Blue Cross Blue Shield of Michigan

2026 Hospital Pay-for-Performance Program

Peer Groups 1 through 4

November 2025

VALUE Partnerships

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Program overview

Blue Cross Blue Shield of Michigan's Hospital Pay-for-Performance program recognizes short-term acute-care hospitals in Peer Groups 1 through 4 for achievements and improvements in quality and population-health management. The program pays hospitals, in aggregate, an additional 5% of statewide inpatient and outpatient operating payments — over $200 million statewide.

The P4P program structure and measures are developed with input from hospitals through the P4P Measurement Workgroup. The P4P rate earned during the 2026 program year will be applied to inpatient and outpatient operating payments starting October 1, 2027.

To help hospitals better assess their performance across all program measures throughout the program year, Blue Cross will provide hospitals with quarterly informational P4P performance reports. Hospitals also may request patient-level readmissions information to assist in readmission reduction efforts.

What's new in 2026

The 2026 P4P program year will follow the component weights of the 2025 program year, with the following updates:

- MVC component changes
  - Introduction of Michigan Medicaid data to calculations and scoring
  - Introduction of a new health outcome variation metric worth one point
  - Updated menu offerings for engagement points
- HIE Claims Pilot Project retired

2026 program components and weights	
Prequalifying condition	0%
Collaborative Quality Initiatives (CQIs)	40%
Michigan Value Collaborative (MVC)	10%
Plan All-Cause Readmission (PCR)	30%
Health Information Exchange (HIE)	20%

Payment methodology

Statewide **aggregate** P4P payout is equal to the full 5% value of the program. Although some hospitals will earn a P4P rate less than 5%, some high-performing hospitals may earn P4P rates greater than 5%.[1]

The performance scoring multiplier concept will be used to redistribute any unearned incentive dollars differentially within each program component. This allows a larger portion of unearned incentive to go to the highest performing hospitals in each individual program component.

A fixed-dollar bonus will be given to hospitals who participate in all CQIs for which they have been recruited and meet eligibility criteria for participation. This bonus is paid from the unearned incentive dollars within the CQI component. A hospital is defined as "recruited" if at any time since a CQI's program inception, a hospital was recruited by the CQI's coordinating center and meets participation eligibility criteria set forth by the CQI's coordinating center (the coordinating center acts as the program manager office for a CQI's activities). This requirement predates the implementation of this bonus. If a hospital is determined ineligible for the bonus, an exception can be requested if either of the following conditions are met:

- Hospital provides documentation they no longer meet the eligibility criteria to participate in that CQI.
- Hospital confirms that CQI is no longer accepting new hospitals participants.

All other remaining unearned dollars will be paid based on the multiplier concept, see Appendix A for a mock distribution of the multiplier concept.

This chart provides the potential bonus by hospital, depending on the number of CQIs in which they participate:

Number of eligible or participating CQIs	Potential unearned dollar fixed bonus
1-4 CQIs	$20,000
5-9 CQIs	$50,000
10 or more CQIs	$75,000

To be eligible to earn multiplier dollars, hospitals must meet **one** of the following criteria:

- CMS hospital star rating of at least 2
- Leapfrog hospital safety grade of at least a C

[1] If a hospital's reimbursement arrangement doesn't comply with the formula established within Blue Cross' *Participating Hospital Agreement*, its payout is limited to 4% of its inpatient operating payment only. Non-model hospitals also will not be eligible to receive any unearned incentive.

Prequalifying condition

All P4P participating hospitals must meet a patient-safety prequalifying condition to be eligible to receive incentives for performance in the P4P program. Hospital compliance with this prequalifying condition is determined by CEO attestation due by **March 31, 2026.**

To successfully meet this condition, hospitals must fully comply with the following three requirements:

1. Conduct regular patient walk rounds with hospital leadership.
2. Assess and improve patient safety performance by fully meeting one of the following options:

    - Complete and submit the National Quality Forum Safe Practices section of the *Leapfrog Hospital Survey* at least once every 18 months.
    - Complete the Joint Commission Periodic Performance Review of National Patient Safety Goals at least once every 18 months.
        - First established by the Joint Commission in 2002 to help accredited organizations target critical areas where safety can be improved.
        - All Joint Commission-accredited health care organizations are surveyed for compliance with the requirements of the goals — or acceptable alternatives — as appropriate to the services the organization provides.
        - Goals and requirements are reevaluated each year and new NPSGs are announced in the year prior to their implementation.
        - For more information, visit National Patient Safety Goals.*
    - Review compliance with the Agency for Healthcare Research Patient Safety indicators at least once every 18 months.
        - Set of indicators providing information on potential in hospital complications and adverse events following surgeries, procedures, and childbirth
        - Can be used to help hospitals identify potential adverse events that might need further study and provide the opportunity to assess the incidence of adverse events and in hospital complications using administrative data found in the typical discharge record.
        - For more information, download the Patient Safety Indicators Brochure.*
    - Participate in a federally qualified patient safety organization.
        - Federally listed by the Agency for Healthcare Research and Quality.

- Provides a secure environment to assist health care providers collect, aggregate, and analyze data to identify and reduce safety risks, learn from errors and prevent future harm.
- For more information, visit AHRQ PSO.*

3. Ensure results of the patient safety assessment and improvement activities are shared with the hospital's governing body and incorporated into a board-approved, multidisciplinary patient safety plan that is regularly reviewed and updated.

*Blue Cross Blue Shield of Michigan and Blue Care Network do not own or control this website.

Collaborative Quality Initiatives 40%

Hospitals can earn up to 40% of their P4P points based on performance across Blue Cross-supported CQIs.

Individual CQI weights

The CQI component of the P4P is weighted equally for all hospitals, regardless of the number of CQIs a hospital participates in. Therefore, hospitals participating in fewer CQIs will have a greater portion of their incentive allocated to each initiative, while hospitals participating in a greater number of CQIs will have a smaller portion allocated to each initiative. Hospitals participating in more than 10 CQIs will be scored using only the top 10 individual CQI performance scores.

The following chart provides the weight per CQI based on the number of initiatives a hospital participates in:

Number of CQIs	Overall potential incentive	Potential incentive per CQI
1	40%	40%
2	40%	20%
3	40%	13.33%
4	40%	10%
5	40%	8%
6	40%	6.67%
7	40%	5.71%
8	40%	5%
9	40%	4.44%
10+	40%	4%

Required CQIs

In 2026, seven of the Blue Cross-sponsored CQIs have been categorized as “required” (see Appendix B). No new CQIs were added to the required CQI category for 2026, nor were any removed from the required category.

If a hospital is recruited to participate in a “required” CQI, but declines to participate, the hospital will forfeit the percentage points attributed to that CQI. If a hospital isn’t recruited to participate in a “required” CQI, there is no penalty for nonparticipation.

To find out whether your hospital is eligible for a specific CQI and its potential effect on your hospital's 2026 P4P score, contact Blue Cross' CQI administration team at CQIPrograms@bcbsm.com.

CQI data abstraction and reporting funding support

Funding support

Eligible hospitals participating in Blue Cross-supported CQIs receive annual funding support, **outside of the P4P**, for a portion of the costs they incur for data abstraction and reporting. These funds are expected to directly support CQI associated data abstraction and reporting and are designed to minimize cost barriers to participation, including abstracting medical record data, patient follow-up, and CQI data reporting. The data abstraction funding model for each CQI is developed by its respective coordinating center with review by Blue Cross' CQI administration.

In return for these specific funds, hospitals are expected to comply with all participation expectations agreed to upon joining the initiative (refer to Appendix B). These expectations and the hospital's compliance are determined by each CQI's coordinating center and Blue Cross. Specific participation expectations for each CQI are available from the associated coordinating center.

Payment schedule

Hospitals that meet these expectations in CQIs are reimbursed 84% of the estimated costs associated with medical record data abstraction, which is associated with approximate percentage cases that of Blue Cross Commercial (PPO and Medicare Advantage), Blue Care Network (including BCN-Advantage), Blue Cross Complete, CMS Medicare and Medicaid, uninsured, and self-insured cases. These costs are determined using a data abstraction model specific to each CQI and projected hospital case volumes. The intention of the funding support is to abstract clinical data on all cases deemed clinically relevant by the respective CQI's coordinating center, not just those aforementioned.

Blue Cross converted each hospital's payment amount into a "per-unit" add-on to its payment rate, effective on the first day of each hospital's own fiscal year. Subsequent updates to the per-unit amount will be reviewed with hospital contracting staff.

Michigan Value Collaborative 10%

The Michigan Value Collaborative represents a partnership between over 100 Michigan hospitals and 33 physician organizations, which aims to improve the health of Michigan through sustainable high-value health care. Supported by Blue Cross Blue Shield of Michigan, MVC helps its members better understand their performance using robust multi-payer data, customized analytics, and at-the-elbow support. As part of this, MVC fosters a collaborative learning environment to enable providers to learn from one another in a cooperative, non-competitive space.

2026 measure expectations

For a hospital to be eligible to earn points for its selected metrics, it must first meet the quality requirement. This stipulates that it is in-hospital mortality or related readmission rate for the selected condition isn't statistically below the 10th percentile in the relevant performance year.

A more detailed description of the 2026 performance-based measures can be found in the MVC Component of the BCBSM P4P Program Technical Document on MVC's website.

Timeline of the 2026 MVC-based P4P performance measure:

Baseline period	CY 2023
Performance period	CY 2025
Data analysis and claims adjudication	CY 2027

Points from 30-day total episode payments

Each hospital will choose one of four conditions to be evaluated on using mean total risk-adjusted, price standardized 30-day episode payment. Each hospital's condition-specific total episode payment will be assessed for year-over-year improvement compared to its baseline year and for achievement respective to the appropriate MVC cohort. Hospitals must meet the minimum in-hospital mortality and readmission rate quality threshold for the selected condition to earn points. If the threshold is met, hospitals will earn the higher of their improvement or achievement points for a total of 0 – 3 points.

MVC's 2026 Episode Spending Condition options are:

- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Coronary artery bypass graft (CABG)
- Percutaneous coronary intervention (PCI)

Improvement Z-score Equation

$$\textbf{Improvement Z} - \textbf{Score} = \frac{Hospital\ Baseline\ Payment - Hospital\ Mean\ Performance\ Payment}{MVC\ All\ Standard\ Deviation\ from\ Baseline}$$

$$\textbf{Achievement Z} - \textbf{Score} = \frac{MVC\ Cohort\ Mean\ at\ Baseline - Hospital\ Mean\ Performance\ Payment}{MVC\ All\ Standard\ Deviation\ from\ Baseline}$$

Z-Score Thresholds for Assigning Episode Spending Points

Z-score threshold	Point value
<0	0 Points
0 - <0.1	1 Point
0.1 –< 0.2	2 Points
> 0.2	3 Points

Points from value metrics

All value metrics are evidence-based, actionable measures of utilization for specific clinical contexts. Hospitals will be rewarded for high rates of high-value services or low rates of low-value services. Each hospital's chosen value metric will be assessed for year-over-year improvement compared to its baseline year and for achievement respective to the appropriate MVC cohort. Hospitals will earn the higher of their improvement or achievement points for a total of 0 – 4 points.

MVC's 2026 Value Metric options are:

- Cardiac rehabilitation within 90 days after CABG
- Cardiac rehabilitation within 90 days after percutaneous coronary intervention (PCI)
- Follow-up within 7 days after CHF
- Follow-up within 14 days after COPD
- Follow-up within 7 days after pneumonia
- Follow-up within 14 days after sepsis
- Preoperative testing

Improvement and achievement Z-score equations for high and low value metrics

High Value Metrics	Low Value Metrics
Improvement Z-score $\frac{\text{Hospital performance} - \text{Hospital baseline}}{\text{MVC All standard deviation from baseline}}$	**Improvement Z-score** $\frac{\text{Hospital baseline} - \text{Hospital performance}}{\text{MVC All standard deviation from baseline}}$
Achievement Z-score $\frac{\text{Hospital performance} - \text{Cohort baseline}}{\text{MVC All standard deviation from baseline}}$	**Achievement Z-score** $\frac{\text{Cohort baseline} - \text{Hospital performance}}{\text{MVC All standard deviation from baseline}}$

Z-Score thresholds for assigning value metric points

Z-score threshold	Point value
<0	0 Points
0 - <0.25	1 Point
0.25 - <0.50	2 Points
0.50 - <0.75	3 Points
>0.75	4 Points

Points from Health Outcome Variation measure

Variation in payer-specific all-cause readmissions will be evaluated for each hospital through the calculation of a population-weighted, risk-adjusted index of variation. Each hospital's index of variation will be assessed for year-over-year improvement compared to its baseline year and for achievement respective to the appropriate MVC cohort. Hospitals will earn the higher of their improvement or achievement points for a total of 0 – 1 point.

Measure calculation

The health outcome variation measure will be calculated using the following steps:

1. Overall hospital-level readmission rate is subtracted from each payer-level readmission rate, resulting in difference values for each payer group
2. Absolute values of differences are multiplied by the respective payer group population proportions, summed, and divided by the total population

3. The resulting value is multiplied by 100 to generate the final index of variation used for scoring

Hospitals can earn one point in the health outcome variation component by either improving (reducing) their index of variation over time (improvement) or by comparing favorably against the collaborative (achievement). Hospitals will earn a maximum of one point.

Engagement points

Hospitals can earn up to two points by performing a combination of engagement activities during the program year (engagement activities in calendar year 2026 count towards program year 2026). These points are intended to increase engagement with other hospitals and the MVC Coordinating Center. MVC engagement offerings can be found in Table 7 of the Technical Document on MVC's website. Hospitals may select their own combination of activities, and the activities available will be offered in 2026 and 2027. The MVC Coordinating Center reserves the right to make changes to eligible activities and their point values in the future but will communicate all P4P-eligible engagement activities prior to and during both program years.

Readmissions 30%

In 2026, P4P participating hospitals will have the opportunity to earn 30% of their potential P4P incentive based on readmission performance. Each hospital will be evaluated based upon performance determined by the NCQA-endorsed Plan All-Cause Readmissions (PCR) metric. PCR assesses the rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge among commercial members. A change to this metric allows introduction of risk adjustment to readmission performance in the P4P and aligns performance measurement across all Blue Cross value-based programs.

Readmission scoring methodology:

With the introduction of risk adjustment, readmission performance can be further stratified. Readmissions will now be scored based on combination of year-over-year trend and relative ranking performance. Year-over-year performance will compare the hospital's previous calendar year performance against the current program year performance. For hospitals meeting specific criteria, confidence interval scoring will remain. Final score will be based upon the best score achieved through either the year-over-year percent trend performance or relative ranking:

Year-over-year trend % change	**Score**	**Example baseline**	**Example performance**
More favorable than -2.5% year-over-year improvement	100%	10%	< 9.75%
Year-over-year improvement up to -2.5%	75%	10%	9.75% - 10%
Increase of 2.5% or less	50%	10%	>10% to 10.25%
Increase of >2.5%	0%	10%	>10.25%
Relative ranking	**Score**		
Readmission rate ranking in Quartile 1	100%		
Readmission rate ranking in Quartile 2	75%		
Readmission rate outperforms P4P statewide readmission rate	50%		
Decile improvement, 1 decile	25%		

Confidence intervals

Introduced in the 2018 program, confidence intervals are a range of values so defined that there is a specified probability that the value of the parameter lies within it. On hospital compare, CMS calculates hospital-specific confidence intervals for the majority of its measures and compares them against a national rate. Similarly, the 2026 P4P program will calculate hospital-specific confidence intervals and compare them against the **Michigan P4P participating hospital statewide readmission rate**.

The more favorable methodology (year-over-year trend and relative ranking versus confidence intervals) will be used for a hospital if any of the following conditions are met:

- Hospital shows improved readmission rate (regardless of performance against the P4P statewide readmission rate)
- Hospital 2026 CY readmission rate is less than the P4P statewide readmission rate.
- Hospital is considered low volume (<250 IP discharges)

Confidence interval	Score
Entire confidence interval is less than P4P statewide readmission rate	100%
P4P statewide readmission rate falls within confidence interval	50%
Entire confidence interval is greater than the P4P statewide readmission rate	0%

Health Information Exchange 20%

The Health Information Exchange component of the P4P program is designed to ensure caregivers have the data they need to effectively manage the care of their patients. The HIE component is focused on improving the quality of data transmitted through the Michigan Health Information Network statewide service, expanding the types of data available through the service, and developing capabilities that will help facilitate statewide data exchange going forward.

In its January 2018 Health Information Exchange Fact Sheet, CMS states its expectation for HIE sender and receiver collaboration.[2] The intent is to promote data quality from the initiating provider so the receiving provider can incorporate the data into its patient-associated processes of care. If the receiver is unable to use the sender's data, then the receiver is unable to provide patients with appropriate and timely care. Blue Cross shares CMS' vision of promoting the transmission of quality data that can be effectively used by a patient's providers.
The following table summarizes the 2026 HIE measures and weights.

Measure number	Measure description	Total points possible	Points available by quarter			
			1Q	2Q	3Q	4Q
1	Maintain ADT data quality conformance with inclusion of the common key	6	1.50	1.50	1.50	1.50
2	Maintain CCDA data conformance for inpatient, observation, and ER visits	6	1.50	1.50	1.50	1.50
3	Transmit all ambulatory CCDA data	4	1.00	1.00	1.00	1.00
4	Maintain data conformance for statewide lab result data	4	1.00	1.00	1.00	1.00

Changes from the 2025 program are as follows:

- The Claims Pilot Project has been officially retired as of December 31, 2025. Hospitals will no longer be able to participate in this project.

[2] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HealthInformationExchange_2017.pdf (Blue Cross Blue Shield of Michigan and Blue Care Network don't own or control this website.)

The HIE bonus point for standardization of the codes used in the race and ethnicity fields will continue in the 2026 plan. Hospitals earning full HIE points are still eligible for the additional point.

To earn the extra bonus point, hospitals should update their data collection approach and practices to ask about race/ethnicity in a single question and update the categories based on revised federal guidance. The single question should be as follows:

What is your race and/or ethnicity?

Select all that apply.

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Middle Eastern or North African
- Native Hawaiian or Pacific Islander
- White
- Unknown

To earn the extra bonus point, hospitals must submit a screenshot of their data collection approach by October 1, 2026. Although using the categories noted above is preferable, if the hospital uses more, or different categories than those on the list above, they must provide a crosswalk for converting their categories to the federal categories. Hospitals should submit their screenshot and crosswalk (if applicable) to P4PHospital@bcbsm.com by October 1, 2026.

- Note: (HL7 specifications haven't yet changed to allow for combined race and ethnicity reporting, so Blue Cross isn't requiring a change in the way the hospital report race and ethnicity to MIHIN via the HL7 specifications.)

Details on the HIE measures can be found in Appendix D.

All participating facilities of the Blue Cross P4P program will monitor their data submission and conformance using the MiHIN MiGateway Conformance Module.

Performance scoring multiplier methodology

Table B below displays how the CQI incentive pool is calculated, based on actual CQI performance and the redistribution of unearned CQI dollars. In this example, an overall CQI incentive pool of $20 million is calculated based on the potential CQI incentive for each hospital, determined by individual CQI eligibility. The earned CQI incentive is then determined by multiplying each hospital's actual CQI performance by its potential CQI incentive amount. The unearned dollars resulting from less than 100% CQI performance, which is $2.45 million in this example, is then redistributed to hospitals by a scoring multiplier.

Continuing in 2026, before the unearned CQI incentive dollars are redistributed to hospitals, some of these unearned dollars will be used to give a bonus to hospitals that participate in *all* CQIs for which they have been recruited. This bonus is intended to recognize and reward hospitals for the additional work and resource commitment it takes to participate in all multiple CQI programs. The potential bonus amount for each hospital is shown in table A below:

Table A. Multi-CQI Bonus

CQI count	Bonus amount
1-4 CQIs	$20,000
5-9 CQIs	$50,000
≥10 CQIs	$75,000

If a hospital drops out of a CQI, it is no longer eligible for this bonus. Similarly, if a hospital is recruited to join a CQI, regardless of whether it is a required CQI or not, and chooses not to join, it will not receive the bonus.

The Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE) CQI is exempt from being held to the bonus criteria due to the significant IT component of ASPIRE required to join. Hospitals that are unable to join ASPIRE when invited will remain eligible for the bonus.

Table B. CQI Performance Multiplier Methodology

Hospital name	**Collaborative Quality Initiatives** (Fixed 40% of P4P incentive)								
	Potential CQI Incentive (fixed 40%)	CQI performance	Earned CQI incentive	CQI full-participation bonus	Unearned CQI incentive	Scoring Multiplier (hospital earned/ total earned)	Additional CQI incentive earned	Total earned CQI incentive ($, %*)	
Hospital A	$100,000	95%	$95,000			0.5%	$13,404	$108,404	108.4%
Hospital B	$250,000	80%	$200,000			1.1%	$28,218	$228,218	91.3%
Hospital C	$350,000	78.57%	$275,000	$20,000		1.6%	$38,800	$333,800	95.4%
Hospital D	$500,000	100%	$500,000			2.9%	$70,546	$570,546	114.1%
Hospital E	$750,000	93.33%	$700,000			4.0%	$98,764	$798,764	106.5%
Hospital F	$800,000	91.25%	$730,000	$50,000		4.2%	$102,997	$882,997	110.4%
Hospital G	$1,500,000	60%	$900,000			5.2%	$126,983	$1,026,983	68.5%
Hospital H	$2,250,000	88.89%	$2,000,000			11.5%	$282,184	$2,282,184	101.4%
Hospital I	$3,500,000	100%	$3,500,000			20.1%	$493,822	$3,993,822	114.1%
Hospital J	$10,000,000	85%	$8,500,000	$75,000		48.9%	$1,199,282	$9,774,282	97.7%
Total	**$20,000,000**		**$17,400,000**	**$145,000**	**$2,455,000**		**$2,455,000**	**$20,000,000**	**100.0%**

Hospital CQI programs		
CQI name	**Description**	**Required Yes/No**
Michigan Cardiovascular Consortium, or BMC2 *	Improve the quality of care and reduce health care costs for patients undergoing percutaneous coronary interventions, vascular surgery, and carotid interventions by reducing complications and focusing on the appropriate use.	Yes
Michigan Bariatric Surgery Consortium, or MBSC *	Innovate the science and practice of metabolic and bariatric surgery through comprehensive, lifelong, patient-centered obesity care.	Yes
Michigan Emergency Department Improvement Collaborative, or MEDIC	Advance the science and delivery of emergency care for adult and pediatric patients across a diversity of emergency department settings.	No
Michigan Society of Thoracic and Cardiovascular Surgeons, or MSTCVS, Quality Collaborative*	Improve the quality of care for patients who undergo cardiac surgery, general thoracic surgical procedures, transcatheter valve replacements and perfusion practices.	Yes
Michigan Surgical Quality Collaborative, or MSQC	Develop and implement practical approaches to better outcomes and lower costs for patients undergoing general surgery by focusing on reducing venous thromboembolism, surgical site infections and implementing enhanced recovery programs.	Yes
Michigan Trauma Quality Improvement Project, or MTQIP	Improve the quality of care administered to trauma patients, while reducing the costs associated with trauma care.	Yes
Hospital Medicine Safety, or HMS, Consortium	Improve the quality of care for hospitalized medical patients who are at risk for adverse events.	Yes
Michigan Radiation Oncology Quality Consortium, or MROQC	Improve the quality of the radiation treatment experience for patients with breast, lung, or prostate cancer or cancer that has spread to the bones by identifying best practices in radiation therapy that minimize the side effects that patients may experience from radiation treatment.	No
Michigan Arthroplasty Registry Collaborative for Quality Improvement, or MARCQI*	Engage hospitals and physicians in quality improvement activities for patients undergoing hip and knee joint replacement surgery procedures.	No
Michigan Anticoagulation Quality Improvement Initiative, or MAQI2	Improve the safety, quality of care and outcomes of patients requiring anticoagulation.	No
Michigan Spine Surgery Improvement Collaborative, or MSSIC*	Engages orthopedic surgeons and neurosurgeons with the aim of improving the quality of care of spine surgery, by improving patient care outcomes and increasing efficiency of treatment.	No
Anesthesiology Performance Improvement and Reporting Exchange, or ASPIRE	Integrate surgeon and anesthesiologist perspectives to assess variation in practice, identify best practices, and measure process adherence and patient outcomes to improve the quality of anesthesiology care.	No
OB Initiative, or OBI	Reduce cesarean deliveries for low-risk pregnancies.	Yes

*Participation associated with maintenance of Blue Distinction Specialty Care designation status

CQI scoring method

The tables in this appendix list the measures used to score hospital performance on each CQI. The measures within each index apply to a hospital only if it is eligible to participate in the corresponding CQI. Each CQI index is scored on a 100-point basis.

A hospital participating in multiple CQIs will have its index scores combined into one overall score. For example, assume the following:

Hospital A participates in 5 CQIs (for which it has been recruited and is eligible)

Total CQI weight is 40%.

Individual CQI weight is 8% – 40%/5 CQI programs

Performance in CQI No. 1 is 80%.

Performance in CQI No. 2 is 90%.

Performance in CQI No. 3 is 100%.

Performance in CQI No. 4 is 80%.

Performance in CQI No. 5 is 90%.

Hospital A's overall CQI score is calculated as follows:

	Index score		**CQI weight**		**Earned score or potential score**
CQI No. 1	80%	x	8%	=	6.4%
CQI No. 2	90%	x	8%	=	7.2%
CQI No. 3	100%	x	8%	=	8.0%
CQI No. 4	80%	x	8%	=	6.4%
CQI No. 5	90%	x	8%	=	7.2%
Total CQI aggregate score	**88%**		**40%**		**35.2%**

In this example, Hospital A earned a total CQI score of 35.2% out of a potential 40%. Hospital A left on the table approximately 4.8% of its potential maximum incentive reward tied to CQIs. See Appendix A for a more detailed breakdown of how unearned CQI incentive dollars are distributed to hospitals within the CQI incentive pool based on a comparative CQI performance.

CQI performance index scorecards

The Comprehensive CQI Performance Index Program Guide, a compilation of all CQI performance scorecard indices, will be made available as a separate addendum to the 2026 Pay-for-Performance program guide in mid- to late-December 2025. In addition, each CQI performance index scorecard will be made available through each coordinating center which will be provided to the participating sites at an earlier date.

All performance index measures and weights are established by each individual CQI coordinating center. The weights and measures of a specific CQI performance scorecard may be adjusted for newly participating hospitals. The coordinating center for each CQI will evaluate and score each hospital's performance index and submit the final aggregate score to Blue Cross.

The measurement period for each performance index measure is January through December, unless otherwise specified by the CQI coordinating center.

Specific questions and comments pertaining to the performance index measures should be directed to the respective CQI coordinating center. Contact information will be available in the performance index scorecard addendum to the 2026 P4P program guide.

General CQI participation requirements

General expectations that Blue Cross has for CQI site participants and affiliated clinicians are listed below. Each CQI coordinating center also has distinct expectations for CQI engagement and participation, which are made available by the respective CQI coordinating centers.

- Identify "physician champions" at participating sites who can affect change, collaborate in generating data for enhanced knowledge and analysis of processes and outcomes of care.
- Identify an administrative contact at participating sites.
- Thoroughly and accurately collect comprehensive data (such as no consistent pattern of errors or omissions regarding data elements) on patient cases, as specified by the coordinating center on all cases.
- Submit data in a timely manner for entry into registry, in the format specified by the coordinating center.
- Respond to queries from the coordinating center in a timely manner.
- Cooperate with data quality audits conducted by the coordinating center.
- Attend and participate in all collaborative meetings (attendees include the physician champion, administrative project lead or an assigned designee who can impart QI within the organization).
- Participate in collaborative-wide QI activities or site-specific initiated QI activities related to the work of the CQI.
- Demonstrate that comparative performance reports provided by the CQI are actively used in QI efforts.

- Participate in inter-institutional QI activities (for example, sharing best practices).
- Report on the effect of QI activities and provide examples of specific QI interventions to the coordinating center.
- Obtain institutional approval for CQI data collection requirements, as specified by the coordinating center (such as Institutional Review Board approval).
- Maintain personnel to collect data.
- Obtain signatures required for the site's data use agreement or business associate agreements, which are to be signed by the site's president or CEO or a site representative who holds sign-off authority for the hospital and in the case of the signed data use agreement, returned to the coordinating center.

Health Information Exchange measures

The Blue Cross conformance standards are designed to continually improve data that flows through the Michigan Health Information Network, ensuring it is complete and actionable when it is received by practitioners using the information.

Hospitals are expected to monitor conformance using the MiGateway Conformance Module. MiHIN also sends notifications to hospitals monthly.

For Measure 1 - ADT:

- A hospital will be considered in conformance and receive full points if **all** fields are populated at or above the relevant threshold.
- A hospital will be considered in conformance and receive two thirds of the points if **26 of 27** fields are populated at or above the relevant threshold.
- A hospital will be considered in conformance and receive one third of the points if **25 of 27** fields are populated at or above the relevant threshold.
- The following fields will be combined for scoring purposes - missing more than one field in any category, will only count as missing a single field.

    - PID-5.1 , PID-5.2
    - PID-29 , PID-30
    - IN-1.3 , IN-1.4
    - DG1-3.1 , DG1-3.2 , DG1-6

For Measure 2 - Exchange CCDA (Hospital):

- A hospital will be considered in conformance and receive full points if **all** fields are populated at or above the relevant threshold.
- A hospital will be considered in conformance and receive two thirds of the points if **27 of 28** fields are populated at or above the relevant threshold.
- A hospital will be considered in conformance and receive one third of the points if **26 of 28** fields are populated at or above the relevant threshold.
- The following fields will be combined for scoring purposes - missing more than one field in any category, will only count as missing a single field.

    - Patient First Name, Patient Last Name
    - Patient Address, Patient City, Patient Zip Code
    - Attending Provider First Name, Attending Provider Last Name
    - Discharge Medication Dose Unit, Discharge Medication Dose Quantity
    - Visit Diagnosis Code (ICD10), Visit Diagnosis Description

For Measure 3 - Ambulatory (Outpatient) CCDA:

- A hospital will be considered in conformance and receive full points if Ambulatory CCDA data is transmitted for all patients.
- There are no conformance thresholds currently assigned.

For Measure 4 - Statewide Lab results:

- A hospital will be considered in conformance and receive full points if **all** fields are populated at or above the relevant threshold.
- A hospital will be considered in conformance and receive two thirds of the points if **18 of 19** fields are populated at or above the relevant threshold.
- A hospital will be considered in conformance and receive one third of the points if **17 of 19** fields are populated at or above the relevant threshold.
- The following fields will be combined for scoring purposes - missing more than one field in any category, will only count as missing a single field.
    - PID-5.1, PID-5.2
    - PID-11.1, PID-11.5

Specific conformance thresholds for each measure are outlined in the tables below.

Measure 1: Maintain ADT data quality conformance with inclusion of the common key - 6 points

Hospitals can earn up to six points for maintaining ADT data conformance. The following table shows the required ADT data fields and performance thresholds. Messages must meet and maintain the associated conformance threshold across all three categories: complete routing, complete mapping, and adherence to coding standards.

Measure 1: ADT and CKS Conformance Thresholds – 6 points	
Group A: Complete routing - messages must be populated with all the following fields	Threshold
PID-5.1: Patient Last Name	≥95%
PID-5.2: Patient First Name	≥95%
PID-7: Patient Date of Birth	≥95%
PID-11.5: Patient ZIP	≥95%
PV1-19: Visit Number	≥95%
PV1-37: Discharged to Location	≥95%
PV1-44: Admit Date/Time	≥95%
PV1-45: Discharge Date/Time	≥95%
PID-29: Patient Death Date/Time	≥95%
PID-30: Patient Death Indicator	≥95%
IN1-3: Insurance Company ID	≥95%
IN1-4: Insurance Company Name	≥95%
PID-3.1 Common Key	≥60%

Group B: Complete mapping - MiHIN mapping tables must be kept current for the following fields *	Threshold
MSH-4.1: Sending Facility- Hospital OID	≥95%
PV1-36: Discharge Disposition	≥95%
PID-8: Patient Sex	≥95%
PID-10: Patient Race	≥95%
PID-22: Ethnic Group	≥95%
PV1-2: Patient Class (e.g., observation bed)	≥95%
PV1-4: Admission Type	≥95%
PV1-14: Admit Source	≥95%
DG1-6: Diagnosis Type	≥95%
PV1-10: Hospital Service	≥95%
Group C: Adherence to Coding Standards - values must be sent using the standard indicated below *	Threshold
PV1-7.1: Attending Doctor ID (NPI)	≥95%
PV1-17.1: Admitting Doctor ID (NPI)	≥95%
DG1-3.1: Diagnosis Code ID (ICD10)	≥95%
DG1-3.2: Diagnosis Code Description	≥95%

*Group B and C fields must be populated on at least 95% of messages, and correctly mapped or formatted

Measure 2: Maintain CCDA data conformance for inpatient, observation, and ED visits - 6 points

Hospitals can earn up to six points for maintaining CCDA data conformance for all inpatient, observation, and ER visits. The following table shows the required CCDA data fields and performance thresholds required. There are several fields at the bottom of the table that don't have conformance thresholds yet. However, hospitals are expected to transmit these fields so the information can be analyzed for potential future conformance development.

Measure 2: Exchange CCDA Conformance Thresholds - 6 points	
CCDA – Med Rec Relevant Fields	Threshold
Visit ID	≥95%
Patient Date of Birth	≥95%
Patient Sex	≥95%

Patient First Name	≥95%
Patient Last Name	≥95%
Patient Address	≥95%
Patient City	≥95%
Patient ZIP Code	≥95%
Encounter Type	≥95%
Attending Provider First Name	≥95%
Attending Provider Last Name	≥95%
Attending Provider NPI	≥95%
Attending Provider Phone	≥95%
Admission Medications Present	≥95%
Discharge Medication Name	≥50%
Discharge Medication Begin Date	≥50%
Discharge Medication Dose Unit	≥50%
Discharge Medication Dose Quantity	≥50%
Discharge Medication Instructions	≥50%
Discharge Medication Code (RxNorm or NDC)	≥50%
Allergies	≥95%
Active Problems Present	≥95%
Chief Complaint	≥95%
Visit Diagnosis Code (ICD10)	≥95%
Visit Diagnosis Description	≥95%
Vital Signs	≥95%
Immunizations	≥50%
Results/Laboratory	≥95%
Patient SSN – when available	Not scored
Discharge Medication End Date	Not scored
Discharge Medication Status	Not scored
Advanced Directives	Not scored
Discharge Instructions	Not scored
Functional Status	Not scored

Plan of Care	Not scored
Procedures	Not scored
Progress Notes	Not scored
Reason for Referral	Not scored
Social History	Not scored
Tests Ordered	Not scored

Measure 3: Transmit all ambulatory (outpatient) CCDA data - 4 points

Hospitals will earn four points by transmitting all ambulatory (outpatient clinic) CCDA data for all patients. This includes outpatient encounters and office visits to physicians or APPs sharing the hospital's EMR, both employed and non-employed. There are no conformance thresholds currently. Instead, hospitals will be scored only on whether they transmit the data. The data will be analyzed with the intent of developing conformance standards for future program years.

Measure 4: Statewide lab data conformance - 4 points

Hospitals can earn up to four points for statewide lab data conformance. The table below contains the fields required. There are several fields at the bottom of the table that do not have conformance thresholds yet. However, hospitals are expected to transmit these fields so the information can be analyzed for potential future conformance development.

Measure 4: Statewide Lab Result Data Conformance Thresholds - 4 points	
ORU message – lab result relevant fields	Threshold
MSH-10: Message Control ID	75%
MSH-3.1: Sending Application Namespace ID	75%
MSH-4.1: Sending Facility Namespace ID	75%
MSH-4.2: Sending Facility Universal ID Date/Time of Message	75%
MSH-9.2: Trigger Event	75%
PID-10: Race	75%
PID-11.1: Street Address	75%
PID-11.5: ZIP	75%
PID-2: Patient ID**	75%
PID-5.1: Patient Last Name	75%
PID-5.2: Patient First Name	75%

PID-7: DOB	75%
PID-8: Sex	75%
PV1-2: Patient Class	75%
OBR-16: Ordering Provider	75%
OBX-11: Observation Results Status	75%
OBX-2: Value Type	75%
OBX-3: Observation Identifier	75%
OBX-5: Observation Value	75%
OBR-22: Results Rpt/Status Chng - Date/Time	Not scored
OBR-25: Result Status	Not scored
OBR-3: Filler Order Number	Not scored
OBR-32: Principal Result Interpreter	Not scored
OBR-4: Universal Service Identifier	Not scored
OBX-19: Date and Time of Analysis	Not scored
OBX-23: Performing Organization Name	Not scored
OBX-24: Performing Organization Address	Not scored
OBX-6: Units	Not scored
OBX-7: Reference Ranges	Not scored
PID-13: Home Phone	Not scored
PID-22: Ethnic Group	Not scored
PID-3.1: Patient Identifier Value	Not scored
ORC-1: Order Control	Not scored
ORC-12: Ordering Provider	Not scored
ORC-3: Filler Order Number	Not scored
OBR-1: Set ID - OBR	Not scored
OBR-14: Date and Time Specimen Received	Not scored
OBR-15: Specimen Source	Not scored
OBX-8: Abnormal Flags	Not scored

** Either PID 2 or PID 3 will be accepted and neither measure will be scored until available in MiGateway