BlueCross BlueShield Nebraska

Medicare Advantage

Provider Excellence Program

2019

BlueCross BlueShield Nebraska

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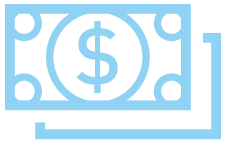
BlueCross BlueShield Nebraska

2019 Medicare Advantage Provider Excellence Program

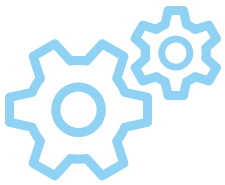


The Medicare Advantage (MA) Provider Excellence Program is designed to reward participating MA providers for the role they play in helping achieve the objectives of the National Committee for Quality Assurance (NCQA) and Centers for Medicare and Medicaid Services (CMS) star ratings program.

The objectives of the incentive program are aligned with the **Triple Aim Initiatives**:

- Higher quality of care
- Healthier people and communities
- Affordable 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:

- Colorectal cancer screening – Appropriate screenings for colorectal cancer
- Diabetes care:
  - Controlling blood sugar (HgbA1C control ≤ 9%)
  - Monitoring for nephropathy
  - Retinal eye exam
- Statin Use in Persons with Diabetes

Provider Excellence Program incentive potential = $250 per member

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 affiliated with the BCBSNE Medicare Advantage Core and Choice Program for the entire 2019 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 December 31, 2019, 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 February 29, 2020) or by submitting supplemental medical record documentation. Supplemental medical record documentation is to be submitted by December 15, 2019.
- 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.

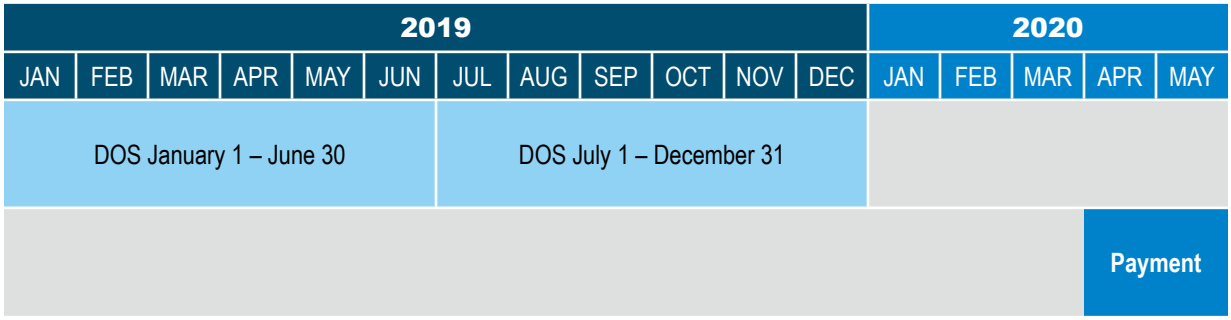
Each primary care provider's quality performance measurement data is derived directly from BCBSNE reporting data.

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 colorectal cancer screening 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 ≤ 9% using the latest lab conducted in 2019
- $50 for each statin use in persons with diabetes gap closed

Payment Schedule



Disclaimer: BCBSNE will make every reasonable effort to remit the 2019 incentive payment for services received January 1 through December 31, 2019, based on claims received through February 29, 2020 and medical records received through December 15, 2019, by second quarter 2020.

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:	Patients are eligible if they are:
• Have an appropriate specialty: Internal Medicine, Family Practice, etc. • Are the rendering provider on a claim	• Members with an eligible BCBSNE Medicare Advantage product • Nebraska residents

STEP 2: Define eligible claims

Claims are eligible if they:	With one or more of the following procedure codes:
• 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	• 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, 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:

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Health Care Outcomes:

Preventative Health

Colorectal Cancer Screening

Product Lines	Medicare Advantage Core and Medicare Advantage Choice
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 Medicare Advantage plan for the measurement year and the year prior to the measurement year.
Age Criteria	Members 50-75 years as of December 31, 2019
Exclusionary Criteria	• Diagnosis of colorectal cancer anytime during the member's history through 2019 (cancer of the small intestine does not count). • Total colectomy anytime during the member's history through 2019 (partial or hemicolectomies do not count). • Has an advanced illness and frailty: ○ Medicare members 66 years of age and older with advanced illness (includes dispensed dementia medication) in the measurement year or the year prior to the measurement year AND frailty in the measurement year as evidenced by claims data. • Patient in hospice, enrolled in a SNP, or living long term in any institution at any time during the measurement year.
Compliant Population (Numerator)	One or more screenings for colorectal cancer. Any of the following meet criteria: • Colonoscopy January 1, 2010 through December 31, 2019 • Flexible sigmoidoscopy January 1, 2015 through December 31, 2019 • CT Colonography January 1, 2015 through December 31, 2019 • FIT-DNA December 1, 2017 through December 31, 2019 • Fecal occult blood test during January 1, 2019 through December 31, 2019
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	• 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. • 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- • A pathology report that indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed meets criteria.

*Please refer to HEDIS specifications for more detailed information

Health Care Outcomes:

Disease Management

Diabetes Care: HbA1C ≤ 9%

Product Lines	Medicare Advantage Core and Medicare Advantage Choice
Source	HEDIS/CMS Stars
Description*	The percentage of members with diabetes and a documented HbA1c ≤ 9% using the latest lab conducted in 2019
Continuous Enrollment	Must be continuously enrolled with the same Medicare Advantage plan for 2019.
Age Criteria	Members 18-75 years as of December 2019
Exclusionary Criteria	• Diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during 2018 or 2019. • Has an advanced illness and frailty: ○ Medicare members 66 years of age and older with advanced illness in the measurement year or the year prior to the measurement year AND frailty in the measurement year are excluded when claims are received with advanced illness (includes dispensed dementia medication) and frailty codes. ○ Advanced illness codes include conditions such as metastatic cancer, heart failure and late stage kidney disease, billed in the measurement year or the year prior. ○ Frailty codes (billed in the current measurement year) include equipment that are typically included on claims, such as hospital beds, wheelchairs and oxygen. However, there are frailty codes that are not always routinely included on claims such as weakness, fatigue, falls, etc. • Patient in hospice, enrolled in a SNP, or living long term in any institution at any time during the measurement year.
Compliant Population (Numerator)	• The number of members with diabetes with an HbA1c ≤9.0%. This measure considers the last lab conducted in 2019. • The member is not compliant if the most recent result is >9%, missing a result from the most recent test, or the test was not done during 2019.
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) 3045F - Most recent hemoglobin A1c (HbA1c) level 7.0-9.0% (compliant) 3046F - Most recent hemoglobin A1c (HbA1c) level greater than 9.0% (while non-compliant, this will reduce need to locate lab result)
OR	
Medical Record documentation to support gap closure	• Documentation in the medical record should include a copy of the lab report. • 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. • Most recent hemoglobin A1c level value must ≤9.0%.

*Please refer to HEDIS specifications for more detailed information

Health Care Outcomes:

Disease Management

Diabetes Care: Monitoring Nephropathy

Product Lines	Medicare Advantage Core and Medicare Advantage Choice
Source	HEDIS/CMS Stars
Description*	The percentage of members with diabetes who have had one of the following: • At least one screen for micro/macro albumin in 2019 • Received medical treatment for nephropathy in 2019 • Had a visit with a nephrologist in 2019 • At least one dispensing event of ACE[I]/ARB medication in 2019 • Evidence of Stage 4 CKD, ESRD or kidney transplant
Continuous Enrollment	Must be continuously enrolled with the same Medicare Advantage plan for 2019.
Age Criteria	Members 18-75 years as of December 2019
Exclusionary Criteria	• Diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during 2018 or 2019. • Has an advanced illness and frailty: ○ Medicare members 66 years of age and older with advanced illness in the measurement year or the year prior to the measurement year AND frailty in the measurement year are excluded when claims are received with advanced illness (includes dispensed dementia medication) and frailty codes. ○ Advanced illness codes include conditions such as metastatic cancer, heart failure and late stage kidney disease, billed in the measurement year or the year prior. ○ Frailty codes (billed in the current measurement year) include equipment that are typically included on claims, such as hospital beds, wheelchairs and oxygen. However, there are frailty codes that are not always routinely included on claims such as weakness, fatigue, falls, etc. • Patient in hospice, enrolled in a SNP, or living long term in any institution at any time during the measurement year.
Compliant Population (Numerator)	Members with diabetes who have had one of the following: • At least one screen for micro/macro albumin in 2019 • Received medical treatment for nephropathy in 2019 • Had a visit with a Nephrologist in 2019 • At least one dispensing event of ACE(I)/ARB medication in 2019
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)	3060F - Positive microalbuminuria test result documented and reviewed 3061F - Negative microalbuminuria test result documented and reviewed 3062F - Positive microalbuminuria test result documented and reviewed 3066F - For documentation of treatment for nephropathy 4010F - For evidence of ACE(I)/ARB therapy prescribed or taken
OR	
Medical Record documentation to support gap closure	Documentation in the medical record in support of screening or treatment should include: • Screening for nephropathy • 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: 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. • Evidence of medical attention for nephropathy that includes at least one of the following: ○ Documentation of a visit to a nephrologist ○ Documentation of a renal transplant ○ 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. ○ Evidence of angiotensin-converting enzyme inhibitor or angiotensin II receptor blocker therapy. • Evidence of an ambulatory prescription for ACE inhibitors or ARBs in the measurement year.

*Please refer to HEDIS specifications for more detailed information

Health Care Outcomes:

Disease Management

Diabetes Care: Retinal Eye Exam

Product Lines	Medicare Advantage Core and Medicare Advantage Choice
Source	HEDIS/CMS Stars
Description*	The percentage of members with diabetes who have had one of the following: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. • 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.
Continuous Enrollment	Must be continuously enrolled with the same Medicare Advantage plan for 2019.
Age Criteria	Members 18-75 years as of December 2019
Exclusionary Criteria	• Diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during 2018 or 2019. • Has an advanced illness and frailty: ○ Medicare members 66 years of age and older with advanced illness in the measurement year or the year prior to the measurement year AND frailty in the measurement year are excluded when claims are received with advanced illness (includes dispensed dementia medication) and frailty codes. ○ Advanced illness codes include conditions such as metastatic cancer, heart failure and late stage kidney disease, billed in the measurement year or the year prior. ○ Frailty codes (billed in the current measurement year) include equipment that are typically included on claims, such as hospital beds, wheelchairs and oxygen. However, there are frailty codes that are not always routinely included on claims such as weakness, fatigue, falls, etc. • Patient in hospice, enrolled in a SNP, or living long term in any institution at any time during the measurement year.
Compliant Population (Numerator)	Members with diabetes who have had one of the following: • At least one retinal eye exam by an eye care professional (optometrist or ophthalmologist) in 2019. • 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. • Bilateral eye enucleation anytime during the member's history through December 31 of the measurement year.
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) 2024F - Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed. 2026F - Eye imaging validated to match diagnosis from seven standard field stereoscopic photo result documented and reviewed. 3072F - Low risk for retinopathy (no evidence of retinopathy in the prior year).
OR	
Medical Record documentation to support gap closure	Documentation in the medical record in support of screening or treatment should include: • A letter or copy of the eye exam report prepared by an ophthalmologist or optometrist indicating that an ophthalmoscopic exam was completed, the date and the results of the exam. The letter can also be written by a PCP indicating that a retinal exam was performed, date of service and the results. • A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an eye care professional reviewed the results. • Results from a qualified center that operates under the direction of a retinal specialist.

*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 Core and Medicare Advantage Choice
Source	Prescription Drug Event (PDE) data which is prescription claims data sent to CMS by the BCBSNE PBM
Description	Members who are 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 December 2019
Exclusionary Criteria	Patients are excluded if they: • are diagnosed with ESRD • are in hospice any time during the measurement year • are on insulin
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.