What's New in 2023

BlueCross BlueShield Kansas

Agenda

- Review of 2023 Annual CAP Report
- Review of Quality-Based Reimbursement (QBRP)
- Review of 2023 Policy Memo Changes

2023 Competitive Allowance Program (CAP) Contract

- Being the insurer Kansans trust with their health.
- Implementation of Affordable Care Act requirements.
- Low administrative expenses.
- BCBSKS addresses the health care needs of 954,629 Kansans.
- BCBSKS contracts with 99 percent of physicians and 97 percent of all professional providers in our Kansas Plan area.
- BCBSKS is 100 percent URAC accredited in health plan, case management, and disease management.
- BCBSKS continues to support and expand Patient-Centered Medical Home (PCMH) and Accountable Care Organization (ACO) arrangements.

2023 Reimbursement – Increasing

- Anesthesia conversion factor
- Air Ambulance base rates, Rotary Mileage, Fixed Wing Mileage
- Ground Ambulance mileage
- Specialty Care Transport
- Some Evaluation and Management (E&M) codes
- Some Behavioral Health codes
- Some Applied Behavioral Analysis (ABA) codes

2023 Reimbursement – No Change

- Professional consultation codes
- Undervalued CPT codes
- Overvalued CPT codes
- Durable Medical Equipment
- Ground Ambulance base rates
- Physical Therapy, occupational therapy, and speech pathology services
- Rural County Incentive – Services billed by primary care and behavioral health providers located in counties with a population of 13,000 or less.

2023 Reimbursement – Decreasing

- Clinical lab codes

Tiered Reimbursement

Definition – The allowances for professional services has been designated as a percentage of MAP based on the provider specialty. Refer to the table on page seven of CAP mailing for a list of specialty providers.

If services are rendered by an eligible provider, you are required to file the claim under that provider's individual NPI.

Quality-Based Reimbursement Program (QBRP)

- Incentive plan designed to promote efficient administration and improved quality with better patient care and outcomes.
- Prerequisite – Turn off paper (claims, remittance advice, newsletters), and be a provider in good standing with BCBSKS.
- Excluded – Clinical lab (using codes on the Medicare clinical lab fee schedule), pharmacies/pharmaceuticals, and dental services.

Quality-Based Reimbursement Program (QBRP)

- Metrics are categorized into three groups – A, B, and C.
- Achievement of a metric can be measured at different intervals, depending upon the metric.
- Refer to CAP mailing for defined time frames.
- Incentives will be earned at the individual level unless otherwise specified.

QBRP – Group A Components

- Applies to all eligible CAP professional providers.
- Incentive – Applies to all eligible CPT/HCPCS codes except for clinical lab (using codes on Medicare clinical lab fee schedule), pharmaceuticals and dental services.

QBRP – Group A

Electronic Self-Service

(ES3) – 2.0% (96%-100%) or

(ES2) – 1.0% (86%-95%)

- Metric is broken down into two tiers and is reimbursed at a greater level as the percentage of self-service increases.
- Evaluated at the group level on a semi-annual basis.

QBRP – Group A

Electronic Self Service

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, 2022	January 1, 2023
February 1 - April 30, 2023	July 1, 2023

QBRP – Group A

Provider Information Portal (PRT) – 3.0

Percent incentive

Must verify provider information every 90 days for each provider tied to your contract.

The first attestation date sets the start date for the new rolling 90 day attestation contractual requirement.

- Completion is done through BCBSKS secure website (Blue Access) found on Availity.

QBRP – Group A

Provider Information Portal (PRT)

Qualifying Period	Incentive
September 2022 - November 2022	January 1, 2023
December 2022 - February 2023	April 1, 2023
March 2023 - May 2023	July 1, 2023
June 2023 - August 2023	October 1, 2023

QBRP – Group A

Electronic Provider Message Board (EPM) – 1.0 Percent Incentive

Provider Messaging Portal:

A unique electronic communication interface by which providers can address and upload requested claim information for the purposes of supporting final claim adjudication.

- Provider should submit claims for reimbursement as described in the Contracting Provider Agreement.
- BCBSKS will notify Provider through the Provider Messaging Portal if additional documentation is required to substantiate a claim.
- Provider will have fifteen (15) calendar days to upload requested medical records to the Provider Messaging Portal.
- If Provider fails to substantiate the claim within 15 calendar days, the claim will be denied. Provider is responsible for resubmitting the claim if denied for lack of medical records substantiation.

QBRP – Group A

Electronic Provider Message Board (EPM)

Qualifying Period	Incentive
1st - 15th of any given month	1st of the following month
16th - 31st of any given month	1st of the 2nd month after receipt
If the electronic provider message board (EPM) is used as outlined in the EPM agreement, one-time authorization allows for continuation of qualifying period without interruption.	

QBRP – Group A

MiResource (MiR)

Metric	%	Group	Description	Qualifying Period
MiResource (MiR) (Applies to Behavior Health Providers only)	0.5	A	Must enroll in MiResource provider directory in order to be eligible.	Monthly

Qualifying for MiResource Incentive (MiR)

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

NOTE: Existing providers that have already signed up with MiResource will be made effective 1-1-2023 for this QBRP incentive.

Qualifying Period	Incentive begins
1st - 15th of any given month	1st of the following month
16th - 31st of any given month	1st of the 2nd month after receipt

QBRP – Group A

CPT II Codes (CAT2) - .50 Percent Incentive

- Add Supplemental Procedure Codes to claims
- Decreases need for medical record requests
- Produces a more accurate HEDIS score
- During the measurement period must be greater than or equal to 30 encounters
- Calculated at the individual provider level

Qualifying Period	Incentive begins
August 1 - October 31, 2022	January 1, 2023
February 1 - April 30, 2023	July 1, 2023

QBRP – Group A

ICD-10 SDoH Codes (ZZZ) - .75 Percent Incentive

SDoH – Social Determinants of Health

- Supplemental diagnosis codes used to identify SDoH, 'history of' procedures, or 'acquired absence of' codes used to support HEDIS
- During the measurement period must be greater than or equal to 30 encounters
- Calculated at the individual provider level

Qualifying Period	Incentive begins
August 1 - October 31, 2022	January 1, 2023
February 1 - April 30, 2023	July 1, 2023

QBRP – Group B-Components

- Applies to prescribing providers (MD, DO, DPM, OD, APRN, PA, CRNA).
- Incentive – Applies to all eligible CPT codes except for clinical lab (using codes on the Medicare clinical lab fee schedule), pharmaceuticals, and dental services.

QBRP – Group B

Kansas Health Exchange

Qualifying for CDR/HIE Incentives

BCBSKS has begun evaluating provider data that's been contractually agreed to be sent through KHIN to VN to BCBSKS. There have been some data attributes that are not being sent in the message types identified below. The message types have been the criteria for CDR/HIE incentives to date. BCBSKS wants to ensure that providers are sending meaningful data contained within the message types and as a result have created a HL7 v2 specification that should help providers or EMR vendors ensure they're sending data attributes that BCBSKS desires.

For additional technical information regarding the metric column and specific data attributes BCBSKS desires, please see the following BCBSKS HL7 v2 specification (links below). This information will be useful for your HL7 interface engine administrators, EMR vendor, or other HL7 technical resources.

BCBSKS wants to let providers know as soon as possible about upcoming change requests so that providers may plan, coordinate, and implement HL7 change requests accordingly. These changes are preferred for 2023 and required in 2024.
https://www.bcbsks.com/providers/professional/publications

QBRP – Group B

Kansas Health Exchange - 1.25 percent incentive

All 5 metrics must be met to qualify

- HIE HL7 V2, Demographic including race, ethnicity, primary language), admissions, discharges, transfers.
- HIE HL7 V2, Progress Notes
- HIE HL7 V2, Vitals, Diagnosis, Procedure coding
- HIE HL7 V2, Lab Reporting
- HIE HL7 V2, Medication Records OR
- CCD Complete Continuity of Care Document (CCD HL7 V3)
- HL7 V2, ADT
- HL7 V2, Lab (ORU)

QBRP – Group B

Verinovum Clinical Data Repository – 3.75 percent incentive

- » All 5 metrics must be met to qualify
- » CDR HL7 V2, Demographic (including race, ethnicity, primary language), admissions, discharges, transfers.
- » CDR HL7 V2, Progress Notes
- » CDR HL7 V2 Vitals, Diagnosis, Procedure coding
- » CDR HL7 V2, Lab Reporting
- » CDR HL7 V2, Medication Records OR
- » CCD Complete Continuity of Care Document (CCD Hl7 V3)
- » CDR V2, ADT
- » CDR V2, Lab

QBRP – Group B

KHIN/Verinovum Clinical Data Repository Qualifying periods

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, 2022	January 1, 2023
February 1 - April 30, 2023	July 1, 2023

QBRP – Group B

CMS-approved Registry Data (REG) – 2.5 percent Incentive

Must send patient information to meet CMS quality measurement.

- Measured at the group level.
- Applies only to:
  - Anesthesia
  - Pathology
  - Radiology
  - Urology
  - Chiropractors
  - Optometrists
  - Ophthalmologists
  - Arthritis and Rheumatology
  - Pulmonary
  - Gastroenterology

QBRP – Group B

CMS-approved Registry Data (REG) Qualifying Periods

Qualifying for 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, 2022	January 1, 2023
December 1, 2022 - May 31, 2023	July 1, 2023

QBRP – Group B

- **Access Formulary Electronically** (EEX) – .75 percent incentive
  - Access benefit information 120 times per quarter.
- **Generic Utilization Rate** (GUR) – .75 percent incentive
  - Minimum generic prescribing is 85 percent (for all BCBSKS members with a prescription drug benefit).

QBRP – Group B

- **Access Formulary Electronically** (EEX) & **Generic Utilization Rate** (GUR) Qualifying Periods

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, 2022	January 1, 2023
March 1 - May 31, 2023	July 1, 2023

QBRP – Group B

Anesthesia Performed in a Level 1 Trauma Center (ATC) – 7.5 percent.

Must be a dedicated onsite 24 hours a day, seven days a week, 365 days a year to be a level 1 trauma center facility with a PICU and NICU involved with teaching anesthesia residents.

QBRP – Group B

HEDIS Measures

Incentives are calculated at the group level, the group must have at least five attributable members. Individual providers in the group must have at least one attributable member to receive incentive.

QBRP – Group B

Group B –Breast Cancer Screening (BCS) – 1.0 percent incentive.

Mammography for women ages 50 to 74 (52 to 74 as of the end of the measurement period) who had a mammogram anytime in the past two years. Percentage must be greater to or equal to 75 percent to meet the metric.

QBRP – Group B

Cervical Cancer Screening (CCS) –1.5 percent incentive.

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.

QBRP – Group B

Colorectal Cancer Screening (COL) –1.0 percent incentive.

The percentage of adults 50-75 years of age (51-75 as of Dec. 31 of the measurement year) who had appropriate screening for colorectal cancer. Must be greater than or equal to 60 percent to meet the metric.

QBRP – Group B

Low-Back Pain (LBP) –1.0 percent incentive.

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.

Must be greater than or equal to 85 percent to meet the metric. This percentage is reported as an inverted rate. A higher reported rate indicates appropriate treatment of low-back pain.

The member is attributed to the provider associated with the earliest date of service for an eligible encounter with the low-back pain.

QBRP – Group B

- **Well-Child visits (W30A)** –1.0 percent incentive

Six-plus visits in first 15 months of life

- **Well-Child visits (W30B)** –1.0 percent incentive

Two or more visits between15-30 months of life

- Must be with a PCP
- Must be greater than 80 percent to meet the metric

QBRP – Group B

- **Well-Child visits (WCV)** –1.0 percent incentive. The percentage of members who were 3-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.
- Must be greater than 50 percent to meet the metric

QBRP- Group B

Statin Therapy for Patients with Cardiovascular Disease (SPC) – 1.25 percent incentive.

Percentage of males 21-75 years of age and females 40-75 years of age during measurement year identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who were dispensed at least one high intensity or moderate intensity statin medication during the measurement year.

Must be greater than or equal to 85 percent to meet the metric.

QBRP– Group B

Statin Therapy for Persons with Diabetes (SPD) – 1.25 percent incentive.

Percentage of members 40-75 years of age during measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one statin medication of any intensity during the measurement year.

Must be greater than or equal to 65 percent to meet the metric.

QBRP – Group B

Eye Exams for Patients with Diabetes (EED)

1.0 percent incentive.

Percentage of members 18-75 years of age at the end of the measurement year with diabetes (type 1 or 2) who had an eligible screening or monitoring for diabetic retinal disease as identified by administrative data.

Must be equal greater than or equal to 55 percent to meet the metric.

BREAK

QBRP – Group C

- Applies to all prescribing provider types (MD, DO, DPM, OD, PA, APRN, and CRNA).
- Incentive applies to E&M CPT codes only.

Incentives are earned at the group level, if the group has at least five attributable members (for physicians with at least one attributed member).

QBRP – Group C

Avoidance of Antibiotic Treatment in Members with Acute Bronchitis (AAB) – 2.0 percent incentive.

Measures percentage of members 3 months of age and older with diagnosis of acute bronchitis/bronchiolitis who were NOT dispensed an antibiotic prescription. Must be equal to or greater than 30 percent to meet the metric.

QBRP – Group C

Appropriate Testing for Children with Pharyngitis (CWP) –1.5 percent incentive.

Measures percentage of members 3 years of age and older diagnosed with pharyngitis, dispensed and antibiotic and received a group A Streptococcus (strep) test for the episode.

Must be greater than or equal to 80 percent to meet the metric.

QBRP – Group C

Appropriate Treatment for Members with Upper Respiratory Infection (URI) –2.0 percent incentive.

The percentage of members 3 months of age and older who were given a diagnosis of URI and were NOT dispensed an antibiotic prescription. Must be greater than or equal to 85 percent to meet the metric.

Provider Policies and Procedures Summary of Changes for 2023

Policy Memo No. 1, Section X – Waiver Form

- Page 11: Updated verbiage for clarity that the waiver form does not exempt provider write-off.
- **NOTE –** The waiver cannot be utilized for services considered to be content of another service provided, nor can it be used to bill the patient the difference between the provider charge and the allowed amount.

Provider Policies and Procedures Summary of Changes for 2023

Policy Memo No. 1, Section XXV – Tiered Reimbursement and Provider Number Requirements

Page 22: Updated verbiage to add clarity for tiered reimbursement.

Added, Registered Behavior Technician

Added, Clinical laboratory, radiology, and drug MAPS are excluded from tiered reimbursement and will apply base MAP.

Provider Policies and Procedures Summary of Changes for 2023

Policy Memo No. 6, Opening Paragraph

Page 3: Updated verbiage to clarify and not assume concurrent care is hospital care only, clarify that waiver was not ever needed, and that medical records are needed only upon request, not with claim submission.

Provider Policies and Procedures Summary of Changes for 2023

Policy Memo No. 6 – Section I: Instances When Concurrent Care Policy Applies

Page 3: Updated verbiage to clarify and not assume concurrent care is hospital care only, clarify that waiver was not ever needed, and that medical records are needed only upon request, not with claim submission.

- Two or more providers rendering medical and/or surgical services to the same patient on the same day.
- The Waiver form in not required with claims submission.
- Medical records must be supplied, upon request.

Provider Policies and Procedures Summary of Changes for 2023

Policy Memo No. 6 - Section II – Instances Where Concurrent Care Policy Does Not Apply

- **Page 3:** Added verbiage for clarity regarding when concurrent care does not apply.

G. Same provider specialties, different diagnosis

H. Same diagnosis, different provider specialties

Provider Policies and Procedures Summary of Changes for 2023

Policy Memo No. 9 – Section I: Global Fee Concept

- Page 3 & 4: Updated verbiage to clarify major surgery days and consistency using days.

- To determine the global period for major procedures, count one day immediately before the day of the procedure, the day of the procedure and 42 days immediately following the day of the procedure.

Provider Policies and Procedures Summary of Changes for 2023

Policy Memo No. 9 – Section I: Global Fee Concept

Page 5: Update verbiage for consistency.

7. Modifier "78" is used to identify a separate but related procedure being rendered during a postoperative period of another procedure.

9. When a service performed is considered a lesser service and billed with a modifier "52", reimbursement may be reduced to an allowance reflective of the service performed.

Provider Policies and Procedures Summary of Changes for 2023

Policy Memo No. 9 – Section VII: Unusual Circumstances

Page 4: Updated Verbiage for consistency in the use of modifier.

Surgeries for which the services performed are significantly greater than usually required may be billed with the modifier 22 added to the CPT code for the procedure.

Provider Policies and Procedures Summary of Changes for 2023

Policy Memo No. 12 – Section V: Method of Determining the Maximum Allowable Payment (MAP)

Page 4: Added Verbiage to ensure clarity of processing of anesthesia units.

3. Anesthesia units are rounded up to the next whole number for payment purposes.

No Surprises Act

- Consolidated Appropriations Act (CAA)
  - Passed by Congress in December 2020
  - Contains COVID – 19 relief measures
  - Legislative items impacting healthcare and health insurance industries
  - Changes will impact individual and group health plans (grandfathered and non-grandfathered)
  - Regulators working on final details
- Implementation January 1 2022

No Surprises Act

- Key Points:
  - *Balance Billing: Surprise Bills, from out of network providers, must be covered at in-network rates for:*
    - Emergency Services
    - Air Ambulance Services

No Surprises Act

- Key Points:
  - *Advanced Explanation of Benefits*
    - Explains benefits and estimates of cost-sharing.
    - Provided within 3 business days when services are scheduled more than 10 days in advance
    - Provided within 1 business day when services are scheduled within 10 days
  - *Providers will furnish good-faith estimates*
    - Must include related billing and diagnostics codes.

No Surprises Act

- Key Points:
  - *In-network rates with providers*
    - Regularly updated, machine-readable files
    - Personalized OOP cost information will be made available upon request
    - OOP cost info provided in two waves:
      - Initial list of 500 after Jan. 1, 2022
      - All remaining items Jan. 1, 2023 or after

Provider Message Portal

- Ability to upload records when requested via group email
- Replaces receiving a letter record request
- Registration beginning April 1, 2022
- Implementation May 1, 2022
- 1% QBRP Incentive
- Located in Blue Access
- Response required within 15 days of weekly email

Provider Message Portal – Sign up

Provider Message Portal – Sign up

Experience the Message Portal.

Please contact your provider relations representative with any questions you may have.

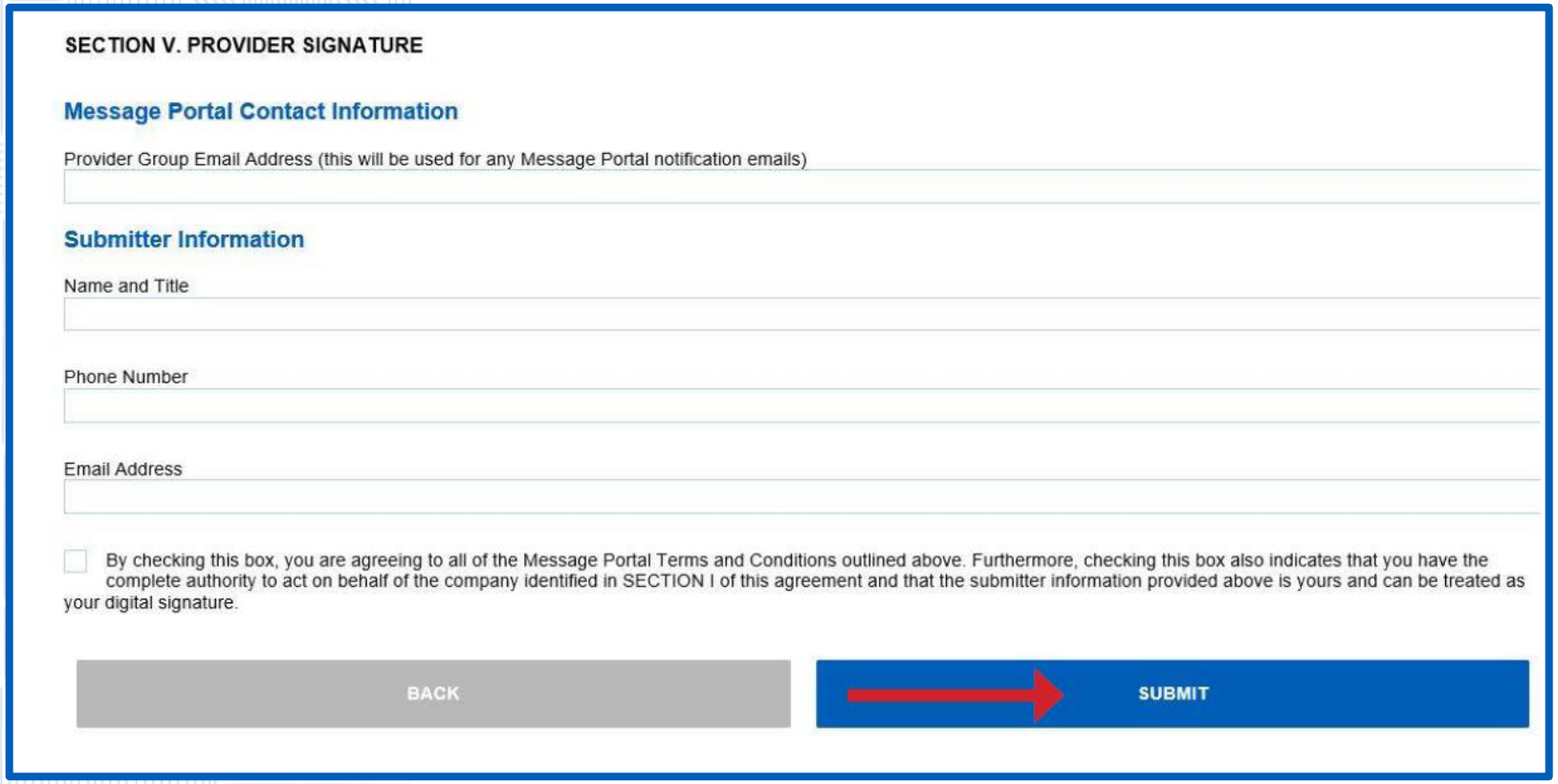
Provider Information

Provider Name: ABC Clinic **Provider Tax ID:** 123456789 **Provider NPI:** 987654321

To enroll for the message portal, please review and submit the Message Portal Addendum.

The message portal will become active and available on the date the addendum is submitted.

Provider Message Portal – Sign up



BREAK

QBRP Score Card

Located on BCBSKS Blue Access/Availity

QBRP Score Card

Located on BCBSKS Blue Access/Availity

Provider Information

Provider Name: ABCXYZ Internal Medicine Group **Provider Tax ID:** 999999999 **Provider NPI:** 1234567890

Save as an Excel spreadsheet

QBRP Measure Code	QBRP Measure Name	Care Gap Closed	Total Members	HEDIS Rate	QBRP Goal	QBRP Goal Met?
BCS	Breast Cancer Screening	50	82	60.98%	75%	No
CCS	Cervical Cancer Screening	63	120	52.5%	75%	No
CDC	Comprehensive Diabetes Care - HbA1c Tested	60	66	90.91%	90%	Yes
CDC	Comprehensive Diabetes Care - Eye Exam	31	66	46.97%	55%	No

QBRP Score Card

Located on BCBSKS Blue Access/Availity

Breast Cancer Screening (BCS)

The percentage of women 52-74 years of age who had a mammogram to screen for breast cancer.

The table below provides information on members who were counted toward the score for this measure as well as a determination as to whether the care gap was closed for each individual.

Provider Information

Provider Name: ABCXYZ Internal Medicine Group **Provider Tax ID:** 999999999 **Provider NPI:** 1234567890

Save as an Excel spreadsheet

Member Last Name	Member First Name	Date of Birth	Care Gap Closed?
ALEXANDER	SUSAN	1958-07-20	No
BAMM	JEAN	1953-03-08	Yes
BARONA	MARY	1965-11-17	No
BECKETT	CORRINE	1960-10-08	No
BLAND	BERNICE	1966-11-26	No
BONNER	REBECCA	1964-09-09	Yes
BORBOA	JODI	1956-09-14	Yes
BRANTLEY	PATRICIA	1969-02-05	Yes
BROOKS	CAROL	1958-01-10	Yes
BRUNGARDT	KASSONDRA	1961-07-15	Yes

1-10 of 82 members 1 2 3 4 5 6 7 8 9 10

RETURN TO SCORE CARD

QBRP Reporting

Located on BCBSKS Blue Access/Availity

QBRP Reporting

Located on BCBSKS Blue Access/Availity

Performing NPI

QBRP Earned/ Total Allowed = % of Total Allowed

QBRP Reporting

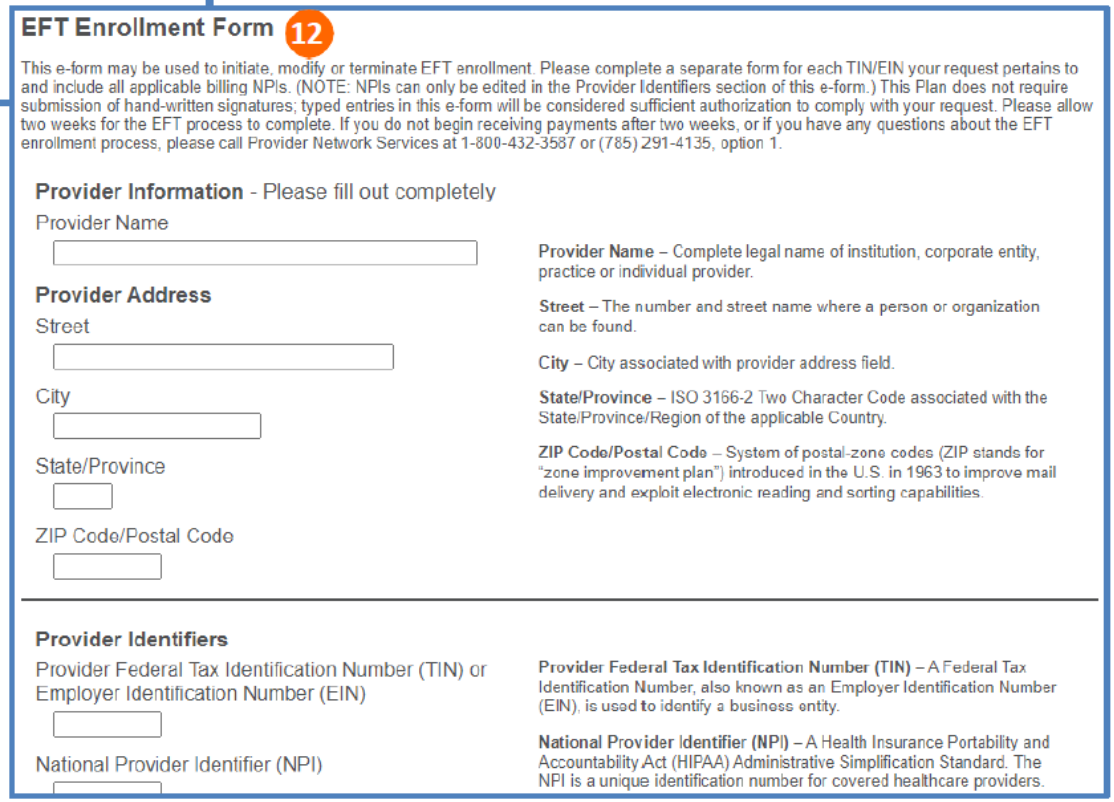
Located on BCBSKS Blue Access/Availity

- Click the arrow to display the components for individual performing providers.
- Click the "Expand All" button to see components for all performing providers.
- Click the "Collapse All" button to hide components for all performing providers.

EFT Enrollment

Located on BCBSKS Blue Access/Availity

EFT Enrollment



Additional Training Opportunities
How Can We Help You?

- Literature/documentation (newsletters, etc.)
- Workshops
- Office/staff training
- Webinars

Questions?

Thank you for being a contracting provider