blue california

Primary Care Fee-for-Service Plus (FFS+) Incentive Program

2025

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Primary Care Fee-for-Service Plus Incentive Program (FFS+ Program)

Blue Shield of California is committed to supporting our primary care providers in maintaining a vibrant and sustainable practice that is personally and professionally rewarding for you, which translates to optimal care for our members. The FFS+ Program was created to appropriately reward practices like yours for improving health outcomes for our fully insured Commercial PPO members.

FFS+ emphasizes the clinician-patient relationship, preserves autonomy in the provision of care, and links reimbursement to quality and efficiency. Our overall goal is to restore the strength of primary care and improve population health. We hope you will join us in this effort. We look forward to collaborating with you and helping to ensure your practice's success.

Methodology

Your practice may be eligible to receive an additional incentive payment for each attributed Commercial PPO member based on your ability to meet targets for clinical quality, resource utilization, and patient experience metrics. The FFS+ Program includes measure sets for both adult and pediatric patients.

Eligibility

Eligibility is based on providers' continued participation in Blue Shield's PPO network under the TIN associated with the FFS+ Incentive Program attestation. Other eligibility criteria are shown below.

Clinicians	Family practice, general practice, internal medicine, and pediatric physicians
Practices	Outpatient only
Lines of business	Fully insured Commercial PPO only
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)

Attribution

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

Performance measures

Adult measures

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

Domain	Name	Minimum denominator	Maximum incentive per attributed member
Resource utilization	Emergency room (ER) visits per 1,000 members	30 members	$1.00
	Inpatient admits (IA) per 1,000 members	150 members	$1.00
Clinical quality	Glycemic status assessment for patients with diabetes: Glycemic status <8.0%†	1 member	$0.625
	Controlling high blood pressure	1 member	$0.625
	Breast cancer screening	1 member	$0.625
	Colorectal cancer screening	1 member	$0.625
Patient experience	Patient experience survey	1 member	$0.50
Maximum incentive per attributed member			**$5.00**

†This measure was previously titled "Diabetes: Hemoglobin HbA1c good control (<8.0%)."

Pediatric measures

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

Domain	Name	Minimum denominator	Maximum incentive per attributed member
Resource utilization	Emergency room (ER) visits per 1,000 members	30 members	$0.60
Clinical quality	Childhood immunization status: Combo 10	1 member	$1.00
	Immunizations for adolescents: Combo 2	1 member	$1.00
	Weight assessment and counseling for nutrition and physical activity for children/adolescents		
	– BMI percentile documentation	1 member	$0.3333
	– Counseling for nutrition	1 member	$0.3333
	– Counseling for physical activity	1 member	$0.3333
Patient experience	Patient experience survey	1 member	$0.40
Maximum incentive per attributed member			**$4.00**

Incentive payments

The number and timing of incentive payments is linked to when your practice joins the FFS+ Program. Incentive payments are based on the practice's performance against resource utilization, clinical quality, and patient experience metrics.

Partial advance incentive payments are paid in Q3 of a given year. Incentive payments are made on an estimated basis 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. Regardless of the outcome of the reconciliation, Blue Shield will not collect any payment from the practice.

All incentive payments will be made via electronic transfer to a bank account designated by the practice.

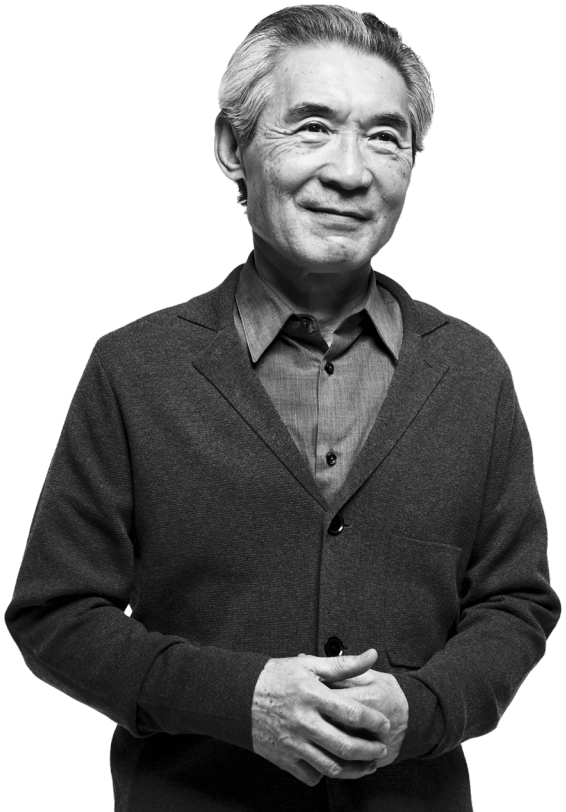
Payment schedule example

The table below describes the payment schedule based upon the month in which a given practice begins FFS+ participation.

Program start month	Program 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

Measure definitions

Adult	
Resource use measures	
Emergency room visits	• Emergency room (ER) visits per 1,000 members • Includes ER visits which do not result in an admission • Separate measures for pediatrics and adults • Measure must meet minimum denominator size of 30 members to be included for payment
Inpatient admits	• Inpatient admits per 1,000 members • Includes adult medical and surgical admissions • Risk adjustment using concurrent DxCG risk score • Measure must meet minimum denominator size of 150 members to be included for payment
Clinical quality measures	
Glycemic status assessment for patients with diabetes: Glycemic status <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 18 years of age as of 12/31 • ER visits per 1,000 members • Measure must meet minimum denominator size of 30 members to be included in incentive payment • Includes ER visits which do not result in an admission • Separate measures for pediatrics and adults
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. • 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 chickenpox (VZV) vaccination • 4 pneumococcal conjugate (PCV) vaccinations • 1 hepatitis A (HepA) vaccination • 2 or 3 rotavirus (RV) vaccinations • 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 and 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?"

Claims submission
There is no change to the way practices submit claims for attributed Commercial PPO members.

Data submission and reporting
Performance data are collected and reported as follows:

- **Claims data**
  Claims data are utilized to calculate clinical quality and resource use utilization metrics. Where appropriate, practices should use CPTII codes when submitting claims.

- **Supplemental data**
  While not required, practices are encouraged to submit supplemental data to close care gaps and enhance performance rates for measures.

Termination

Either party may terminate participation in FFS+ without cause, upon one hundred twenty (120) days' prior written notice. Any termination shall become effective the first day of the month following the expiration of such notice period. Termination from FFS+ shall have no effect upon the Independent Physician and Provider Agreement, however termination of provider's PPO network agreement shall also terminate provider's participation in the FFS+ Incentive Program.

Questions
If you have questions about the FFS+ Program, email **primarycarereimagined@blueshieldca.com**.

This document does not modify and may not be used to assert the modification of any contractual obligation. The incentives and performance measures described in this brochure are not intended to serve as and are not a substitute for professional medical advice, diagnosis, or treatment. Health care providers assume full responsibility for how to meet incentive measurements. Providers should exercise their own independent professional medical judgment based on all available information, including the provider's evaluation of their patient's condition and health care needs. Measurements are based on provision of covered services under the member's evidence of coverage. Regardless of this program, the final decision about any service or treatment is between the member and their health care provider and should not be based on meeting performance measurements to receive incentives. Any efficiencies generated through this program are to result from care coordination and/or elimination of unnecessary services. Blue Shield of California disclaims all liability for any direct, indirect, implied, punitive, special, incidental, or other consequential damages arising directly or indirectly from participation in this FFS+ Program, which is completely voluntary.

Approved: 11/24