2024 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.

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): In 2020, BCBSKS advised providers we had been working with Verinovum as a clinical data repository for BCBSKS. In addition, BCBSKS 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. In 2023, BCBSKS termed their agreement with Verinovum. We will continue to work with KHIN directly to obtain clinical data from the repository our providers are utilizing via KHIN today.

BCBSKS will 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. We have extended the transition to allow providers to achieve the full transmission requirements for the last four years. Starting in 2024, providers must meet the requirements to earn the HIE incentive.

IMPORTANT REMINDER — The 2024 QBRP program is effective for services performed January 1, 2024 through December 31, 2024. Since the 2024 Annual CAP Report is sent out in July 2023 providers have several months to prepare to meet the various QBRP metrics and qualify for incentives effective January 1, 2024, in accordance with the metric review schedule (see pages 10-17). Please read the requirements and metrics for the 2024 QBRP program so you are prepared to maximize the available incentives. Any subsequent pertinent information or clarification will be communicated accordingly.

Criteria for 2024

In accordance with the 2024 Policy Memo No. 1, Section XXIX. Reimbursement for Quality, this document describes the components of QBRP effective January 1, 2024 through December 31, 2024. This program applies to all BCBSKS CAP, PPO, FEP, EPO and BlueCard professional providers and services except for clinical lab (using codes on the Medicare clinical lab fee schedule), pharmacies and pharmaceuticals, and dental services.

This program will offer an opportunity for eligible providers to earn increased reimbursement allowances based on a three-group approach (Groups A, B, and C). These reimbursement allowances will be in addition to the established base MAPs for 2024.

Please note — Changes in CPT codes (added/deleted) will be effective prospectively. QBRP adjustments/corrections will be effective the first of the following month, unless otherwise specified.

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In order to pay incentives on the metrics in Groups B and C, 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, 2024, 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.

Please note — BCBSKS built enhancements to the provider information portal to include self-service QBRP information.

All metrics, with the exception of the Provider Information Portal, will be reviewed on a semi-annual basis and any incentives earned will be effective either January 1, 2024 or July 1, 2024 as applicable.

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We will conduct a QBRP refresh in the first and second quarters (depending on the metric) of 2024 for an effective date of July 1, 2024 to determine if providers are continuing to meet the performance standards for the metric(s) earned for the incentive payments effective January 1, 2024. 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, 2024 for the remainder of the year. Confirmation of QBRP measure can be obtained real time on the provider portal. The portal will reflect effective and termination dates of all applicable QBRP measures.

QBRP PREREQUISITES AND GROUPS FOR PROVIDERS	
QBRP Participation Prerequisites	Providers must conduct business with BCBSKS electronically (i.e. turn off paper remittance advices (R/A)). 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. Provider must be in good standing with BCBSKS to qualify for and receive QBRP. QBRP will cease if provider is no longer in good standing.
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 all prescribing provider types (MD, DO, DPM, OD, PA, APRN, CRNA) as applicable to the measure and only to covered E&M codes.

Metric	%	Group	Description	Qualifying Period
Electronic Self-Service (ES3, ES2)	**2.0 (ES3)** (96% or >) **1.0 (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 every 90 days 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.	Every 90 days
Electronic Provider Message Board (EPM)	1.0	A	Must sign agreement to supply needed information for claim processing review/completion. Time frame for return of the requested information must be within the agreement time frame (15 days) through the provider message board portal.	Semi-annual

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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.	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, 2023	January 1, 2024
February 1 - April 30, 2024	July 1, 2024

Qualifying for Provider Information Portal (PRT)

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

Qualifying Period	Incentive
September 2023 - November 2023	January 1, 2024
December 2023 - February 2024	April 1, 2024
March 2024 - May 2024	July 1, 2024
June 2024 - August 2024	October 1, 2024

Qualifying for Electronic Provider Message Board (EPM)

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

Qualifying Period	Incentive
June 2023 - November 2023	January 1, 2024
December 2023 - May 2024	July 1, 2024
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.	

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 allowed for continuation of qualifying period without interruption for this QBRP incentive.

Qualifying Period	Incentive begins
June 2023 - November 2023	January 1, 2024
December 2023 - May 2024	July 1, 2024

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Metric	%	Group	Description	Qualifying Period
CPT II Codes (CAT2)	**.50**	A	CPT-II codes are supplemental procedure codes that are used to identify clinical components not associated with a relative value unit (RVU). These codes are often used to identify results of HbA1c tests, eye exams, blood pressure, medication reconciliation, cholesterol tests, and prenatal and postpartum visits for example. By providing these supplemental procedure codes on claims, there will be a decreased need for medical records while producing a more accurate HEDIS score for applicable measures. **The number of eligible CPT Category II codes submitted during the measurement period, must be greater than or equal to 30 encounters to be eligible, calculated at the individual provider level.** A complete list of QBRP eligible CPT-II codes can be found on pages 27-28 in the HEDIS Coding and Reference Guide for QBRP.	Semi-annual
ICD-10 SDoH Codes (ZZZ)	**.75**	A	Select ICD-10 Z codes can be useful diagnosis codes used to help identify social determinants of health (SDoH) as well as 'history of' procedures or 'acquired absence of' codes used to support HEDIS. By providing these supplemental diagnoses codes on claims, social factors that impose barriers to a person's health and wellness can be identified, allowing appropriate resources to be allocated to better address the social needs of our members. **The number of eligible ICD-10 Z codes submitted during the measurement period, must be greater than or equal to 30 encounters to be eligible, calculated at the individual provider level.** A complete list of QBRP eligible ICD-10 Z codes can be found on pages 23-26 in the HEDIS Coding and Reference Guide for QBRP.	Semi-annual

Qualifying for CPT II Codes (CAT2)/ ICD-10 SDoH Codes (ZZZ) Incentives

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

Qualifying Period	Incentive begins
July 1, 2022 - June 30, 2023 (as paid through September 30, 2023)	January 1, 2024
January 1, 2023 - December 30, 2023 (as paid through March 31, 2024)	July 1, 2024

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Metric	%	Group	Description	Qualifying Period
CCD or HIE HL7 use to State-approved HIO's Each provider must have a user ID and HL7 real-time connectivity to qualify. **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	3.0	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) Vitals, Diagnosis, Procedure coding		B	Must send vitals, 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

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

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

Qualifying Period	Incentive begins
May 1 - October 31, 2023	January 1, 2024
November 1 - April 30, 2024	July 1, 2024

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Metric	%	Group	Description	Qualifying Period
Registry Data (REG) (*applies only to anesthesia, pathology, radiology, urology, chiropractors, optometrists, ophthalmologists, arthritis, rheumatology, pulmonary and gastroenterology)	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)	7.5	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
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
Cervical Cancer Screening (CCS)	1.5	B	The percentage of women 21-64 years of age who were screened for cervical cancer. Must be greater than or equal to 75 percent to meet the metric, calculated at the provider group level having at least five attributed/eligible patients. Individual providers in the group must have at least one attributed/eligible patient to receive incentive.	Semi-annual
Colorectal Cancer Screening (COL)	1.0	B	The percentage of adults 45-75 years of age (46-75 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

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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 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. **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 (W30A) 6-plus visits in first 15 months	1.0	B	The percentage of members 0-15 months who had six or more well-child visits with a PCP during the first 15 months of life. Must be greater than 80 percent to meet the metric, calculated at the provider group level having at least 5 attributed/eligible patients. Individual providers in the group must have a least one attributed/eligible patient to receive incentive.	Semi-annual
Well-Child visits (W30B) 2 or more visits during months 15-30	1.0	B	The percentage of members 15-30 months who had two or more well-child visits with a PCP between 15-30 months of life. Must be greater than 80 percent to meet the metric, calculated at the provider group level having at least 5 attributed/eligible patients. Individual providers in the group must have a least one attributed/eligible patient to receive incentive.	Semi-annual
Well-Child visits (WCV) 1 or more visits for members 3-21 years of age	1.0	B	The percentage of members 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, calculated at the provider group level having at least 5 attributed/eligible patients. Individual providers in the group must have a least one attributed/eligible patient to receive incentive.	Semi-annual
Statin Therapy for Patients with Cardiovascular Disease (SPC)	1.25	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 were dispensed at least one high-intensity or moderate-intensity statin medication 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

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Metric	%	Group	Description	Qualifying Period
Statin Therapy for Patients with Diabetes (SPD)	1.25	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) 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, 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
Eye Exams for Patients with Diabetes (EED)	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 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
Avoidance of Antibiotic Treatment in Members with Acute Bronchitis (AAB)	2.0	C	The percentage of members 3 months of age and older with a diagnosis of acute bronchitis/bronchiolitis who were not dispensed an antibiotic prescription. 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. **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
Appropriate Testing for Members with Pharyngitis (CWP)	1.5	C	The percentage of members 3 years of age and older 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 70 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 Members with Upper Respiratory Infection (URI)	2.0	C	The percentage of members 3 months of age and older who were given a diagnosis of upper respiratory infection and were not dispensed an antibiotic prescription. 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 URI, regardless of specialty.	Semi-annual

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Metric	%	Group	Description	Qualifying Period
Follow-up After Hospitalization for Mental Illness (FUH)	0.5	C	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of a selected mental illness or intentional self-harm diagnosis and who had a follow-up visit with a mental health provider within 7 days after discharge. Must be greater than or equal to 70 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 of an eligible encounter with a principal diagnosis of mental illness or intentional self-harm, regardless of the specialty.	Semi-annual

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, 2023	January 1, 2024
December 1, 2023 - May 31, 2024	July 1, 2024

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, 2023	January 1, 2024
March 1 - May 31, 2024	July 1, 2024

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QBRP CHANGES FOR 2024		
Metric	**Change**	**Reason**
MiResource (MiR)	Revised qualifying period	To align with most qualifying periods
Electronic Provider Message Board (EPM)	Revised qualifying period	To align with most qualifying periods
CPT Codes (CATx)/ICD-10 SDoH Codes (ZZZ)	Revised qualifying period	To align with most qualifying periods
HIE	Revised incentive/measure	To reflect the merging of two metrics
Verinovum Clinical Data Repository (CDR)	Removed incentive/measure	No longer a metric
Low-Back Pain (LBP)	Revised measure	To improve engagement and results
Statin Therapy for Patients with Cardiovascular Disease (SPC)	Revised measure	To improve engagement and results
Eye Exams for Patients with Diabetes (EED)	Revised measure	To improve engagement and results
Avoidance of Antibiotic Treatment in Members with Acute Bronchitis (AAB)	Revised measure	To improve engagement and results
Appropriate Testing for Members with Pharyngitis (CWP)	Revised measure	To improve engagement and results
Appropriate Treatment for members with Upper Respiratory Infection (URI)	Revised measure	To improve engagment and results
Follow-up After Hospitalization for Mental Illness (FUH)	Added QBRP measure	To increase participation in follow-ups after hospitalization for mental illness