BlueCross BlueShield of North Carolina MEDICARE

September 2023

Availity: Medicare provider-facing talking points and FAQ

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

Background:

We continue to focus and expand our consumer tools and content to assist members in making more informed and personalized healthcare decisions. Provider performance can vary widely in relation to efficiency, quality, and member experience. 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.

Beginning January 1, 2023, we added a new sorting option on the FindCare tool for members to leverage when they are searching for a primary care 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 are listed in order of their total score, though no individual scores appear within the tool or be visible to Medicare covered patients. The Personalized Match Phase 1 algorithm is based on quality and efficiency criteria to assist members in making more informed choices about their medical care. Other sorting options are still available on FindCare for our members.

Personalized Match Phase 1 Highlights:

- We strive to make healthcare simpler, more affordable, and more accessible, and one of the ways to help achieve that goal is to ensure that consumers are connected with care providers who have strong track records delivering quality care.
- Beginning on November 10, 2023, we will upgrade the online FindCare tool for Medicare members with a new sorting option called Personalized Match Phase 1, to match consumers with providers who perform well in efficiency and quality metrics within a certain geographical distance.
- The new sorting option, known as Personalized Match Phase 1, will be the default for consumers who search for Medicare non-primary specialty care providers in FindCare.
- We currently offer *Personalized Match* to Commercial consumer members. *Personalized Match* seeks to match consumers with documented health conditions with provider ranked based on cost effectively managing quality care. For example, if a consumer who

Note: Availity, LLC is an independent company providing administrative support services for Healthy Blue + Medicare providers on behalf of Blue Cross and Blue Shield of North Carolina.

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

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has been given a diagnosis of diabetes conducts a search, they will be matched with providers whose patients are more likely to cost effectively manage similar patients with diabetes (for example, consistently receive recommended A1c tests A consumer who is a 60-year-old male would receive different *Personalized Match* provider rank order than a consumer who is a 30-year-old female). The goal is to move to this full *Personalized Match* solution in Medicare in the future. *Personalized Match Phase 1* only analyzes providers' quality and efficiency performance regardless of member characteristics for generating the sort order.

- You may review a copy of the new sorting methodology which has been posted on Availity.
- If you have general questions regarding this new sorting option, please submit an inquiry via the web on Availity.
- If you would like information about your scoring used for this sorting option or if you would like to request reconsideration of your score, you may do so by submitting an inquiry via the web on Availity.
- This change is part of a greater effort to help improve access to high quality, affordable healthcare, which is essential to our customers.

FAQ

Why are we reimagining the strategy for evaluating non-primary specialty care providers?
There is variability in provider performance (efficiency, quality, experience), and we want to ensure all members receive high-quality care that leads to improved patient outcomes. The strategy aligns with the future direction of our specialty provider care strategy. This phase of the Medicare FindCare improvement utilizes measures related to appropriate practice (for example, overuse and underuse measures). We utilize a vendor, Motive Medical, to generate an overall Appropriate Practice Score at the NPI level, based on all CMS Fee-for-Service members.

How will I know my inquiry went through successfully once I submit?
An email will be sent to the inquirer acknowledging receipt of inquiry within two business days.

What is the turnaround time from when I submit my question to receiving an answer?
The goal is to have all questions answered within two business days. If further clarification is needed, or if detailed research is required, that time frame will be extended.

How will I receive my response?
An email will be sent with the required information back to the email address provided during the initial inquiry request.

How do I submit an inquiry?
Inquiries can be made at **Availity site**. There are three dropdown options for inquiry types. These are: 1) General Program Inquires, 2) Request a Copy of Your Provider Performance

Scorecard, and 3) Provider Performance Scorecard Inquiries. An open text field is available to describe the nature of the inquiry in more detail.

What type of inquiries can I submit?
Any questions relating to Personalized Match Phase 1 that is not answered in this FAQ or by the Methodology document.

Do providers have any recourse if they feel their Provider Performance Scorecard is inaccurate?
If a provider disagrees with their Provider Performance Scorecard results, the provider can submit an inquiry at **Availity site** detailing their reasoning. We will determine the best course of action as needed, but potential outcomes could be a provider consultation, reanalysis, and potentially a rescoring of provider performance to be reflected in Personalized Match Phase 1 and the Provider Performance Scorecard.

What provider specialties are included in Personalized Match Phase 1?
For 2023, selected non-primary specialty care providers are included. We plan to potentially incorporate other provider specialties in future provider performance evaluations.

What measures are included in quality scoring and why were they included?
The quality measures selected for Personalized Match Phase 1 include underuse and overuse measures, within the appropriate practice domain. Measures vary by specialty and are available on request.

How are measures weighted?
Motive Medical considers three factors in weighting the importance of each measure as it impacts the overall NPI Appropriate Practice Score (APS):

- Measure volume (for example, the number of instances a provider is eligible for measurement)
- Cost differential (for example, the difference in cost between the inappropriate service chosen versus the cost of the appropriate alternative), and
- Patient harm (for example, measures weigh more heavily if they have a stronger negative impact on the patient).

What measurement year and source are used in quality scoring?
Motive Medical's Fall 2022 Refresh was used for quality scoring with varying claim periods by measure including dates from January 1, 2019, to December 31, 2021.

What are the inclusion criteria for quality scoring?
A non-primary specialist care provider must have at least three appropriateness measures with at least ten members in each measure (a few measures require 20 members) for the APS score to be calculated. If the provider does not meet this threshold, the APS score is not available.

The APS score can be described in the following steps:

- Within each specialty, calculate the mean Motive Medical APS score to be used as the national-specialty benchmark.

- For each non-primary care specialty provider, calculate an APS Observed to Expected (O/E) ratio, comparing the provider to the benchmark for the same specialty:
- Provider's APS / national-specialty benchmark.
- The quality score is the provider's APS O/E percentile ranking at the national-specialty level.

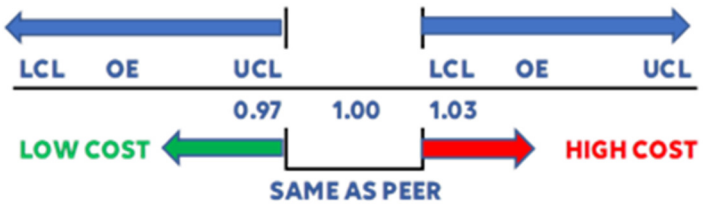
What factors go into your efficiency target?
The factors going into our efficiency target are the episodes of the members are assigned to provider specialty who has the highest cost within the episode for Surgery and Evaluation costs. The *observed* cost of an episode is the sum of provider's total allowed 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. For ETGs the measure is at the condition level (diabetes, asthma) and for PEGs it's the procedure level (knee replacement, lumbar fusions):

- Observed cost: Total provider cost
- Expected cost: Specialty average cost for same case mix * physician volume
- Efficiency index = observed / expected

How is your efficiency target set?
Efficiency scores from the condition ETG and PEG procedure (observed/expected ratio scores) are blended 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 high-cost cases, how do you normalize which can occur across different groups?
We exclude outlier episodes from the scoring, low cost and high-cost episodes are flagged by the software at Condition/Procedure, Severity, and Line of business level.

Provider Specialties with Quality Measures:

- Cardiac electrophysiology
- Cardiac surgery
- Cardiology
- Colorectal surgery
- Endocrinology
- Gastroenterology
- General surgery
- Geriatric psychiatry
- Hand surgery
- Hematology
- Hematology/oncology
- Interventional cardiology
- Medical oncology
- Nephrology
- Neurology
- Neurosurgery
- Obstetrics gynecology
- Ophthalmology
- Orthopedic surgery
- Otolaryngology
- Psychiatry
- Pulmonary disease
- Radiation oncology
- Rheumatology
- Surgical oncology
- Thoracic surgery
- Urology
- Vascular surgery