Blue Cross Blue Shield of North Dakota
Medicaid Expansion Alternative Payment Model Report
Submitted: April 1, 2023

2022 BlueAlliance Care+ Program Description

Blue Cross Blue Shield of North Dakota (BCBSND) established a value-based program for the Medicaid Expansion population in 2022. The program, named BlueAlliance Care+, is a spinoff of BCBSND's commercial value-based program and focuses on quality of care delivered to Medicaid Expansion (ME) members by in-network primary care providers. The program also contains measurements focused on utilization of services, such as unnecessary emergency department (ED) utilization and inpatient admissions.

The 2022 BlueAlliance Care+ program consists of two main components which financially incentivize participating provider organizations: a care management payment and a performance-based incentive payment. The care management payment is a flat, per member, per month payment to all participating provider organizations, regardless of quality performance. The intent of this payment is to allow provider organizations to fund infrastructure or staff needed to successfully manage the ME population. The performance-based incentive payment is based on a provider organization's performance on an identified set of quality and utilization measures. More detail around measures in the program and the related performance-based incentive payment for providers is included in this report.

Member Attribution

In this program, BCBSND uses a two-step methodology to attribute members to provider organizations.

In the first step, members are attributed to a provider organization based on which organization's primary care practitioners (PCP) billed the most eligible evaluation and management (E&M) services during the performance period. If more than one provider organization tied for billing the most eligible E&M services, the provider organization that billed the most non-E&M services for an ME member provided by a PCP during the performance period is selected. If still a tie, the provider organization with the highest number of unique dates of service with a PCP is selected.

If BCBSND did not receive a claim for a member showing they received an eligible E&M visit during the performance period, they are attributed to a provider organization based on geographical assignment. In this process, a member is assigned to a primary care clinic based the clinic selected by the member during enrollment or, if the member did not select a primary care clinic, the clinic assigned by BCBSND based on proximity to member's home address. In this process, the member is ultimately attributed to the provider organization associated with the primary care clinic.

Over the course of the 2022 performance year, an upward trend occurred in the number of members attributed through claims, while a downward trend occurred in the number of members attributed geographically. This was to be expected as more members sought primary care services throughout the year. However, of those members attributed to a provider organization participating in the BlueAlliance Care+ program at the end of the 2022 performance year, still only about 57% were attributed through claims, showing that there are still many Medicaid Expansion members that were not seen by a primary care provider in 2022. While the aggregate number of Medicaid Expansion members is likely to decrease going forward as the redetermination process begins again, there is still great opportunity to engage these members to encourage preventive care in a primary care setting.

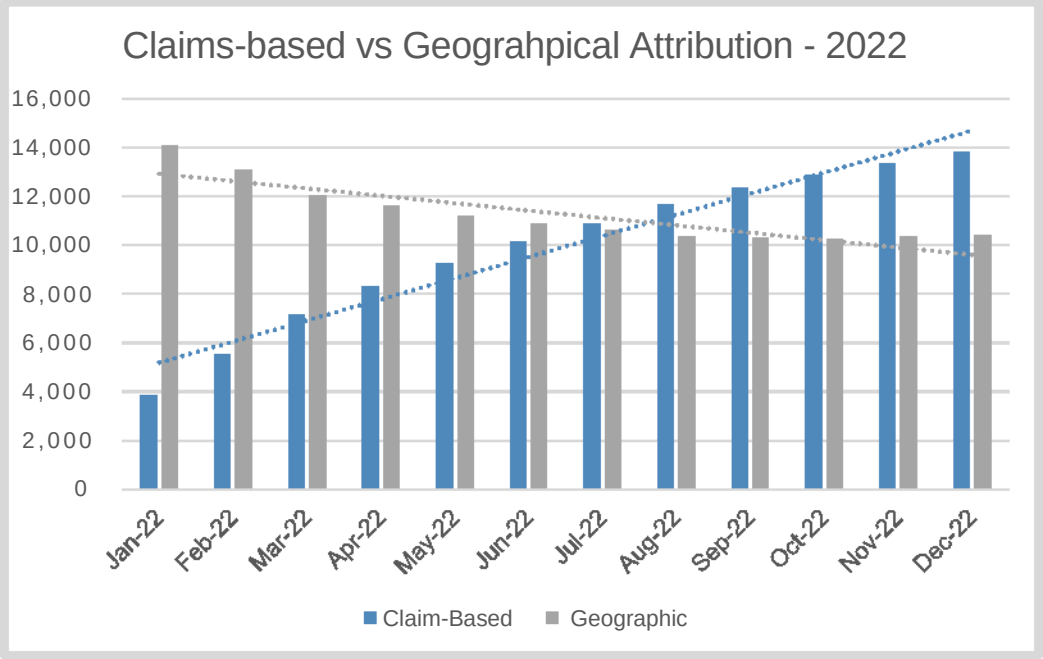

Figure 1: Trend in Claims-based Attribution vs Geographical Attribution

Care Management Payment

Provider organizations receive a monthly care management payment per attributed member, per month. The total payment to providers fluctuates monthly based on the number of Medicaid Expansion members attributed to each organization each month.

Performance-Based Incentive Payment

The second component of the program is a performance-based incentive payment, which a provider organization can earn based on performance in the Medicaid Expansion quality program. The 2022 quality program includes four measures: Primary Care Visits, Potentially Preventable ER Visits, Potentially Preventable Admissions and Post Discharge Follow-up Visits. A description of each measure can be found in **Table 1.** Projected quality tier is based on quality performance through October 2022, calculated with claims paid through December 2022. Final performance is expected to be calculated in May 2023.

Table 1: 2022 Quality Measures

Quality Measure	Quality Measure Description
Primary Care Visits	The percentage of Attributed Members with a visit to any PCP where qualified services were rendered at a qualified place of service in the Eligibility Period. This excludes ER or urgent care visits. This measure can be identified with primary care codes including, but not limited to, the following codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, G0402, G0438 and G0439. Minimum member count for measure to be included when calculating Quality Score is nineteen (19).
Potentially Preventable ER Visits (PPV)	Percent difference between expected PPV and observed PPV for Attributed Members. Expected PPV rate is adjusted to include the clinical risk group of patient panel and rounded up to the nearest whole number.
Potentially Preventable Admissions (PPA)	Percent difference between expected PPA and observed PPA for Attributed Members. Expected PPA rate is adjusted to include the clinical risk group of patient panel and rounded up to the nearest whole number.

Post Discharge Follow-up Visits	Percentage of Attributed Members with a visit to a qualified place of service with any qualified provider where qualified services were rendered within 30 days after an acute care hospitalization discharge, excluding deliveries and surgeries. Only one discharge is counted if multiple claims exist for the same length of stay to ensure follow-up visits aren't assessed against multiple claims filed for the same stay. This excludes ED or urgent care visits. This measure is identified with a combination of codes that relate to qualified inpatient and observation stays along with outpatient visits that would qualify for follow up. Some examples of these codes include, but are not limited to: 99201-99205, 99211-99215, 99217-99226, 99231-99236, 99241-99245, 9925199255, 99487-99491, 99495 and 99496. Minimum eligible case count for measure to be included when calculating Quality Score is six (6).

To determine the value of the performance-based incentive payment for each provider organization, BCBSND will calculate a provider organization's performance on each measure using claims data for their attributed members. A provider organization can earn up to eight (8) points in the program. Earned points in each measure are determined based on a provider organization's performance compared to quality thresholds for each measure, as shown in **Table 2** below.

Table 2: Quality Thresholds

Measure	1 Point	2 Points	Max Points by Measure
Primary Care Visits			2
Potentially Preventable ER Visits			2
Potentially Preventable Admissions			2
Post Discharge Follow-up Visits			2

The Provider Organization will be ranked into one of four quality tiers (A, B, C or D) based on their overall quality score, which will be used to determine the provider organization's performance-based incentive payment, as shown in **Table 3** below. The dollar value associated with each tier is a per member, per month figure, meaning a provider organization's total member months throughout the performance period are multiplied by the dollar value of their associated quality tier. Member months are calculated by summing the number of ME members attributed to a provider organization each month of the performance period.

For example, if the number of members attributed to a provider organization was consistent at 2,000 over the course of the performance year, their total member months would be 2,000 x 12 = 24,000. BCBSND is obligated per contract to deliver the final performance-based incentive payments to provider organizations no later than June 30, 2023 for the 2022 performance year.

Table 3: Quality Scoring

Quality Tier	Quality Percentage	Performance-Based Incentive Payment
A	75% - 100%	
B	>62% - 74.99% (62.01% - 74.99%)	
C	>37% - 62% (37.01% - 62%)	
D	≤37%	

Arkos Health

In September 2022, BCBSND engaged Arkos Health to provide transitional care management, emergency department coordination, social services, in-home palliative care services and in-home intensive care management to meet the complex needs of ME members.

BCBSND and Arkos Health continue to collaborate frequently around care management of the ME members. In addition, Arkos Health has started to engage local providers in North Dakota to partner in the care management of the ME members, while also ensuring streamlined processes are in place to achieve the greatest level of positive impact on the health and wellbeing of the ME members.

2023 BlueAlliance Care+ Program Design

For 2023, the BlueAlliance Care+ program has a very similar design to the 2022 program. One main change to the program will be an additional quality measures around inpatient readmissions being incorporated into the performance-based incentive program. With this addition, provider organizations can earn up to ten (10) points in the program. The description of the Potentially Preventable Readmission measure is below.

Quality Measure	Quality Measure Description
Potentially Preventable Readmissions (PPR)	Percent difference between expected PPR and observed PPR for Attributed Members. Measured by calculating expected PPR within thirty (30) days. Expected PPR rate is adjusted to include the clinical risk group of patient panel and rounded to the nearest whole number.

With the incorporation of an additional measure, BCBSND is also increasing the funding for the program to incentivize providers to continue to focus on performance on all quality measures, which has direct positive impact on ME members.

Quality Tier	Quality Score	Performance-Based Incentive Payment
A	8, 9, 10 points	
B	6 or 7 points	
C	4 or 5 points	
D	<4 points	

Future Program Design

The long-term goals of the BlueAlliance Care+ program are to improve the quality of care delivered to ME members, reduce unnecessary utilization, especially in high-cost settings such as the ED and inpatient setting, while also using the program as a supplemental component to manage the overall cost associated with the care delivered to the ME population. While this will not be accomplished solely through incentives offered to provider organizations through a value-based program, BCBSND believes such a program is an essential component to accomplish these goals. In the future, it is likely that the program will be refined to contain more comprehensive utilization metrics, while also incorporating measurements around overall costs associated with caring for this population.

When designing future quality programs, several factors will be considered. For example, one consideration will be alignment of measures with BCBSND's commercial program and other industry-standard value-based programs (i.e. Medicare Shared Savings Program). There is a recognition that there may be deviation needed to address specific health conditions that may be more prevalent with the ME population. A second is alignment with measures in which BCBSND's performance is measured in the contract with the Department of Health and Human Services (i.e. "withhold measures). A third example is the potential addition of measures related to the social determinants of health or health equity.

Additionally, BCBSND is looking for opportunities to expand the footprint of value-based programs tied to the ME population outside of just this primary-care based program. Some current areas of exploration include orthopedics and behavioral health. BCBSND is evaluating partners to engage in pilot programs in these two areas, with the potential to expand to other provider organizations in the future, depending on success of the pilot programs. Other specialties may be targeted for value-based programs in the future