MCT2D Performance Measure - HbA1c Year 2

Specialty: Primary Care
Performance Period: 06/01/2025 - 04/30/2026
VBR Reward Year: 09/1/2026 - 08/31/2027

Eligible Population (Denominator)

For all BCBSM/BCN/BCBS-MA/BCN-A patients attributed to an MCT2D participating primary care physician who are:
- aged ≥18 and ≤75 and
- meet the MCT2D criteria for inclusion in the data registry and
- who have had at least one A1C record (whether clinical or claims) between the start of the lookback period (06/01/2024) and the end of the performance period (04/30/2026).

Reward Amount

Moving forward, BCBSM will not have a separate participation and performance measure VBR. It will be part of a single scorecard that adds up to 100 points, consisting of both performance measures and participation measures. Different point thresholds will constitute different VBR earnings, with a point threshold required for 102% VBR, 103% VBR, and 105% VBR. These specific thresholds will be available by early June.

Eligible Physicians

All physicians at MCT2D participating at primary care practices deemed eligible for VBR by BCBSM are eligible for the A1C Year 2 performance measure VBR.

Measurement Level

Practice level measurement: All primary care practices, irrespective of the size of their patient population, will be measured at the practice level.

Measurement Population Definition

The percent of members aged ≥18 and ≤75 with type 2 diabetes whose most recent glycemic status (A1C) was at the following level during the measurement year:
- A1C <8% for Commercial insurance
- A1C ≤9% for Medicare insurance

Please note that patients who are 75 years old will remain in the measure until which time they turn 76. When they turn 76 they will drop out of the measure. For the two month locked period (see data section below), patients will be proactively dropped who will turn 76 before the end of the performance period (04/30/2026).

Goal Rate

MCT2D will continue aligning with the HEDIS 90th percentile rate for commercial and the projected 90th percentile rate for Medicare populations:
- 74.45% of patients with an A1C less than 8% for the commercial population
- 91% of patients with an A1C less than or equal to 9% for the Medicare population

Data

MCT2D will be using the MCT2D dashboards developed by the Michigan Data Collaborative to track performance on the metric. MCT2D will use A1C rates from both clinical (PPQC data) and claims data.

In contrast to last year, the denominator will not be locked in until the final 2 months of the performance period. The population denominator will be allowed to change until February 28, 2026, at which point it will be held steady beginning March 1st, 2026, such that new patients are not added to the denominator for the final 2 months.

MCT2D analysis of the data demonstrated that the number of attributed patients remains fairly stable throughout the year, such that this should not negatively impact any practices. The reason for not locking the population at the beginning of the performance year is to allow for the normal movement of providers and their patients between practices and places of employment, instead of the removal of these patients from the denominator at subsequent data refreshes. To be as fair as possible, the locking of the population for the last 2 months is to limit the occurrences where a patient is attributed to a physician near the end of the performance year, and the practice is held accountable for that patient's A1C when they have not yet had the opportunity to see the patient.

Because the denominator will not be locked, MCT2D will not be providing baseline patient lists. Instead, practices may use the Patient Data Dashboard to view the patients that are currently attributed to them and their current performance. A patient list will also not be provided after locking in the denominator population for the last 2 months, as we will not receive the data through 02/28/2026 until after the end of the measurement period.

Timeline

Since the denominator is not locked until the final two months of the measure, the patient population is not based on a specific subset of patients who had an A1C in a period of time prior to the performance period. Rather, we will use the most recent A1C for a patient between the

beginning of a lookback period (06/01/2024) and the end of the performance period (04/30/2026) - which we will collectively refer to as the "Measurement Period." Any patient without any A1C in this timeframe (06/01/2024 - 04/30/2026) will not be counted in the measure. The purpose of using the lookback period is to ensure that a practice cannot avoid counting an uncontrolled patient in the measure by choosing not to perform a follow-up A1C test during the performance period.

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Lookback period: 06/01/2024 to 05/31/2025

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Performance period: 06/01/2025 to 04/30/2026

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Measurement period: 06/01/2024 to 04/30/2026

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Current performance rates, including a 'baseline' rate will be provided to practices through the MCT2D patient data dashboard and reports that will be shared with the practices through the MCT2D Administrative Portal.

Performance Period

06/01/2025 - 04/30/2026

Please note, due to the data lag, baseline data that will be released at the end of July will allow MCT2D to provide you your baseline rates by early August. The performance period will begin on June 1st, thus there will be two months where you will be working on the measure without knowing your baseline performance. However, patients attributed to you with an uncontrolled A1C can always be viewed in the Patient Data Dashboard.

Data Release Estimates

The MCT2D Patient Data Dashboard will be refreshed throughout the year in order for practices to run improvement cycles and improve their performance throughout the year. The anticipated release schedule is below. Please note, 2026 dates may shift slightly.
- 07/25/2025 (data through 05/31/2025) - Baseline Performance Report Provided in August 2025
- 10/31/2025 (data through 08/31/2025) - Progress Report Provided in November 2025

- 12/30/2025 (data through 10/31/2025)
- 01/30/2026 (data through 11/30/2025) - Progress Report Provided in February 2026
- 03/31/2026 (data through 01/31/2026)
- 04/30/2026 (data through 02/28/2026)
- 06/30/2026 (data through 04/30/2026) - Final Performance Report Provided in July 2026

Data Reconciliation Plan

We will use the data refresh on 6/30/2026 (data through 04/30/2026) to calculate final performance as this will have data through the end of the performance period. MCT2D will submit a list of physicians who earned the VBR to BCBSM by 7/15/2026 and BCBSM will review and reconcile data in order to finalize and pay VBR on 9/1/2026.

Additional Requirements

The PO is required to log into the MCT2D Patient Data Dashboard on a quarterly basis and disseminate information to their practices. This will be verified by reviewing the log in and usage information provided by the Michigan Data Collaborative

Summary of Changes Compared to the Year 1 (2024-2025) HbA1c Performance Measure

1) Addition of upper age limit of <76 years of age for inclusion in the measure to align with HEDIS.
2) Delineation between Commercial and Medicare will be made by whether a patient is 65 years of age or older OR via a specific indicator from BCBSM/BCN that indicates that a patient is a Medicare patient.
3) Removal of aggregate groups.
4) Inclusion of Physician Organizations with less than 100 total eligible patients.
5) Removal of denominator lock until the last 2 months of the performance period.
   a) MCT2D will not be providing a list of patients included in the measure at the beginning of the measure as it is not locked, nor will we provide one after locking in the denominator population for the last 2 months, as we will not receive data through 02/28/2026 until after the end of the measurement period.
6) Removal of the additional requirement to submit a data dashboard dissemination plan.
7) Removal of the additional requirement for practices currently meeting the measure to submit uncontrolled A1C forms.

FAQs on the HbA1c Year 2 Performance Measure

1. *Why is MCT2D removing aggregate groups and measuring each practice individually?*

    While aggregation can be valuable in certain contexts, we've found that it introduces several administrative and analytical challenges—particularly during periods of organizational change, such as PO and practice merges, provider migration and/or retirements, etc.

    One of the biggest issues is the instability of patient populations across practices. As practices gain or lose patients, the composition of aggregate groups shifts, requiring re-aggregation. This undermines consistency over time and makes it difficult to interpret trends with confidence. For instance, an aggregate group might appear to meet performance in one reporting cycle, but due to re-aggregation in the next, the same group might fall short—despite little or no change in actual clinical performance.

    Additionally, aggregation creates interdependence across practices. A single underperforming practice can bring down the overall performance of the group, even if the others are performing well. This dynamic can lead to frustration and confusion among practices who feel they are being penalized for factors beyond their control.

    Ultimately, the goal of these performance measures is to improve care at the practice level. Being able to evaluate each practice on its own performance helps us better identify where support is needed and drive meaningful improvement for patients. For these reasons, we are proceeding without aggregation at this time, with the goal of maintaining transparency, stability, and meaningful practice-level insight. MCT2D will evaluate the performances of smaller practices at the end of the cycle and revisit this decision in the future.

2. *Why does the number of patients attributed to my practice not match the sum of the patients attributed to each of the providers at my practice?*

    Patients may be attributed to multiple providers within a practice. In the attribution counts, a patient may be attributed to two providers at the same practice and show in each of the providers individual patient attribution counts. However, for the purpose of the practice level performance, a patient is only counted once regardless of how many providers within the practice they see, therefore in the practice level attribution count, they would only be counted once.

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