BCBS ACO Provider Report Package User Guide

The guide below should help you navigate the BCBS ACO Provider Report Package. Resources are provided at the end of this document if you have questions or need additional training.

I. Introduction

The purpose of the BCBS ACO Provider Report Package is to share a new type of data with QHP providers, related to cost efficiency. In this case, cost represents the payors' paid claim amounts, or the cost to the payor. Shared risk arrangements build on the work QHP has already done with quality measures by incorporating the financial component into a product that is designed to reduce overall claim cost for a defined population while continuing to meet quality metrics. The information presented in the BCBS ACO Provider Report Package is intended to be informational only, and to allow providers to learn about a new type of data from the payors' perspective. This type of reporting can only be done in a shared risk arrangement, in which the payor shares all claims data with the contracted provider group. Our goal is to distribute this report semi-annually, and to allow providers to track their own cost related data over time.

II. BCBS ACO Provider Report Package- PDF File

The main report content is the PDF file, named BCBS ACO Provider Report Package. This file contains multiple pieces of information that the provider may use to learn more about cost patterns.

a. Page 1- Title Page
b. Page 2-3- Summary and Footnote Pages
    i. Quality Scores on page 2 represent overall QHP provider performance, individual details are presented later in the report.
    ii. The risk score definitions correspond with one of the Supplemental Excel Files reviewed in the next section, the Member Level Detail file. These scores and definitions are provided by Blue Cross.
c. Page 4- Generic Drug Look Up Tool
    i. This is included for providers who may wish to research drugs listed in one of the Supplemental Excel Files reviewed in the next section, the Generic Rx Detail File.
d. Page 5- Gaps in Care
    i. This is a snapshot of actual quality gaps specific to the provider receiving the report. The data is mostly claims based, so gaps may show for patients 2-3 months after they have received the service in question. If this is the case, you can disregard that gap; the gap will close when the claim is received and processed by the payor.
    ii. The QHP team sends supplemental data as well, from the QHP Registry tool. This helps close gaps for non-claims related services such as A1c and BP values.

It also helps close gaps for items with a long look-back period, such as mastectomy, hysterectomy, or colonoscopy.

iii. A link to the measure definitions is included on this page, clicking the link will take the user to the QHP website, where the definitions are located.

e. Page 6- Cost by Provider QHP
    i. This data is modified based on data provided by Blue Cross and represents the time period noted at the top of the first footnote and summary page. The calculation is the AVERAGE of all provider PMPM values for the specified QHP organization.

f. Page 7- Cost by Provider Organization Specific
    i. This data is provided by Blue Cross and represents the time period noted at the top of the first footnote and summary page. Diagnoses from claims billed to Blue Cross have been added, as well as demographics from the Blue Cross membership file.
    ii. We only share detailed provider data within a QHP organization, not across organizations.

g. Page 8- Generic Prescribe Rate
    i. This data is generated by our Analytics team. We receive partial claims data from Blue Cross and load into our IBM software. Our Analyst writes code to pull this information from IBM; all data for this report is pulled from pharmacy claims.
    ii. We only share detailed provider data within a QHP organization, not across organizations.

h. Page 9- Distinct Hospital Outpatient Revenue Codes
    i. This data is generated by our Analytics team. We receive partial claims data from Blue Cross and load into our IBM software. Our Analyst writes code to pull this information from IBM; all data for this report is pulled from hospital outpatient medical claims.
    ii. We chose revenue codes as our data point for hospital outpatient reporting. In this case the report is limited to revenue codes that tend to be high cost drivers: ED, Surgery, and CT/MRI. Only activity under these revenue codes is reported.
    iii. The report indicates patient name/dob, whether they have a PCP visit in the calendar year, and date of service, including day of week.

i. Page 10- Hospital Outpatient Revenue Codes Roll-Up
    i. This data is generated by our Analytics team. We receive partial claims data from Blue Cross and load into our IBM software. Our Analyst writes code to pull this information from IBM; all data for this report is pulled from hospital outpatient medical claims.
    ii. We chose revenue codes as our data point for hospital outpatient reporting. All revenue codes are included and listed from highest cost driver to lowest cost driver.

iii. The report includes the count of times the service was billed, and the number of patients who had received that service. For example, lab codes tend to have high volume counts because they may be performed as part of a maintenance routine, and therefore occur multiple times per year.

III. Supplemental Excel Files

There will be at least three supplemental Excel files included in each BCBS ACO Provider Report Package. All providers will receive the reports listed below. If no data is available for any of the reports, a blank file will be generated with the message: No Data Available. Depending on what a provider's data may show, there could be additional Supplemental Excel Files to help explain cost drivers.

a. Attachment I- Member Level Detail File
    i. This is mostly a Blue Cross provided file, with a few additions from the Analytics team. Additional fields are CY202x Medical Cost YTD and PCP Seen in CY202x. Data for both of these fields comes from IBM, medical claims only.
    ii. All providers will receive the most recent Member Level Detail file with each BCBS ACO Provider Report Package.
    iii. This file lists all BCBS ACO members who Blue Cross has attributed to a QHP provider. Depending on how an organization bills, mid-levels may have their own data, separate from their supervising physician.
    iv. The main sections of this report are patient demographics, chronic conditions, Blue Cross generated risk scoring, and IP, ED, and some specialty utilization.
    v. This report has a 12 month look-back period.
    vi. All data related to chronic conditions comes from claims submitted to Blue Cross.
    vii. Blue Cross generated risk score definitions are included in the Summary and Footnotes section of the BCBS ACO Provider Report Package PDF file. They are an indicator of likely higher claims cost in the present or near future.
    viii. Utilization data is based on claims data, both within and outside of QHP. Provider information is blinded for providers outside QHP. Some diagnoses may also be blinded, such as behavioral health or substance abuse, among others.
    ix. This report will have filters added along the field headers. In order to drill on a certain field, such as diabetes or IP visits > 2, click the triangle icon and check only the data you would like displayed. You may reset to original by clicking the triangle icon and check the Select All box.
    x. You may also wish to sort the report by cost or risk scores. In order to do so, highlight all fields within the report, then go to the Data tab and click Sort.
b. Attachment II- Non-Generic Rx Detail File
    i. This data is generated by our Analytics team. We receive partial claims data from Blue Cross and load into our IBM software. Our Analyst writes code to pull

this information from IBM; all data for this report is pulled from pharmacy claims.

ii. This report will provide all detail available regarding a prescribed drugs name, prescription fill date, and whether the drug is generic or name brand.
iii. The report is filtered on Non Generic only. In order to expand to include Generic prescriptions, click the triangle icon in the report field header and check only all data you would like displayed.
iv. The purpose of this report is informational, it is not an indicator that a provider is doing anything right or wrong, only to share information that a provider may not have been aware of with their own prescribe patterns.

c. Attachment III- ED Report File
    i. This data is provided by Blue Cross and represents the time period noted at the top of the first footnote and summary page, based on claims that have been billed and paid.
    ii. This report allows a provider to see all of their Blue Cross attributed patients with ED visits, the date and day of week for each visit, primary billed diagnosis, and whether they were admitted as inpatient.
    iii. The intent of this data is to provide an opportunity to quickly review for possible trends in inappropriate ED utilization, a major cost driver.

To schedule a formal training on the BCBS ACO Provider Report Package, please contact Jenny Hertter at jennifer.hertter@sih.net or Steve Coty at steven.coty@sih.net.