Annual CAP Report

2020 Contracting

BlueCross BlueShield of Kansas

bcbsks.com

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 2020 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 (see page 18 for territory map) or Provider Network Services.

PR Staff	Location	Toll-Free Phone #	Local Phone #	Email
Doug Scott, Director	Topeka	(800) 432-0216 ext. 8831	(785) 291-8831	doug.scott@bcbsks.com
Robyne Goates, Manager	Topeka	(800) 432-0216 ext. 8206	(785) 291-8206	robyne.goates@bcbsks.com
Gwen Nelson	Topeka	(800) 432-0216 ext. 8716	(785) 291-8716	gwen.nelson@bcbsks.com
Darin Fieger	Topeka	(800) 432-0216 ext. 8207	(785) 291-8207	darin.fieger@bcbsks.com
Christie Mugler	Topeka	(800) 432-0216 ext. 8651	(785) 291-8651	christie.mugler@bcbsks.com
Jennifer Falk	Topeka	(800) 432-0216 ext. 7724	(785) 291-7724	jennifer.falk@bcbsks.com
Kyle Abbott	Wichita	(800) 432-0216 ext. 1674	(316) 269-1674	kyle.abbott@bcbsks.com
Vickie Kloxin	Wichita	(800) 432-0216 ext. 1674	(316) 269-1674	vickie.kloxin@bcbsks.com
Debra Meisenheimer	Hutchinson	(800) 432-0216 ext. 4273	(620) 663-1313	debra.meisenheimer@bcbsks.com
Jennie Fellers-Morgan	Hays	(800) 432-0216 ext. 4223	(785) 261-9969	jennie.fellers-morgan@bcbsks.com
Provider Network Services	Topeka	(800) 432-3587 option 1 or 3	(785) 291-4135 option 1 or 3	prof.relations@bcbsks.com

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.

$98.7M
BCBSKS is projecting $98.7 million in QBRP incentives in 2019 (professional and institutional).

991,457
BCBSKS and its subsidiaries serve 991,457 members across all lines of business, including BlueCard, as of May 31, 2019.

661,433
BCBSKS serves 661,433 members locally, as of May 31, 2019.

9.04%
BCBSKS spent 9.04 percent of annual premium income on administrative expenses for the year 2018.

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 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.
- Provider portal to attest to your data, review your QBRP incentives, and correspond with BCBSKS.

NOTE — In 2020, 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.

2020 Reimbursement and Policy Memo changes

On June 28, 2019, the BCBSKS Board of Directors met and approved reimbursement and policy memo changes for 2020. A summary of the policy memo changes is enclosed for your review.

Highlights of the 2020 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 2020 will continue to create opportunities for providers to earn incentives by meeting the criteria as outlined in the 2020 QBRP as described on pages 7-16.

A charge comparison report reflecting reimbursement changes for 2020 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 2019. The charge comparison format provides the lesser of your charge or the MAP for each procedure code you performed thus far in 2019.

Overview of 2020 Reimbursement

Please note that along with base rate changes, additional reimbursement is available through the QBRP program where noted. (See QBRP section, pages 7-16.)

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)	
Anesthesia conversion factor at $62.56 (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 17.	
Overall QBRP incentives	Evaluation and Management (E&M) codes (eligible for QBRP)	
	Surgical codes (eligible for QBRP)	
	Mileage rates for fixed wing and rotary wing (eligible for QBRP)	
	Pain management (eligible for QBRP)	
	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 2020).

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.

Note: Telehealth services by approved specialty are allowed at 85 percent in accordance with applicable fee schedule.

2020 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. 2020 will begin the ninth 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 2020 to better align expectations with Federal Employee Program (FEP) and/or Healthcare Effectiveness Data and Information Set (HEDIS) requirements.

Important Information regarding Health Information Exchange (HIE): Last year, we advised you we had been evaluating the value being received by both providers (as reported to us by providers) and BCBSKS from our long standing HIE incentives and elected to shift a portion of those incentives to other metrics for 2019. We have continued to assess our options in the latter half of 2018 and the first half of 2019 by engaging Verinovum, Inc. in a pilot program to determine whether, through their participation as the clinical data clearing house, we could obtain enhanced clinical data that would be much more robust and thus more actionable in areas such as care delivery and risk adjustment, and to lighten the burden on providers related to our requests for medical records.

That pilot was extremely successful and has convinced us much improvement can be made on this front by engaging Verinovum on an ongoing basis. As such, we will continue the phase-out of the professional provider incentives in 2020 associated with submission and use of clinical data linked to the two State-approved HIOs (health information organizations). We will be adding new incentives toward the creation of a BCBSKS clinical data repository (CDR) that will initially apply in 2020 to providers we have identified as the most engaged with this initiative. We will begin an onboarding process with those providers during the remainder of 2019 and will continue to offer all providers the opportunity to make this transition during the next few years as our capacity permits.

As this transition progresses, BCBSKS will gradually reduce the incentives available for providers submitting clinical data to the two State-approved HIOs and maintain or increase the incentives for those submitting to BCBSKS through Verinovum. More information regarding Verinovum, the technical requirements, and the BCBSKS clinical data repository will be available during your onboarding process.

IMPORTANT REMINDER — The 2020 QBRP program is effective for services performed January 1, 2020 through December 31, 2020. Since the 2020 CAP letter is sent out in July 2019, providers have several months to prepare to meet the various QBRP metrics and qualify for incentives effective January 1, 2020, in accordance with the metric review schedule (see pages 10-16). Please read the requirements and metrics for the 2020 QBRP program so you are prepared to maximize the available incentives. Any subsequent pertinent information or clarification will be communicated accordingly.

Criteria for 2020

In accordance with the 2020 Policy Memo No. 1, Section XXX. Reimbursement for Quality, this document describes the components of QBRP effective January 1, 2020 through December 31, 2020. This program applies to all BCBSKS CAP, PPO, 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.

2020 Professional Providers QBRP

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 2020.

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 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, 2020, 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 2020 incentives effective January 1, 2020 will be sent mid-December 2019.

Please note — In 2018, BCBSKS built enhancements to the provider information portal to include self-service QBRP information. We have seen an uptick in the number of providers who are viewing their QBRP results through the portal. 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, 2020 or July 1, 2020 as applicable. We will continue monthly reviews for 2020 to identify providers who did not qualify for incentive(s) beginning January 1, 2020 because of not meeting prerequisites, or new providers/groups after January 1, 2020, 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 2020 for an effective date of July 1, 2020 to determine if providers are continuing to meet the performance standards for the metric(s) earned for the incentive payments effective January 1, 2020. 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, 2020 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.

2020 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.

2020 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)	3.0	A	Must verify and attest to 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, 2019	January 1, 2020
February 1 - April 30, 2020	July 1, 2020

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, 2019	January 1, 2020
December 1, 2019 - May 31, 2020	July 1, 2020

2020 Professional Providers QBRP

Metric	%	Group	Description	Qualifying Period
Registry Data (REG) (*applies only to anesthesia, pathology, radiology, urology, chiropractors, optometrists)	2.5	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. Quality Improvement Activity (approved by BCBSKS) for Primary Spine Providers (DC, MD, DO) may be included at a later time.	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
CCD or HIE HL7 use to State-approved HIO's — Each provider must have a user ID and HL7 real-time connectivity to qualify. Providers may earn either individual HL7 incentives **or** CCD incentive, but not both.				
a-HIE HL7 V2 (ADT) Demographic, admissions, discharges, transfers	.5	B	Must send all records for demographics, admissions, discharges, and transfers. This includes office visits.	Semi-annual
b-HIE HL7 V2 (OPN) Progress notes	.5	B	Must send progress notes on all patient encounters.	Semi-annual
c-HIE HL7 V2 (ABS) Diagnosis, Procedure coding	.5	B	Must send diagnosis and/or procedure coding on all patient encounters.	Semi-annual
d-HIE HL7 V2 (LAB) Lab reporting	.5	B	Must send all lab reports on all patient lab tests.	Semi-annual
e-HIE HL7 V2 (MED) Medication records	.5	B	Must send medication history on all patient encounters.	Semi-annual
f-CCD complete/all data (KCCD) **(NEW)**	2.5	B	Must send complete and comprehensive Continuity of Care Document (CCD HL7 V3) record, HL7 V2 ADT, and HL7 V2 lab.	Semi-annual

Note — Providers may earn the HIE incentives or CDR incentives, but **NOT** both.

2020 Professional Providers QBRP

Metric	%	Group	Description	Qualifying Period
BCBSKS/Verinovum Clinical Data Repository (CDR) (NEW) — Each provider must have HL7 real-time connectivity to qualify. Providers may earn either individual HL7 incentives **or** CCD incentive, but not both.				
a-CDR HL7 V2 (VADT) Demographic, admissions, discharges, transfers **(NEW)**	.75	B	Must send all records for demographics, admissions, discharges, and transfers. This includes office visits.	Semi-annual
b-CDR HL7 V2 (VOPN) Progress notes **(NEW)**	.75	B	Must send progress notes on all patient encounters.	Semi-annual
c-CDR HL7 V2 (VABS) Diagnosis, Procedure coding **(NEW)**	.75	B	Must send diagnosis and/or procedure coding on all patient encounters.	Semi-annual
d-CDR HL7 V2 (VLAB) Lab reporting **(NEW)**	.75	B	Must send all lab reports on all patient lab tests.	Semi-annual
e-CDR HL7 V2 (VMED) Medication records **(NEW)**	.75	B	Must send medication history on all patient encounters.	Semi-annual
f-CCD complete/all data (VCCD) **(NEW)**	3.75	B	Must send complete and comprehensive Continuity of Care Document (CCD HL7 V3) record, HL7 V2 ADT, and HL7 V2 lab.	Semi-annual
Note — Providers may earn the HIE incentives or CDR incentives, but **NOT** both.				
Anesthesia Performed in a Health System with a Level 1 Trauma Center (ATC)	5.5	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)	1.0	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)	1.0	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
Compre-hensive Diabetes Care (A1c testing) (CDC)	1.0	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

2020 Professional Providers QBRP

Metric	%	Group	Description	Qualifying Period
Colorectal Cancer Screening (COL)	1.0	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
Low-Back Pain (LBP)	1.0	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
Well-Child visits (W15) 6-plus visits in first 15 months	1.0	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	1.0	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
Statin Therapy for Patients with Cardiovascular Disease (SPC) **(NEW)**	1.0	B	The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period. 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

2020 Professional Providers QBRP

Metric	%	Group	Description	Qualifying Period
Statin Therapy for Patients with Diabetes (SPD) (NEW)	1.0	B	The percentage of members 40-75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who remained on a statin medication of any intensity for at least 80 percent of the treatment period. 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
Diabetes Care — Eye Exam - retinal (CDCE) (NEW)	1.0	B	The percentage of members 18-75 years of age as of the end of the measurement year with diabetes (type 1 or type 2) who had an eligible screening or monitoring for diabetic retinal disease as identified by administrative data. Must be greater than or equal to 55 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
Diabetes Care — Medical Attention for Nephropathy (CDCN) (NEW)	1.0	B	The percentage of members 18-75 years of age as of the end of the measurement year with diabetes (type 1 or type 2) who had an eligible nephropathy screening or monitoring test, or evidence of treatment for nephropathy, as documented through administrative data. 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
Breast Cancer Screening (BCS)	1.0	B	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
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

2020 Professional Providers QBRP

Metric	%	Group	Description	Qualifying Period
Appropriate Testing for Children with Pharyngitis (CWP)	1.5	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)	1.5	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)	1.5	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

Qualifying for CDR/HIE Incentives (ADT, OPN, ABS, LAB, MED, CCD, VADT, VOPN, VABS, VLAB, VMED, VCCD)

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

Qualifying Period	Incentive begins
August 1 - October 31, 2019	January 1, 2020
February 1 - April 30, 2020	July 1, 2020

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, 2019	January 1, 2020
March 1 - May 31, 2020	July 1, 2020

2020 Professional Providers QBRP

QBRP CHANGES FOR 2020		
Metric	**Change**	**Reason**
Provider Information Portal	Increased incentive from 2.75 to 3 percent.	To increase participation.
Registry Data	Increased incentive from 1.5 to 2.5 percent.	To increase quality registry data participation, submission.
HIE CCD Complete/all data	Added.	Alternative to HIE HL7 use metrics.
HIE HL7 V2 Demographic, admissions, discharges, transfers	Decreased incentive from .75 to .5 percent.	Developed alternative to HIE.
HIE HL7 V2 Diagnosis, Procedure coding	Decreased incentive from .75 to .5 percent.	Developed alternative to HIE.
HIE HL7 V2 Lab reporting	Decreased incentive from .75 to .5 percent.	Developed alternative to HIE.
HIE HL7 V2 Medication records	Decreased incentive from .75 to .5 percent.	Developed alternative to HIE.
HIE HL7 V2 Progress notes	Decreased incentive from .75 to .5 percent.	Developed alternative to HIE.
BCBSKS/Verinovum Clinical Data Repository (CDR) metrics	Added.	Alternative to HIE.
CDR CCD complete/all data	Added.	Alternative to CDR HL7 use metrics.
Anesthesia Performed in Level 1 Trauma Center	Increased incentive from 2.0 to 5.5 percent.	Recognize unique services.
Adolescent Well-Care Visits	Increased incentive from .5 to 1.0 percent.	Greater impact on HEDIS, FEP, and STARS rating.
Cervical Cancer Screening	Increased incentive from .5 to 1.0 percent.	Greater impact on HEDIS, FEP, and STARS rating.
Colorectal Cancer Screening	Increased incentive from .5 to 1.0 percent.	Greater impact on HEDIS, FEP, and STARS rating.
Comprehensive Diabetes Care (A1c testing)	Increased incentive from .5 to 1.0 percent.	Greater impact on HEDIS, FEP, and STARS rating.
Low-Back Pain	Increased incentive from .5 to 1.0 percent.	Greater impact on HEDIS, FEP, and STARS rating.
Well-child visits in first 15 months	Increased incentive from .5 to 1.0 percent.	Greater impact on HEDIS, FEP, and STARS rating.
Well-child visits 3-6 years old	Increased incentive from .5 to 1.0 percent.	Greater impact on HEDIS, FEP, and STARS rating.
Appropriate Testing for Children with Pharyngitis	Increased incentive from 1.0 to 1.5 percent.	Greater impact on HEDIS, FEP, and STARS rating.
Appropriate Treatment for Children with Upper Respiratory Infection	Increased incentive from 1.0 to 1.5 percent.	Greater impact on HEDIS, FEP, and STARS rating.
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Increased incentive from 1.0 to 1.5 percent.	Greater impact on HEDIS, FEP, and STARS rating.
Diabetes Care — Eye Exam - retinal	Added.	To align with HEDIS, FEP, and STARS rating.
Diabetes Care — Medical Attention for Nephropathy	Added.	To align with HEDIS, FEP, and STARS rating.
Statin Therapy for Patients with Cardiovascular Disease	Added.	To align with HEDIS, FEP, and STARS rating.
Statin Therapy for Patients with Diabetes	Added.	To align with HEDIS, FEP, and STARS rating.
Breast Cancer Screening	Moved from Group C to Group B.	Allow more providers to receive incentive.

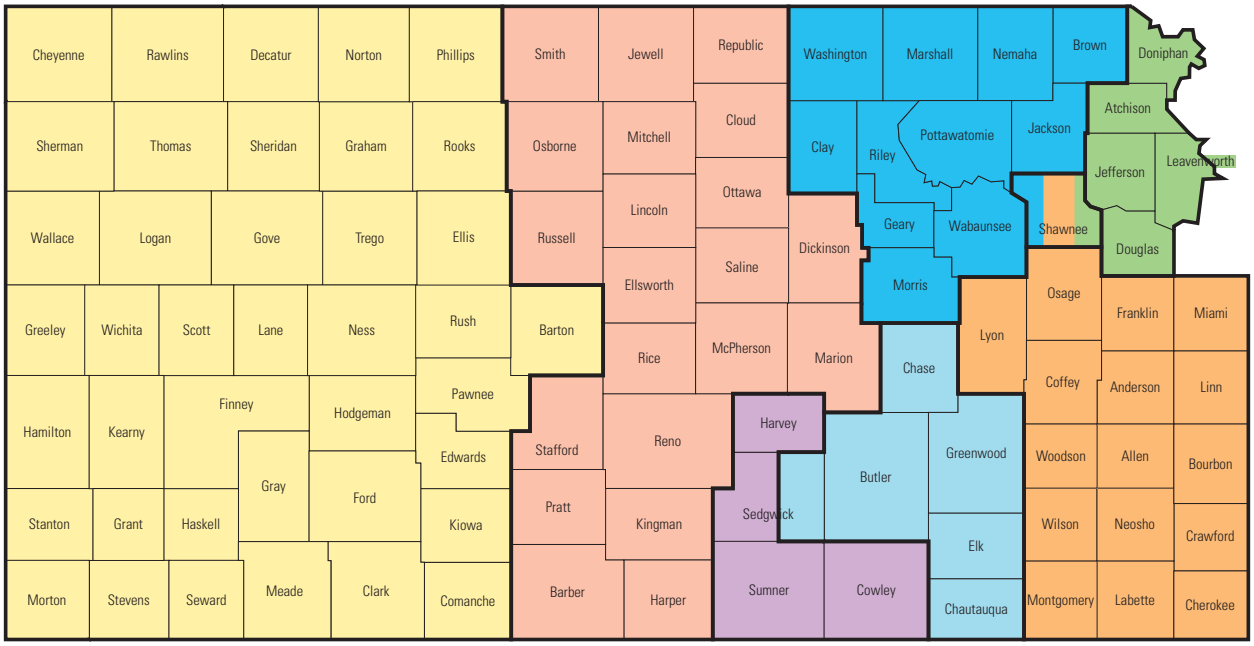
Rural Access Counties

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 2018 Estimated Census)

County	Population
Allen	12,444
Anderson	7,878
Barber	4,472
Brown	9,598
Chase	2,629
Chautauqua	3,309
Cheyenne	2,660
Clark	2,005
Clay	7,997
Cloud	8,729
Coffey	8,233
Comanche	1,748
Decatur	2,871
Doniphan	7,682
Edwards	2,849
Elk	2,508
Ellsworth	6,196
Gove	2,612
Graham	2,492
Grant	7,336
Gray	6,033
Greeley	1,227
Greenwood	6,055
Hamilton	2,607
Harper	5,506
Haskell	3,997
Hodgeman	1,818
Jewell	2,841
Kearny	3,943
Kingman	7,310
Kiowa	2,516
Lane	1,560
Lincoln	3,023
Linn	9,750
Logan	2,844

County	Population
Marion	11,950
Marshall	9,722
Meade	4,146
Mitchell	6,150
Morris	5,521
Morton	2,667
Nemaha	10,155
Ness	2,840
Norton	5,430
Osborne	3,475
Ottawa	5,802
Pawnee	6,562
Phillips	5,317
Pratt	9,378
Rawlins	2,508
Republic	4,664
Rice	9,531
Rooks	5,013
Rush	3,093
Russell	6,907
Scott	4,897
Sheridan	2,533
Sherman	5,899
Smith	3,603
Stafford	4,178
Stanton	1,987
Stevens	5,559
Thomas	7,711
Trego	2,793
Wabaunsee	6,899
Wallace	1,503
Washington	5,420
Wichita	2,105
Wilson	8,665
Woodson	3,183

Professional Relations Field Representative Territorial Map



MD, DO, DPM, DC, DDS, PA, APRN, CRNA, LSCSW, PHD, OD, OOD, OSAF, CCC-SLP (speech), OTR, RPT

- Gwen Nelson – Topeka – Rep. Code C
- Vickie Kloxin – Wichita – Rep. Code M
- Kyle Abbott – Wichita – Rep. Code P
- Jennie Fellers-Morgan – Hays – Rep. Code R
- Debra Meisenheimer – Hutchinson – Rep. Code K
- Christie Mugler – Topeka – Rep. Code Z
- Darin Fieger – Topeka – Rep. Code D

Pharmacy and Infusion Therapy

Ken Mishler, PharmD, MBA – Topeka – Rep. Code B

CCC-A (AUD), Hearing Aid Dispenser (HAD), HME, Orthotists, Private Duty Nurses, Prosthetists, Sleep Labs (SLAB), AMB

Jennifer Falk – Topeka – Rep. Code V

BlueCross BlueShield of Kansas

bcbsks.com

BlueCross
BlueShield
of Kansas

bcbsks.com