Annual CAP Report

2021 Contracting

BlueCross BlueShield 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 2021 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.

2020 has not been a normal year by any stretch of the imagination. As the pandemic continues to spread throughout the world and disrupt the normal flow of most everything, we want to thank you for the courageous work you have done on the front lines battling this invisible but dangerous virus while continuing to deliver high quality care to our members in need.

While elective services were postponed, appointments canceled, and routine tests delayed, many patients and health care providers turned to telehealth as a safe and effective alternative to in person care. BCBSKS is proud of how Kansans acted responsibly and we're also proud we stood shoulder to shoulder with our members and providers to expand access to telehealth services and lessen its cost. We did this by paying for telehealth services on par with comparable in person visits, waiving member cost share on many services beyond those related to COVID-19, offered interest free advanced payments, assisted members with delayed premium payments, and reduced or eliminated administrative burdens to simplify access to care. Through all of this, you stood with us. We value the partnership we have with you and look forward to continuing our journey through the remainder of 2020 and 2021.

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.

Introduction

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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 Member Satisfaction.

$88.83M
BCBSKS is projecting $88.83 million in QBRP incentives in 2020 (professional and institutional).

998,449
BCBSKS and its subsidiaries serve 998,449 members across all lines of business, including BlueCard, as of May 31, 2020.

656,927
BCBSKS serves 656,927 local members, as of May 31, 2020.

8.78%
BCBSKS spent 8.78 percent of annual premium income on administrative expenses for the year 2019

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 2021, 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.

2021 Reimbursement and Policy Memo changes

On June 26, 2020, the BCBSKS Board of Directors met and approved reimbursement and policy memo changes for 2021. A summary of the policy memo changes is enclosed for your review.

Highlights of the 2021 reimbursement are noted on page 6. 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 2021 will continue to create opportunities for providers to earn incentives by meeting the criteria as outlined in the 2021 QBRP as described on pages 8-17.

A charge comparison report reflecting reimbursement changes for 2021 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 October 2019 through February 2020. The charge comparison format provides the lesser of your charge or the MAP for each procedure code you performed thus far in 2020.

Overview of 2021 Reimbursement

Please note that along with base rate changes, additional reimbursement is available through the QBRP program where noted. (See QBRP section, pages 8-17.)

Increasing	No change	Decreasing
Undervalued CPT codes (eligible for QBRP)	Professional consultation codes (eligible for QBRP)	
Ambulance base rates for fixed wing (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)	Durable Medical Equipment (DME) services (eligible for QBRP)
Anesthesia conversion factor at $63.34 (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 18.	Some overvalued CPT codes (eligible for QBRP)
Allow smoking cessation with office visit	Evaluation and Management (E&M) codes (eligible for QBRP)	Venipuncture (eligible for QBRP)
Administration for injectable drugs (eligible for QBRP)	Surgical codes (eligible for QBRP)	
	Mileage rates for fixed wing and rotary wing (eligible for QBRP)	
	Pain management (eligible for QBRP)	
	Most overvalued CPT codes (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 percent changes for 2021).

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	Master's Level Social Workers Licensed Marriage and Family Therapist Licensed Master Level Psychologist Licensed Master Level Social Worker Licensed Master Addiction Counselor Licensed Professional Counselor	

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

2021 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. 2021 will begin the tenth year for QBRP incentives.

Each year, BCBSKS seeks opportunities to best align meaningful administrative and clinical metrics with incentives to drive improved outcomes.

Important Information regarding Health Information Exchange (HIE): Last year, we advised you we had been working with Verinovum as a clinical data repository for BCBSKS. In addition, we had completed a partnered transaction with KHIN which allowed providers to continue to submit EMR data to KHIN and consent for KHIN to transmit their clinical data to Verinovum. Most of the providers have consented to transmitting their data and a few have directly connected to Verinovum. We are pleased to see the progress made to allow Verinovum to begin curating the data to a usable format. We anticipate providers being able to extract data from Verinovum beginning in late 2021. We will let all providers know when that function is available.

We previously communicated that effective January 1, 2021 we would only allow QBRP incentives for HIE if the provider either transmits all five HL7 feeds or transmits a CCD, ADT and ORU (lab). We are working to establish a comprehensive clinical data repository and anything short of complete and comprehensive data will prevent us from reaching our goal. 2020 is a transition year to allow providers to add the additional feeds in order to continue to receive QBRP in 2021.

Finally, we had also stated in the 2020 Annual CAP mailing that we would begin reducing QBRP incentives for data submission to the state approved HIOs as we transition to Verinovum. Subsequent to the distribution of that mailing, as noted above we reached agreement with KHIN to allow providers to continue to submit data to KHIN and applicable QBRP incentives would still be available for providers doing that and consenting to allow KHIN to forward that data to Verinovum. As such, HIE incentives for the submission of data to the state approved HIOs have been reduced for 2021 except in the above scenario. Please see the QBRP HIE incentives. Starting in 2022, incentives will only be paid for data submitted to Verinovum or KHIN with consent for KHIN to forward the data to Verinovum.

IMPORTANT REMINDER — The 2021 QBRP program is effective for services performed January 1, 2021 through December 31, 2021. Since the 2021 Annual CAP Report is sent out in July 2020, providers have several months to prepare to meet the various QBRP metrics and qualify for incentives effective January 1, 2021, in accordance with the metric review schedule (see pages 10-16). Please read the requirements and metrics for the 2021 QBRP program so you are prepared to maximize the available incentives. Any subsequent pertinent information or clarification will be communicated accordingly.

Criteria for 2021

In accordance with the 2021 Policy Memo No. 1, Section XXIX. Reimbursement for Quality, this document describes the components of QBRP effective January 1, 2021 through December 31, 2021. This program applies to all BCBSKS CAP, PPO, FEP, and BlueCard professional providers and services except for clinical

2021 Professional Providers QBRP

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 2021.

Please note — Changes in CPT codes (added/deleted) will be effective prospectively, including QBRP. In addition, any adjustments to QBRP payments will also be made prospectively.

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, 2021, 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 2021 incentives effective January 1, 2021 will be sent mid-December 2020.

Please note — 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, 2021 or July 1, 2021 as applicable. We will continue monthly reviews for 2021 to identify providers who did not qualify for incentive(s) beginning January 1, 2021 because of not meeting prerequisites, or new providers/groups after January 1, 2021, 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.

2021 Professional Providers QBRP

We will conduct a QBRP refresh in the first and second quarters (depending on the metric) of 2021 for an effective date of July 1, 2021 to determine if providers are continuing to meet the performance standards for the metric(s) earned for the incentive payments effective January 1, 2021. 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, 2021 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.

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. The Group C incentive is earned 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.

2021 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, 2020	January 1, 2021
February 1 - April 30, 2021	July 1, 2021

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, 2020	January 1, 2021
December 1, 2020 - May 31, 2021	July 1, 2021

2021 Professional Providers QBRP

Metric	%	Group	Description	Qualifying Period
CCD or HIE HL7 use to State-approved HIO's (When a provider has not consented to allowing KHIN to send their data to Verinovum) — Each provider must have a user ID and HL7 real-time connectivity to qualify. **In either case, the provider must send all five HL7 V2 feeds (a. - e.) OR CCD complete (f.) to receive any incentives.**				
a-HIE HL7 V2 (ADT) Demographic, admissions, discharges, transfers	1.25	B	Must send all records for demographics, admissions, discharges, and transfers. This includes office visits.	Semi-annual
b-HIE HL7 V2 (OPN via MDM) Progress notes		B	Must send progress notes on all patient encounters.	Semi-annual
c-HIE HL7 V2 (ABS via ADT) Diagnosis, Procedure coding		B	Must send diagnosis and/or procedure coding on all patient encounters.	Semi-annual
d-HIE HL7 V2 (LAB via ORU) Lab reporting		B	Must send all lab reports on all patient lab tests.	Semi-annual
e-HIE HL7 V2 (MED via RDE) Medication records		B	Must send medication administration on all patient encounters.	Semi-annual
f-CCD complete/all data (KCCD)		B	Must send complete and comprehensive Continuity of Care Document (CCD HL7 V3) record, HL7 V2 ADT, and HL7 V2 lab (ORU).	Semi-annual
BCBSKS/Verinovum Clinical Data Repository (CDR) Either direct data feed to Verinovum or through KHIN and consent to allow KHIN to send to Verinovum — Each provider must have HL7 real-time connectivity to qualify. **In either case, the provider must send all five HL7 V2 feeds (a. - e.) OR CCD complete (f.) to receive any incentives.**				
a-CDR HL7 V2 (VADT) Demographic, admissions, discharges, transfers	3.75	B	Must send all records for demographics, admissions, discharges, and transfers. This includes office visits.	Semi-annual
b-CDR HL7 V2 (VOPN via MDM) Progress notes		B	Must send progress notes on all patient encounters.	Semi-annual
c-CDR HL7 V2 (VABS via ADT) Diagnosis, Procedure coding		B	Must send diagnosis and/or procedure coding on all patient encounters.	Semi-annual
d-CDR HL7 V2 (VLAB via ORU) Lab reporting		B	Must send all lab reports on all patient lab tests.	Semi-annual
e-CDR HL7 V2 (VMED via RDE) Medication records		B	Must send medication administration on all patient encounters.	Semi-annual
f-CCD complete/all data (VCCD)		B	Must send complete and comprehensive Continuity of Care Document (CCD HL7 V3) record, HL7 V2 ADT, and HL7 V2 lab (ORU).	Semi-annual

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

2021 Professional Providers QBRP

Metric	%	Group	Description	Qualifying Period
Registry Data (REG) (*applies only to anesthesia, pathology, radiology, urology, chiropractors, optometrists, **ophthalmologists, arthritis and rheumatology)**	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
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
Comprehensive 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
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

2021 Professional Providers QBRP

Metric	%	Group	Description	Qualifying Period
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)	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 percent 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
Statin Therapy for Patients with Diabetes (SPD)	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

2021 Professional Providers QBRP

Metric	%	Group	Description	Qualifying Period
Diabetes Care — Eye Exam - retinal (CDCE)	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)	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

2021 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, 2020	January 1, 2021
February 1 - April 30, 2021	July 1, 2021

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, 2020	January 1, 2021
March 1 - May 31, 2021	July 1, 2021

2021 Professional Providers QBRP

QBRP CHANGES FOR 2021		
Metric	**Change**	**Reason**
Registry Data	Added opthalmology and arthritis/ rheumatology	To increase quality registry data participation, submission.
HIE CCD Complete/all data	Decreased incentive from 2.5 to 1.25 percent	Phasing out HIO incentives
HIE HL7 V2 Demographic, admissions, discharges, transfers	Removed individual incentive	No longer paying incentive for individual HL7 feeds. Must send all five.
HIE HL7 V2 Diagnosis, Procedure coding	Removed individual incentive	No longer paying incentive for individual HL7 feeds. Must send all five.
HIE HL7 V2 Lab reporting	Removed individual incentive	No longer paying incentive for individual HL7 feeds. Must send all five.
HIE HL7 V2 Medication records	Removed individual incentive	No longer paying incentive for individual HL7 feeds. Must send all five.
HIE HL7 V2 Progress notes	Removed individual incentive	No longer paying incentive for individual HL7 feeds. Must send all five.
CDR HL7 V2 Demographic, admissions, discharges, transfers	Removed individual incentive	No longer paying incentive for individual HL7 feeds. Must send all five.
CDR HL7 V2 Progress notes	Removed individual incentive	No longer paying incentive for individual HL7 feeds. Must send all five.
CDR HL7 V2 Diagnosis, Procedure coding	Removed individual incentive	No longer paying incentive for individual HL7 feeds. Must send all five.
CDR HL7 V2 Lab reporting	Removed individual incentive	No longer paying incentive for individual HL7 feeds. Must send all five.
CDR HL7 V2 Medication records	Removed individual incentive	No longer paying incentive for individual HL7 feeds. Must send all five.
CCD complete/all data (VCCD)	Removed individual incentive	No longer paying incentive for individual HL7 feeds. Must send all five or the complete CCD.

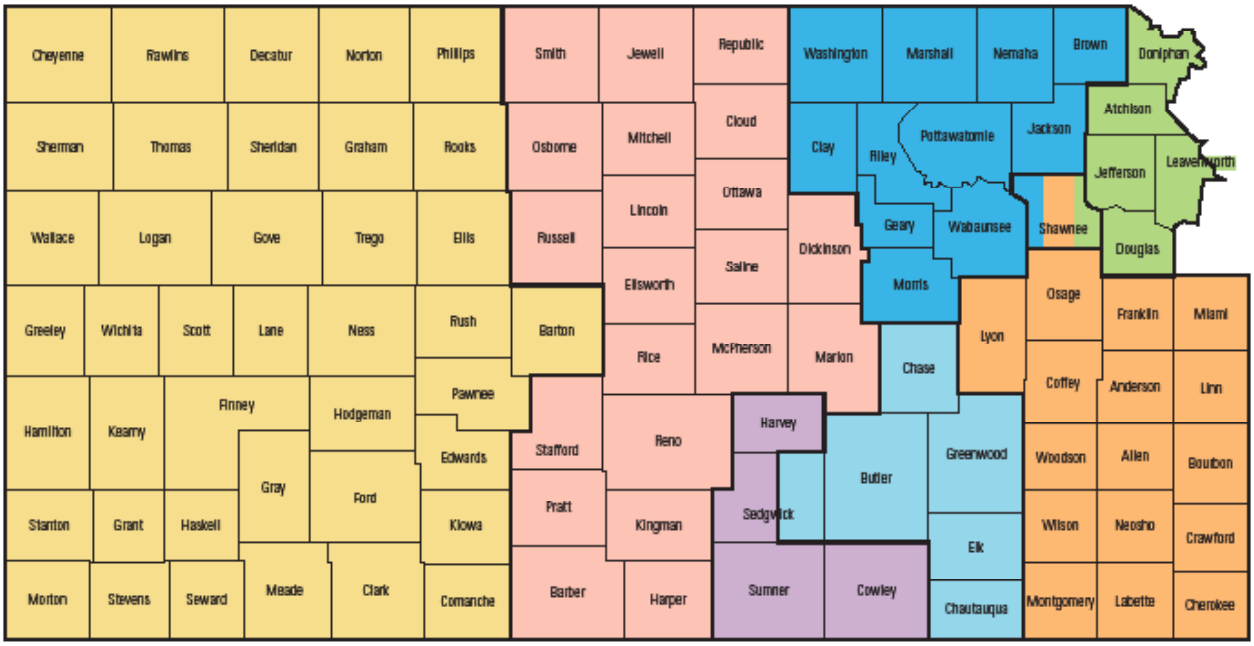
Rural Access Counties

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 2019 Estimated Census)

County	Population
Allen	12,369
Anderson	7,858
Barber	4,427
Brown	9,564
Chase	2,648
Chautauqua	3,250
Cheyenne	2,657
Clark	1,994
Clay	8,002
Cloud	8,786
Coffey	8,179
Comanche	1,700
Decatur	2,827
Doniphan	7,600
Edwards	2,798
Elk	2,530
Ellsworth	6,102
Gove	2,636
Graham	2,482
Grant	7,150
Gray	5,988
Greeley	1,232
Greenwood	5,982
Hamilton	2,539
Harper	5,436
Haskell	3,968
Hodgeman	1,794
Jewell	2,879
Kearny	3,838
Kingman	7,152
Kiowa	2,475
Lane	1,535
Lincoln	2,962
Linn	9,703
Logan	2,794

County	Population
Marion	11,884
Marshall	9,707
Meade	4,033
Mitchell	5,979
Morris	5,620
Morton	2,587
Nemaha	10,231
Ness	2,750
Norton	5,361
Osborne	3,421
Ottawa	5,704
Pawnee	6,414
Phillips	5,234
Pratt	9,164
Rawlins	2,530
Republic	4,636
Rice	9,537
Rooks	4,920
Rush	3,036
Russell	6,856
Scott	4,823
Sheridan	2,521
Sherman	5,917
Smith	3,583
Stafford	4,156
Stanton	2,006
Stevens	5,485
Thomas	7,777
Trego	2,803
Wabaunsee	6,931
Wallace	1,518
Washington	5,406
Wichita	2,119
Wilson	8,525
Woodson	3,138

Professional Relations Field Representative Territorial Map



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

- Gwen Nelson – Topeka – Rep. Code C
- Victia Klozin – 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 Fleger – 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

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