Professional Relations

Annual CAP Report

2019 Contracting

BlueCross BlueShield of Kansas

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Introduction

Blue Cross and Blue Shield of Kansas (BCBSKS) is the insurer Kansans trust with their health. Much of that status can be attributed to the high-quality care delivered by our network providers. This document outlines the details related to our 2019 Competitive Allowance Program (CAP) offer and includes the specifics of our Quality-Based Reimbursement Program (QBRP), which has been designed to reward your efforts toward maintaining high-quality standards.

BCBSKS continues to offer contracting providers top-notch services, including professional provider representatives and provider network services.

If you need clarification or additional information related to any information included herein, contact your Professional Relations representative or Provider Network Services.

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By the numbers

Blue Cross and Blue Shield of Kansas provides the best service in the industry and strives to be the health insurance company of choice for our members and providers.

#1

BCBSKS is top-ranked for Provider Satisfaction.

$86M

BCBSKS is projecting $86 million in QBRP incentives in 2018 (professional and institutional).

971,997

BCBSKS and its subsidiaries serve 971,997 members across all lines of business, including BlueCard, as of May 31, 2018.

653,003

BCBSKS serves 653,003 members locally, as of May 31, 2018.

7.63%

BCBSKS spent 7.63 percent of annual premium income on administrative expenses for the year of 2017.

100%

BCBSKS is 100 percent URAC accredited in health plan, case management, and disease management.

99%

BCBSKS contracts with 99 percent of all physicians in the Plan area.

97%

BCBSKS contracts with 97 percent of all professional providers in the Plan area.

PCMH/ACO

BCBSKS continues to support and expand Patient-Centered Medical Home (PCMH) and Accountable Care Organization (ACO) arrangements.

The value in contracting

BCBSKS provides business services that bridge the gap between the delivery and financing of health care. Services creating significant value for contracting providers include:

Local member contracts structured to allow charges up to 100 percent of the MAP for participating CAP providers (subject to member benefits).	**Opportunity to earn additional revenue** through the Quality-Based Reimbursement Program (QBRP).
Detailed claim-payment information provided to both you and the member explaining their financial responsibilities.	**Direct payment from BCBSKS,** which minimizes your collection efforts and increases cash flow.
A dedicated field staff available to visit your office to address any operational issues.	**Electronic remittance advice** and payment capabilities.
Access to professional relations provider network services personnel to answer policy questions or obtain assistance with claim coding questions.	**Opportunity to participate on specialty liaison committees** and provide direct input in the development of medical policies and emerging issues.
Contracting providers' names made available to BCBSKS members through a number of sources including the internet, employer groups, and other contracting providers for referral purposes, which increases the potential for new patients.	**Periodic workshops** conducted by Professional Relations staff that delivers continuous training for new and experienced medical assistant staff, helping update your staff on new administrative procedures to ensure timely claim payments.

Website (bcbsks.com) and self-service access through Availity, which improves your office efficiencies and maximizes your employee resources.

- Secure services include detailed claims payment information, member eligibility, remittance advice, and provider enrollment information.
- Other services include training modules, podcasts, newsletters, manuals, policy memos, and medical policies/guidelines.

NOTE — In 2019, for the majority of our business, non-contracting providers' services will be paid direct to the member at a charge up to 80 percent of the MAP (i.e. there is a 20-percent penalty for members receiving services from a non-contracting provider), subject to member benefits. In addition, assignment of benefits to non-contracting providers is not allowed. Also, non-contracting providers do not qualify for QBRP incentives.

2019 Reimbursement and Policy Memo changes

On June 29, 2018, the BCBSKS Board of Directors met and approved reimbursement and policy memo changes for 2019. A summary of the policy memo changes is enclosed for your review.

Highlights of the 2019 reimbursement are noted on page 5. We continue to build on the Quality-Based Reimbursement Program (QBRP) started in 2012 to encourage higher quality care and better control of health care costs. Our reimbursement program for 2019 will continue to create opportunities for providers to earn incentives by meeting the criteria as outlined in the 2019 QBRP as described on pages 7-15.

A charge comparison report reflecting reimbursement changes for 2019 is available by contacting your Professional Relations representative or our Provider Network Services area. The charge comparison is based on services billed by you during the first five months of 2018. The charge comparison format provides the lesser of your charge or the MAP for each procedure code you performed thus far in 2018. In addition, the report shows whether each procedure code qualifies for QBRP.

Overview of 2019 Reimbursement

Please note that along with base rate changes, additional reimbursement is available through the QBRP program where noted. (See QBRP section, pages 7-15.)

Increasing ▲	No change –	Decreasing ▼
Undervalued CPT codes (eligible for QBRP)	Professional consultation codes (eligible for QBRP)	Overvalued CPT codes (eligible for QBRP)
Ambulance base rates for fixed wing (eligible for QBRP)	Administration for injectable drugs (eligible for QBRP)	Clinical lab codes (not eligible for QBRP)
Ambulance base rates for rotary wing (eligible for QBRP)	Physical therapy, occupational therapy, and speech pathology services (eligible for QBRP)	Some Durable Medical Equipment (DME) services (eligible for QBRP)
Anesthesia conversion factor at $61.64 (eligible for QBRP)	Services billed by primary care providers located in counties within a population of 13,000 or less will continue to receive a 5 percent add-on to the MAP on all eligible CPT codes (not eligible for QBRP). See county listing on page 16.	
	Evaluation and Management (E&M) codes (eligible for QBRP)	
	Sleep medicine (eligible for QBRP)	
	Surgical codes (eligible for QBRP)	
	Mileage rates for fixed wing and rotary wing (eligible for QBRP)	
	Pain management (eligible for QBRP)	
	Some Durable Medical Equipment (DME) services (eligible for QBRP)	

Tiered Reimbursement

The allowances for professional services associated with the following specialties have been set at the identified percentages of the MAP (no reimbursement changes for 2019).

85 percent*	70 percent*	50 percent*
Advanced Practice Registered Nurses (APRNs) [not including Certified Registered Nurse Anesthetists (CRNAs)]	Community Mental Health Centers	Certified Occupational Therapy Assistants (COTAs)
Chiropractors	Licensed Clinical Marriage and Family Therapists	Certified Physical Therapist Assistants (CPTAs)
Clinical Psychologists	Licensed Clinical Professional Counselors	Licensed Athletic Trainers (LATs)
Occupational Therapists	Licensed Clinical Psychotherapists	Individual Intensive Support (IIS) providers
Physical Therapists	Licensed Specialist Clinical Social Workers (LSCSWs)	
Physician Assistants	Outpatient Substance Abuse Facilities	
Speech Language Pathologists	Autism Specialists (AS)	
Licensed Dieticians/Certified Diabetic Educators		

*Amounts are rounded to the nearest $0.01 per line item.

2019 Professional Providers QBRP

The BCBSKS Quality-Based Reimbursement Program (QBRP) is designed to promote efficient administration, improved quality, and better patient care and outcomes. Contracting BCBSKS providers have an opportunity to earn additional revenue through add-ons to allowances for meeting the defined quality metrics. BCBSKS claims data is used to determine qualification for any applicable metric requiring data. 2019 will begin the eighth year for QBRP incentives.

Each year, BCBSKS seeks opportunities to best align meaningful administrative and clinical metrics with incentives to drive improved outcomes. New metrics have been added for 2019 to better align expectations with Federal Employee Program (FEP) and/or HEDIS requirements. In addition, we are evaluating the value received by both providers and BCBSKS from the HIE incentives and have elected to shift a portion of those incentive weights to other metrics as BCBSKS completes its assessment.

IMPORTANT REMINDER — The 2019 QBRP program is effective for services performed January 1, 2019 through December 31, 2019. Since the 2019 CAP letter is sent out in July 2018, providers have several months to prepare to meet the various QBRP metrics and qualify for incentives effective January 1, 2019, in accordance with the metric review schedule (see pages 10-14).

Please read the requirements and metrics for the 2019 QBRP program so you are prepared to maximize the available incentives. Any subsequent pertinent information or clarification will be communicated accordingly.

Criteria for 2019

In accordance with the 2019 Policy Memo No. 1, Section XXX. Reimbursement for Quality, this document describes the components of QBRP effective January 1, 2019 through December 31, 2019. This program applies to all BCBSKS CAP, BlueCross BlueShield of Kansas Solutions, Inc. (a wholly owned subsidiary of BCBSKS), FEP, and BlueCard professional providers and services except for clinical lab (using codes on the Medicare clinical lab fee schedule), pharmacies and pharmaceuticals, and dental services.

This program will offer an opportunity for eligible providers to earn increased reimbursement based on a four-group approach (Groups A, B, C, and D). This reimbursement will be in addition to the established base MAPs for 2019.

Please note — Changes in CPT codes (added/deleted) will be effective prospectively, including QBRP.

In order to pay incentives on the metrics in Groups B, C, and D, we developed a doctor/patient registry. BCBSKS will review claims from the preceding 12 to 24 months and attribute patients to the applicable physicians based on the frequency of office visit encounters with a given physician. In the event multiple physicians have the same number of encounters for the same patient, the patient will be attributed to the physician with the most recent encounter.

The quality-based incentives will be earned at the individual provider level unless otherwise specified.

Qualification to participate in the incentives made available in the program will vary depending on provider type. An eligible provider may independently qualify for each metric, except when measured on a group basis. The QBRP metrics are multiplied individually by the MAP, then totaled with the MAP to determine the total

2019 Professional Providers QBRP

reimbursement “QBRP MAP.” BCBSKS will allow the lesser of the provider’s charge or the “QBRP MAP.”

In order for incentive payments to begin January 1, 2019, BCBSKS will use information on file or available from outside sources to determine which incentives providers qualify for based on unique provider individual NPI numbers, billing NPI numbers or tax ID, whichever is applicable. Confirmation notices with the qualifying incentive category, amount, and effective date will be generated for each individual provider and sent by email to the address on file. Email delivery of the confirmation notices for QBRP 2019 incentives effective January 1, 2019 will be sent mid-December 2018.

Please note — In 2018, BCBSKS built enhancements to the provider information portal to include self-service QBRP information. At some point, the portal may replace the email confirmation process. More information and instructions will be communicated if any changes are made to the notification process.

All metrics will be reviewed on a semi-annual basis and any incentives earned will be effective either January 1, 2019 or July 1, 2019 as applicable. We will continue monthly reviews for 2019 to identify providers who did not qualify for incentive(s) beginning January 1, 2019 because of not meeting prerequisites, or new providers/groups after January 1, 2019, but may subsequently qualify for incentive(s). Qualifying will be based on the most current data/reports available and in accordance to the schedule(s) listed in this document. If/when one of these two situations occur, the incentive(s) will be effective the first of the following month. A confirmation notice will be emailed to the provider to include the new incentive category and effective date. Any corrections will be effective the first of the following month unless otherwise specified.

We will conduct a QBRP refresh in the first and second quarters (depending on the metric) of 2019 for an effective date of July 1, 2019 to determine if providers are continuing to meet the performance standards for the metric(s) earned for the incentive payments effective January 1, 2019. If the refreshed data indicates a provider is no longer meeting the performance standards for the metric(s), then the associated QBRP incentive(s) will cease beginning July 1, 2019 for the remainder of the year. If a provider no longer meets the performance standards for the metric(s), a new communication advising of the change in QBRP incentive(s) qualifications will be sent.

2019 Professional Providers QBRP

QBRP PREREQUISITES AND GROUPS FOR PROVIDERS	
QBRP Participation Prerequisites	Providers must conduct business with BCBSKS electronically (i.e. turn off paper). Providers must submit all eligible claims electronically, accept electronic remittance advice documents (ERAs: either through receiving the ANSI 835 transaction or by downloading the RA from the BCBSKS secured website (and turn off printed RAs), and receive all communications (newsletters, etc.) electronically.
Group A	Applies to all eligible contracting professional providers and to all eligible/covered CPT and HCPCS codes (excludes Clinical Lab [using codes on Medicare clinical lab fee schedule], Pharmacy and Pharmaceuticals, and Dental services).
Group B	Applies to all prescribing provider types (MD, DO, DPM, OD, PA, APRN, CRNA) as applicable to the measure and to all eligible/covered CPT codes (excludes Clinical Lab [using codes on the Medicare clinical lab fee schedule], Pharmacy and Pharmaceuticals, and Dental services).
Group C	Applies to primary care professionals including supervised mid-levels (FP, GP, Peds, IM, PA, APRN) unless otherwise noted and only to covered E&M codes. Group C incentives are earned at the group level (for physicians with attributed members) with the exception of Level 3 PCMH Recognition, which is incentivized at the individual level. New providers joining a group or changing tax IDs will not be eligible for the HEDIS metrics under the new arrangement until the refresh period.
Group D	Applies to all prescribing provider types (MD, DO, DPM, OD, PA, APRN, CRNA) as applicable to the measure and only to covered E&M codes.

2019 Professional Providers QBRP

Metric	%	Group	Description	Qualifying Period
Electronic Self-Service (ES3, ES2)	**3.0 (ES3)** (96% or >) **1.5 (ES2)** (86-95%)	A	Must use Availity portal or ANSI 270/271 & 276/277 transactions to electronically obtain BCBSKS patient eligibility, benefit, and claims status information. Electronic access must meet one of the percentages at left compared to the provider's total number of queries to BCBSKS, regardless of the mode of inquiry to receive the corresponding incentive. Providers billing under a single tax ID number will have their inquiries combined for determining the applicable percent.	Semi-annual
Provider Information Portal (PRT)	2.75	A	Must verify provider information twice a year according to the qualifying schedule below. Each individual provider's information within a group must be verified. Verification must be completed within the BCBSKS provider information portal.	Semi-annual

Qualifying for Electronic Self-Service Incentive (ES3, ES2)

The following is a list of incentive effective dates and the corresponding qualifying periods:

Qualifying Period	Incentive begins
August 1 - October 31, 2018	January 1, 2019
February 1 - April 30, 2019	July 1, 2019

Qualifying for Provider Information Portal (PRT) and Registry Data (REG) Incentives

The following is a list of incentive effective dates and the corresponding qualifying periods:

Qualifying Period	Incentive begins
June 1 - November 30, 2018	January 1, 2019
December 1, 2018 - May 31, 2019	July 1, 2019

2019 Professional Providers QBRP

Metric	%	Group	Description	Qualifying Period
Registry Data (REG) (applies only to anesthesia, pathology, radiology, urology, chiropractors, optometrists)	1.5	B	Must send sufficient patient information to meet CMS quality measures to a CMS-approved registry. Electronic submission is preferred. Providers under a group qualify as a group. Must send report to BCBSKS demonstrating acceptance of submitting data and meeting registry requirements. **Note —** Although not prescribing providers, chiropractors will be eligible for this Group B measure.	Semi-annual
Access Formulary Electronically (EEX)	.75	B	Must electronically access member benefit information for eligibility, formulary, and medication history a minimum of 120 times per quarter.	Semi-annual
Generic Utilization Rate (GUR)	.75	B	Minimum generic prescribing of 85 percent (for all BCBSKS members with a prescription drug benefit).	Semi-annual
HIE HL7 use — Each provider must have a user ID and real-time connectivity to qualify for:				
a-HIE HL7 (ADT) Demographic, admissions, discharges, transfers	.75	B	Must send all records for demographics, admissions, discharges, and transfers. This includes office visits.	Semi-annual
b-HIE HL7 (OPN) Progress notes	.75	B	Must send progress notes on all patient encounters.	Semi-annual
c-HIE HL7 (ABS) Diagnosis, Procedure coding	.75	B	Must send diagnosis and/or procedure coding on all patient encounters.	Semi-annual
d-HIE HL7 (LAB) Lab reporting	.75	B	Must send all lab reports on all patient lab tests.	Semi-annual
e-HIE HL7 (MED) Medication records	.75	B	Must send medication history on all patient encounters.	Semi-annual

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Metric	%	Group	Description	Qualifying Period
Anesthesia Performed in a Health System with a Level 1 Trauma Center (ATC) (NEW)	2.0	B	Must be dedicated onsite 24 hours a day, seven days a week, 365 days a year to a level 1 trauma center facility with a PICU and NICU and involved with teaching anesthesia residents.	Semi-annual
Adolescent Well-Care Visits (AWC) (NEW)	.5	B	The percentage of members who were 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. Must be greater than or equal to 50 percent to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.	Semi-annual
Cervical Cancer Screening (CCS) (NEW)	.5	B	The percentage of women 21-64 years of age who were screened for cervical cancer. Must be greater than or equal to 75 percent to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.	Semi-annual
Colorectal Cancer Screening (COL) (NEW)	.5	B	The percentage of adults 50-75 years of age (51-75 as of December 31 of the measurement year) who had appropriate screening for colorectal cancer. Members with multiple screenings will be counted only once as appropriately screened. Must be greater than or equal to 60 percent to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.	Semi-annual
Compre-hensive Diabetes Care (A1c testing) (CDC) (NEW)	.5	B	The percentage of members 18-75 years of age with diabetes (type 1 or type 2) who had a Hemoglobin A1c test during the measurement year. Must be greater than or equal to 90 percent to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.	Semi-annual
Low-Back Pain (LBP) (NEW)	.5	B	The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis. The percentage is reported as an inverted rate, therefore, a higher reported rate indicates appropriate treatment of low back pain (i.e. proportion for whom imaging studies did not occur). Must be greater than or equal to 85 percent to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive. **Note —** The member is attributed to the provider associated with the earliest date of service for an eligible encounter with a principal diagnosis of low back pain, regardless of specialty. Although not prescribing providers, chiropractors will be eligible for this Group B measure.	Semi-annual

2019 Professional Providers QBRP

Metric	%	Group	Description	Qualifying Period
Well-Child visits (W15) 6-plus visits in first 15 months	.5	B	The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. Must be greater than or equal to 80 percent to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.	Semi-annual
Well-Child visits (W34) 1 or more visits for 3-6 year olds	.5	B	The percentage of members 3 to 6 years of age who had at least one well-child visit with a PCP during the measurement year. Must be greater than or equal to 80 percent to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.	Semi-annual

Qualifying for HIE Incentives (ADT, OPN, ABS, LAB, MED)

The following is a list of incentive effective dates and the corresponding qualifying periods:

Qualifying Period	Incentive begins
August 1 - October 31, 2018	January 1, 2019
February 1 - April 30, 2019	July 1, 2019

Qualifying for Access Formulary Electronically, Generic Utilization Rate Incentives (EEX, GUR)

The following is a list of incentive effective dates and the corresponding qualifying periods:

Qualifying Period	Incentive begins
September 1 - November 30, 2018	January 1, 2019
March 1 - May 31, 2019	July 1, 2019

Metric	%	Group	Description	Qualifying Period
PCMH Recognition (BST) Level 3	2.0	C	Provider must achieve Level 3 NCQA and/or URAC Patient Centered Medical Home recognition.	Semi-annual
Breast Cancer Screening (BCS)	1.0	C	The percentage of women 50 to 74 years of age (52 to 74 as of the end of the measurement period) who had a mammogram anytime in the past two years. Must be greater than or equal to 75 percent to meet the metric, calculated at the provider group level having at least five attributed/eligible patients for breast cancer screening. Individual providers in the group must have at least one attributed/eligible patient to receive incentive. **Note —** OB/GYN and Geriatrician providers can qualify as well.	Semi-annual

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Metric	%	Group	Description	Qualifying Period
Appropriate Testing for Children with Pharyngitis (CWP)	1.0	D	The percentage of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e. appropriate testing). Must be greater than or equal to 80 percent to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive. **Note —** The member is attributed to the provider associated with the earliest date of service for an eligible encounter with a principal diagnosis of pharyngitis, regardless of specialty.	Semi-annual
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	1.0	D	The percentage of children 3 months to 18 years of age who were given a diagnosis of upper respiratory infection and were not dispensed an antibiotic prescription. Must be greater than or equal to 85 percent to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive. **Note —** The member is attributed to the provider associated with the earliest date of service for an eligible encounter with a principal diagnosis of URI, regardless of specialty.	Semi-annual
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	1.0	D	The percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription. Must be greater than or equal to 30 percent to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive. **Note —** The member is attributed to the provider associated with the earliest date of service for an eligible encounter with a principal diagnosis of acute bronchitis, regardless of specialty.	Semi-annual

2019 Professional Providers QBRP

QBRP CHANGES FOR 2019		
Metric	**Change**	**Reason**
Electronic Self-Service	Increased incentive for ES3 from 2.5 to 3.0 percent.	To increase self-service.
Provider Information Portal	Increased incentive from 2.0 to 2.75 percent.	To increase provider data validation adherence.
Registry Data	Added optometrists.	To increase quality registry data participation, submission.
Access Formulary Electronically	Decreased incentive from 1.0 to .75 percent.	Overall average use has increased and becoming norm.
Generic Utilization Rate	Raised threshold from 80 to 85. Also decreased incentive from 1.0 to .75 percent.	Overall average has increased to 88 percent. Generics are becoming norm.
HIE HL7 Demographic, admissions, discharges, transfers	Decreased incentive from 1.0 to .75 percent.	Considering alternatives to HIE.
HIE HL7 Diagnosis, Procedure coding	Decreased incentive from 1.0 to .75 percent.	Considering alternatives to HIE.
HIE HL7 Lab reporting	Decreased incentive from 1.0 to .75 percent.	Considering alternatives to HIE.
HIE HL7 Medication records	Decreased incentive from 1.0 to .75 percent.	Considering alternatives to HIE.
HIE HL7 Progress notes	Decreased incentive from 1.0 to .75 percent.	Considering alternatives to HIE.
Anesthesia Performed in Level 1 Trauma Center	Added.	Recognize unique services.
Adolescent Well-Care Visits	Added.	To align with W15 and W34.
Cervical Cancer Screening	Added.	To align with FEP.
Colorectal Cancer Screening	Added.	To align with FEP.
Comprehensive Diabetes Care (A1c testing)	Added.	To align with FEP.
Low-Back Pain	Added.	To align with FEP.
Well-child visits in first 15 months	Increased incentive from .25 to .5 percent.	Greater impact on FEP and STARS rating.
Well-child visits 3-6 years old	Increased incentive from .25 to .5 percent.	Greater impact on FEP and STARS rating.
Breast Cancer Screening	Raised threshold from 70 to 75 percent.	To be consistent with other HEDIS measures.
Appropriate Testing for Children with Pharyngitis	Moved from Group C to Group D.	Allow more providers to qualify.
Appropriate Treatment for Children with Upper Respiratory Infection	Moved from Group C to Group D.	Allow more providers to qualify.
Monitoring Patients on Persistent Medications	Removed.	To align with FEP.

Rural Access Counties

The following is a list of counties with a population of 13,000 or less that qualify for a Rural Access incentive. (Source: U.S. County 2017 Estimated Census)

County	Population
Allen	12,519
Anderson	7,833
Barber	4,586
Brown	9,641
Chase	2,683
Chautauqua	3,363
Cheyenne	2,683
Clark	2,004
Clay	7,958
Cloud	8,991
Coffey	8,224
Comanche	1,790
Decatur	2,885
Doniphan	7,727
Edwards	2,893
Elk	2,498
Ellsworth	6,330
Gove	2,631
Graham	2,495
Grant	7,526
Gray	5,958
Greeley	1,249
Greenwood	6,123
Hamilton	2,640
Harper	5,590
Haskell	4,053
Hodgeman	1,842
Jewell	2,850
Kearny	3,960
Kingman	7,360
Kiowa	2,485
Lane	1,559
Lincoln	3,043
Linn	9,726
Logan	2,821

County	Population
Marion	11,986
Marshall	9,745
Meade	4,303
Mitchell	6,128
Morris	5,455
Morton	2,740
Nemaha	10,118
Ness	2,869
Norton	5,441
Osborne	3,610
Ottawa	5,863
Pawnee	6,680
Phillips	5,370
Pratt	9,547
Rawlins	2,497
Republic	4,691
Rice	9,660
Rooks	5,043
Rush	3,103
Russell	6,915
Scott	4,961
Sheridan	2,527
Sherman	5,930
Smith	3,668
Stafford	4,207
Stanton	2,060
Stevens	5,612
Thomas	7,788
Trego	2,884
Wabaunsee	6,874
Wallace	1,524
Washington	5,485
Wichita	2,125
Wilson	8,675
Woodson	3,147

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