BlueCross BlueShield of North Carolina

Practice Cost Report FAQs

What members are included in the cost report?

Members who fit the following criteria are included in the analysis:

- Under 65 years old or 0-21 years old (Pediatrics)
- Continuously enrolled during the 12 month measurement period

What primary care providers (PCP) are included in the analysis?

Family Medicine, General Practice, Internal Medicine and Pediatrics physicians as well as nurse Practitioners and Physician Assistants credentialed with participation status for primary care are considered primary care providers. If a member is attributed to an OBGYN practice, the following specialties are included: OBGYN, OBGYN Group, Gynecology, NP-OBGYN, and NP Women's Health.

How are members attributed (assigned) to my practice?

As of 2019, the reports include results produced using an updated attribution model that incorporates a larger pool of attributed members compared with the old model.

Members are attributed to the PCP practice they have visited most for primary care utilization (based upon Wellness and E&M claims). In the new model, Blue Cross NC evaluates a member's 15-month claims history and applies a stepwise hierarchical approach in order to attribute a member to a PCP practice:

The order is as follows: 1. PCP Wellness Visit; 2. PCP E&M codes; 3. Specialty Care Provider Wellness Visit or E&M codes; 4. PCP Selection. In the case of PCP Selection, a member has notified BCBSNC of their preferred PCP or OBGYN provider (typically during the member enrollment process).

If there is a tie, attribution is based on the most recent visit. If there is no PCP utilization during the study period, then we allow attribution to OBGYNs, Endocrinologists, or Cardiovascular Disease Specialty Care Providers, taking into account the most recent visit when there is a tie.

Members without any primary care utilization during the study period are not included because there are no relevant claims by which to attribute those members to a provider.

Additionally, changes in the methodology expand the places of service assessed and visit and diagnoses codes deemed as primary care utilization resulted in an increase in the total population of attributed members. These changes are reflected in the metrics in 2019 reports.

Is this report risk adjusted?

Yes. The cost report adjusts for illness burden during the year of analysis. Risk scores represent a member's overall health status and utilization based upon the member's history with BCBSNC.

What practices are included in the peer groups?

Peer group practices are selected based on primary care practice specialty according to BCBSNC credentialing provider tables. In addition, rural practices are compared with other rural practices and urban practices to other urban practices based on the county listed in BCBSNC records. Please note that the peer groups include health system affiliated practices (i.e. not limited to independent practices).

UTILIZATION DATA:

How are the utilization metrics reported?

All utilization metrics are reported per 1,000 members, per year.

What is considered a primary care visit?

A primary care visit is an office or telehealth visit with a practitioner with one of the following specialties: Family Medicine, General Practice, Internal Medicine, OB-GYN, or Pediatrics. Additionally, visits to Nurse Practitioners who are contracted with BCBSNC as primary care providers are counted as primary care visits. Multiple services performed on the same day within the same office count as a single visit.

What is considered an urgent care visit?

An urgent care visit is an office visit at an urgent care center. Multiple services performed on the same day within the same office count as a single visit.

What is considered a retail walk-in clinic visit?

A retail walk-in visit is an office visit to a retail or pharmacy-based clinic, such as Walgreens. Multiple services performed on the same day within the same office count as a single visit.

What is considered a specialist visit?

A specialist visit is an office visit with a non-primary care practitioner, including midlevel practitioners who are not contracted as primary care providers. Specialist visits **do not** include labs, imaging, urgent care, physical therapy, occupational therapy, or speech therapy. Multiple services performed on the same day within the same office count as a single visit.

How is the Specialist visit rate determined?

The Specialist visit rate is determined by the number of times an attributed member visits a specialist. It is not calculated based only upon the referrals made by the PCP. We recognize that many health plans allow a member to see a specialist without a PCP referral. We encourage PCPs to work with members to coordinate the use of specialty care when appropriate.

What is the difference between ER visits and PI (Potentially Inappropriate) ER visits?

PI ER visits are potentially inappropriate ER visits and a subset of total ER visits. These are visits for primary diagnoses that are most likely non-emergent or emergent but treatable within primary care. We use the classification system developed by New York University to determine whether each ER visit is potentially inappropriate. Within this system, any visit with a joint probability higher than 75% is reported as a PI ER visit. As an example: a visit to the ER in the past year was billed for dizziness and giddiness with a secondary diagnosis of a urinary tract infection, and an allowed amount of $4019.30. The NYU method takes into account the probability that the visit was non-emergent (72%) paired with the probability that the visit was emergent but treatable in a primary care setting (20%) to generate a 92% probability that the ER visit was inappropriate.

For more information on the NYU classification system, please visit:

- http://wagner.nyu.edu/faculty/billings/nyued-background

What are considered inpatient visits? Are visits to our office considered inpatient visits?

Inpatient visits are defined as visits to a facility that bills as an inpatient facility. Hospital stays and inpatient services are examples of visits within in this category.

What are considered outpatient visits? Are visits to our office considered outpatient visits?

Outpatient visits are defined as visits to a facility that bills as an outpatient facility (typically a Hospital Outpatient Department or HOPD). A visit for an outpatient surgical procedure is an example of a visit counted in this category. Admissions and ER visits are not counted as outpatient visits. In addition, visits to independent primary care offices are not outpatient visits because they are not associated with a hospital facility. In addition, visits solely for imaging are excluded from this category.

What are considered MRI and CAT Scans visits? Are visits to our office considered MRI and CAT Scans visits?

MRI, MRA (Magnetic Resonance Angiography), and CAT scan visits are defined as visits solely for purposes of imaging or radiology using high tech imaging tools or techniques. These visits are not related to an inpatient stay and can be conducted in either outpatient or office visit settings, with different cost ranges associated with place of service. (For example, within the Durham Chapel-Hill, NC area, an MRI of the Pelvis w/o & w/ Contrast in an outpatient setting can cost $1,575 versus compared with $1,087 for the same service in an office setting.)

What are considered Xrays and Ultrasounds visits? Are visits to our office considered Xrays and Ultrasounds visits?

Xrays, Ultrasounds, and Nuclear Medicine visits are defined as visits solely for imaging or radiology purposes using low tech imaging tools or techniques. These visits are not related to an inpatient stay and can be conducted in either outpatient or office visit settings, with different cost ranges associated with place of service (for example, an Ultrasound of Pelvis in an outpatient setting can cost $834 compared with the cost of $108 for the same service in an

office setting). The costs associated with these visits and the relevant utilization metrics are included in this report.

COST DATA

How are the cost metrics calculated?

All allowed amounts are averages across the relevant population. All cost categories are capped at the lower of the 99th percentile rounded to the nearest $1,000 or $100,000 for each individual. For example, the 99th percentile for annual ER cost at the individual level rounded to the nearest $1,000 is $16,000. Any single individual with an annual ER cost greater than $16,000 will have that amount capped at $16,000 for purposes of calculating the provider's cost report. This is done to prevent single individuals or outliers from having an overly large influence on average costs for a specific provider.

How are the dollar amounts calculated in the cost report?

The dollar amounts are the total allowed amounts for each type of service divided by the total number of attributed members. For example, an inpatient allowed amount of $300 does not mean that the average of inpatient visits was $300. Rather, it means that on average, every attributed member had $300 worth of inpatient care.

Why are the allowed amounts presented as total averages? How does that compare to using the average allowed amount per service?

We show the allowed amounts as total allowed per category divided by number of attributed members to allow providers to compare amounts relative to one another and the total allowed amount per member. Presenting the allowed amounts as total allowed per member gives perspective on how much each particular category contributes towards the total allowed amount.

Say that the average allowed amount for an urgent care visit is $150 and the average allowed amount for a primary care visit is $100. This gives information about the average unit cost of a service but does not incorporate any information about how frequently each service is used. For the same practice, say the average allowed amount for urgent care per member is $10 and the average allowed amount per member for primary care is $500. Although urgent care visits are more expensive, they are not a high frequency type of service and only make up a fraction of the total allowed amount per practice.

Do these categories represent the total allowed amount for attributed members?

No, this report does not include professional ancillary services (labs, physical therapy, DME, pathology) or specialty medications paid through the medical benefit. These services are included in the total PMPM but are not split out as separate categories. The utilization measures selected for the peer comparison were intended to focus on areas specific to primary care and thus are not wholly inclusive of every service received by a member.

How is the relative cost index (located in the top right corner of the report) calculated?

The relative cost index calculation is:

$$\frac{\text{(Average risk-adjusted cost per member for the practice)}}{\text{(Average risk-adjusted cost per member of the peer comparison practices)}}$$

The numerator and denominator are not reported in the cost report. The cost index is meant to give you an idea of your practice's cost relative to peer primary care practices. A relative cost index of 1.0 means your practice cost is the same as the peer practice group (see page 1 for a description of how the peer group is determined). A relative cost index of 1.1 indicates that your practice is 10% more expensive than the peer group practices.

Why is the relative cost index risk-adjusted?

Risk adjustment is standard practice in provider reporting for a payer. All members have underlying health risks that affect their need for and use of health care services, hence some members having a higher risk score than others. Risk adjustment, in the context of medical expenditures or use of specific services, is designed to control for that type of underlying risk variation in a population. By applying the risk adjustment, providers can then be evaluated "peer to peer" on the remaining variation in expenditures or utilization which can be affected by patterns in provider care and referrals. The risk adjustment is designed to protect providers from being held accountable for appropriate utilization for members with serious health conditions, such as cancer.

Why is my cost index different from last quarter?

As of 2019, the reports include results produced using an updated attribution model that incorporates a larger pool of attributed members compared with the old model.

Members are attributed to the PCP practice they have visited most for primary care utilization (based upon Wellness and E&M claims). In the new model, Blue Cross NC evaluates a member's 15-month claims history and applies a stepwise hierarchical approach in order to attribute a member to a PCP practice:

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Who do I contact if I have additional questions about the cost report?

If you are in the Blue Quality Physician Program, please email bqpp@bcbsnc.com if you have any further questions.

If you are in the Ob-gyn Care Collaborative Program, please email obgyn@bcbsnc.com if you have any further questions.