Frequently Asked Questions

In a Special Bulletin sent in early December 2008, Blue Cross and Blue Shield of Alabama introduced its Physician Quality and Transparency Program and used information from Healthcare Effectiveness and Data Information Set (HEDIS) to show how Blue Cross and Blue Shield of Alabama compares to national averages.

HEDIS originated in the late 1980s and is used nationally as a standard of excellence by Blue Cross Plans, Employers, Health systems and other commercial insurers. HEDIS measures were developed by the National Committee for Quality Assurance (NCQA), based on the input of physicians via medical advisory panels and multiple physician specialty organizations, such as The American College of Obstetrics and Gynecology, the United States Preventative Services Task Force, and the National Cancer Care Network. The measures are reviewed and revised each year by NCQA and various physician panels to ensure that the measures are in line with the most current evidence based medical practices and research.

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Program Information

1. Why is Blue Cross and Blue Shield of Alabama starting this program?

The program is an effort to improve the health and safety of Alabamians. The Physician Quality and Transparency Program was founded as a response to our customers' demands for greater transparency on quality and outcomes related information.

The goal of this program is to provide meaningful, accurate, and actionable feedback for an individual physician's practice in order to increase the overall health of Alabama. It also serves as a method of recognition for the delivery of evidence based medical care in selected preventive and treatment services.

2. Will I have to explain this program to members?

Patients will likely have some questions. We will provide educational materials for our members. Also, questions from patients can be referred the customer service number on the back of their insurance card.

3. Did Blue Cross seek input from any external groups in developing this program?

Yes, Blue Cross worked closely with the officers and members of the Medical Association of the State of Alabama (MASA), leadership from Alabama Quality Assurance Foundation (AQAF), the Alabama Hospital Association (AlaHA), and with various medical specialty societies to select the clinical quality indicators.

In addition, Blue Cross utilized a Quality Collaborative Committee. The Quality Collaborative Committee was formed in response to our customers' demands for greater transparency on quality measures and related information. The group consists of leaders from the physician community, hospitals, business, and Blue Cross and Blue Shield of Alabama. The Quality Collaborative Committee has been instrumental in incorporating multiple perspectives into the design of the program.

4. What other states are doing programs like this?

Other health plans in other states have implemented similar programs. In addition to private insurance programs, such as those Blue Cross Blue Shield plans in other states, many states have legislated mandatory reporting. Colorado, Pennsylvania, Minnesota, and New Jersey are a few examples.

5. Are there any other Blue Cross Plans are doing this?

Many Blue Cross Plans across the country have implemented quality-based incentive programs and provider transparency programs. Here is a list of the Plans:

- Blue Cross Blue Shield of Tennessee
- Health Care Service Corporation (Blue Cross and Blue Shield of Illinois, Texas, and Oklahoma)
- Hawaii Medial Service Association (Blue Cross Blue Shield Hawaii)
- Regence BlueShield (Idaho, Oregon and Washington)
- Blue Cross and Blue Shield of Minnesota
- Blue Cross and Blue Shield of Florida, Inc.
- Blue Shield of California
- Blue Cross and Blue Shield of Georgia
- Hawaii Medical Service Association
- Blue Cross of Idaho
- Wellmark Blue Cross and Blue Shield (Iowa, South Dakota)
- Premera Blue Cross and Blue Shield (Alaska, Washington)
- Blue Cross and Blue Shield of Kansas
- Blue Cross and Blue Shield Louisiana
- Blue Cross and Blue Shield of Michigan
- Blue Cross and Blue Shield of Kansas City
- Blue Cross and Blue Shield of Montana
- Blue Cross and Blue Shield of Nebraska
- Empire BlueCross BlueShield (New York)
- Excellus BlueCross BlueShield (New York)
- Blue Shield of Northeastern New York
- Blue Cross Blue Shield Western New York
- Blue Cross Blue Shield of North Dakota
- Capital Blue Cross (Pennsylvania)
- Highmark Blue Cross Blue Shield(Pennsylvania)
- Independence Blue Cross (Pennsylvania)
- Blue Cross Blue Shield of Rhode Island
- Horizon Blue Cross Blue Shield of New Jersey
- Blue Cross of Northeastern Pennsylvania
- Blue Cross and Blue Shield of North Carolina
- Blue Cross Blue Shield Massachusetts
- Anthem Blue Cross Blue Shield (California (Blue Cross), Colorado, Connecticut, Kentucky, Indiana, Maine, Missouri, New Hampshire, Ohio, Virginia)
- Blue Cross and Blue Shield of South Carolina
- CareFirst, Inc.
- Blue Cross and Blue Shield of Montana
- Arkansas Blue Cross and Blue Shield

Additionally, many other commercial health insurers and quality organizations are doing similar activities.

Physician Quality Indicators

1. What type of measures will be dedicated to physician practices?

The measures are broken down into various categories such as diagnosis, screening, prevention, medication monitoring, disease management, medication adherence, and effectiveness of care. The measures dedicated to physicians will be determined by the types of patients the physician sees. For example, a cardiologist may be attributed to the indicator "ACE Inhibitor Use in Heart Failure," while a pediatrician may be attributed to the indicator "Childhood Immunizations for Measles, Mumps, and Rubella."

2. Why were these measurements selected?

There were several factors considered when selecting quality indicators including the level of clinical evidence to support the measure and statewide concerns about common conditions such as diabetes and obesity. In addition, current initiatives and programs within Blue Cross and across the state were considered. Finally, the ability to accurately measure the clinical quality indicator using claims data was a determining factor.

3. Where are the measures coming from?

Initially, the measures are based on clinical benchmarks that are endorsed by national standards making bodies, such as the NCQA, the National Quality Forum (NQF) and guidelines and recommendations from various specialty organizations.

4. What does it mean to be endorsed by the NCQA or the NQF?

The NCQA and the NQF are impartial organizations that are dedicated to the improvement of healthcare quality across the country. When a measure is endorsed by either of these independent quality agencies, the measure has been thoroughly vetted by physicians and clinical quality experts.

5. Will the list of measures change or expand?

Yes, as the program develops, more of the physician facing measures will be transitioned to consumer facing measures as issues are addressed and concerns handled.

6. Will all physicians have the same measures?

No, physician data will be determined by the type of patients that the doctor sees and his or her peer specialty.

7. Can we review the measure definitions?

Yes, the measure definitions and source information including the medical literature referenced will be available at **Blue Cross provider web site** under "View the Current List of Physician Quality Indicators." These documents also include exact definitions for inclusion and exclusion from the "numerator" and the "denominator" used in the calculations, as well as a checklist of information that will be needed for self-reporting for each measure. The measure definitions are also available within the HBI self-reporting tool.

9. Although it is no longer available, the PROQUAD vaccine combined the MMR with the Varicella-Zoster Virus vaccine and was available during the measurement year (7/1/2007-6/30/2008). Many of my pediatric patients received this vaccine, but I am not seeing this reflected when I check my self-reported data. Why is this and how can it be corrected?
Credit is given for the PROQUAD vaccine if the physician filed CPT code 90710. A patient who had a claim filed with CPT 90710 would show as having received both the MMR and the VZV vaccine, even though it was one injection.

For patients who are flagged as not having received an MMR or VZV vaccine, physicians may self-report (for either or both) if the patient in fact did receive the vaccine. Each vaccine must be self-reported separately, however, once information has been submitted for either one of the vaccines, the tool will automatically bring up a screen to allow data entry for the other vaccine as well (if applicable).

If the physician did file a claim with Blue Cross and Blue Shield of Alabama for CPT 90710 for a patient, but the patient is not showing as having received either the MMR or the VZV vaccine, you may send the doctor's name, NPI, and the list of patients impacted (name, date of birth, and member id) to the **ProviderQuality@bcbsal.org** email box for further investigation. Of course, you may also self-report this information as indicated above.

Data

1. How do I know that the data presented is correct?

With any quality initiative, it is a best practice to examine the data and the data analysis methods used in order to ensure that the information presented is accurate. Blue Cross employed multiple methods to ensure that the published HEDIS information was correctly presented.

- Blue Cross uses an NCQA certified vendor, DST Health Group, to process our calculations and to produce reports. This ensures that Blue Cross is following NCQA best practices in calculating and reporting the HEDIS rates. As a requirement for other components of our business, we submit our HEDIS process for an NCQA certified audit. The purpose of the audit is to assure fair and accurate reporting among all Blue Cross plans, not just Blue Cross and Blue Shield of Alabama. The audit is comprehensive in that it covers everything from claims processing to systems flowcharts to final report submission.
- Blue Cross has successfully passed two audits with high marks.

2. Who will be doing the attribution?

The attribution will be done by Health Benchmarks, Inc., an external vendor with whom Blue Cross has contracted.

3. Who is Health Benchmarks, Inc., and why were they selected?

Several vendors were reviewed in detail during the vendor selection process. Health Benchmarks, Inc. (HBI) is a leading applied health services research company that specializes in transforming healthcare data into meaningful, accurate, actionable information. HBI was selected based on their experience with other health insurance plans and their level of clinical expertise. They have over ten years of experience in this type of analysis.

4. What type of data is used?

The data is based on administrative claims information, which is then, in the case of some of the indicators, compared to HEDIS, a national standard that was developed by the NCQA.

5. Are denied claims used for the evaluation?

Yes, we understand that a claim for a particular test or service may be denied due to the contract benefit limitations. These claims are still counted. For example, a routine screening colonoscopy for a patient that does not currently have coverage for routine testing would be counted if a claim was submitted and denied.

6. What time period do these quality measures cover?

The different measures cover various time periods, ranging from six months to five years. The measures will be compared against up to five years of administrative claims data.

7. The Blue Cross and Blue Shield of Alabama claims processing system only reads the first diagnosis code on a claim, so how will the physician be given credit for HEDIS measures if that diagnosis is not picked up?
While the claim does process off the first diagnosis code, Blue Cross actually stores up to five diagnoses that are submitted on a claim. These codes are passed to our vendor HBI, Inc. for analysis. Any codes on the patient's claim are attributed to the patient, and any physician who treats that patient is given credit for the test.

8. Many of my patients get their prescriptions from stores that offer reduced price or free prescriptions. Is this information being collected by Blue Cross and Blue Shield of Alabama and will it impact my quality score?
For reduced price prescriptions, we can and do accept these claims, and this information was passed along to HBI for analysis. Blue Cross and Blue Shield of Alabama can only collect this information when a patient presents his or her drug card for prescriptions. For patients that choose to pay out of pocket costs and not present their insurance card (and the pharmacy has no record of their insurance), the information will not be collected.

The "free" prescriptions that are offered by some chains, such as Publix, only involve antibiotic prescriptions. While Blue Cross and Blue Shield of Alabama does not currently collect information on these "free" prescriptions, we have determined that the data is not having a negative impact on the measure involving antibiotics. The denominator for the Narrow Spectrum Antibiotics measure only includes members with a diagnosis of acute strep who filled a prescription for an antibiotic.

9. Does this program include diagnostic tests?
Yes

Attribution

1. What type of visits does this program cover?
The data is based on evaluating up to five years of administrative claims data for outpatient, face-to-face visits. Pharmacy, inpatient, outpatient, and diagnostic claims will be included in the evaluation. Only outpatient face-to-face visits will be used for linking a patient to a physician.

2. What is the methodology for attributing certain patients to certain physicians?
Health Benchmarks, Inc. uses a claims-based algorithm to attribute the care of patients to physicians who are considered responsible for providing a particular process of care. This algorithm was developed through the HBI Benchmarking, Inc. overseen database, which has data on over 30 million health plan members. The following are the three filters used to link patients to appropriate physicians:

- A physician must have a key event with the patient.
- The key event must occur in a predetermined timeframe.
- A physician must practice in an appropriate specialty area.

3. I have a patient who sees several others physicians. Will I get "credit" for the tests performed by the other physicians, or will I need to perform all the tests to receive "credit"?
Physicians will receive "credit" for a given service provided to a patient if the service is performed by you or another physician as long as that service occurred within a predetermined timeframe as outlined by the clinical quality indicator. For more information on the timeframes for each of the clinical quality indicators, please visit the **Blue Cross physician web site**.

4. I have a nurse practitioner in my practice who sees many of my patients for routine visits. How will these patient visits be attributed?
If a physician has seen the patient during the continuous enrollment period and filed a claim under their physician number, then the subsequent patient visits and testing would be attributed to that physician, even if a nurse practitioner performed the tests and follow up and filed under his or her provider number. If a nurse practioner working in your practice provides the service, that claim should be filed, as before, using the nurse practioner's provider number.

However, if the nurse practitioner is the only clinician within the practice to have ever seen the patient and to have filed a claim, the patient would not be attributed to the physician. The patient will not be included in the numerator or denominator for the physician's quality indicator. Blue Cross is currently working to address this matter.

5. Why were some physicians excluded?
No Preferred Medical Doctor (i.e., PPO participating physician) has been purposefully excluded from the program. Current measures were selected based on specialty and are mostly outpatient services. Blue Cross is working to expand this list to include inpatient measures, other specialties, and eventually outcomes data.

6. What does "continuous enrollment" mean?
For each measure, the patient must be continuously enrolled as a Blue Cross subscriber during the required period with no breaks in coverage. Currently, we are working five years of claims data.

7. Which patients will be included in this program?
All of our private business customers with primary coverage will be included in this program, including Blue Advantage and AllKids members. Medicare physician claims data cannot be included due to federal program restrictions. The member must have had continuous enrollment with Blue Cross and Blue Shield of Alabama during the period required for the measure to be included in the denominator for a measure. For example, the measure for Childhood Immunizations: MMR requires that the child be enrolled continuously for a year. If the child had Medicaid has their primary insurance anytime during that year, they are removed from the denominator.

Specialty

1. What is the methodology for assigning me to a practice specialty?

Blue Cross will use your peer specialty for this purpose. Peer specialty means Blue Cross uses data from claims submitted to us from your practice to help determine in which area of medicine you practice. Your peer specialty is what is currently used for the Preferred Medical Doctor (PMD) Profile.

2. Will the physician specialties not included be a part of future programs?

Yes, the program will expand in an attempt to incorporate the majority of PMD physicians. At this time, accepted measures are not available for all specialties.

3. What specialties are included in this program?

The following specialties could potentially have clinical quality indicators for the consumer and physician view or just the physician view:

- Adolescent Medicine
- Allergy/Immunology
- Cardiology
- Colon-Rectal Surgery
- Dermatology
- Emergency Medicine
- Endocrinology
- ENT
- Family Practice
- Gastroenterology
- General Practice
- General Surgery
- Geriatrics
- Infectious Disease
- Internal Medicine
- Nephrology
- Obstetrics/Gynecology
- Oncology
- Ophthalmology
- Optometry
- Orthopedics
- Pediatric Pulmonary
- Pediatrics
- Plastic/Reconstructive Surgery
- Preventive Medicine
- Public Health
- Pulmonary Diseases
- Rheumatology
- Surgical Oncology

4. I practice as two different specialties, but only one specialty is currently showing on the HBI On-Line physician web site. Why is this?

The program uses your peer specialty, the same as on your PMD profile. We had to limit each provider to one specialty type for this program. On our public view website, however, patients will be able to search for physicians by either specialty type.

If you believe that your practice patterns more reflect that of another specialty, we can review claims history and reassign as needed. Please send requests for review to **ProviderQuality@bcbsal.org**.

Physician View and Self-Reporting

1. Is there a self-reporting period in 2010? When does it start?
Yes, there will be a self-reporting period in 2010. The self-reporting period will start in early February 2010 and will last 60 days.

2. What measurement year does this self-reporting period cover?
The measurement year for this self-reporting period is July 1, 2008 through June 30, 2009.

3. I self-reported information for my patients last year. Will I have to reenter this information?
If the self-reported information is applicable to the measure and to the measure timeframe, then the information is stored by the system and will be carried over into this self-reporting period, giving "credit" that the test, screening or service was received by the patient. For example, if you self-reported that a female patient over 40 received a breast cancer screening on June 1, 2008, this would be applied to the information, and you would not need to self-report for this patient for this measure again.

4. Is there a way that I (or someone in my office) can reconcile and correct information?
Yes, data can be viewed through a web portal where you can update patient information ("self report" medical record data) and supplement additional tests and information that may not have been gleaned from claims data.

There will be a "self-report" mechanism for 11 measures in Phase I. This will allow the physician and his/her staff to supplement the administrative claims information. Reviewing your data is not a program requirement, but it is strongly recommended. This functionality will be available behind a secure sign-in thru *ProviderAccess*. Basic information from the chart will be required to supplement the record. Details on what information may or may not be needed for each measure is available at the **Blue Cross provider web site**. Additional questions can be sent to **ProviderQuality@bcbsal.org** or call 1 877 854-8430.

5. What is an example of how "self reporting" can be used?
Some measures will benefit more from self-reporting due to the timeframes outlined by the measures. For example, if a woman had a mastectomy during a time that she was not enrolled with Blue Cross and Blue Shield of Alabama, medical record data may be beneficial to include in the analysis as it applies to the breast cancer screening measure. This measure excludes women who have a mastectomy, and if a member underwent this procedure prior to enrollment with Blue Cross and Blue Shield of Alabama, that information may not be available via administrative claims data alone.

6. Why can I not self-report data for every measure?
The measures that have been chosen for self-reporting are those that, in HBI's experience, have commonly been identified as those that could be enhanced via medical record data. HBI continues to add functionality and additional measures to the web tool as we gather information and do extensive scientific research on each of the measures.

7. How many measures will be displayed for physicians?
Starting October 2009, physicians had the ability to view all 50 clinical quality measures.

8. Is this different than how many measures will be displayed for consumers?
In May 2010, up to 20 measures will be available for consumer view.

7. How will I know which measures that I can "self report" for?
The complete list of indicators is available at the **Blue Cross provider web site**, under "View the list of current Physician Quality Indicators." Measures that have a self-report capability are indicated and a checklist of the clinical information that may be needed from the chart is also available.

8. Where are the instructions on how to self-report?
The instructions for self-reporting are available on the **Blue Cross provider web site** under the link "HBI User Manual." There is also a tutorial with screen shots available.

9. I logged into *ProviderAccess* to self-report information and got a pop-up message explaining that I do not have the correct permissions to self-report. How do I correct this?
Your practice administrator should be able to update your permissions to include "Quality and Transparency." There are instructions for practice administrators on our **Blue Cross provider web site**. If there are additional questions about setting up permissions in *ProviderAccess*, please contact our EDI services department at 205 220-6899.

10. I submitted self-reporting information for a patient that was not correct, but I am now locked out of updating the patient's record again for that measure. How do I unlock this patient to correct the information that I previously reported?
Please send the provider ID, patient ID (as listed on the HBI tool), and the measure to **ProviderQuality@bcbsal.org**, and we will be happy to send your request directly to HBI.

11. **My patient has had a procedure that excludes him/her from a measure. The procedure was performed before the person was my patient, and the information is not in the chart. How do I self-report this information?**
In some cases, the exact date of a procedure may not be known. If there is evidence in the chart that the procedure was performed at some point in the patient's history, it is acceptable to enter a "best estimate" for the date of the procedure. (ex: patient had a hysterectomy 20 years ago and should be excluded from the Cervical Cancer Screening measure). Due to the five years of claims data, we were able to capture a large percentage, but not all of these patients. For more recent services for which information should be available in the patient records (ex: lipid test performed last year), the correct date of service should be entered.

Non-compliance

1. Some of my patients are not compliant with my testing recommendations or refuse to have the testing done. Will I be able to provide this information in the self-report function and have these patients dropped from the calculations of my rates?

Changes in the numbers used in calculation due to patient non-compliance are not accepted by NCQA/HEDIS or other nationally recognized clinical guidelines that were used to develop the clinical quality indicators. We follow HBI specifications exactly for consistency with national data, and these specifications are based on national recommendations, trends, and medical literature. The majority of plans that HBI has worked with have followed national guidelines from HEDIS and other clinical guidelines and have not made an exception to allow patient refusal of a recommended study as denominator exclusion.

One hundred percent performance is not expected for any of the measures, and some patient refusal of recommendations happens in all areas and almost all practices. It averages out among the entire provider population resulting in like comparisons. Like comparisons, or benchmarks, are what is used for identifying physicians who most closely follow standards of care. Most health plans when faced with this consideration were concerned that permitting such a data modification could potentially harm the persistence and level of encouragement of provider recommendations to patients for important screening studies, thus hindering the basic goal of improving the quality of care delivered to their members/patients.

2. When I started to self-report information for my patients, I noticed that patient non-compliance was not listed as an exclusion for the majority of the measures. How do I report if a patient was non-compliant?

Patient non-compliance is not a valid exclusion from the measures, and a certain level of non-compliance is expected across all providers' patients. Some measures do have the option to indicate that a patient or parent was instructed to have the test or service but did not. Selecting this option will not remove this patient from the measure, but will be used for informational purposes. The measures with this option include:

- Childhood Immunization: Measles, Mumps, and Rubella (MMR)
- Childhood Immunization: Varicella-Zoster Virus (VZV)
- Colorectal Cancer Screening
- Mammography Screening
- Cervical Cancer Screening
- Diabetic Retinal Exam

Physicians can also enter information into the "Other" option, but the "Other" information will not necessarily remove the patient from the measure.

Consumer View

1. How do you anticipate consumers using this information?
Through the Doctor Finder tool on **www.bcbsal.com**, consumers are able to compare hospitals and physicians in term of quality measures, national standards and demographic information. Improvements in process measures have been shown to lead to better outcomes for patients.

2. When was the data be made available to the community?
July 2009

3. When will data be refreshed on the consumer view?
May 2010

3. Who will be able to see this information?
The information will be available for public view on **www.bcbsal.com**.

4. How many patients need to be attributed to a measure for that measure to display as part of the public view in July 2009?
Measures with less than 15 patients in the denominator will not be displayed on the consumer view.

The self-reporting view is only seen by the physician and his/her office staff. In the self-reporting view, a physician or his/her office staff can review measures with any patients attributed to the denominator, even for less than 15 patients. This is to allow the physician to self-report on as many patients as possible and to be fully transparent with the data.

Scoring Methodology

1. How is the star rating calculated?

Ratings show how doctors score on specific services when compared to other doctors in Blue Cross and Blue Shield of Alabama's network of doctors. Scores are based on how often a doctor's patients receive services, based on the patients' conditions and demographics. For example, a female patient over the age of 40 should receive an annual mammogram. These services are recommended by national quality organizations including the National Committee on Quality Assurance, a nationally recognized organization focused on improving healthcare quality. Doctors must have performed a service on at least 15 patients with Blue Cross and Blue Shield of Alabama coverage to receive a rating for that service.

2. What do each of the star ratings represent and how were they determined?

Doctors can receive ratings ranging from one to three stars for each service. Two stars is the average rating and means a doctor's patients receiveservices as often as most other doctors. Steps are taken to ensure scores are statistically valid. Factors, such as sample size, are taken into account when calculating scores. Statistical methods may account for variances.

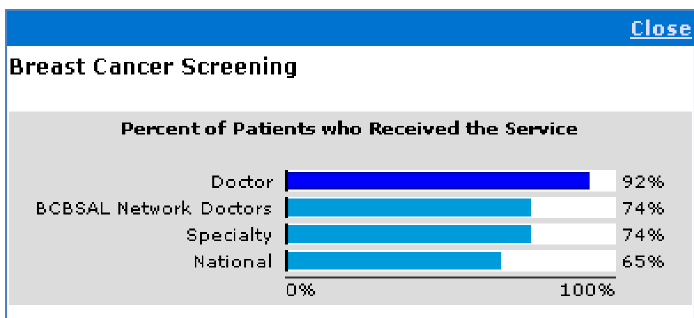
The "normal" performance range (to be identified by 2 stars) is determined by measuring performance within the 25th to 75th percentiles. To determine star ratings of 1 and 3 we identify and categorize physicians performing significantly higher or lower than that "norm". Those physicians with performance outside the "norm" are those above the 75th percentile and those below the 25th percentile. To ensure that a physician's performance is statistically different from the network "normal/expected" range, we have applied a 90% confidence interval to each of his measures. If we cannot say with high statistical confidence that a physician's true performance falls in the measured range, then that physician will receive the 2-star "normal" rating. For example, a physician scoring in the bottom 25 percent of a given measure may be assigned a star rating of 2 instead of 1 based on the statistical likelihood that the physician's actual performance is better than the measured performance.

The table below explains each star rating.

Rating	Description
★★★	**Top 25th Percentile with CI of 90%**
★★☆	**25th to 75th Percentile**
★☆☆	**Bottom 25th Percentile with CI of 90%**

In addition to the star rating, there will be a comparison to the national average on the web site. There will also be measure specific information on scores for doctors within the same peer specialty and for doctors within the network.

The representation will be similar to the graphic below:



Mammograms are a common screening tool for breast cancer. A mammogram is an x-ray of the breast. This test may find tumors that are too small to feel. A mammogram may also find ductal carcinoma in situ, abnormal cells in the lining of a breast duct, which may become invasive cancer in some women. The ability of a mammogram to find breast cancer may depend on the size of the tumor, the density of the breast tissue, and the skill of the person reading the test.

Why Screening is Important
The earlier breast cancer is found, the better the chances that treatment will work. The goal is to find cancers at an early stage, before they can spread. The American Cancer Society has stated that detecting breast cancer early, before it spreads, greatly increases survival rates.

Questions and Concerns

1. If I disagree with my data, how can I appeal?

Physicians will be able to address questions regarding their data during a comment period that will be set aside well before publication of the data on the Phase I measures in July 2009. During this time, a physician or his or her staff may also input information to supplement administrative claims.

The comment sections will be available on the web tool where physicians will have the opportunity to provide feedback and additional pertinent information for patients. If outstanding issues persist, a physician may initiate an investigation by contacting their Network Services Representative. Such appeals will be carefully reviewed. It is our goal to provide accurate and meaningful information in a fair and understandable format.

2. How can I review my data and comment if I do not have internet access?

Due to the timeframe of this project, web access will be the only way for physicians to view their data. The physician does not have to view the data in their office, as the web portal can be accessed from any computer with Internet capabilities.

3. As a rural physician, I may not have access to all of my patient's information or know when he/she receives tests. Are rural physicians going to penalized?

This is a concern that shared by many physicians. It is important to remember that many other areas of the country have implemented physician quality programs, including states with similar rural compositions such as Tennessee and Arkansas.

Blue Cross and Blue Shield of Alabama is closely examining this program, and if we do see a significant difference in rural areas, we will work with groups in those areas to review benefits to address primary care in a more substantial way. Also, this program only applies to Blue Cross and Blue Shield of Alabama customers, and not a physician's entire patient list.

4. Can I have patients reviewed to see when I had an appointment with the patient?

Yes, please send your name and the patient's name, member ID, and date of birth, along with the measure in question, to **ProviderQuality@bcbsal.org**.

5. Who should we contact at Blue Cross with questions regarding the Physician Quality and Transparency Program?

Please submit questions and concerns to **ProviderQuality@bcbsal.org.** The dedicated customer service number is 1 877 854-8430. These e-mails will be reviewed daily, and issues, questions, and concerns will be addressed promptly. Program information can be obtained on the Blue Cross and Blue Shield of Alabama web site, **www.bcbsal.com**, and through your physician Network Services Representative. This Question and Answer document will be updated on a regular basis and is available on the Blue Cross and Blue Shield of Alabama web site. We welcome your continued review and input.