



# Medicare Advantage

Provider Excellence Program  
**2021**

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## 2021 Medicare Advantage Provider Excellence Program

The Medicare Advantage (MA) Provider Excellence Program is designed to reward participating MA providers for the role they play in helping achieve the objectives of the National Committee for Quality Assurance (NCQA) and Centers for Medicare and Medicaid Services (CMS) star ratings program.



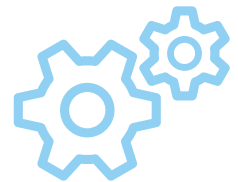
The objectives of the incentive program are aligned with the “triple aim” of achieving:

- Higher quality of care
- Healthier people and communities
- Increased affordability of care



The goal of the MA Provider Excellence Program is to achieve positive clinical results and to improve performance on Healthcare Effectiveness Data and Information Set (HEDIS®) measures and CMS star ratings.

This booklet describes the components of the MA Provider Excellence Program and the attribution methodology utilized to assign a member to a Primary Care Provider (PCP).



PCPs must have attributed/assigned members to participate in the MA Provider Excellence Program.

## Incentive Program Measures

The MA Provider Excellence Program rewards participating providers for successfully managing their patients by encouraging them to get preventive care and properly managing their health in key areas. Blue Cross and Blue Shield of Nebraska (BCBSNE) will award the participating MA provider \$50 for each of the following closed HEDIS quality gaps:

- Annual wellness visit
- Colorectal cancer screening
- Controlling blood pressure
- Diabetes care:
  - Controlling blood sugar (HgbA1C control  $\leq$  9%)
  - Monitoring for nephropathy
  - Retinal eye exam
- Statin use in persons with diabetes

Provider Excellence Program incentive potential = \$350 per member

\* Please refer to HEDIS specifications for more detailed information. HEDIS®, which stands for Healthcare Effectiveness Data and Information Set, is a registered trademark of the National Committee for Quality Assurance (NCQA).

## Program Qualifications

1. The MA provider must have signed a valid BCBSNE Medical Services Agreement and must be in full compliance with all terms and conditions of the BCBSNE Medical Services Agreement, including:
  - BCBSNE standards for timely and accurate provision of encounter, referral and claims data
  - Remittance of any funds due to BCBSNE for prior contract years
2. The MA provider must be in the BCBSNE Medicare Advantage Provider Network for the entire 2021 calendar year and be affiliated with BCBSNE at the time of payment (with the exception of recently retired providers).
3. BCBSNE retains the right to modify the incentive program for any reason and at any time. Modifications may include, but are not limited to:
  - Exclusion or removal of measures from the program
  - Changes to the program's calculation methodologies
4. Provider data submitted in relation to this incentive program are auditable. BCBSNE retains the right to conduct periodic random audits.

## Performance Measurement Guidelines

- PCPs will be credited for services provided through Dec. 31, 2021, to members continuously enrolled with the plan for the entire year.
- Credit will be granted to the PCP for each measure only when the specific, identified service is documented as provided to the member either through a claim (received by Feb. 28, 2022) or by submitting supplemental medical record documentation. Supplemental medical record documentation is to be submitted by \*Dec. 15, 2021.
- We recognize that many PCP offices send reminder letters or document that a diagnostic test has been ordered. This type of documentation will not be accepted in place of the provision of the service to count toward the PCP's credit for the measure.



Each primary care provider's quality performance measurement data is derived directly from BCBSNE reporting data.

## Payment Guidelines

Payment for the MA Provider Excellence Program is based on the member’s eligibility for each quality metric in each category and will be calculated as follows:

- \$50 for each annual wellness visit completed
- \$50 for each colorectal cancer screening gap closed
- \$50 for each controlling blood pressure gap closed
- \$50 for each monitoring for nephropathy gap closed
- \$50 for each retinal eye exam gap closed
- \$50 for the last HbA1c level that is  $\leq 9\%$  using the latest lab conducted in 2021
- \$50 for each statin use in persons with diabetes gap closed

## Payment Schedule

2021												2022				
JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY
DOS Jan. 1 – June 30						DOS July 1 – Dec. 31										
															Payment	

**Disclaimer:** BCBSNE will make every reasonable effort to remit the 2021 incentive payment for services received Jan. 1 through Dec. 31, 2021, (based on claims received through Feb. 28, 2022 and medical records received through \*Dec. 15, 2021), by second quarter 2022.

\* It is recommended to have all supplemental medical record documentation submitted by Dec. 15, 2021 for timely abstraction and reporting.

## Member Attribution Methodology

In order to evaluate incentive payments, BCBSNE uses the following care relationship / attribution model.

### Care Relationship / Attribution Model

A care relationship is the relationship between a patient and the provider most responsible for that patient's care during a specific time period, based on relevant claims data. The steps below are used to automatically determine attributed members for each PCP.

#### STEP 1: Determine eligible providers and members

##### Providers are eligible if they:

- Have an appropriate specialty: Internal medicine, family practice, etc.
- Are the rendering provider on a claim

##### Patients are eligible if they are:

- Members with an eligible BCBSNE MA product
- Nebraska residents

#### STEP 2: Define eligible claims

##### Claims are eligible if they:

- Occurred in an outpatient hospital or office setting
- Are paid claims
- Have a date of service within last 24 months using two months of run-out

##### Billed with one or more of the following procedure codes:

- Base E&M (99201-99205, 99211-99215, 99381-99387, 99391-99397, 99490, 99495,99496)
- Consultations (99241-99245)
- Preventive counseling (99401-99429)
- Immunization (90281-90756)

#### STEP 3: Assessment logic

##### Blue Cross and Blue Shield of Nebraska applies the following logic when determining attribution

1. Review E&M claims to the PCP within the last 12 months.
  - If none exist, search within 18 months and then 24 months.
  - If no E&M claims are found, review for consult / prevent / immunization claims to PCP in past 12, 18 and 24 months.
2. If more than one PCP is identified, the physician with the most visits is selected.
3. If the number is the same, the PCP with the most recent visit is selected.



## Contact Information

If you have questions or concerns regarding the MA Provider Excellence Program, please contact:

**Deb Esser, M.D., MMM, FAAFP**  
**Chief Medical Officer**

Blue Cross and Blue Shield of Nebraska  
1919 Aksarben Drive  
Omaha, NE 68180

[Debra.Esser@NebraskaBlue.com](mailto:Debra.Esser@NebraskaBlue.com)

Health Care Outcomes:

# Preventive Health

## Annual Wellness Visit

Product Lines	Medicare Advantage (MA) Core, Choice and Access
Source	HEDIS/CMS Stars
Description	Annual wellness visit or annual physical exam within the measurement year. Medicare Advantage patients can also complete a free annual wellness visit such as: <ul style="list-style-type: none"> <li>• A traditional face-to-face visit in your office.</li> <li>• An online telehealth visit using a smartphone, computer, or tablet with audio and video capability.</li> <li>• A telephone-only visit for patients who do not have video capability.</li> </ul>
Continuous Enrollment	Must be continuously enrolled with the same MA plan for the measurement year.
Compliant Population (Numerator)	All members
Eligible Population (Denominator)	All members
Level of measure	Provider level
Payout	\$50 per compliant member as defined above
Procedure codes that support gap closure (can be billed by the primary care provider)	<ul style="list-style-type: none"> <li>• Physical exam codes: 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397</li> <li>• Wellness exams: G0438, G0439</li> <li>• Welcome to Medicare exam: G0402</li> </ul>

\*Please refer to HEDIS specifications for more detailed information



## Health Care Outcomes:

# Preventive Health Colorectal Cancer Screening

Product Lines	Medicare Advantage (MA) Core, Choice and Access
Source	HEDIS/CMS Stars
Description*	The percentage of members who had appropriate screening for colorectal cancer
Continuous Enrollment	Must be continuously enrolled with the same MA plan for the measurement year and the year prior to the measurement year.
Age Criteria	Members 50-75 years as of Dec. 31, 2021
Exclusionary Criteria	<ul style="list-style-type: none"> <li>• Diagnosis of colorectal cancer anytime during the member's history through 2021 (cancer of the small intestine does not count).</li> <li>• Total colectomy anytime during the member's history through 2021 (partial or hemicolectomies do not count).</li> <li>• Are 66 and older with advanced illness and frailty (for details and coding information please see the Advanced Illness &amp; Frailty Guide).</li> <li>• Patient received hospice or palliative care any time during the measurement year.</li> <li>• Medicare members 66 years of age and older enrolled in an Institutional SNP or Long-Term institution.</li> </ul>
Compliant Population (Numerator)	<p>One or more screenings for colorectal cancer. Any of the following meet criteria:</p> <ul style="list-style-type: none"> <li>• Fecal occult blood test during the measurement year.</li> <li>• Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.</li> <li>• Colonoscopy during the measurement year or the nine years prior to the measurement year.</li> <li>• CT colonography during the measurement year or the four years prior to the measurement year.</li> <li>• FIT-DNA test (Cologuard) during the measurement year or the two years prior to the measurement year.</li> </ul>
Eligible Population (Denominator)	The population of members that are eligible for colorectal cancer screening measure
Level of measure	Provider level
Payout	\$50 per compliant member as defined above
Medical Record documentation to support gap closure	<ul style="list-style-type: none"> <li>• Include a note in the medical history indicating the type of test and the date when the colorectal cancer screening was performed, or if the patient met exclusion criteria.</li> <li>• A result is not required if the documentation is clearly part of the "medical history" section of the record; if this is not clear, the result or findings must also be present (this ensures the screening was performed and not merely ordered). -or-</li> <li>• A pathology report that indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed.</li> </ul> <p><b>If telehealth, telephone or e-visits are utilized instead of face-to-face visits:</b></p> <ul style="list-style-type: none"> <li>• Discuss the need for colorectal cancer screening</li> <li>• Refer the patient for testing, or</li> <li>• Ask the patient if they would be willing to do an in-home FIT-DNA test; the test will be sent to their home. If the result is negative, they will not require another screening for 3 years</li> </ul>
Procedure codes that support gap closure (can be billed by the primary care provider)	<ul style="list-style-type: none"> <li>• Flexible sigmoidoscopy: CPT<sup>iv</sup> 45330-45335, 45337-45342, 45346- 45350, HCPCS: G0104</li> <li>• FIT-DNA (known as Cologuard<sup>®</sup>): CPT 81528</li> <li>• Occult blood test (FOBT, FIT, guaiac):CPT 82270, 82274, HCPCS: G0328</li> <li>• Colonoscopy: CPT 44388-44397, 44401-44408, 45355-45398, HCPCS: G0105, G0121</li> <li>• CT Colonography: CPT 74261, 74262, 74263</li> </ul>

\*Please refer to HEDIS specifications for more detailed information



## Health Care Outcomes:

# Disease Management

## Diabetes Care: HbA1C ≤ 9%

Product Lines	Medicare Advantage (MA) Core, Choice and Access
Source	HEDIS/CMS Stars
Description*	The percentage of members with diabetes and a documented HbA1c ≤ 9% using the most recent lab conducted in 2021
Continuous Enrollment	Must be continuously enrolled with the same MA plan for 2021.
Age Criteria	Members 18-75 years as of Dec. 2021
Exclusionary Criteria	<ul style="list-style-type: none"> <li>• Diagnosis of gestational diabetes or steroid-induced diabetes, or polycystic ovarian syndrome in any setting during 2020 or 2021.</li> <li>• Are 66 and older with advanced illness and frailty (for additional definition information, see the Advanced Illness &amp; Frailty Guide).</li> <li>• Patient in hospice, enrolled in a SNP, or living long term in any institution at any time during the measurement year.</li> <li>• Are in palliative care.</li> <li>• Are deceased during the measurement year.</li> </ul>
Compliant Population (Numerator)	<ul style="list-style-type: none"> <li>• The number of members with diabetes with an HbA1c ≤9.0%. This measure considers the last lab conducted in 2021.</li> <li>• The member is not compliant if the most recent result is &gt;9%, missing a result from the most recent test, or the test was not done during 2021.</li> </ul>
Eligible Population (Denominator)	All members with diabetes as defined above
Level of measure	Provider level
Payout	\$50 per compliant member as defined above (based on last reading of year)
Additional procedure codes that support gap closure (if service is performed in-office)	3044F: Most recent hemoglobin A1c (HbA1c) level less than 7.0% (compliant) 3046F: Most recent hemoglobin A1c (HbA1c) level greater than 9.0% (while non-compliant, this will reduce need to locate lab result) 3051F: Most recent hemoglobin A1c (HbA1c) level ≥ 7% and <8% (compliant) 3052F: Most recent hemoglobin A1c (HbA1c) ≥ 8% and ≤ 9%
Medical Record documentation to support gap closure	<ul style="list-style-type: none"> <li>• Documentation in the medical record should include a copy of the lab report.</li> <li>• In the absence of the lab report, the HbA1c collected date and result must be documented in the medical record. The following notation in the chart counts towards compliance: A1c, HbA1c, HgBA1c, hemoglobin A1c, glycohemoglobin A1c.</li> <li>• The last hemoglobin A1c level value ≤9.0% of the measurement year will be used for HEDIS compliance determination.</li> <li>• An EMR data file can be utilized for documentation of gap closure for certain hybrid measures.</li> </ul>

\*Please refer to HEDIS specifications for more detailed information

## Health Care Outcomes:

# Disease Management

## Diabetes Care: Monitoring for Nephropathy

Product Lines	Medicare Advantage (MA) Core, Choice and Access
Source	HEDIS/CMS Stars
Description*	The percentage of members with diabetes who have had one of the following: <ul style="list-style-type: none"> <li>• At least one screen for micro/macro albumin in 2021</li> <li>• Received medical treatment for nephropathy in 2021</li> <li>• Had a visit with a nephrologist in 2021</li> <li>• At least one dispensing event of ACE (I)/ARB medication in 2021</li> <li>• Evidence of Stage 4 CKD, ESRD or kidney transplant</li> </ul>
Continuous Enrollment	Must be continuously enrolled with the same MA plan for 2021.
Age Criteria	Members 18-75 years as of Dec. 2021
Exclusionary Criteria	<ul style="list-style-type: none"> <li>• Diagnosis of gestational diabetes or steroid-induced diabetes, or polycystic ovarian syndrome in any setting during 2020 or 2021.</li> <li>• Are age 66 and older with advanced illness and frailty.</li> <li>• Patient in hospice, enrolled in a SNP, or living long term in any institution at any time during the measurement year.</li> <li>• Patient is in palliative care.</li> <li>• Patient is deceased during the measurement year.</li> </ul>
Compliant Population (Numerator)	Members with diabetes who have had one of the following: <ul style="list-style-type: none"> <li>• At least one screen for micro/macro albumin in 2021</li> <li>• Received medical treatment for nephropathy in 2021</li> <li>• Had a visit with a Nephrologist in 2021</li> <li>• At least one dispensing event of ACE(I)/ARB medication in 2021</li> </ul>
Eligible Population (Denominator)	All members with diabetes as defined above
Level of measure	Provider level
Payout	\$50 per compliant member as defined above
Additional procedure codes that support gap closure (can be billed by the primary care provider)	3066F: For documentation of treatment for nephropathy 4010F: Use when you prescribe an ACE (I)/ARB
OR	
Medical Record documentation to support gap closure	Screening for nephropathy includes one of the following: <ul style="list-style-type: none"> <li>• A urine test for albumin or protein. At minimum, documentation must include a note indicating the date when a urine test was performed and the result or finding. Any of the following meet criteria: <ul style="list-style-type: none"> <li>◦ 24-hour urine for albumin or protein, timed urine for albumin or protein, spot urine for albumin or protein, urine for albumin/creatinine ratio, 24-hour urine for total protein, random urine for protein/creatinine ratio.</li> </ul> </li> <li>• Evidence of medical attention for nephropathy that includes at least one of the following: <ul style="list-style-type: none"> <li>◦ Documentation of a visit to a Nephrologist</li> <li>◦ Documentation of a renal transplant</li> <li>◦ Documentation of medical attention for any of the following: diabetic nephropathy, end-stage renal disease, chronic renal failure, chronic kidney disease, renal insufficiency, proteinuria, albuminuria, renal dysfunction, acute renal failure, dialysis, hemodialysis or peritoneal dialysis.</li> <li>◦ Evidence of angiotensin-converting enzyme inhibitor or angiotensin II receptor blocker therapy.</li> </ul> </li> <li>• Evidence of an ambulatory prescription for ACE(I)/ARB in the measurement year.</li> </ul>

\*Please refer to HEDIS specifications for more detailed information

Health Care Outcomes:

# Disease Management

## Diabetes Care: Retinal Eye Exam

Product Lines	Medicare Advantage (MA) Core, Choice and Access
Source	HEDIS/CMS Stars
Description*	The percentage of members with diabetes who have had one of the following: <ul style="list-style-type: none"> <li>• A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.</li> <li>• A negative retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year.</li> </ul>
Continuous Enrollment	Must be continuously enrolled with the same MA plan for 2021.
Age Criteria	Members 18-75 years as of Dec. 2021
Exclusionary Criteria	<ul style="list-style-type: none"> <li>• Diagnosis of gestational diabetes or steroid-induced diabetes, or polycystic ovarian syndrome in any setting during 2020 or 2021.</li> <li>• Are 66 and older with advanced illness and frailty (for additional definition information, see the Advanced Illness &amp; Frailty Guide).</li> <li>• Patient in hospice, enrolled in a SNP, or living long term in any institution at any time during the measurement year.</li> <li>• Patient is in palliative care.</li> <li>• Patient is deceased during the measurement year.</li> </ul>
Compliant Population (Numerator)	Members with diabetes who have had one of the following: <ul style="list-style-type: none"> <li>• At least one retinal eye exam by an eye care professional (optometrist or ophthalmologist) in 2021.</li> <li>• A negative retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year.</li> <li>• Bilateral eye enucleation anytime during the member’s history through Dec. 31 of the measurement year.</li> </ul>
Eligible Population (Denominator)	All members with diabetes as defined above.
Level of measure	Provider level
Payout	\$50 per compliant member as defined above
Additional procedure codes that support gap closure (can be billed by the primary care provider also for services provided in the year prior to the measurement year)	2022F: Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed. May be billed by any provider when they receive the eye exam report from the eye care professional (can be billed alone; an office visit is not necessary). 2023F: Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed, without evidence of retinopathy. 2024F: Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed. 2025F: Standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed, without evidence of retinopathy. 2026F: Eye imaging validated to match diagnosis from seven standard field stereoscopic photo result documented and reviewed. 2033F: Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed, without evidence of retinopathy. 3072F: Low risk for retinopathy (no evidence of retinopathy in the prior year).
OR	
Medical Record documentation to support gap closure	<ul style="list-style-type: none"> <li>• A letter or copy of the eye exam report prepared by an eye care professional or primary care provider indicating that the retinal exam was completed with the date the exam was performed and the results.</li> <li>• A chart or photograph of the retina, the date it was performed and evidence that an eye care professional reviewed the results.</li> <li>• Results in the chart can also be from a qualified reading center that operates under the direction of a retinal specialist.</li> </ul>

\*Please refer to HEDIS specifications for more detailed information

## Health Care Outcomes:

# Disease Management

## Diabetes Care: Statin Use in Persons with Diabetes (SUPD)

Product Lines	Medicare Advantage (MA) Core, Choice and Access
Source	Prescription Drug Event (PDE) data which is prescription claims data sent to CMS by the BCBSNE PBM
Description	Members who were dispensed at least two diabetes medication fills who received a statin medication fill in the current measurement year
Age Criteria	Members 40-75 years of age as of Dec. 31, 2021
Exclusionary Criteria	Patients are excluded if they: <ul style="list-style-type: none"><li>• Are in hospice care</li><li>• Have end-stage renal disease diagnosis</li><li>• Have liver disease, pre-diabetes, or polycystic ovary syndrome (PCOS)</li><li>• Are pregnant, lactating, or undergoing fertility treatment</li><li>• Have rhabdomyolysis or myopathy</li></ul>
Compliant Population (Numerator)	Members in the denominator who were dispensed at least one fill of a statin medication during the measurement year
Eligible Population (Denominator)	Medicare Part D beneficiaries who received at least two diabetes medication fills during the measurement year
Level of measure	Provider level
Payout	\$50 per compliant member as defined above.
Additional information to support gap closure	Only claims data will be used to close gaps; supplemental and medical record data may not be used.

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