2018 PCP Quality Incentive Program

Blue Cross Blue Shield of Rhode Island

Dear Provider,

Blue Cross & Blue Shield of Rhode Island (BCBSRI) is committed to improving the health of our members and all Rhode Islanders, by supporting access to high-quality, cost-effective healthcare. One way we are doing this is through our continued efforts to reward primary care providers (PCPs) for improving quality and closing gaps in care. To that end, I'm pleased to share details about our 2018 PCP Quality Incentive Program.

Each year, BCBSRI is evaluated by a number of organizations—including the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA)—on the health outcomes of our members. We recognize that, as a primary care provider, you have much more influence than BCBSRI in affecting improvement on many of the measures identified, specifically those related to closing potential gaps in care.

BCBSRI wants to help you maximize gap closure, through using CPT® Category II codes. Using CPT Category II codes for certain preventative care services and test results makes it easier for you to share data with BCBSRI quickly and efficiently, while helping you close gaps in care that are tied to the Healthcare Effectiveness Data and Information Set (HEDIS*). When you add CPT Category II codes, BCBSRI will not need to request charts from your office to confirm care that has already been completed. You can find more information on CPT Category II codes in our Detailed Measure Description section of this booklet.

For our PCP Quality Incentive Program, we have selected key measures used by CMS and NCQA to evaluate health plans for performance incentive and accreditation programs. You will receive compensation for gaps in care that were closed throughout the year.

If you have questions about the 2018 PCP Quality Incentive Program, please contact your provider relations representative, or send an email to ProviderRelations@bcbsri.org.

Thank you for your support of the 2018 PCP Quality Incentive Program.

Sincerely,

Gus Manocchia, M.D.
Senior Vice President & Chief Medical Officer

**HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).*

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I. Introduction

BCBSRI is pleased to offer the 2018 PCP Quality Incentive Program, which rewards PCPs for improving quality and closing gaps in care. As in past years, BCBSRI will make incentives available to PCPs to support improvements in quality, as outlined by nationally recognized programs and measures. BCBSRI's continued investment in quality incentives underscores our plan to support primary care, limit fee-for-service rate increases, and offer payments to PCPs through incentives to improve quality of care.

This 2018 PCP Quality Incentive Program handbook includes detailed information regarding:

- Specific measurement attributes of the program
- Access to data to assist in meeting targets
- Expectations for providers, so you can maximize your earning potential

The 2018 PCP Quality Incentive Program is open to all PCPs. This program includes BlueCHiP for Medicare and Commercial BCBSRI populations. The program is based on nationally accepted quality measures developed and/or endorsed by a number of organizations, including:

- National Committee for Quality Assurance
- Centers for Medicare and Medicaid Services
- Oregon Pediatric Improvement Partnership
- National Quality Forum
- State Innovation Model

BCBSRI evaluates performance measures yearly. Categories and targets are adjusted based on input from BCBSRI's provider and health system partners, as well as the healthcare industry.

II. Reporting and Payment Schedule

2018 Incentive Payment Schedule

Measurement Period	Supplemental Data	Analyze Data	Payment & Reporting Date
January – December 2018	BCBSRI will provide Microsoft Excel® files for supplemental data submission in mid-January 2019. BCBSRI must receive data files back no later than 2/15/2019.	March – August 2019	September 2019

III. PCP Quality Incentive Program Measures

For detailed descriptions of these measures, please see Section IX of this document.

Adult Program Measures

BlueCHiP for Medicare

1. Breast Cancer Screening
2. Adult BMI Assessment
3. Diabetes – Hemoglobin A1c Control ≤9%
4. Diabetes – Nephropathy Screening
5. Diabetes – Eye Exam
6. Controlling High Blood Pressure
7. Colorectal Cancer Screening

Commercial

1. Breast Cancer Screening
2. Adult BMI Assessment
3. Diabetes – Hemoglobin A1c Control <8%
4. Diabetes – Nephropathy Screening
5. Diabetes – Eye Exam
6. Controlling High Blood Pressure
7. Colorectal Cancer Screening
8. Tobacco Use: Screening and Cessation Intervention (NEW)

Pediatric Program Measures

Commercial

1. Well-Child Counseling for Nutrition
2. Well-Child Counseling for Physical Activity
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4. Adolescent Immunization Status – Combination 2 (NEW)
5. Developmental Screening in the First Three Years of Life – 1st Year
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7. Developmental Screening in the First Three Years of Life – 3rd Year

IV. Highlighted Program Enhancements

Although many program components remain the same, there are some key changes:

- One new Commercial Adult measure was added to the incentive program:
  - Tobacco Use: Screening and Cessation Intervention
- One Pediatric measure was modified for the 2018 Program:
  - Adolescent Immunization Status – Combination 2 (Combination 2 includes Tdap, meningococcal vaccine, and HPV vaccines for females and males)

Medicare Advantage members who are residing in a long-term care setting are excluded from the following three measures:

- Breast Cancer Screenings
- Colorectal Cancer Screenings
- Controlling High Blood Pressure

BCBSRI will calculate payments at the provider level (instead of the practice level.)

Quality Bonus

Providers will be eligible for a bonus amounting to 10% of their overall calculated incentive total, if their overall quality score is 90% or higher by product. The overall quality score is calculated by dividing the sum of the gaps closed by the sum of the eligible gaps across all PQIP measures. The overall quality score will be calculated separately for Commercial and Medicare.

V. Supplemental Data

Claims data submitted to BCBSRI will be used to close gaps in care, when applicable. Providers will have the opportunity to submit supplemental data for gaps in care that are not closed through claims submissions. Supplemental data is clinical data from your medical record or electronic health record. The following rules apply:

- Data must be reported at the individual patient level, not aggregated.
- The actual date of service must be reported for all services. The order date for a test or procedure will not be accepted.
- For measures requiring a result to be entered, such as blood pressure readings, BMI value or percentile, or HbA1C result, the submitted supplemental data must match the result documented in the patient's medical record.
- Any supplemental data submitted is subject to audit.
- Practices must have Microsoft Excel or appropriate software.
- BCBSRI cannot provide technical and software support on the installation and use of Excel, including any Microsoft Office Suite products.
- Practices should have independent knowledge on installing and using Excel spreadsheets, along with other third party software programs.

If providers wish to submit supplemental data, they must notify BCBSRI that they wish to receive the Excel file. Providers can email ***ProviderRelations@bcbsri.org.***

VI. Participation Rules and Requirements

- Program does not include members participating in BCBSRI's Federal Employee Plan (FEP), Classic Blue plan, New England Health Plan Home with a PCP outside of Rhode Island, or New England Health Plan Host.
- Incentives will be calculated at the individual provider level (Type 1 NPI, Type 2 NPI, and Tax ID).
- If a provider belongs to a system of care (SOC) that has contractual responsibilities for quality, the incentive payment and all reporting will be sent to the SOC. The SOC will be responsible for paying the incentive to its providers, in accordance with the terms of the contract between the SOC and provider.
- Providers must be active and participating within BCBSRI's network, as of October 1, 2018 to receive an incentive payment.
- Payments will be made via electronic funds transfer, if banking information is on file with BCBSRI. Otherwise, payment will be made by check.
- The claims data and supplemental information that you provide to BCBSRI will be used for making payments for the 2018 PCP Quality Incentive Program. Supplemental data must match the data found in the patient's medical record.
- The patient panel for each provider will be frozen as of October 1, 2018 for the purposes of 2018 PCP Quality Incentive Program. However, gaps in care may continue to be identified until December 1, 2018 for members who are part of a provider's panel.
- Incentives will be calculated based on a provider's affiliation in BCBSRI's internal databases, as of October 1, 2018. SOCs and practice sites are required to notify BCBSRI, via a Practitioner Change Form, when a provider joins or leaves a practice. There are no appeals of the incentive calculation if notification to BCBSRI did not occur prior October 1, 2018.
- BCBSRI reserves the right to recover overpayment, should we discover that we have overpaid on an incentive payment.
- BCBSRI will not pay interest on incentives, should the payment be made later than the documented payment date found in this handbook.
- BCBSRI reserves the right to remove or modify a measure that is part of this program, if the measure is removed or retired by the entity that is the source of the measure.
- Any self-reported supplemental data is subject to medical record review and audit. BCBSRI reserves the right to implement financial penalties for any errors found upon review or audit.
- BCBSRI reserves the right to audit any information received. Random audits will be performed.

VII. Measure Targets and Payouts

The payment schedule for Base, Tier 1, and Tier 2 varies by product and, in some instances, by measure, allowing higher potential payouts for measures where improvement is critical.

2018 BlueCHiP for Medicare Targets and Payouts

Count	Measure	Tier 1 Target	Tier 2 Target	Base Payment	Tier 1 Payment	Tier 2 Payment
1	Breast Cancer Screening	84%	90%	$10	$50	$75
2	Adult BMI Assessment	98%	100%	$10	$50	$75
3	Diabetes – Hemoglobin A1c Control ≤9%	85%	90%	$10	$50	$75
4	Diabetes – Nephropathy Screening	98%	100%	$10	$50	$75
5	Diabetes – Eye Exam	81%	85%	$10	$50	$75
6	Controlling High Blood Pressure	86%	90%	$10	$50	$75
7	Colorectal Cancer Screening	80%	85%	$10	$50	$75

2018 Commercial Targets and Payouts: Adult Measures

Count	Measure	Tier 1 Target	Tier 2 Target	Base Payment	Tier 1 Payment	Tier 2 Payment
1	Breast Cancer Screening	82%	85%	$5	$25	$37.50
2	Adult BMI Assessment	90%	94%	$5	$25	$37.50
3	Diabetes – Hemoglobin A1c Control <8%	69%	72%	$5	$25	$37.50
4	Diabetes – Nephropathy Screening	93%	96%	$5	$25	$37.50
5	Diabetes – Eye Exam	76%	79%	$5	$25	$37.50
6	Controlling High Blood Pressure	80%	82%	$5	$25	$37.50
7	Colorectal Cancer Screening	80%	82%	$5	$25	$37.50
8	Tobacco Use: Screening and Cessation Intervention	NA	65%	$.50	NA	$1.50

2018 Commercial Targets and Payouts: Pediatric Measures

Count	Measure	Tier 1 Target	Tier 2 Target	Base Payment	Tier 1 Payment	Tier 2 Payment
1	Well-Child Counseling for Nutrition	90%	92%	$5	$25	$37.50
2	Well-Child Counseling for Physical Activity	85%	87%	$5	$25	$37.50
3	Well-Child BMI Assessment	90%	92%	$5	$25	$37.50
4	Adolescent Immunization Status – Combination 2	38%	40%	$5	$25	$37.50
5	Developmental Screening in the First Three Years of Life – Age 1	N/A	70%	$.50	N/A	$1.50
6	Developmental Screening in the First Three Years of Life – Age 2	N/A	70%	$.50	N/A	$1.50
7	Developmental Screening in the First Three Years of Life – Age 3	N/A	70%	$.50	N/A	$1.50

Examples of Potential Payments

Medicare

Measure	# of Eligible Members	# of Compliant Members	Compliance Rate	Payment Level	Payment Rate	Amount Earned
Breast Cancer Screening	59	50	85%	Tier 1	$50	$2,500
Adult BMI Assessment	186	180	97%	Base	$10	$1,800
Diabetes – Hemoglobin A1c Control ≤9%	31	26	84%	Base	$10	$260
Diabetes – Nephropathy Screening	31	31	100%	Tier 2	$75	$2,325
Diabetes – Eye Exam	31	25	81%	Base	$10	$250
Controlling High Blood Pressure	64	50	78%	Base	$10	$500
Colorectal Cancer Screening	48	40	83%	Tier 1	$50	$2000
Total Incentive (Medicare)						$9,635
Quality Bonus (Medicare)	**450**	**402**	**89%**			$0
Total (Medicare)						$9,635

Commercial Adult

Measure	# of Eligible Members	# of Compliant Members	Compliance Rate	Payment Level	Payment Rate	Amount Earned
Breast Cancer Screening	119	100	84%	Tier 1	$25	$2,500
Adult BMI Assessment	158	150	95%	Tier 2	$37.50	$5,625
Diabetes – Hemoglobin A1c Control <8%	40	30	75%	Tier 2	$37.50	$1,125
Diabetes – Nephropathy Screening	40	35	88%	Base	$5	$175
Diabetes – Eye Exam	40	35	88%	Tier 2	$37.50	$1,312.50
Controlling High Blood Pressure	151	145	96%	Tier 2	$37.50	$5,437.50
Colorectal Cancer Screening	29	29	100%	Base	$5	$145
Tobacco Use: Screening and Cessation Intervention	10	10	100%	Base	$.50	$5
Total Incentive (Commercial)						$16,325
Quality Bonus (Commercial)	587	534	91%			$1,632.50
Total (Commercial)						$17,957.50
Grand Total						$27,592.50

VIII. Attribution Methodology

A member's PCP is determined through BCBSRI's attribution process, as listed below:

- Self-selection (i.e., a member selects their PCP). This step is only used when:
  - The member's plan requires PCP selection, and
  - The PCP's name appears on the member's ID card.

If no PCP has been self-selected, then:

- Using the most recent 24 months of claims data, the PCP with the most recent well visit (CPT codes: 99381–99387, 99391–99397) is attributed as the PCP.

If there is no well visit, then:

- Using the most recent 24 months of claims data, the PCP with the greatest number of sick visits (CPT codes: 99201–99205, 99211–99215) is attributed as the PCP. In the event of two or more PCPs having the same number of sick visits, the PCP with the most recent sick visit will be attributed as the PCP.

Excluded Members

Members excluded from the 2018 PCP Quality Incentive Program include:

- Members participating in BCBSRI's Federal Employee Program
- Classic Blue members
- New England Health Plan Home members with a PCP outside of Rhode Island
- New England Health Plan Host members
- Medicare Advantage members residing in a long term-care facility
- Members actively receiving hospice care (hospice care defined as members who begin home-based or facility-based hospice coverage.)

Attribution of members and PCP assignments cannot be appealed.

IX. Detailed Measure Descriptions

Breast Cancer Screening	
Measure Definition	Female members aged 50–74 who had a mammogram to screen for breast cancer between October 1, 2016 and December 31, 2018.
Measure Source	HEDIS 2018
Age Criteria	Member is female and is 52–74 years old as of December 31, 2018.
Qualifying Event Criteria	N/A
Measurement Period	October 1, 2016 – December 31, 2018
Exclusions	Bilateral mastectomy at any time during the member's history through December 31, 2018. Any of the following meet the criteria: • Bilateral mastectomy • Unilateral mastectomy with a bilateral modifier • Two unilateral mastectomies on different dates of service with service dates 14 or more days apart • Both of the following on the same or different dates of service: - Unilateral mastectomy with a left-side modifier - Unilateral mastectomy with a right-side modifier Does not count biopsies, breast ultrasounds or MRIs toward the numerator for this measure. Exclusions for Medicare members only: • Enrolled in an Institutional SNF anytime in 2018 • Living long-term in an institution any time during 2018
Line(s) of Business	Medicare Adult, Commercial Adult

Adult BMI Assessment	
Measure Definition	Members aged 18–74 who had an outpatient visit during 2018 or the year prior, and whose body mass index (BMI) was documented during 2018 or 2017. For members 20 years and older on the date of service, documentation must indicate the weight and BMI value. The weight and BMI must be from the same data source. For members younger than 20 years on the date of service, documentation must include the height, weight, and BMI percentile documented during 2018 or 2017. The height, weight, and BMI percentile must be from the same data source. For BMI percentile, the following documentation meets criteria: • BMI percentile documented as a value (e.g., 85th percentile) • BMI percentile plotted on an age-growth chart Ranges and thresholds do not meet criteria for this indicator. A distinct BMI value or percentile, if applicable, is required for numerator compliance. Documentation of >99% or <1% meet criteria because a distinct BMI percentile is evident.
Measure Source	HEDIS 2018
Age Criteria	Member is 18 years as of January 1, 2017 to 74 years as of December 31, 2018.
Qualifying Event Criteria	Member has a claim for an outpatient visit during 2018 or 2017.
Measurement Period	January 1, 2017 – December 31, 2018
Exclusions	Members who have a diagnosis of pregnancy during 2018 or 2017
Line(s) of Business	Medicare Adult, Commercial Adult
Codes	ICD-10CM® Codes to Identify BMI • Adult BMI Value: Z68.1–Z68.45 • BMI Percentile: Z68.51–Z68.54

Diabetes – Hemoglobin A1c Control ≤ 9% – Medicare	
Measure Definition	Members aged 18–75 with diabetes (type 1 and type 2) whose HbA1c was documented as ≤9% as of the end of 2018.
Measure Source	HEDIS 2018
Age Criteria	Member is 18–75 years as of December 31, 2018.
Qualifying Event Criteria	Member meets any of the following criteria during 2018 or 2017: • At least two of the following visit types, on different dates of service, with a diagnosis of diabetes: - Outpatient - Emergency department - Observation - Non-acute inpatient • At least one acute inpatient encounter with a diagnosis of diabetes • Was dispensed insulin or hypoglycemic/antihyperglycemics on an ambulatory basis
Measurement Period	January 1, 2018 – December 31, 2018
Exclusions	Members are excluded if they do not have a diagnosis of diabetes, in any setting, during 2018 or 2017 **and** have a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during 2018 or 2017.
Line(s) of Business	Medicare Adult
Codes	CPT Category II Codes to Identify Hemoglobin A1c Levels • A1c <7: 3044F • A1c 7–9: 3045F • A1c >9: 3046F

Diabetes – Hemoglobin A1c Control <8% – Commercial	
Measure Definition	Members aged 18–75 with diabetes (type 1 and type 2) whose HbA1c was documented as <8% as of the end of 2018
Measure Source	HEDIS 2018
Age Criteria	Member is 18–75 years as of December 31, 2018.
Qualifying Event Criteria	Member meets any of the following criteria during 2018 or 2017: • At least two of the following visit types, on different dates of service, with a diagnosis of diabetes: - Outpatient - Emergency department - Observation - Non-acute inpatient • At least one acute inpatient encounter with a diagnosis of diabetes • Was dispensed insulin or hypoglycemic/antihyperglycemics on an ambulatory basis
Measurement Period	January 1, 2018 – December 31, 2018
Exclusions	Members are excluded if they do not have a diagnosis of diabetes, in any setting, during 2018 or 2017 **and** have a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during 2018 or 2017.
Line(s) of Business	Commercial Adult
Codes	CPT Category II Codes to Identify Hemoglobin A1c Levels • A1c <7: 3044F • A1c >9: 3046F Do not use code 3045F for Commercial members. That code does not designate that the HbA1c was less than 8%.

Diabetes – Nephropathy Screening	
Measure Definition	Members aged 18–75 with diabetes (type 1 and type 2) who had a nephropathy screening test or evidence of nephropathy during 2018. This includes members who had one of the following: • A urine test for albumin or protein including: - 24-hour urine for albumin or protein - Timed urine for albumin or protein - Spot urine (e.g. urine dipstick or test strip) for albumin or protein - Urine for albumin/creatinine ratio - 24-hour urine for total protein - Random urine for protein/creatinine ratio • Evidence of treatment for nephropathy or ACE/ARB therapy • Evidence of stage 4 chronic kidney disease • Evidence of end-stage renal disease • Evidence of kidney transplant • A visit with a nephrologist (no restriction on the diagnosis or procedure code submitted) • At least one ACE inhibitor or ARB dispensing event
Measure Source	HEDIS 2018
Age Criteria	Member is 18–75 years as of December 31, 2018.
Qualifying Event Criteria	Member meets any of the following criteria during 2018 or 2017. • At least two of the following visit types, on different dates of service, with a diagnosis of diabetes: - Outpatient - Emergency department - Observation - Non-acute inpatient • At least one acute inpatient encounter with a diagnosis of diabetes • Dispensed insulin or hypoglycemic/antihyperglycemics on an ambulatory basis
Measurement Period	January 1, 2018 – December 31, 2018
Exclusions	Members are excluded if they do not have a diagnosis of diabetes, in any setting, during 2018 or 2017 **and** have a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during 2018 or 2017.
Line(s) of Business	Medicare Adult, Commercial Adult
Codes	Code to Identify Chronic Kidney Disease • ICD-10 CM Code: N18.4 Codes to Identify ESRD • ICD-10 CM Codes: N18.5, N18.6, Z91.15, Z99.2

	Codes to Identify Kidney Transplant • ICD-10 CM Code: Z94.0 Nephropathy Screening • CPT Codes: 81000–81005, 82042–82044,84156 • CPT Category II Codes: 3060F, 3061F, 3062F Nephropathy Treatment • CPT Category II Codes: 3066F, 4010F ICD-10 CM Codes: • E08.21, E08.22, E08.29, E09.21, E09.22, E09.29, E10.21, E10.22, E10.29, E11.21, E11.22, E11.29, E13.21, E13.22, E13.29, I12.0, I12.9, I13.0, I13.10, I13.11, I13.2, I15.0, I15.1, N00.0–N08, N14.0–N14.4, N17.0–N19, N25.0–N25.9, N26.1–N26.9, Q60.0–Q60.6, Q61.00–Q61.02, Q61.11, Q61.19, Q61.2–Q61.9, R80.0–R80.9

Diabetes – Eye Exam	
Measure Definition	Members aged 18–75 with diabetes (type 1 and type 2) who had an eye screening for diabetic retinal disease. This includes diabetics who had one of the following: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in 2018 • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in 2017 • Bilateral eye enucleation any time during the member's history through December 31,2018.
Measure Source	HEDIS 2018
Age Criteria	Member is 18–75 years as of December 31, 2018.
Qualifying Event Criteria	Member meets any of the following criteria during 2018 or 2017. • At least two of the following visit types, on different dates of service, with a diagnosis of diabetes: - Outpatient - Emergency department - Observation - Non-acute inpatient • At least one acute inpatient encounter with a diagnosis of diabetes • Was dispensed insulin or hypoglycemic/antihyperglycemics on an ambulatory basis
Measurement Period	January 1, 2018 – December 31, 2018
Exclusions	Members are excluded if they do not have a diagnosis of diabetes, in any setting, during 2018 or 2017 and have a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during 2018 or 2017.
Line(s) of Business	Medicare Adult, Commercial Adult
Codes	CPT Category II Codes to Identify Diabetic Retinal Screening with an Eye Care Professional • 2022F – Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed • 2024F – Seven standard field stereoscopic photos with interpretation by an ophthalmologist documented and reviewed • 2026F – Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed CPT Category II Code to Identify Diabetic Retinal Screenings Negative for Retinopathy • 3072F – Low risk for retinopathy (no evidence of retinopathy in the prior year)

Controlling High Blood Pressure	
Measure Definition	Members aged 18–85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled as of the end of 2018. Results must be from the last blood pressure reading in 2018. Adequate blood pressure control is defined as : • Less than 140/90 for members 18-59 years of age • Less than 140/90 for members 60-85 years of age with a diagnosis of diabetes • Less than 150/90 for members 60-85 years of age without a diagnosis of diabetes
Measure Source	HEDIS 2018
Age Criteria	Member is 18–85 years as of December 31, 2018.
Qualifying Event Criteria	Members are identified as hypertensive if there is at least one outpatient visit with a diagnosis of hypertension during the first six months of 2018.
Measurement Period	January 1, 2018 – December 31, 2018
Exclusions	The following members are excluded: • All members with evidence of end-stage renal disease (ESRD) or kidney transplant on or prior to December 31, 2018 (Medical record must include a dated note indicating evidence of ESRD, kidney transplant, or dialysis.) • All members with a diagnosis of pregnancy during 2018 • All members who had a non-acute inpatient admission during 2018 Exclusions for Medicare Members only: • Enrolled in an Institutional SNF anytime in 2018 • Living long-term in an institution any time during 2018
Line(s) of Business	Medicare Adult, Commercial Adult
Codes	CPT Category II Codes to Identify Blood Pressure Results: • 3074F - Most recent systolic blood pressure less than 130 • 3075F - Most recent systolic blood pressure between 130-139 • 3078F - Most recent diastolic blood pressure less than 80 • 3079F - Most recent diastolic blood pressure between 80-89

Colorectal Cancer Screening	
Measure Definition	Members aged 50–75 who had appropriate screening for colorectal cancer. Any of the following are compliant: • Fecal occult blood test during 2018 • Flexible sigmoidoscopy during 2018 or the four years prior to 2018 • Colonoscopy during 2018 or the nine years prior to 2018 • CT colonography during 2018 or the four years prior to 2018 • FIT-DNA (Cologuard) test during 2018 or the two years prior to 2018
Measure Source	HEDIS 2018
Age Criteria	Member is 51–75 years as of December 31, 2018
Qualifying Event Criteria	N/A
Measurement Period	January 1, 2018 – December 31, 2018
Exclusions	Either of the following at any time in the member's history through December 31, 2018: • Colorectal cancer • Total colectomy Exclusions for Medicare Members only: • Enrolled in an Institutional SNF anytime in 2018 • Living long-term in an institution any time during 2018
Line(s) of Business	Medicare Adult, Commercial Adult
Codes	Codes to Identify Fecal Occult Blood Screening • CPT Codes: 82270, 82274 • HCPCS Code: G0328 Codes to Identify FIT-DNA Test • CPT Code: 81528 • HCPCS Code: G0464

Well-Child Counseling for Nutrition	
Measure Definition	Members aged 3 to 17 who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition documented during 2018. Documentation must include a note indicating the date and at least one of the following: • Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors) • Checklist indicating nutrition was addressed • Counseling or referral for nutrition education • Member receiving educational materials on nutrition during a face- to-face visit • Anticipatory guidance for nutrition • Weight or obesity counseling Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit. Services specific to assessment or treatment of an acute or chronic condition do not count toward the measure. Documentation related to a member's appetite or an observation such as well-nourished alone is not compliant because it does not indicate counseling for nutrition.
Measure Source	HEDIS 2018
Age Criteria	Member is 3 to 17 years of age as of December 31, 2018.
Qualifying Event Criteria	Member has a claim for an outpatient visit with a PCP or OB/GYN during 2018.
Measurement Period	January 1, 2018 – December 31, 2018
Exclusions	Members who have a diagnosis of pregnancy during 2018.
Line(s) of Business	Commercial Pediatric
Codes	Identification of Well-Child Counseling for Nutrition • CPT Codes: 97802–97804 • HCPCS Codes: G0270, G0271, G0447, S9449, S9452, S9470 • ICD-10CM Codes: Z71.3

Well-Child Counseling for Physical Activity	
Measure Definition	Members aged 3 to 17 who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity documented during 2018. Documentation must include a note indicating the date and at least one of the following: • Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation) • Checklist indicating physical activity was addressed • Counseling or referral for physical activity • Member receiving educational materials on physical activity during a face-to-face visit • Anticipatory guidance specific to the child's physical activity • Weight or obesity counseling Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit. Services specific to assessment or treatment of an acute or chronic condition do not count toward the measure.
Measure Source	HEDIS 2018
Age Criteria	Member is 3 to 17 years of age as of December 31, 2018.
Qualifying Event Criteria	Member has a claim for an outpatient visit with a PCP or OB/GYN during 2018.
Measurement Period	January 1, 2018 – December 31, 2018
Exclusions	Members who have a diagnosis of pregnancy during 2018.
Line(s) of Business	Commercial Pediatric
Codes	Identification of Well-Child Counseling for Physical Activity • HCPCS Codes: G0447, S9451 • ICD-10CM Code: Z02.5, Z71.82

Well-Child BMI Assessment	
Measure Definition	Members aged 3 to 17 who had an outpatient visit with a PCP or OB/GYN and who had a BMI percentile documented during 2018. Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value. Documentation must include height, weight, and BMI percentile. The height, weight, and BMI percentile must be from the same data source. Either of the following meets criteria for BMI percentile: • BMI percentile documented as a value (e.g., 85th percentile) • BMI percentile plotted on age-growth chart Ranges and thresholds do not meet criteria for this indicator. A distinct BMI percentile is required for numerator compliance. Documentation of >99% or <1% meet criteria because a distinct BMI percentile is evident (i.e., 100% or 0%).
Measure Source	HEDIS 2018
Age Criteria	Member is 3 to 17 years of age as of December 31, 2018.
Qualifying Event Criteria	Member has a claim for an outpatient visit with a PCP or OB/GYN during 2018.
Measurement Period	January 1, 2018 – December 31, 2018
Exclusions	Members who have a diagnosis of pregnancy during 2018.
Line(s) of Business	Commercial Pediatric
Codes	Codes to Identify Well-Child BMI Assessment • ICD-10 CM BMI Percentile Codes: Z68.51, Z68.52, Z68.53, Z68.54

Adolescent Immunization Status – Combination 2	
Measure Definition	Adolescents 13 years of age who had the following vaccinations by their 13th birthday: • One meningococcal conjugate vaccine between the member's 11th and 13th birthdays, and • One tetanus, diphtheria toxoids, and acellular pertussis vaccine (Tdap), between the member's 10th and 13th birthdays. • Completed the HPV vaccine series by receiving EITHER at least 2 HPV vaccines with dates of service at least 146 days apart between the member's 9th and 13th birthdays; OR at least 3 HPV vaccines between the member's 9th and 13th birthdays
Measure Source	HEDIS 2018
Age Criteria	Adolescents who turn 13 years of age during 2018
Qualifying Event Criteria	Turned 13 years of age during 2018
Measurement Period	Age 9 to 13
Exclusions	Anaphylactic reaction to the vaccine or its components.
Line(s) of Business	Commercial Pediatric
Codes	Codes for Immunizations • Meningococcal: 90734 • Tdap: 90715 • HPV: 90649, 90650, 90651

Developmental Screening in the First Three Years of Life	
Measure Definitions	Members who are screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday. This measure identifies children who were screened for risk of developmental, behavioral, or social delays using a standardized tool. Tools must meet the following criteria: • *Developmental domains*. The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional. • *Established reliability.* Reliability scores must be approximately 0.70 or above. • *Established findings regarding the validity*. Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and use an appropriate standardized developmental or social-emotional assessment instrument(s). • *Established sensitivity/specificity*. Sensitivity and specificity scores must be approximately 0.70 or above. Current recommended tools that meet these criteria: • Ages and Stages Questionnaire (ASQ): 2 months to 5 years • Ages and Stages Questionnaire (ASQ-3) • Battelle Developmental Inventory Screening Tool (BDI-ST): Birth to 95 months • Bayley Infant Neuro-developmental Screener (BINS): 3 months to 2 years • Brigance Screens II: Birth to 90 months • Child Development Inventory (CDI): 18 months to 6 years • Infant Developmental Inventory: Birth to 18 months • Parents' Evaluation of Developmental Status (PEDS): Birth to 8 years • Parents' Evaluation of Developmental Status: Developmental Milestones (PEDS-DM) • Survey of Wellbeing of Young Children (SWYC)
Measure Source	Oregon Pediatric Improvement Partnership at Oregon Health and Science University
Age Criteria	Member turns 1, 2, or 3 years of age during 2018. Three separate rates are calculated, one for each age category.
Qualifying Event Criteria	None
Measurement Period	January 1, 2018 – December 31, 2018

Exclusions	None
Line(s) of Business	Commercial Pediatric
Codes	Codes to Identify Developmental Screening • CPT-4 Codes: 96110

Tobacco Use: Screening and Cessation Intervention	
Measure Definition	The percentage of members age 18 and older who were screened for tobacco use one or more times within 24 months and who received cessation counseling intervention if identified as a tobacco user. *Tobacco Use* – includes any type of tobacco *Tobacco Cessation Intervention* – Includes brief counseling (3 minutes or less) and/or pharmacotherapy
Measure Source	National Quality Forum
Age Criteria	18 years of age or older as of December 31, 2018.
Qualifying Event Criteria	Had encounter during the measurement period.
Measurement Period	January 1, 2017 – December 31, 2018
Exclusions	Members for whom tobacco screening was not performed for medical reasons.
Line(s) of Business	Commercial Adult
Codes	CPT Category II code to identify tobacco use screening and cessation intervention: • 4004F CPT Category II code to identify tobacco use screening and identified as non-user of tobacco: • 1036F CPT Category II code to identify tobacco screening not performed for medical reasons (Exclusion): • 4004F with modifier 1P

X. Reference Guide

- Providers must have a minimum of 30 patients in a measure's denominator to be eligible for Tier 1 and Tier 2 payouts. Providers with less than 30 patients in a measure's denominator will receive the base payment for that measure.
- If a measure is hybrid, or has a measurement period that spans multiple years (e.g., Colorectal Cancer Screening, Diabetic Eye Exam), payment will be made to the provider for each year that the gap is closed, and the member is compliant for that measure. Example: If a member has a colonoscopy in 2017, the provider will receive payout on that measure, each year, for the entire 10 years that the member is compliant for that measure.
- If a provider belongs to an SOC, all reporting around that provider's PCP Quality Incentive Program performance will go to the SOC.
- BCBSRI is not required to pay interest or penalties on late payments should they be delayed.
- Gap in care data follows the member, not the provider. Even if a provider closes and documents a gap, at the end of the analysis that provider will not get credit for the closed gap if the member has been reattributed to a new provider.
- BCBSRI will not allow for any deadline extensions. All data collections/analyses will start and end at the same time. BCBSRI cannot analyze, create, write, and/or run programs for specific shared savings/contracted groups to accommodate early or late payment calculations.
- Providers must be active within BCBSRI's internal documentation, as of October 1, 2018. **If a provider leaves the BCBSRI network between October 2, 2018 and December 31, 2018, no payment will be made.**
- Incentives will be calculated based on the provider's affiliation (i.e., SOC) in BCBSRI's internal documentation, as of **October 1, 2018**.
- If a member is associated with a PCP who is no longer active and the member is not reattributed to a PCP within the same practice site, that member will not be included in the final payment.
- If practices are wholly associated with an SOC, which all providers are associated with, the payment will be sent to the SOC.
- Payments will be based on membership that is attributed to the PCP as of **October 1, 2018**.
- BCBSRI will not accept appeals relative to practice sites wanting to add more data or disputing historically submitted data.
- Payment analysis will be conducted with data that is submitted by the provider or through claims. Errors in data submission that are not corrected before the deadline will not be available for correction.
- If a provider identifies an error in BCBSRI's calculation, BCBSRI will make the necessary adjustments. Please contact your BCBSRI Provider Relations representative at ProviderRelations@bcbsri.org, should you feel that there is an error in your payout.
- Payments cannot be split when a new relationship with an SOC has occurred. Where the provider is located at the end of the year is where the payment will be calculated and sent to.
- Even though BCBSRI will identify money left on the table, you cannot submit

additional data to earn additional incentive dollars after the data submission deadline has ended.

- Compliance rates are calculated at two decimal places. There is no rounding when determining the payment levels.
- Participants of the PQIP program must have an active email address to exchange communication with BCBSRI.
- Each provider participating in the PQIP program must supply BCBSRI with a point of contact for the PQIP program, and the role of that individual within the provider's office/practice.

XI. FAQs

What if I don't submit data by the date required in 2019?
For those gaps in care closures not captured through claims submissions, you will have from mid-January 2019 through **February 15, 2019** to provide supplemental data. No exceptions will be made beyond that date. Please note that the actual date of service must be reported for all services. The order date for a test or procedure will not be accepted.

When will we receive payment?
We will need time for claims to process before we can provide accurate information and missing data elements. Then we will need to tabulate responses from providers who submit supplemental data. We expect that payment will be made in September 2019.

Please be advised that if you are in a system of care (SOC), payment distribution may be different, based on contractual terms.

How do you determine who our patients are?
For BlueCHiP for Medicare and plans that require PCP selection, we use the member self-selection. If the member's plan does not require PCP selection, we use claims to attribute the member to a PCP. Year-end results will be based on attribution as of October 1, 2018. This allows the notified provider to be aware of their panel. Please see Section IV on page 10 for details on our attribution methodology.

What if the patient refuses to do what we order/request?
We recognize that many factors influence patient adherence to recommendations. There may be clinical reasons why some patients may not receive the services suggested by the general guidelines. Patient choice and patient-specific clinical judgment remain essential. Payout targets reflect these factors as they are benchmarked against national comparisons.

We do hope, however, that you will address barriers to care with your patients. As appropriate, seek assistance addressing these barriers by contacting BCBSRI's Care Coordination program by calling (401) 459-CARE (2273) or emailing triage_group@bcbsri.org.

What if I take height and weight, but did not calculate a BMI and record it at the visit?
The measure requires a BMI documented in the record. Documentation in the medical record for the Adult BMI measure must indicate the weight and BMI value, dated during 2017 or 2018. For the Well-Child BMI Assessment, measure documentation must include height, weight, and BMI percentile documented in 2018. This is consistent with documentation and coding guidelines.

If your practice has an electronic health record (EHR), please ensure it is calculating and recording the BMI after entering the patient's height and weight. In many (EHRs), this is a function that needs to be turned on in order to calculate BMI. In practices that routinely perform well on these measures, the clinical workflow includes obtaining and documenting a BMI at every visit, including sick visits, and submitting the appropriate ICD-10CM Codes (see page 13 for codes).

Will I get credit if the gynecologist or surgeon orders a mammogram or an endocrinologist does an A1c?
Yes, controlled A1c levels will need to be in your record, unless supplied to BCBSRI by the lab. BCBSRI will not be contacting hospitals, specialists, or other healthcare professionals with data requests.

What if the measure does not make sense for my patient? For example, a 70-year-old woman with advanced lung cancer does not need a mammogram.
The measures are methods designed to evaluate, generally, evidence-based care. Individual clinician judgment is important. Measures are not guidelines. For example, many clinicians order screening mammography annually, yet the measure accepts one study in the two calendar years. A case like the one described in the question is unlikely to be material in the overall results of any clinician with more than a few members. As mentioned in a previous answer, payout targets take these sort of instances into consideration.

Will we get credit if we can send you a test result even if you did not pay for it? For example, could we send an HbA1c from a hospital stay or a mammogram report?
Yes, you may use data from any source documented in your record (for example, if the service was provided at a Veteran's Administration hospital), or service was rendered while a member had non-BCBSRI coverage.

What is the base payment?
The base payment recognizes that every patient matters and allows incentive payments for those clinicians with smaller populations or populations who do not meet the higher performance thresholds in aggregate. However, the goal is to raise population performance. To do this, we provide incentives to raise the performance percentage in every measure. Therefore, threshold payments are also used.

Why did you pick 30 as a minimum for tiered payouts? What if I am 18/18 for a measure?
We use 30 as a reasonable minimum denominator for statistical purposes. It is the minimum used to calculate the CMS four and five-star quality ratings. These quality ratings are a valuable benchmark for the quality of Medicare Advantage plans and align with BCBSRI's goals of improving the patient experience, improving the health of populations, and reducing the cost of healthcare.