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

How are members attributed (assigned) to my practice?

Members are attributed to the PCP practice they have visited the most (based on E&M claims). If there is a tie, then attribution is based on most recent visit. If there is no PCP utilization during the study period, then we allow attribution to OBGYNs.

Members without any (primary care or OBGYN) utilization during the study period are not included, as there are no relevant claims on which to attribute those members to a provider.

What primary care providers 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 all 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.

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 on 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 to 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, Gynecology, General Practice, Internal Medicine, OB-GYN, or Pediatrics. Additionally, visits to Nurse Practitioners or Physician Assistants 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 a specialist visit?

A specialist visit is an office visit to 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 on 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 PCP's to work with members to coordinate the use of specialty care as appropriate.

What is the difference between ER visits and PI ER visits?

PI ER visits are potentially inappropriate ER visits. PI ER visits are 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. For more information on the NYU classification system, please visit:
http://www.wsha.org/files/169/NYU_Classification_System_for_EDVisits.pdf
http://wagner.nyu.edu/faculty/billings/nyued-background

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

In this report, outpatient visits are defined as visits to a facility billing as an outpatient facility (usually a Hospital Outpatient Department or HOPD). These are visits that are not related to an admission or an ER visit. Outpatient surgical procedures are an example of a visit counted in this category. Visits to an independent primary care office are not outpatient visits because they are not associated with a hospital facility. Outpatient visits exclude visits solely for imaging.

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:

(Average risk-adjusted cost per member for the practice) / (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.

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

Please email bqpp@bcbsnc.com if you have any further questions.