. Sepsis, Pneumonia, Covid, etc.), like you were back in (insert month of hospital stay), to check in with you on how your recovery is going, and to see if you have any questions. Do you have just a few minutes?"

- If they say yes, I say something like "Wonderful, thank you so much. I have your records pulled up in front of me…" It adds some validity and aids in the conversation and any questions.

Question: Will there be a live report in the databases to see where our site falls with the PROs success rate?
Answer: Yes, your follow-up success rate will be available in your live reports (both Sepsis & Antimicrobial) starting in 2025.

Question: Where did the percentage for PROs bonus come from?
Answer: The thresholds for bonus points are based on the current follow-up success rates across the collaborative for the antimicrobial and sepsis registries, independently. The lowest threshold is based on the top 15-25% of hospitals.

Question: For reports only, I was told it was a training class?
Answer: To obtain report-only access to an individual hospital, you will first email a member of the HMS Coordinating Center Administrative Specialist – Casey Gould (cbodenmi@med.umich.edu). You will be asked to sign an attestation statement to ensure the security of the data and complete a review of a learning module via our learning management system. There is no

in-person class or training. Once both are complete, you will receive a username and password to access your hospital-specific data.

Question: Is there official guidance about what to do when a case is complete but awaiting feedback on a ticket sent in?
Answer: When a case is completed yet you are awaiting feedback from the Coordinating Center, we ask that you leave the question blank, submit all forms, and complete the case. Once you have received the response from the Coordinating Center, you can then go back and answer that question.

Question: Does the HMS Pay for Performance Calendar run Jan to Dec or July to June?
Question: What quarter of data are the HMS measures assessed on?
Answer: The period of assessment specifically depends on the measure. Please see below for the list of measures and their respective assessment periods by initiative.

Pay for Performance (P4P) – ABX Measures		
	Increase Use of 5 Days of Antibiotic Treatment in Uncomplicated CAP	**Reduce Use of Antibiotics in Patients with ASB**
Assessment Period	Q4 2025[1]	Q4 2025[1]
Patient Discharges	07/31/25 – 11/05/25	07/31/25 – 11/05/25
Method of Assessment	Adjusted Hospital Specific	Raw – Collaborative Average

1. Adjusted model uses improvement over 1 year to inform the fourth quarter score

Pay for Performance (P4P) – Sepsis Measures			
	Increase antibiotics delivered within 3 hours of arrival for sepsis cases with hypotension	**Increase Discharge/Post-Discharge Care Coordination for Sepsis Patients Discharged to Home-like Setting**	**Increase use of balanced solutions over normal saline in patients with sepsis**
Assessment Period	Q4 2025[1]	Q4 2025[1]	Q4 2025[1]
Patient Discharges	07/01/25 – 10/06/25	07/01/25 – 10/06/25	07/01/25 – 10/06/25
Method	Adjusted Hospital Specific	Adjusted Hospital Specific	Adjusted Hospital Specific

1. Adjusted model uses improvement over 1 year to inform the fourth quarter score

Question: Are we abstracting PICC/ML at all in 2025?
Answer: No, starting in 2025 we will not be abstracting in the PICC/Midline registry. The due date for when the PICC and Midline cases must be entered for the 2024 performance year is on 1/12/2025 at 6:30 pm (EST). Following this date, we will send out a separate communication detailing when the registry will no longer be available to access.

Question: Where can I get more information on how the adjusted model works?
Answer: On our HMS website, we have posted several resources in the 2025 Performance Index section (https://www.mi-hms.org/cqi-performance-index-resources). The resource titled '2025 Performance Index Adjusted Methodology' provides details.

Question: Will we continue to be provided our raw rates for each of these measures in addition to the adjusted rates?
Answer: Yes, for all measures that are assessed using the adjusted rate, you will have access to both your raw and adjusted scores in both the printed and live reports.

Question: How do we find out what the monetary reimbursement amount is based on our performance?
Answer: As for the monetary reimbursement, each hospital is unique in terms of the pay for performance payment from BCBSM and it depends on numerous different factors including the size of the hospital, how many CQI's your hospital participates in, etc. The CQI Coordinating Centers don't have access to this information. I would suggest reaching out your Pay for Performance contact at your hospital. Additionally, you could also email BCBSM Value Partnerships team directly at valuepartnerships@bcbsm.com. Lastly, I've provided the link to the document that describes how the funding works from BCBSM. 2023 Hospital Pay for Performance Program (bcbsm.com)

Value Based Reimbursement (VBR)

Question: What are the eligibility requirements for the HMS VBR Measures?
Answer: To be eligible for 2026 CQI VBR, the practitioner must:

- Meet the performance targets set by the collaborative
- Be a member of a PGIP physician organization for at least one year
- Submit National Provider Identifier (NPI) number to the HMS Coordinating Center via the HMS 2025 Semi-Annual Fall QI Survey

Question: What is PGIP?
Answer: PGIP stands for Physician Group Incentive Program (PGIP). Launched in 2005 by Blue Cross Blue Shield of Michigan (BCBSM), the Physician Group Incentive Program includes over 20,000 primary care and specialist physicians throughout Michigan in provider-led clinical quality improvement efforts. The program connects approximately 40 physician organizations (representing these 20,000 physicians) statewide to collect data, share best practices and collaborate on initiatives that improve the health care system in Michigan.

Question: How does an individual physician know if they are part of PGIP?
Answer: To confirm if you are a member of the Physician Group Incentive Program (PGIP) through Blue Cross Blue Shield of Michigan (BCBSM), the most accurate and up to date method is to contact your physician organization. If you have any additional questions, please contact Elizabeth McLaughlin, MS, RN at emcnair@med.umich.edu.

Question: How will the physicians be identified?
Answer: HMS does not collect physician-specific data in our registries. Therefore, all VBR assessments will be based at the hospital level. For hospitals/physicians eligible for the VBR incentive, HMS will be collecting the National Provider Identifier (NPI) number for each specialty at your hospital. The NPIs will be collected in the Fall 2025 Semi-Annual QI Survey. Each hospital will be responsible for obtaining the list of NPI numbers, and the Physician Champion must approve the final list.

Question: Will physicians be enrolled automatically in the Value Based Reimbursement program through HMS?
Answer: No, physicians will not be automatically enrolled to be eligible for a given HMS VBR measure. To be considered, your hospital will need to provide the NPI numbers of the eligible physicians who represent each specialty at your hospital in the Fall 2025 QI Survey.

Question: How will the Physician NPIs for each provider specialty be obtained?

Answer: HMS collects data on a sample of patients at each hospital and therefore does not collect provider-specific data. Each fall, in our HMS semi-annual quality improvement (QI) survey, we will ask for the list of NPIs for each specialty provider who has practiced (or billed) at your hospital within the last year. 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 NPIs, even if the hospital meets the measure, they will not be eligible for the incentive.

Question: Do the HMS value-based reimbursement measures run January to December or July to June?
Answer: The period of assessment specifically depends on the measure. Please see below for the list of measures and their respective assessment periods by initiative.

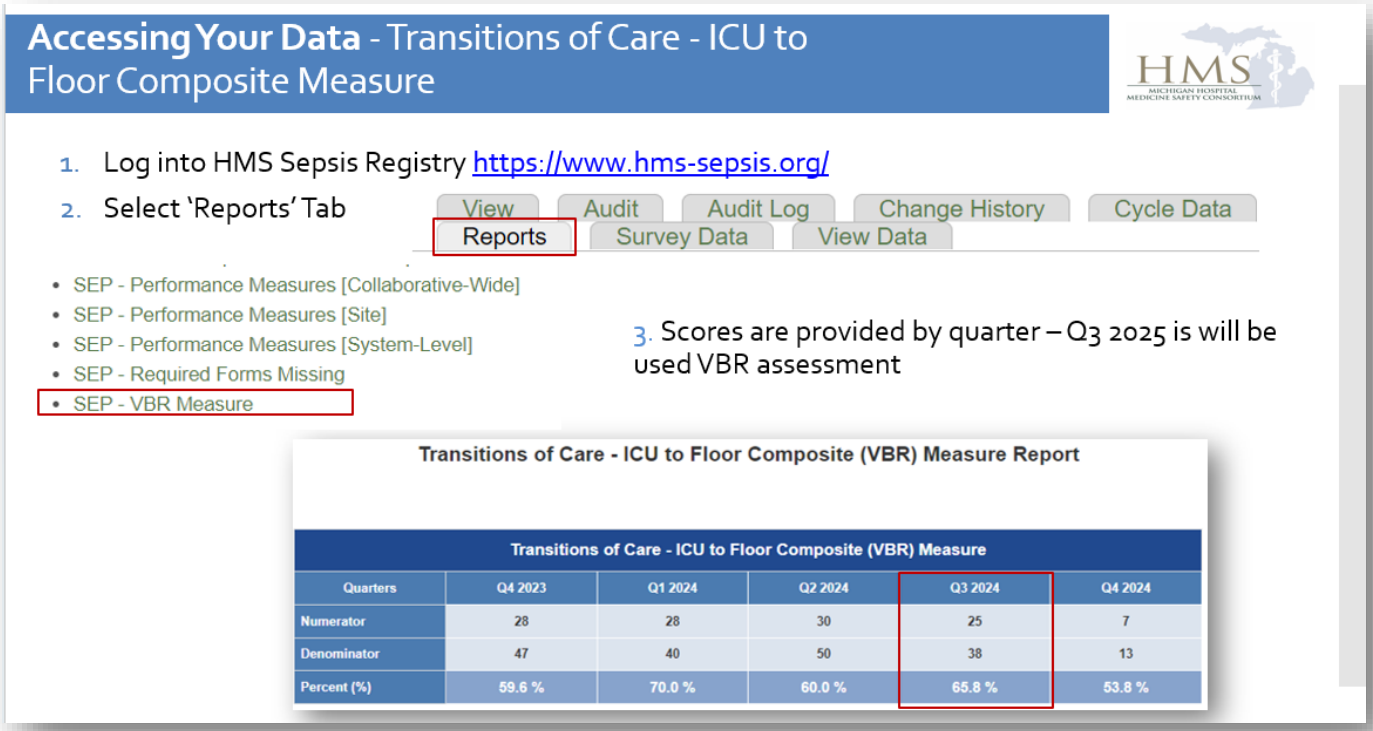
Value Based Reimbursement (VBR)		
	Increase Use of 5 Days of Antibiotic Treatment in Uncomplicated CAP	**Transitions of Care - ICU to Floor Composite** 1) Temporary CVC removal or documentation of need to keep prior to transfer out of ICU 2) Urinary catheter removal or documentation of need to keep prior to transfer out of ICU 3) Communication of fluid volume status at ICU transfer 4) Communication of antibiotic plan at ICU transfer
Specialists	Hospitalists and Infectious Diseases Physicians	Critical Care
Assessment Period	Q3 2025	Q3 2025
Discharge Dates	05/08/25 – 07/30/25	04/08/25 – 06/30/25
Method	Adjusted – Hospital Specific	Raw- Hospital Specific

Question: When will the VBR 2026 fee schedule be sent out so that we can send to stakeholders?
Answer: The payout/reimbursement period for 2026 VBR is from 3/1/26 – 2/28/27.

Question: Does the hospital specific structure of how physicians are funded impact the VBR incentive?
Answer: Each hospital is unique in terms of funding structure (i.e., physicians employed by the hospital vs. privately funded). The incentive will be distributed through the Physician Organization (PO). Engagement in VBR (by the participating physicians) may depend on how your hospital is structured.

Question: Is there any harm in submitting names if we are unsure whether they are PGIP enrolled?
Answer: No, there is no harm in submitting physician name/NPI's. BCBSM does a review of each physician to ensure enrollment, so your hospital is not responsible to confirm PGIP eligibility.

Question: Will the VBR critical care composite measure data be available on our reports? We have the breakdown for each one, but not an overall rate for meeting those.
Answer: Yes, this is currently available in the Sepsis Live reports. Please see this slide on steps to access your site score.



Question: The VBR measure is assessed on the 3rd quarter adjusted data, correct? If our site did not meet the 2024 5-day CAP measure in the 3rd quarter, it would be appropriate to not include the hospitalist and NPI #'s in our fall survey, correct?
Answer: Yes, VBR is assessed on the 3rd quarter of every year. If your site did not meet the threshold for the measure, none of the physicians would be eligible for VBR. You can submit the NPI's, however, they won't be sent to BCBSM.

Question: Is the VBR for all BCBSM patient claims for the codes you mentioned for the hospital or only HMS cases?
Answer: The additional fee schedule increase of 3% is applied to all BCBSM PPO claims for that eligible provider, not just HMS cases.

Question: For the hospitalist VBR measure, does it apply to the entire hospitalist team working at one specific hospital?
Answer: Yes, the hospitalist VBR measure on increasing use of 5 days of antibiotic treatment in Uncomplicated Community-Acquired Pneumonia (CAP) applies to the entire team of hospitalists working at each hospital. Of note, the hospitalist must be a member of a PGIP physician organization for at least 1 year.

Question: Who is responsible for collecting, tracking, and submitting the information for the VBR?
Answer: The collection of data and tracking will be done by us here at the Coordinating Center of HMS. We will provide your hospital's data in terms of performance for each of these measures. It is your hospital's responsibility to communicate that data to the stakeholders. For example, for the CAP 5 Day VBR measure, we do not have a mechanism to contact each hospital's hospitalist group to make them aware of this opportunity. This would be something your hospital would need to communicate to them in terms of the opportunity. Some hospitals may use this to increase engagement. In terms of submitting the information for VBR, in the Fall 2025 QI survey we will ask for the NPIs of the physicians that represent each specialty at your hospital, which will then need to be approved by your physician champion. Then, we at the Coordinating Center will communicate who is eligible to BCBSM.

Question: At my hospital, our Hospitalists are also our Critical Care providers as they all rotate to cover the ICU. With the VBR model, will they receive incentive payments for both CAP 5 Day and Critical Care measure?
Answer: A given provider can only receive the VBR incentive for one measure, even if they count as a provider in multiple specialty measures and the targets are met. Their VBR incentive is capped at a maximum percentage. The good thing is if they fall into 2 or more measures, they have a higher chance of getting the incentive.

Question: For a physician who practices at my hospital but does not officially work at my hospital, how will they receive the funds? For example, several of our physicians technically work for Wayne State University Medical. Will the funds go to Wayne and then directly to them? Our physician champion was wondering how the money is dispersed and who it goes to.
Answer: The VBR is a fee schedule increase that is applied to the physicians billing for BCBSM commercial PPO claims. The VBR you earned will show up on each claim billed and will look like an increase in reimbursement. For instance, if the doctor (or the doctor's agency that handles billing), bills for a consult code that would pay out at $100. If that physician earns a 3% VBR, then the reimbursement would show up at $103. The VBR is tied to the physician billing and nothing else. It's not tied to facility billing. But, if the physician is employed by a hospital or large group, the physician will not necessarily see the increase. If the physician in this case is employed by a hospitalist group but not your hospital, whoever manages and administers the PHYSICIAN billing will see this increase in reimbursement on each claim (with the exception on certain claims related lab, rad, diagnostics, DME, ambulance/air transport). The VBR is primarily applied to Relative Value Unit based codes (which include your E&M, consult, and procedure codes). If the doctor wants to know who's aware of their VBR, it would be the PO, but the PO doesn't get the VBR, and they don't disburse the VBR. The only thing the PO does with VBR is they know who received it and they get reports from BCBSM on how much the total VBR earned was for the period. One important question to determine is whether the interested physicians are part of the Physician Group Incentive Program (PGIP) program which is typically asked through the physician organization.

Question: I would like to get an estimate on the dollars potentially involved, could you help with fine details on the calculations?
Answer: HMS is not able to provide this information as it depends on several factors that HMS does not have access to. PGIP Physician Organizations receive a list of each specialist in their PO and the various VBR percentages the practitioner is receiving based on the VBR programs the practitioner is eligible for. POs also receive a report annually of the amount of VBR each physician in their PO received in the prior year. POs are asked to provide this information to their member practitioners.

Question: Is it a system wide reimbursement? Are all providers eligible for reimbursement or just those involved with HMS work?
Answer: All hospitalists, and separately Infectious Diseases Physicians who are part of the antimicrobial stewardship teams at the individual hospital, who have practiced over the last 1 year at the individual hospital being assessed. I want to clarify that we assess the data at a local hospital level (not at the system level) who meet the eligibility requirements below.
To be eligible for 2025 CQI VBR, the practitioner must:

- Meet the performance targets set by the collaborative
- Be a member of a PGIP physician organization for at least one year
- Submit NPI number to the HMS Coordinating Center via the HMS Semi-Annual Fall QI Survey

Question: Is the reimbursement received over a period of time?
Answer: The payout/reimbursement period for 2026 VBR is from 3/1/26 – 2/28/27.

Question: I would like to know, if I as the abstractor have any role to play in the VBR measures.
Answer: Your role is to help share the opportunity that is available. VBR is optional and not required. If your hospital is looking to obtain the incentive, your role (and your physician champion) will need to help obtain the NPI's and attest that those individuals have practiced at your hospital within the last year.

Question: Do these VBR measures look at adjusted rates or raw?
Answer: The 'Increase Use of 5 Days of Antibiotic Treatment in Uncomplicated CAP' measure is assessed using adjusted rates and the 'Transitions of Care - ICU to Floor Composite' measure is assessed using the raw rate.

Question: Is the target performance required to be met by each provider individually, or just by our group? I assume the target performance is measured based on whole GROUP, but VBR payment applies only to individually eligible providers' billings.
Answer: Yes, the performance is assessed at the hospital level, not individually. This is the reason we must collect the NPI's at every hospital because HMS doesn't have their Names/NPI's in our registry. Basically, if your hospital meets the target – all providers will get the incentive, and it will go through their individual billings.

Question: For the infectious disease physicians, are they eligible even if they practice outpatient too? I think most of them see patients in a clinic setting for follow-up, as well as in the hospital.
Answer: Yes, they are eligible if they see patient's outpatient as well – if the other eligibility criteria are met.

Question: Our physicians see patients at 2 hospitals. Can they receive HMS VBR from both, or just one?
Answer: BCBSM has confirmed that a physician can only receive one VBR even if they practice at 2 hospitals.

Question: What is involved for providers to participate?
Answer: Please see the fact sheet for details. To be eligible, they must be enrolled in the BCBSM PGIP Program and meet the target performance that we set for the specific measure. To find out if they are enrolled in PGIP they would need to work with their physician organization (PO) to determine this. The measure is assessed using our HMS measures so there is no additional data collection. If your hospital meets the target performance, then the physicians will receive the incentive. The most important thing is if your hospital is not meeting the target performance below, then the biggest task is to help improve the scores in these areas for your hospital. For example, if your hospital is not meeting the CAP 5 Day target performance of ≥75% of uncomplicated CAP patients receiving 5 days of antibiotic treatment (i.e. reduce antibiotic duration), then it would be important to bring them into the discussion on how to improve. I would recommend involving them in reviewing cases where patients received more than 5 days of therapy to help identify opportunities for improvement. To be honest, if your hospital is meeting the thresholds already, there is no downside to submitting the NPI's as they will get the incentive since they are already doing well.

Question: Do we need their permission, or can we enter them all?
Answer: No, you don't specifically need their permission. I would let them know that this opportunity is available for them to receive additional incentives from BCBSM claims.

Question: We were wondering who exactly qualifies as a hospitalist for this program? Are internal medicine and family medicine physicians included? We have many physicians that round on patients in the hospital for their own and other physician's patients but aren't categorized as the "typical hospitalist" that we feel should be included but wanted to clarify before proceeding.
Answer: At this time, the VBR program is only eligible for physicians classified as hospitalists at your institution. If there are general internists who only practice in the hospital, they can be "categorized" as a hospitalist when you provide the list of physicians in the Fall. In the situation where internal medicine physicians/family medicine physicians practice in outpatient/ambulatory care determining the VBR incentive/eligibility creates significant challenges as there are also VBR measures separate from HMS for these providers. We decided with BCBSM that at this time we will only provide the incentive for hospitalists.

Question: Speaking for my site, the administrator does not understand any of the VBR information.
Answer: If you have reviewed the FAQ Document and all the resources posted relating to the VBR information and still have additional questions, please reach out to Elizabeth McLaughlin at emcnair@med.umich.edu

Question: I would ask that abstractors be removed from this process, can we just provide the information and direct the physicians to HMS for questions?
Answer: We can't eliminate abstractors from the VBR communications and process, as you are our connection to each hospital. It is also important to be aware. Administrators can contact Elizabeth McLaughlin at emcnair@med.umich.edu

Question: For VBR, would it be possible that physician groups signed up for this without the hospital knowing? We decided not to really publicize it.
Answer: No. The only way that they could get the incentive is if you provide these NPI's in the survey, so there's no other mechanism for how they would get these VBR incentives except through this survey.

Question: Who is asking the providers whether they plan to participate- us or HMS?
Answer: We announced the opportunity for VBR at our November Collaborative Wide meeting. We also held 3 drop-in sessions in October 2024. If your hospital announced it separately, that's how it would have been shared. The other possible way that it could have been shared is at the BCBSM level. BCBSM shares VBR opportunities across their provider network and they may have heard about it through that. Typically, it would have been through you, the abstractor or us at HMS if they came to our Collaborative Wide meeting and reached out.

Question: I had also asked about the Infection control docs. It states that they need to be active on the infection control team. What does that mean? Do they have to attend 50% of the meetings? Can they just read the minutes after the meetings? So, a provider that worked one month of the past year could be included?

Answer: The infectious diseases physicians must be participating in your antimicrobial stewardship work at your hospital. It's not specifically the infection control team. It's if they're involved with stewardship at your hospital. So, let's say your hospital meets quarterly to review your antimicrobial data from HMS and you have an infectious disease physician at that meeting, that would be a perfect person that would be eligible for it.

Question: Asked physician leaders if participating--should we be opening this up to ALL hospitalists?
Answer: Yes, if they are practicing at your hospital.

Question: For more information about HMS VBR, who should I direct the physicians at my hospital to for questions/concerns?
Answer: 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. If you would like to know more information about the program in general through Blue Cross Blue Shield of Michigan, please contact Marc Cohen at mcohen@bcbsm.com.

SEPSIS

Question: For the septic shock measure, when does the 3-hour clock start?
Answer: The 3-hour clock starts at the time of arrival.

Question: Will there be a scorecard dedicated to the Sepsis initiative?
Answer: HMS only has one Performance Index which includes all of our initiatives (Antimicrobial and Sepsis).