BestPractice Patients

Where is a new BlueCross BlueShield member who has not seen a doctor in two years assigned? Is there a system to ensure each member is attributed to a primary care provider (PCP)?

Members who have a health plan that requires them to select a PCP will remain attributed to their selected PCP. Members in a plan that does not require them to choose a PCP and who have not been seen by a PCP for a two-year period will be unassigned and remain unattributed. BlueCross BlueShield member services will help support members who do not have a PCP.

There are two ways that a member is added to a doctor’s patient panel:

Assignment: Patient’s HMO or POS insurance plan requires a PCP selection. Reassigning a member is done by assigning a new PCP of record.

Attribution: Patient’s health insurance plan does NOT require selection of a PCP

Attribution methodology:

- First pass (12 months of claim data) – looks for provider with the most recent preventive visit; if none are found, looks for provider with the most general evaluation and management codes.

How can I determine if a patient is eligible for a preventive visit?

You can refer to HEALTHeNET to determine if a patient is eligible for a preventive visit. If the patient is not eligible for a preventive visit, you can bill CPT codes 99401-99405 (preventive medicine individual counseling) to trigger appropriate attribution.

For Medicare Advantage members who receive an annual wellness visit, you can bill CPT codes G0402, G0438, or G0439.

Where and how do I pull my patient list?

- McKesson Risk Manager (MRM) has a patient risk member list that contains both assigned and attributed members. In MRM, the list can be found at Member > Patient Risk > Patient List. This list can be created once for each line of business and saved so that it can be run monthly.
  - You will be able to view your patient list with the specific payment for each member as well as the applicable performance and member adjustment factors on our secure website.

What to do if patients are missing from my patient list?

- If a patient’s HMO contract requires them to select a PCP, they may complete a PCP change form in the Forms section of the BCBS non-secure website, call our customer service, or change their PCP online.
- If a patient does not require a PCP, they will not appear on a patient list until after a claim is processed and MRM is refreshed. This could take multiple months depending on when MRM is refreshed and when the claim was billed and processed.

What happens if I join a new practice?

- You will continue to be paid fee for service for nine months before you start to receive a per member per month payment. As of the first day of month ten you will be reimbursed based on BestPractice methodology.
What happens when a provider retires or leaves a practice?
- Practices should create a transition plan for when a provider leaves the group, and BlueCross BlueShield should have at least 60 days’ notice. The practice should pull the provider’s patient list and reach out to their patients to establish them with another provider in the practice.
  - If a patient’s HMO contract requires them to select a PCP, they may complete a PCP change form in the Forms section of the BCBS non-secure website, call our customer service, or change their PCP online.
  - If a patient does not require a PCP, the practice should schedule a preventive visit (if eligible) or preventive med counseling visit to update their health records.

If a member is discharged from my practice due to non-compliance, will they be dropped from my practice’s roster?
Members will remain attributed to a provider until they either select a new PCP or are seen by a new provider within the community (if their product does not require selection of a PCP).

What is the minimum number of members I need to participate in BestPractice?
There is no minimum number of members needed to participate in BestPractice.

EFFICIENCY

What is primary care provider efficiency, and what factors determine whether my practice is efficient?
Support and further education around provider efficiency will be released over the next several months. This will include the definition of efficiency, information on how specialists or prescriptions factor into efficiency, and reporting on current or past efficiency.

GENERAL

Are monies collected via deductibles and copays deducted from the cap rate?
No, monies collected from deductibles and copays are not deducted from the cap rate.

Why is BlueCross BlueShield starting a capitation model with PCPs versus high-cost specialists?
We recognize the role that PCPs play in managing the care of their patients. The intent of the BestPractice program is to provide a pool of money to each PCP and allow the PCP the autonomy to decide the best way to manage the specific needs of each individual patient; this includes providing clinical guidance and advice on how and when to use specialty care as well as the use of facilities or other ancillary services.

What type of reporting is available?
You will have access to a monthly report (published before the 15th day of the month) with the base rate and details specific to your practice. This BestPractice Payment Report will be available when you log on to our secure website. Additional reports are available through McKesson Risk Manager.
**LINES OF BUSINESS**

Does BestPractice include BlueCross BlueShield Medicaid products?
BestPractice includes:

- Commercial (Managed Care [HMO 100 and 200], Traditional, PPO, POS, EPO)
- Medicare Advantage (Medicare HMO, PPO)
- Note: This includes ASO business
- Excluded: Essential Plan, FEP, Medicaid, CHP, FHP business, Medigap (Traditional Medicare) and out-of-area BlueCard host members

**PAYMENTS**

How will the capitated services/claims auto post to my EHR?
Previously, the contractual write-off amount and the capitated payment amount, if applicable, were placed under a claims adjustment segment (e.g., CAS*CO*24*130).

The capitated amount is now separate from the contractual write-off amount. The variance is under CAS segment for contractual write-off (e.g., CAS*CO*45*100) and the capitated payment amount is under the capitation CAS segment (e.g., CAS*CO*24*30). Claim line payment amounts will continue to be returned in the SVC03 segment.

Will physician extenders be paid under their supervising doctor’s fee schedule or their quality and efficiency score?
Mid-level clinicians will be assigned a performance adjustment factor on an annual basis and be reimbursed under the same methodology as their supervising provider.

**PCP – URGENT CARE - ER**

How is BlueCross BlueShield going to influence patients to go to primary care offices versus urgent care centers for convenient care?
In addition to maintaining copay differentials for the use of urgent care centers versus the primary care physician, BlueCross BlueShield made a significant change in 2015 to the way urgent care centers are paid. BlueCross BlueShield now employs a diagnosis-based reimbursement methodology that ensures urgent care centers are paid at a rate equal to what a primary care practice would be paid for rendering primary care services. While this does not completely eliminate the use of urgent care centers for convenience, it does eliminate the financial incentive for urgent care centers to solicit the use of their centers primarily for primary care-related services.

How will unauthorized member use of urgent care centers affect our scores/payments?
Efficiency of care management will not be taken into account in BestPractice until 2018. The impact of urgent care centers and the provider’s efficiency score is relative to the provider peers and the individual members risk score. Additional support and education around efficiency will be provided over the next 18 months.
**Per Member Per Month (PMPM)**

**How would someone with a catastrophic illness affect our capitation?**
Catastrophic Illnesses — either acute or chronic — will be reflected in the members’ risk score of which, dependent on the severity of illness, will increase the total payment to the primary care provider.

**After members reach their deductibles, does it erode the overall PMPM capitation money?**
The PMPM payment will not be affected if a member reaches his or her deductible. The member-level adjustment and base rate calculation take into account the expected collection of the member out-of-pocket payments based on their benefit design.

**If someone develops a chronic condition, how quickly does the PMPM increase?**
Providers can anticipate seeing a change in a member’s risk score on a quarterly basis.

**Does PMPM increase after deductible is met?**
No.

**If my quality measure is “better” than my peers, do I receive a higher PMPM capitation rate?**
Yes; depending on an individual clinicians’ annual performance, they may see a relative increase in their total compensation.

**The PMPM base rate is calculated based on historical claims.**
The annual base rate represents the average value of the capitated codes on a PMPM basis. The base rate:

- Is based on two years of claims history/experience from PCPs in Western New York for commercial lines of business, and one year of claims history for Medicare Advantage
- Takes into account changes in service patterns and trends
- Delineations of base rates:

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The BestPractice global base rates are three illustrative PMPM figures. The commercial and Medicare base rates represent the average reimbursement for the CPT codes subject to capitation; the codes subject to capitation represent approximately 40% of total revenue. These rates are paid dollars and do not include the patient cost-share. You will still receive the patient’s cost-share for the visit. More information is available at bcbswny.com/bestpractice.

**Does each physician receive the same PMPM amount? Can you provide a fee-for-service example?**

While all providers receive a consistent base rate, which is determined by the age and benefit design of the member, PMPMs vary due to each member’s unique characteristics (risk) and the provider’s annual quality performance. Each patient’s payment is calculated by the following equation: (Global Base Rate)*(Member Adjustment Factor)*(Performance Adjustment Factor).
When combined, these factors determine your monthly payment. This calculation occurs for each member in your attributed panel, and the sum of these payments equates to your total monthly payment.

It is important that you continue to submit claims for all services in a timely manner, and code to the highest level of specificity.

**Key points:**

- Claims drive member attribution, member cost-share, quality, and risk score
- Claims tell us that a member is attributed to you
- Claims tell you the member responsibility for the service you provided
- Submitting claims demonstrates compliance with HEDIS metrics
- Claims coded to the highest specificity determine your patients’ risk scores

### QUALITY

**What time period will you be looking at to determine quality scores?**

HEDIS performance is measured on an annual basis and requires both the complete collection of claims and an auditing period. Due to these limitations, 2017 provider quality performance is based on 2015 HEDIS performance.

You will be compared to your BestPractice peer group; peer groups are defined as physicians of like specialties, including:

- Family practice/general practice
- Pediatrician/adolescent medicine
- Internal medicine
- Geriatric medicine

How you rank among your peers will determine your performance adjustment factor.

**How do I measure and/or follow quality outcome?**

The Quality Intervention Module (QIM) in McKesson Risk Manager is available to identify gaps in care to assist providers in identifying the measures affecting their overall quality score.

**How can we increase our quality score?**

There is potential to increase quality scores throughout the year, as providers work with their patient population on compliance with specific HEDIS measures. We encourage providers to check the QIM noncompliance reports on a monthly basis and conduct outreach.

You will be able to submit documentation to us to update our system for exclusions (e.g., bilateral mastectomy services) that took place prior to the patient becoming a BlueCross BlueShield member, or where BlueCross BlueShield was not the primary insurer.
I understand how risk score reflects chronic disease burden of a patient, but how will you value acute care (non-chronic illnesses, such as sinus infection, new back pain) in the PMPM and reimburse for those visits?

- A risk score is generated for every member compared to others in a population and measures how healthy or sick a member is. The average risk score of a population is 1.00.
- Risk is calculated based on member's age, gender, and ICD10 codes used by providers.
- Concurrent risk is calculated by looking at the last 12 months of available claims based on the MRM refresh date.
- The risk score predicts what costs should have been during this time period by comparing the actual cost of the member to the average cost of members with the same disease states within a population. Both acute and chronic conditions factor into prediction.

Are risk score, quality measures, and efficiency index weighted equally?
Your 2017 performance adjustment factor (PAF) takes into account only your quality performance. Quality is measured by HEDIS performance on an annual basis and requires both the complete collection of claims and an auditing period. Efficiency factors such as unauthorized patient use of urgent care centers or ERs are not taken into consideration under BestPractice in 2017, but will play a role in 2018. Additional education and support around efficiency will be forthcoming.

The risk score may be geared for sick, but how will you pay for healthy?
The member level adjustment factor takes into account all aspects of the member’s health status and identifies a normalized risk score reflective of expected cost and utilization.

For new BlueCross BlueShield members, how would the risk factor be determined due to BlueCross BlueShield having no history?
The BestPractice concurrent risk score, or predictive score, considers a member’s current disease burden, age, and gender and then predicts utilization based on members with similar medical histories in the region.

What can I do to improve my revenue?
- Code all your chronic conditions as specifically as possible
- Avoid the use of unspecified codes when possible
- Code 99080 can be used to add additional diagnoses

My under 18-patient payments are adjusted for age. Why is it important to code accurately? What if I have a very sick child?
- Your coding will affect your quality scores.
- In 2018, efficiency will also adjust payments.
- Age is the best predictor of expected costs for children. Using risk to account for a sick child would likely underpay the rest of the under 18 population.
- Medical records are a legal document and should always accurately reflect a patient’s health status.
- Accurate documentation and coding provides support for referrals, prescribed treatments, claims payment, and licensure protection.
Is there someone who can help me with coding?
First - Be sure that all diagnoses that affect treatment and care are thoroughly documented and coded to the highest specificity. EMR vendor support may be able to update your EMR template with additional codes. Also, our coding team is available to:

- Review charts for documentation improvement support.
- Provide onsite support with consultants or separate follow-up.
- Review and compare medical record documentation to the submitted claim to determine accuracy and quality of diagnosis coding.

For assistance with coding support, contact Tracy James from BlueCross BlueShield at (716) 887-7532 or james.tracy@bcbswny.com.