BlueCross BlueShield of North Carolina MEDICARE

August 2023

Personalized Match Phase 1: Specialist Provider Overview

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https://www.bluecrossnc.com/providers/networks-programs/blue-medicare/healthy-blue-medicare

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Please note, this communication applies to Healthy Blue + Medicare[SM] (HMO D-SNP) offered by Blue Cross and Blue Shield of North Carolina.

Description/Approach

Provider performance can vary widely in relation to efficiency and quality. Our goal as your Medicare health plan partner is to ensure our members receive high-quality care that leads to improved member health outcomes across a wide range of variables.

We will add a new sorting option on the Find Care tool for members to leverage when they are searching for a non-PCP specialist provider. This sorting option, called Personalized Match Phase 1, is based on each provider's score relative to their peers in the patient's preferred mileage search radius. Providers will be listed in order of their total score, though no individual scores will appear within the tool or be visible to the covered patients. The Personalized Match Phase 1 algorithm will be based on quality and efficiency criteria to assist members in making more informed choices about their medical care. Other sorting options will still be available on Find Care for our members. Members should consider a variety of factors when making decisions for choosing a specialist provider to manage their care.

We evaluate provider groups and individual providers annually, using updated quality and efficiency methodologies and data.

Overview of Quality and Cost

General Approach

We evaluate provider groups and individual providers based on their cost and quality. Quality is assessed relative to national and local market performance, while cost is analyzed at the local market level. Based on certain cost and quality criteria, a provider group can be designated as high performing. The individual provider's overall performance is used in combination with the provider group's designation to create a final digital score. This digital score is used to sort providers within the Find Care tool on the member health plan website.

Throughout the analytical process, provider groups are identified using their Federal Tax Identification Number (TIN) and specialty. Individual providers are identified with their CMS-assigned National Provider Identifier (NPI).

Provider efficiency and quality is compared to threshold values (current benchmarks available at the time of reporting) and used to establish the list of provider groups designated as high performing. Group designation status and provider performance are calculated and published annually.

The methodology outlined in the document applies to Phase I – Personalized Match for Specialty only. This includes the following:

- Medicare only
- Utilizes Motive Medical Appropriateness measures run on the full Medicare membership through Motive's status as a CMS QE (Qualified Entity) vendor.

- Creates a final Digital Score for each individual provider within the profiled specialties to be used by Medicare Provider Finder to sort order.

Quality Measurement Methodology

Quality Measures and Data from Motive Medical Intelligence

We contracted with Motive Medical, a certified CMS Qualified Entity vendor. Motive's methodology for selecting measures is rigorous and all measures are validated clinically and statistically. Additionally, all Motive measures meet the American College of Physician criteria for measurement and are based on clinical practice guidelines from the major specialty and subspecialty societies, primary literature, and quantitative bibliometrics.

Motive creates appropriateness metrics which measure overuse and underuse, as well as appropriateness-based cost efficiency and quality measures across domains. The Appropriate Practice Score (APS) is Motive's way of summarizing its appropriateness measures; this is a single score that combines the weighted average of a provider's performance in each specialty across multiple measures based on normalized cost, volume of cases, and patient harm. A provider will only receive an APS score if they have a minimum of 3 measures with at least 10 members per measure.

The APS score ranges from 0-10, with an APS of 5 indicating average performance. Higher scores indicate better quality appropriateness, while lower scores indicate poor quality. Motive rescales each specialty to the APS median of 5, resulting in some specialties not having high scores of 9-10.

The Appropriate Practice Score (APS) is based on what doctors do and what insurers pay. What is done and what is paid are abstracted from databases covering millions of doctor–patient encounters. Abstracted data are aggregated and analyzed against parameters that matter to patients and payers: harm, cost, and quality. Higher scores are better; lower scores are worse.

The APS is bracketed by a range of better practice (ROBP) that accounts for factors that cannot be captured in claims data (for example, resource-limited practice, geographic considerations, tertiary referral practice). The ROBP validates doctors' concerns, acknowledging that the real world of clinical practice is characterized more by variations than it is by absolutes.

APS allows us to identify providers who practice in ways consistent with best practices.

Inclusion Criteria to Receive an APS Score

Motive Measure denominator criteria for scoring:

- For a measure to be included, a denominator of at least ten members must be present.

Motive Measure count criteria for scoring:

- For a provider to be scored, at least three measures must be included.

Provider Quality Score

We utilize Motive Medical's APS scores to derive a national benchmark for each specialty and create an overall quality score for the individual provider. This quality score is the percentile ranking of the NPI's APS observed to expected (O/E) ratio:

- Observed (O) = Observed APS score for each NPI by specialty
- Expected (E) = Median APS score for a given specialty for all our Medicare contracted providers

As an example, if a cardiology specialist has an APS score (O) of 6.5 and the APS median for the cardiology specialty (E) is 5.0, this specialist will receive an APS O/E of 6.5 / 5 = 1.3. When a provider's APS O/E ratio is greater than 1, their quality is better than at least 50th percentile of providers in their specialty. Higher APS O/E ratios indicate better quality.

Motive's APS scores are currently only available at the individual provider level. To calculate an APS O/E score for each provider group, we use our contracting information to assign individual providers to provider groups. Using an individual providers claim volume within a group to weight scores, provider's APS O/E are rolled up to determine a TIN-specialty level APS O/E. Finally, percentile rankings of the TIN APS OE are calculated and provider groups who are in the top 33% of quality nationally or state-wide can pass the quality threshold for a high performing designation. The details are further described in the Quality Scoring sections of *Methodology – Provider Group Designations* and *Methodology - Specialist Composite Score*.

Efficiency/Cost Measurement Methodology

We use Optum's Episode Treatment Group® (ETG®) and Procedure Episode Groups (PEG®) software to compare the cost efficiency of specialist providers to their peers in the same Line of business, specialty, Case-Mix and geographic region. The ETGs measure efficiency of care at a condition/diagnosis level (for example, diabetes, low back pain). PEGs measure the efficiency of care at a procedure/surgical event level (for example, knee replacements, lumbar fusions).

Key Features:

- All medical and pharmacy services related to the condition or event during a given measured timeframe rendered by any provider in any setting are considered part of the episode of care.
- Episodes are assigned to the specialist provider responsible for generating the most costs in that episode for surgical and E&M visits for ETG and provider performing anchor procedure for PEG.
- Episodes are severity adjusted (most conditions contain three or four levels of severity).
- The observed cost of an episode is the sum of provider's total allowed costs. The expected or peer benchmark cost of an episode is the average cost of treating the same condition or procedure with the same severity level for all specialists in the same line of business, specialty and geographic area multiplied by number of provider's volume.
- Observed Cost: Total Provider Cost
- Expected Cost: Specialty Average Cost for same case mix * Physician Volume
- Efficiency Index = Observed/Expected

Provider Efficiency Score

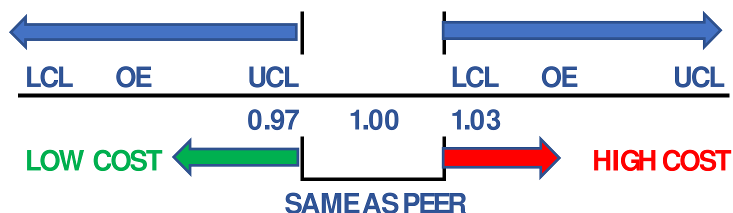
The sum of all the observed costs for all the ETG condition episodes assigned to a provider is divided by the sum of all the expected peer benchmark costs for those same case-mix episodes to arrive at a provider's condition observed/expected ratio score. The same calculation is performed to arrive at a provider's procedural observed/expected ratio score.

As an example, if the provider score for the ETG or PEG is $3,258, and the Same-Specialty Peer Average Cost is $3,467, the ETG Index = 3258 / 3467 = .94. In this example, the provider is 6% more efficient than the average provider. The average provider index is 1.0. Lower scores mean better efficiency.

A final step blends the condition ETG and PEG procedure observed/expected ratio scores into one final efficiency score by weighing the percentage of all the dollars that are tied to procedures vs conditions. This ensures that the efficiency scores for proceduralists (surgeons) are based more heavily on the procedure episodes. This is the final blended efficiency score for the provider:

- A minimum of 20 episodes that have benchmarks are required to calculate a condition efficiency or procedure efficiency score for the provider.
- A 90% statistical confidence interval is computed around the provider's final blended efficiency score to account for the level of statistical uncertainty around the point estimation. For example, a provider with a final blended efficiency score of 0.97 might have the following confidence interval: Upper confidence level (UCL) of 1.03, Lower Confidence level (LCL) of 0.91.
- Cost ratings are then assigned to providers and provider groups using confidence intervals, as shown below. The provider group cost ratings are used for TIN Designation while individual provider cost ratings are used for the Provider composite score.

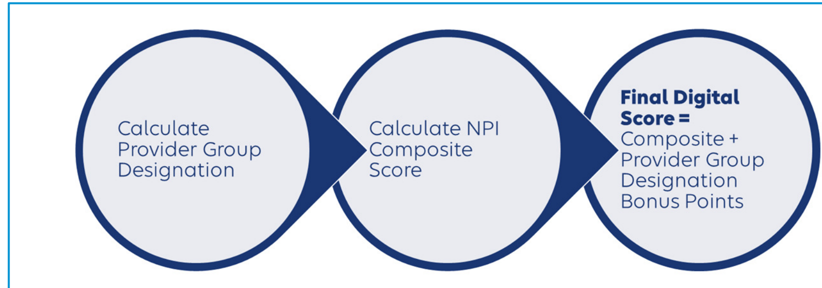
For Cost Scoring, the methodology is the same regardless of the aggregation level.



Overall Performance Assessment

General Approach - Combining the Specialist TIN Designation and the Provider Composite Score

We evaluate provider groups, as well as the individual provider, using both Motive quality data and Optum's ETG and PEG efficiency product. The individual provider's performance is added to the Group Designation to create a final digital score:



- Group designations are evaluated for each TIN, Specialty, and State. A TIN is deemed a high performing group based on their quality and cost data.
- Each individual provider is given a composite score based on quality and cost.
- A provider's individual composite score is combined with their group designation to create a Digital Score:
  - Groups that receive a high performing designation appear first within personalized match and corresponding providers are sorted using their composite score with the best composite score appearing first.
  - Next, groups that do not receive a high performing designation appear within personalized match and again, these providers are sorted based on their composite score.

Both TIN Designation and Provider Composite Score are explained in detail below.

Measurement Period for Phase 1

We Phase I Specialty Methodology uses claims, member, and provider information as follows:

- Providers: We include providers with Motive data that have an active Medicare contract on June 30th, 2022.
- Cost Efficiency: Phase 1 ETG/PEG analytics uses claims and membership from July 1, 2020, to June 30, 2022, with claims paid through September 30, 2022. Members with a gap in coverage greater than 90 days during the claim period are excluded.
- Quality: Phase 1 uses the Motive Appropriate Practice Score from Motive's Fall 2022 release with varying claim periods by measure including dates from January 1, 2019, to December 31, 2021.

Methodology – Provider Group Designations

Evaluated based on quality and cost, a provider group is deemed high performing when they are a top performing group. To be considered as a higher performing group, at least one NPI must perform the majority of their services with the TIN.

Quality Scoring

Motive's provider level quality data is used to derive a national benchmark for each specialty and is also used to create an overall quality score for each group within a specialty.

Calculate Median APS Score:

For each specialty, we derive a national/specialty benchmark using Motive's APS for each provider. We take each Provider's APS within a specialty and calculate the median score. This median score is calculated at the provider level and not the TIN level because providers can have a relationship with more than one TIN. This median score is used to calculate the APS observed to expected (O/E) ratio for each group.

Assign Provider Motive Data to a TIN-Specialty and Roll-up

As previously mentioned, current Motive data is available at the provider (NPI) level only and also includes a domain(s) for each provider. A domain assigns a set of measures:

- First, we use our existing contracting data to assign a Provider to a TIN(s)-state(s) which is line of business specific.
- We also compare the provider's specialty to the Motive domain and remove any non-relevant domains. For example, a cardiologist can be affiliated with a Cardiology domain score and a primary care (PCP) domain score. In this example, we remove the PCP domain APS score from our review.
- Next, we summarize annual claims for a given Provider- TIN and include Provider - TINs with at least 10 claims within the last year.
- Then, we calculate a weighted APS OE score for each group using the provider's APS OE score and claim volume. All providers are rolled up to the TIN/Specialty/State:
  - Provider APS OE = $\frac{Provider's\ APS}{National\ APS\ Median}$
  - TIN APS OE= $\frac{SUM(Provider's\ APS\ OE\ x\ Claim\ Count\ NPI-TIN)}{SUM\ (Claim\ Count\ NPI-TIN\ within\ the\ 1\ TIN)}$
- Each TIN within the specialty is then assigned a quality percentile ranking based on their TIN APS O/E from their associated Providers.

Calculate National and State Rankings

Finally, we rank TINs within a specialty by sorting their O/E ratio from highest to lowest and determine the percentile rank. We also calculate the percentile rank for TINs within a specialty at the state level.

Cost/Efficiency Scoring

As previously stated, we use Optum's Episode Treatment Group® (ETG®) and Procedure Episode Groups (PEG®) software to compare the cost efficiency of specialist providers to their peers in the same specialty and geographic region. Through quarterly automated processes, we calculate an efficiency score and 90% confidence interval for each TIN/specialty/state/LOB to determine a cost rating.

This efficiency score and confidence interval is used to rate the TIN/specialty/state/LOB as follows.

	Lower than Expected Cost	Same as Expected Cost	Higher than Expected Cost	Insufficient Information
Total Cost Rating	Upper confidence Level is at or below a score of .97	Upper confidence level is above 0.97 and lower confidence level is below or at 1.03	Lower confidence level is above a score of 1.03	

Group Designation – Combining Quality and Cost/Efficiency

We examine the cost rating and the national (or state) percentile quality rank to define top performing groups. Provider groups that meet both cost and quality thresholds are designated as top or high performing.

There are two tracks that a TIN/Specialty can qualify as high performing:

- True-High Performing Group:
    - Quality in the top 33% nationally or state
    - Cost rating that is *Lower than Expected* or *Same as Expected*
- Supplemental-High Performing Group:
    - Quality in the top 33% nationally or state
    - Not enough cost data to receive a Cost rating

A point distinction is made between TINs that are a True-High Performing group and those that are a Supplemental-High Performing group. A True-High Performing group will receive more points added to their composite score than a Supplemental-High Performing group.

The TIN Designation is combined with the NPI composite score, which is explained in the next section.

Methodology - Specialist Composite Score

General Approach

We evaluate each individual provider using quality and cost efficiency data and calculate a composite score at the provider-TIN relationship level. The provider will only receive a composite score if they have a valid quality score (for example, sufficient number of quality measures). When available, provider cost efficiency is used to supplement the quality performance. Quality is benchmarked at Provider/Specialty while cost is benchmarked at TIN-Provider/Specialty/State/LOB.

Quality Scoring

Within each specialty, we use Motive's APS and create an APS Observed to Expected (O/E) ratio that incorporates national/specialty benchmarking for all Providers. This APS O/E ratio was created by taking each provider's APS and dividing them by the specialty's overall APS national median.
For all providers that have an APS score, they are assigned a quality percentile ranking based on where their APS O/E score ranks within their specialty. The quality score is determined by the following:

- National benchmarking of motive data at the provider-specialty level:
    - Motive's data is compared to our contracted Medicare providers using contracting information to capture only active providers.

- We determine the median APS from all distinct providers within the specialty to obtain
- APS Observed-to-Expected scores for each distinct provider:
  - Provider's APS OE = $\frac{\text{Provider's APS (observed)}}{\textit{Median APS for the specialty (expected)}}$
- Each provider will receive a quality score, which is their APS O/E percentile ranking at the national/specialty level.

Cost/Efficiency Scoring

Cost points are determined for each provider per specialty and state. Each provider is sorted into a cost tier and given a rating, depending on their blended efficiency score with a confidence interval of 90%:

- For all providers with a valid blended efficiency score, they are assigned a cost tier and a percentile rank based on the efficiency observed to expected ratio, known as cost O/E:
  - Cost Points are then given as follows, based on the cost tiers:
    - Cost within Lower-than-Expected Cost = 1
    - Cost within Higher-than-Expected Cost = 0
    - Cost within *Same as Expected Cost* = Percentile rank of individual Provider's cost within their state/specialty
    - Providers without cost data are not given any cost points.
    - If a provider is affiliated with more than one TIN, all active relationships are included and evaluated. However, we identify the TIN with the highest allowed amount and highest claim volume for a provider and flag this TIN. Medicare Provider Finder sort order will be based on this single TIN for a provider.

Overall Composite Assessment

Providers are given a composite score that incorporates quality and cost.

- Quality: Quality points, based on APS O/E percentile ranking, are given at Provider/Specialty. This score can range from 0 to 1.
- Efficiency: Cost points, based on cost tiering and cost E/O, are given at Provider-TIN/State/Specialty. This score can range from 0 to 1.
- Composite: The composite score will range from 0 to 2. It is the sum of quality and cost points.

Criteria for Inclusions:

- Specialist providers who have an Appropriate Practice Score designated by Motive Medical, defined by a minimum of 3 measures for their specialty and at least 10 members per measure
- Providers that have at least 10 claims within the measurement period to ensure active status
- The provider is required to be in compliance with all terms and conditions of the provider participation agreement (including all attachments and amendments) with the health plan.

Criteria for Exclusion:

- Providers who do not have an Appropriate Practice Score and have less than 10 claims within the measurement period will not be considered for an overall performance score.

Performance Sorting in Our Online Tool

Our Online Tool, Find Care, lists providers at individual Practitioner (NPI) level. The sort order of individual NPIs will incorporate associated provider group designations. In cases where individual NPIs are members of more than one provider group, the NPI's highest dollar/cost-volume group designation will be applied.

There are some in-network providers excluded from the provider performance sorting algorithm (and thus the scoring of either efficiency or quality for provider performance) but as with all in-network providers, these providers are included in the list of providers. If any such providers are within a member's specified search radius, those providers will appear in the member's search results with a score of one, which is approximately in the middle of the provider rankings. Anti-steerage providers will further be identified by a notation by their name as a provider that was not subject to the provider performance search methodology.

Sorting Process

After a member executes a search for an individual provider, individual providers within the member's defined office location search radius are sorted by providers with the highest overall digital score.

Individual providers belonging to groups that receive a high performing designation appear first within personalized match and corresponding providers are sorted based on their digital score with the best performance score appearing first. Groups that do not receive a high performing designation will also appear below those in high performing groups and their providers are sorted based on their digital score.

Ability to Change the Sort

At any time, a member can change the sort of the providers in the directory by changing the sort from provider performance to one of the other sorts, including solely distance.

Appendix A – Motive Measure Information

Number of Measures per Specialty and Types of Measures:

Motive Domain Specialty	Corresponding CMS Specialty	Number of Measures	Types of Measures
Cardiovascular Disease	Cardiology Cardiac Electrophysiology Interventional Cardiology	22	Overuse and Underuse
Cardiothoracic Surgery	Thoracic Surgery Cardiac Surgery	6	Overuse and Underuse
Endocrinology	Endocrinology	10	Overuse and Underuse
Gastroenterology	Gastroenterology	11	Overuse and Underuse
Nephrology	Nephrology	14	Overuse and Underuse
Neurology	Neurology	4	Overuse and Underuse
Oncology	Hematology Hematology/Oncology Medical Oncology	9	Overuse and Underuse
Otolaryngology	Otolaryngology	8	Overuse
Primary Care	General Practice Family Practice Internal Medicine Geriatric Medicine	38	Overuse and Underuse
Psychiatry	Psychiatry Geriatric Psychiatry	8	Overuse and Underuse
Pulmonology	Pulmonary Disease	10	Overuse and Underuse
Radiation Oncology	Radiation Oncology	6	Overuse
Rheumatology	Rheumatology	7	Overuse and Underuse
Surgery	General Surgery Colorectal Surgery Surgical Oncology	7	Overuse
Urology	Urology	7	Overuse
Vascular Surgery	Vascular Surgery	6	Overuse and Underuse
Obstetrics and Gynecology	Obstetrics and Gynecology	18	Overuse and Underuse
Orthopedics	Orthopedic Surgery Neurosurgery Hand Surgery	32	Overuse and Underuse
Pediatrics	Pediatric Medicine	15	Overuse and Underuse
Ophthalmology	Ophthalmology	9	Overuse and Underuse

Appendix B – Example Measures from Cardiology Specialties

Cardiology Appropriateness Measures	
Advanced Diagnostic Testing Overuse after CABG	Laboratory Monitoring Underuse with NOACs
Advanced Diagnostic Testing Overuse after Initial Visit	Left Ventriculography Overuse after Advanced Diagnostic Imaging
Advanced Diagnostic Testing Overuse after PCI	Nuclear Imaging Overuse in Stress Testing
Advanced Diagnostic Testing Overuse after Revascularization	Preoperative Electrocardiogram Overuse in Low-Risk Patients
Advanced Diagnostic Testing Overuse before Elective Surgery	Preoperative TTE Overuse in Low-Risk Patients
Beta Blocker Therapy Underuse in Heart Failure	RAS Inhibitor Underuse in Heart Failure
Beta-Blocker Underuse in Ischemic Heart Disease	RAS Inhibitor Underuse in Ischemic Heart Disease
Carotid Artery Imaging Overuse in Simple Syncope	Repeat TTE Overuse
Coronary Angiography Overuse	Staged Angiography and PCI Overuse
Coronary Angiography Overuse in Stable Ischemic Heart Disease	Staged Percutaneous Intervention Overuse
FFR or iFR Underuse in PCI	Stress/Functional Testing Underuse before Coronary Angiography

* Cardiology specialties include Cardiology, Cardiac Electrophysiology, and Interventional Cardiology

Appendix C – Quality Scorecard Example Medicare

2023 Medicare Provider Data for Dr. Jane Smith (NPI 11-1111111)
Tax ID Data Shown for ABC Cardiology (TIN 999999999)
Specialty - Cardiology
State - Georgia
Cost Efficiency Scores sourced from claims incurred between 7/1/2020 and 6/30/2022
Appropriateness Measures sourced from Motive Fall 2022 refresh

ABC Cardiology (TIN 999999999)	
Tax ID/Specialty Cost Efficiency [1] Lower than Expected	**Tax ID/Specialty Quality** [2] Meets Quality

Dr. Jane Smith (NPI 1111111111)	
NPI/Tax ID Cost Efficiency [1] Higher than Expected	**NPI Appropriate Practice Score** [3] 5.3

Motive Appropriateness Measure Detail

Measure ID	Measure Description	Numerator [4]	Denominator [5]	Compliance Rate [6]	Benchmark Rate [7]	Measure Index [8]
CAR0005	FFR or iFR Underuse in PCI	12	20	60.0%	72.0%	0.83
CAR0006	Staged Angiography and PCI Overuse	11	51	21.6%	24.0%	0.90
CAR0007	Staged Percutaneous Intervention Overuse	41	42	97.6%	91.0%	1.07
CAR0023	Preoperative Electrocardiogram Overuse in Low-Risk Patients	5	15	33.3%	29.0%	1.15
CAR0048	Repeat TTE Overuse	3	12	25.0%	28.0%	0.89

Definitions:
[1] Cost Efficiency: Cost score comparing the Tax ID/Specialty or NPI/Tax ID to peers in the same State, Specialty and Line of Business.
- Lower than Expected: Observed to Expected Upper Confidence Interval <= 0.97
- Same as Expected: Observed to Expected Upper Confidence Interval > 0.97 and Lower Confidence Interval <= 1.03
- Higher than Expected: Observed to Expected Lower Confidence Interval > 1.03
- Insufficient: 0-19 episodes

[2] Tax ID/Specialty Quality: Weighted NPI APS scores, based on the volume of claims each NPI has within the Tax ID.
- Meets Quality: Tax ID/Specialty's weighted APS score >= 66.67th percentile
- Does Not Meet Quality: Tax ID/Specialty's weighted APS score < 66.67th percentile

[3] NPI Appropriate Practice Score: Motive APS score, ranging from 1-10. APS scores are at the NPI level.
[4] Numerator: Members for the measure with appropriate care provided.
[5] Denominator: Total eligible members for the measure.
[6] Compliance Rate: The portion of total eligible members with appropriate care provided. Numerator / Denominator. A higher compliance rate is favorable.
[7] Benchmark Rate: National compliance score for this measure. Total national members with appropriate care / total national members for the measure.
[8] Measure Index: NPI's compliance rate / Benchmark Rate. A measure index >1.0 is favorable.