Annual CAP Report

2022 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 2022 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.

With hopes of 2022 returning to a normal year as the pandemic becomes increasingly under control throughout the world, 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.

BCBSKS continued to be responsive to both our members and providers needs and built on what was started in 2020 including paying for telehealth services on par with comparable in person visits, waiving member cost share, 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 2021 and 2022.

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.

$61.65M
BCBSKS is projecting $61.65 million in QBRP incentives in 2021 (professional and institutional).

983,362
BCBSKS and its subsidiaries serve 983,362 members across all lines of business, including BlueCard, as of May 31, 2021.

639,432
BCBSKS serves 639,432 local members, as of May 31, 2021.

11.35%
BCBSKS spent 11.35 percent of annual premium income on administrative expenses for the year 2020

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 2022, 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.

2022 Reimbursement and Policy Memo changes

On June 25, 2021, the BCBSKS Board of Directors met and approved reimbursement and policy memo changes for 2022. A summary of the policy memo changes is enclosed for your review. Highlights of changes are noted in red.

Highlights of the 2022 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 2022 will continue to create opportunities for providers to earn incentives by meeting the criteria as outlined in the 2022 QBRP as described on pages 8-18.

A charge comparison report reflecting reimbursement changes for 2022 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 January 2021 through May 2021. The charge comparison format provides the lesser of your charge or the MAP for each procedure code you performed during the January through May time frame.

Overview of 2022 Reimbursement

Please note that along with base rate changes, additional reimbursement is available through the QBRP program where noted. (See QBRP section, pages 8-18.)

Increasing	No change	Decreasing
Undervalued CPT codes (eligible for QBRP)	Professional consultation codes (eligible for QBRP)	Overvalued CPT codes (eligible for QBRP)
Air Ambulance base rates (eligible for QBRP)	Anesthesia conversion factor at $63.34 (eligible for QBRP)	Clinical lab codes (not eligible for QBRP)
	Physical therapy, occupational therapy, and speech pathology services (eligible for QBRP)	Durable Medical Equipment (DME) services (eligible for QBRP)
	Services billed by primary care and behavioral health providers located in counties with a population of 13,000 or less will receive a 5 percent add-on to the MAP on all eligible CPT codes. See county listing on page 19.	
	Evaluation and Management (E&M) codes (eligible for QBRP)	
	Ground Ambulance base rates (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 2022).

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 Registered Behavior Technician (RBT)
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.

2022 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. 2022 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): In 2020, 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. As we progress with clinical data transmission in 2022, HIE incentives will only be paid for data submitted to Verinovum direct or through KHIN with consent for KHIN to forward the data to Verinovum.

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. However, 2021 and 2022 will remain as transition years to allow providers to add the additional feeds in order to continue to receive QBRP in 2022.

IMPORTANT REMINDER — The 2022 QBRP program is effective for services performed January 1, 2022 through December 31, 2022. Since the 2022 Annual CAP Report is sent out in July 2021, providers have several months to prepare to meet the various QBRP metrics and qualify for incentives effective January 1, 2022, in accordance with the metric review schedule (see pages 10-17). Please read the requirements and metrics for the 2022 QBRP program so you are prepared to maximize the available incentives. Any subsequent pertinent information or clarification will be communicated accordingly.

Criteria for 2022

In accordance with the 2022 Policy Memo No. 1, Section XXIX. Reimbursement for Quality, this document describes the components of QBRP effective January 1, 2022 through December 31, 2022. This program applies to all BCBSKS CAP, PPO, FEP, and BlueCard professional providers and services except for clinical lab (using codes on the Medicare clinical lab fee schedule), pharmacies and pharmaceuticals, and dental services.

This program will offer an opportunity for eligible providers to earn increased reimbursement based on a three group approach (Groups A, B, and C). This reimbursement will be in addition to the established base MAPs for 2022.

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.

2022 Professional Providers QBRP

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, 2022, 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 2022 incentives effective January 1, 2022 will be sent mid-December 2021.

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, with the exception of the Provider Information Portal and Provider Message Board (will be monthly, effective the 1st of the month when signed up by the 15th of the preceding month) will be reviewed on a semi-annual basis and any incentives earned will be effective either January 1, 2022 or July 1, 2022 as applicable. We will continue monthly reviews for 2022 to identify providers who did not qualify for incentive(s) beginning January 1, 2022 because of not meeting prerequisites, or new providers/groups after January 1, 2022, 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.

2022 Professional Providers QBRP

We will conduct a QBRP refresh in the first and second quarters (depending on the metric) of 2022 for an effective date of July 1, 2022 to determine if providers are continuing to meet the performance standards for the metric(s) earned for the incentive payments effective January 1, 2022. 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, 2022 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. 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) (prior to EPM implementation Jan. 1 - April 30, 2022)	**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
Electronic Self-Service (ES3, ES2) (after EPM implementation May 1 - Dec. 31, 2022)	**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

2022 Professional Providers QBRP

Metric	%	Group	Description	Qualifying Period
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) - (Implementation May 1, 2022)	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.	Monthly - Registration beginning April 1, 2022

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, 2021	January 1, 2022
February 1 - April 30, 2022	July 1, 2022

Qualifying for Provider Information Portal (PRT)

The following is a list of incentive effective dates and the corresponding qualifying periods. The attestation date qualifying the provider for January 1, 2022 incentive will also serve as the start date for the new rolling 90 day attestation contractual requirement.

Qualifying Period	Incentive
September 2021 - November 2021	January 1, 2022
December 2021 - February 2022	April 1, 2022
March 2022 - May 2022	July 1, 2022
June 2022 - August 2022	October 1, 2022

Qualifying for Electronic Provider Message Board (EPM)

The onboarding process for this QBRP will be available April 1, 2022 through Availity.

Qualifying Period	Incentive
1st - 15th of any given month	1st of the following month
16th - 31st of any given month	1st of 2 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.	

2022 Professional Providers QBRP

Qualifying for CPT II and ICD-10 Social Determinates of Health Codes (SDOH)

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 2022 QBRP Measures Coding and Reference Guide.	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 2022 QBRP Measures Coding and Reference Guide.	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
August 1 - October 31, 2021	January 1, 2022
February 1 - April 30, 2022	July 1, 2022

2022 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.

2022 Professional Providers QBRP

Metric	%	Group	Description	Qualifying Period
Registry Data (REG) (*applies only to anesthesia, pathology, radiology, urology, chiropractors, optometrists, ophthalmologists, arthritis, rheumatology, and pulmonary)	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)	1.0	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
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

2022 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 (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 **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.	Semi-annual

2022 Professional Providers QBRP

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
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
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
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 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
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 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

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Metric	%	Group	Description	Qualifying Period
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 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

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, 2021	January 1, 2022
December 1, 2021 - May 31, 2022	July 1, 2022

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, 2021	January 1, 2022
February 1 - April 30, 2022	July 1, 2022

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, 2021	January 1, 2022
March 1 - May 31, 2022	July 1, 2022

2022 Professional Providers QBRP

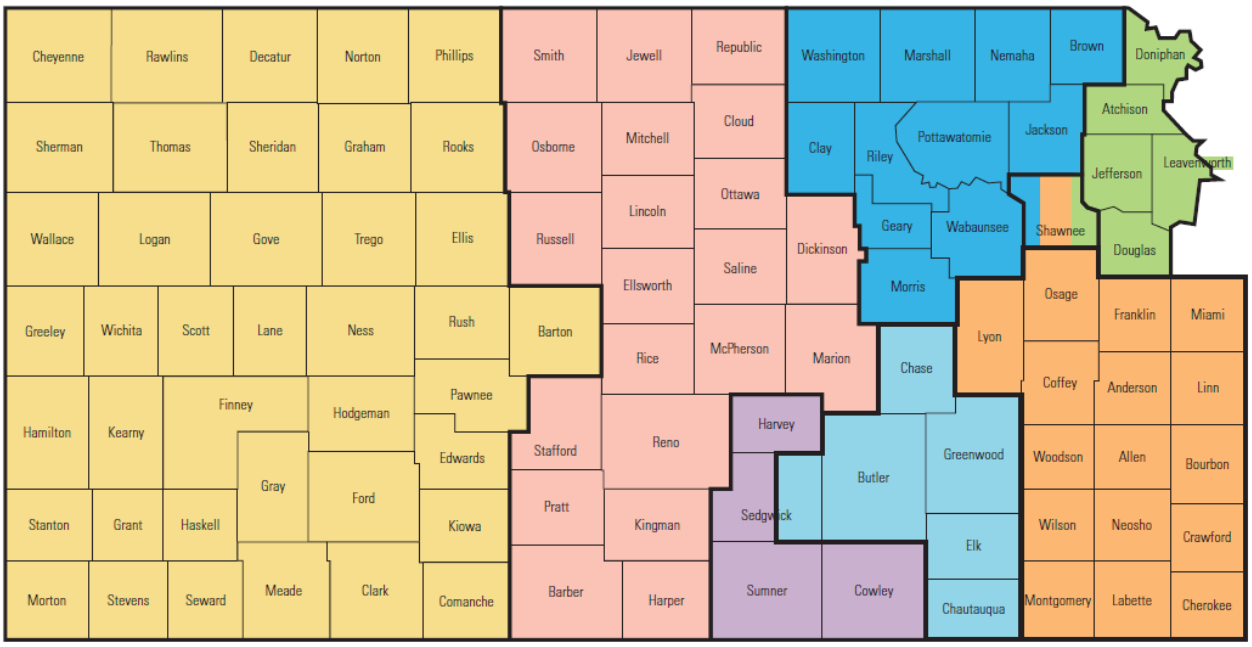
QBRP CHANGES FOR 2022		
Metric	**Change**	**Reason**
Electronic Self Service (ES3, ES2)	Decreased incentives from ES3- 3.0 to 2.0 and ES2 -1.5 to 1.0 effective May 1, 2022 (previous incentives apply until May 1, 2022 date)	To expand allocation of incentives to new QBRP measures
Provider Information Portal (PRT)	Qualifying period updated from Semi-annual to every 90 days	Mandates around attestation of provider data
Registry Data	Added Pulmonology	To increase quality registry data participation, submission
CPT II Codes (CAT2)	Added QBRP Measure	To decrease requests for additional information
ICD-10 SDoH Codes (ZZZ)	Added QBRP Measure	To provide information associated with social determinates and decrease requests for additional information
Electronic Provider Message Board (EPM)	Added QBRP Measure	To promote additional provider self service tool
Registry Data (REG)	Added Pulmonologists	To increase registry data participation submission
Adult Well Care Visits (AWC)	Removed incentive	No longer a HEDIS measure (Updated under (WCV)
Well-Child visits (W30A)	Revised measure, formerly (W15)	HEDIS nomenclature update
Well-Child visits (W30B)	Revised measure, formerly (W34/AWC)	HEDIS nomenclature update
Well-Child visits (WCV)	Revised measure, formerly (AWC)	HEDIS nomenclature update
Statin Therapy for Patients with Cardiovascular Disease (SPC)	Revised incentive/measure	HEDIS nomenclature update and to increase participation for this measure
Statin Therapy for Patients with Diabetes (SPD)	Revised incentive/measure	HEDIS nomenclature update and to increase participation for this measure
Diabetes Care Medical Attention for Nephropathy (CDCN)	Removed incentive	No longer a HEDIS measure for commercial population
PCMH Recognition (BST) Level 3	Removed incentive, eliminating group C, allowing group D to be renamed as group C	To expand allocation of incentives to new QBRP measures
Appropriate Testing for Members with Pharyngitis (CWP)	Revised measure	HEDIS nomenclature update
Appropriate Treatment for Members with Upper Respiratory Infection (URI)	Revised incentive/measure	HEDIS nomenclature update to increase participation for this measure
Avoidance of Antibiotic Treatment in Members with Acute Bronchitis (AAB)	Revised incentive/measure	HEDIS nomenclature update and to increase participation for this measure

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 2020 Estimated Census)

County	Population	County	Population
Allen	12,399	Marion	11,652
Anderson	7,949	Marshall	9,652
Barber	4,358	Meade	4,029
Brown	9,482	Mitchell	5,876
Chase	2,586	Morris	5,559
Chautauqua	3,230	Morton	2,538
Cheyenne	2,600	Nemaha	10,121
Clark	1,963	Ness	2,768
Clay	8,025	Norton	5,328
Cloud	8,642	Osborne	3,439
Coffey	8,158	Ottawa	5,712
Comanche	1,690	Pawnee	6,366
Decatur	2,776	Phillips	5,181
Doniphan	7,496	Pratt	9,127
Edwards	2,750	Rawlins	2,511
Elk	2,507	Republic	4,536
Ellsworth	6,034	Rice	9,362
Gove	2,621	Rooks	4,827
Graham	2,389	Rush	2,947
Grant	7,077	Russell	6,804
Gray	5,954	Scott	4,790
Greeley	1,196	Sheridan	2,520
Greenwood	5,868	Sherman	5,777
Hamilton	2,425	Smith	3,544
Harper	5,336	Stafford	4,046
Haskell	3,923	Stanton	1,969
Hodgeman	1,779	Stevens	5,388
Jewell	2,833	Thomas	7,702
Kearny	3,745	Trego	2,758
Kingman	6,974	Wabaunsee	6,906
Kiowa	2,456	Wallace	1,536
Lane	1,518	Washington	5,427
Lincoln	2,986	Wichita	2,074
Linn	9,654	Wilson	8,362
Logan	2,732	Woodson	3,015

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 – Dodge City – Rep. Code R
- Patrick Romm – Hutchinson – Rep. Code K
- Jennifer Falk – 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

Heather Schultz – Topeka – Rep. Code V

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