BlueCross BlueShield Association

BlueDistinction®
Specialty Care

Program Selection Criteria: Maternity Care

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About This Document

The Program Selection Criteria outlines the selection criteria and evaluation process used to determine eligibility for the Blue Distinction Centers for Maternity Care program (the Program).

This document is organized into five sections:

1. Overview of the Blue Distinction Specialty Care Program
2. Evaluation process and data sources
3. Quality Selection Criteria
4. Business Selection Criteria
5. Cost of Care Selection Criteria

About the Blue Distinction Specialty Care Program

Blue Distinction Specialty Care is a national designation program recognizing healthcare providers that demonstrate expertise in delivering quality specialty care — safely, effectively, and cost efficiently. The goal of the program is to help consumers find both quality and value for their specialty care needs, while encouraging healthcare professionals to improve the overall quality and delivery of care nationwide and providing a credible foundation for local Blue Cross and/or Blue Shield Plans (Blue Plans) to design benefits tailored to meet employers' own quality and cost objectives[1]. The Blue Distinction Specialty Care Program includes two levels of designation:

- **Blue Distinction Centers (BDC)**: Healthcare providers recognized for their expertise in delivering specialty care.
- **Blue Distinction Centers (BDC+)**: Healthcare providers recognized for their expertise and cost efficiency in specialty care.

Quality is key: only those providers that first meet nationally established quality measures for BDC will be considered for designation as a BDC+.

Executive Summary

In early 2017, local Blue Plans invited 2,674 facilities across the country to be considered for the Maternity Care designation under this Program; over 1,500 facilities applied and were evaluated on objective, transparent selection criteria with quality, business, and cost of care components. This program focuses on Vaginal Delivery and Cesarean Delivery episodes of care; routine obstetrical services and follow up care are also included. Table 1 outlines the Maternity Care Program highlights.

[1] Benefit design is determined independently by the local Blue Plan and is not a feature of any Blue Distinction program.

Table 1: Program Highlights

PROGRAM HIGHLIGHTS	
Designation Levels	• BDC • BDC+
Accreditations Considered	• National Accreditation Organizations
Facility Types Considered For This Program	• Acute Care, Inpatient Facility • Children's Hospitals that offer *Maternity Services*
Evaluated Procedures	• Vaginal Delivery • Cesarean Delivery
Data Sources	• Quality: Provider Survey • Business: Plan Survey and Blue Brands evaluation; Local Blue Plan Criteria (if applicable) • Cost: Blue Plan healthcare claims data
Quality Data	• Cases occurring between April 1, 2015 through March 31, 2016.
Cost Data	• Blue Plan healthcare claims data, with cases occurring between January 1, 2014 through December 31, 2015. • Female Patients ages 18 – 64 years

Note: The complete Selection Criteria and evaluation process are described fully throughout the remainder of this document.

Understanding the Evaluation Process

Selection Process

The selection process balances quality, cost, and access considerations to offer consumers meaningful differentiation in quality and value for specialty care facilities that are designated as BDC and BDC+. Guiding principles for the selection process include:

Quality

Nationally consistent approach to evaluating quality and safety was used, incorporating quality measures with meaningful impact, including delivery system features and specific quality outcomes to which all can aspire.

Cost

Nationally consistent and objective approach for selecting BDC+ was used to address market and consumer demand for cost savings and affordable healthcare.

Access

Blue members' access to Blue Distinction Centers was considered to achieve the Program's overall goal of providing differentiated performance on quality and, for the BDC+ designation, cost of care.

Evaluation Components: Data Sources

Objective data from detailed Provider Survey, Plan Survey and Blue Plan healthcare claims data information were used to evaluate and identify facilities that meet the Program's Selection Criteria. A facility must meet all of the Program's Selection Criteria, defined by the following evaluation components (Table 2), to be eligible for the BDC or BDC+ designation:

Table 2: Evaluation Components

EVALUATION COMPONENT	DATA SOURCE	BLUE DISTINCTION CENTERS (BDC)	BLUE DISTINCTION CENTERS+ (BDC+)
Quality	Information obtained from a facility in the Provider Survey.	✓	✓
Business	Information obtained from the local Blue Plan in the Plan Survey and Blue Brands evaluation.	✓	✓
Cost of Care	Blue Plan Healthcare Claims Data.		✓

Measurement Framework

Blue Distinction Specialty Care programs establish a nationally consistent approach to evaluating quality and safety by incorporating quality measures with meaningful impact. Selection Criteria continues to evolve through each future evaluation cycle, consistent with medical advances and measurement in this specialty area. The measurement framework for this and other Blue Distinction value-based initiatives were developed using the following guiding principles:

- Utilize a credible process and produce credible results with meaningful, differentiated outcomes.
- Align with other national efforts using established measures, where appropriate and feasible.
- Simplify and streamline measures and reporting processes.
- Enhance transparency and ease of explaining program methods.
- Utilize existing resources effectively, to minimize costs and redundancies.
- Meet existing and future demands from Blue Plans, national accounts, and Blue Members.

Quality Selection Criteria

Facilities were evaluated on quality metrics developed through a process that included: input from the medical community and quality measurement experts; review of medical literature, together with national quality and safety initiatives; and a thorough analysis of

meaningful quality measures. The quality evaluation was based on facility responses to the Provider Survey which included objective and transparent, quality metrics.

The Quality Selection Criteria includes general facility structure metrics and patient outcome metrics that are specific to maternity care. For measure reliability, the outcome measures must have sufficient denominator volume of equal to or greater than 11 cases. The denominator for the PC-01 Early Elective Delivery metric is specific to patients delivering newborns with greater than or equal to 37 and less than 39 weeks gestation; thus, it will meet Selection Criteria if it is equal to 0 (as no early elective deliveries occurred). Facility results were analyzed using a confidence interval (90 percent) around the point estimate from the reported numerator and denominator events. A "confidence interval" is a term used in statistics that measures the probability that a result will fall between two set values. The lower confidence limit (LCL) was then compared to the national Selection Criteria thresholds.

Table 3 identifies the Quality Selection Criteria used in the evaluation of each facility. A facility must meet all Quality Selection Criteria and Business Selection Criteria requirements to be considered eligible for the Blue Distinction Centers for Maternity Care designation.

Table 3: Quality Selection Criteria

DOMAIN	SOURCE	QUALITY SELECTION CRITERIA
National Accreditation*	Provider Survey Q#4	Facility is fully accredited by **at least one** of the following national accreditation organizations:* • The Joint Commission (TJC) in the Hospital Accredited Program. • Healthcare Facilities Accreditation Program (HFAP) of the Accreditation Association for Hospital and Health Systems (AAHHS) as an acute care hospital. • DNV GL Healthcare in the National Integrated Accreditation for Healthcare Organizations (NIAHO®) Hospital Accreditation Program. • Center for Improvement in Healthcare Quality (CIHQ) in the Hospital Accreditation Program. **NOTE: To enhance quality while improving Blue Members' access to qualified providers, alternate local Accreditations that are at least as stringent as any National Accreditations, above, may be offered under the local Blue Plan Criteria; for details, contact the facility's local Blue Plan.*
PC-01: Early Elective Delivery	Provider Survey Q#11	Percent of newborns whose deliveries were scheduled early (1-3 weeks early), when a scheduled delivery was not medically necessary, calculated lower confidence limit (LCL), is **at or below 5%.**
PC-02: Cesarean Section	Provider Survey Q#12	Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section, calculated lower confidence limit (LCL), is **at or below 27%.**

DOMAIN	SOURCE	QUALITY SELECTION CRITERIA
Incidence of Episiotomy	Provider Survey Q#16	Vaginal Deliveries during which an episiotomy was performed, calculated lower confidence limit (LCL), is **at or below 15%.**

Informational Quality Metrics

Additional informational analyses based on Blue Plan healthcare claims data was performed to calculate the Severe Maternal Morbidity (SMM) Rate, a measure developed by the Centers for Disease Control (CDC). The SMM measure is supported and is being used by several state-level and public health stakeholders, and encompasses the most severe complications of pregnancy and includes conditions resulting from or aggravated by pregnancy that adversely affect a woman's health.

Measurement results under the Center for Disease Control's (CDC) Severe Maternal Morbidity (SMM) specifications were calculated using data derived from Blue Plan healthcare claims, with dates of service from January 1, 2014 through December 31, 2015. SMM results were not used in the current Quality Selection Criteria for Blue Distinction eligibility status, and are shared with facilities as informational feedback to raise internal awareness and stimulate quality improvement.

Additional information on this measure is available at http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/SevereMaternalMorbidity.html.

Business Selection Criteria

The Business Selection Criteria (Table 4) consists of three components:

1. Facility Participation;
2. Blue Brands Criteria; and
3. Local Blue Plan Criteria (if applicable)

A facility must meet **all** components listed in Table 4 to meet the Business Selection Criteria for the Blue Distinction Centers for Maternity Care designation.

Table 4: Business Selection Criteria

BUSINESS SELECTION CRITERIA	
Facility Participation	Facility is required to participate in the local Blue Plan's BlueCard Preferred Provider Organization (PPO) Network.
Blue Brands Criteria	Facility meets BCBSA criteria for avoiding conflicts with BCBSA logos and trademarks.
Local Blue Plan Criteria (if applicable)	An individual Blue Plan, at its own independent discretion, may establish and apply local business requirements as additional selection criteria for eligibility in a Blue Distinction Centers program, for facilities located within its Service Area.

Note: *Physician participation in the local Blue Plan's PPO Network is not part of the Selection Criteria and evaluation for this Program at this time but will become a requirement in the future. Members should check with their local Blue Plan to confirm physician network participation.*

Cost of Care Selection Criteria

Cost of care measures were designed to address market and consumer demand for cost savings and affordable healthcare. The Cost of Care Selection Criteria was used to provide a consistent and objective approach to identify BDC+ facilities.

> ***Quality is key:*** only those facilities that first meet nationally established, objective quality measures for BDC will be considered for designation as a BDC+.

Cost Data Sources and Defining the Episodes

Cost of Care evaluation was based on a nationally consistent claims analysis of Blue Plan healthcare claims data. The scope of this analysis included:

- Two years of Maternity Care episodes are included in the analysis, with triggering inpatient deliveries occurring between January 1, 2014 through December 31, 2015
- Maternity Care episodes were identified and triggered by inpatient deliveries, either Vaginal Delivery or Cesarean Delivery. Maternity episodes are identified and triggered by Medicare Severity Diagnosis Related Groups (MSDRG) and the relevant clinical categories for vaginal and cesarean deliveries are outlined below:

  Clinical Category 1: Vaginal Deliveries

  - MS-DRG 774 = Vaginal Delivery with Complicating Diagnoses
  - MS-DRG 775 = Vaginal Deliveries without Complicating Diagnoses

  Clinical Category 2: Cesarean Section Deliveries

  - MS-DRG 765 = Cesarean Section with CC/MCC*
  - MS-DRG 766 = Cesarean Section without CC/MCC*

Note: * CC = Complications and Comorbidities/MCC = Major Complications and Comorbidities.

- Vaginal Deliveries coded under MS-DRG 767 (Vaginal Delivery with Sterilization &/or D&C) or MS-DRG 768 (Vaginal Delivery with O.R. Procedure except Sterilization &/or D&C) were excluded from the cost analysis due to very low volume of cases, each representing < 0.5% volume of delivery cases nationwide.
- Adjusted allowed amounts for professional and in-network facility claims were included, using specific maternity clinical categories – either Vaginal or Cesarean Deliveries noted above – for continuously enrolled commercial Blue female members with both a facility and professional claim.
- Members are excluded if they meet any of the following criteria:
  - Exclude age <18 or >64 years
  - Non-female gender
  - Discharge status Left Against Medical Advice (LAMA)

  - In-hospital death of the mother
  - Multiple deliveries (e.g., twins, triplets, etc.)
  - Primary payer is not a Blue Plan
- Episode window for maternity begins 280 days before the date of admission of the index admission and ends 90 days after the date of the discharge from the index admission.
  - The 280-day look-back period includes routine obstetric physician costs for office visit Evaluation and Management (E&M) CPT codes. The index admission includes all costs during admission (e.g., facility, delivering OB physician, other professional and ancillary costs).
  - The 90-day look-forward period includes relevant services, relevant diagnoses, and complications.

Adjusting Episode Costs

Facility episode costs were analyzed separately for each clinical category (i.e., Vaginal Delivery was evaluated separately from Cesarean Delivery), as follows:

- A geographic adjustment factor was applied to the episode cost, to account for geographic cost variations in delivering care. Episode costs were adjusted using the CMS Geographic Adjustment Factors (GAF), resulting in a Geographically Adjusted Facility Episode Cost.
- Risk adjustment was used to adjust for variation in cost that may relate to differences in patient severity (with or without comorbidity), using the following steps:
  - Identified patient severity levels, using the MS-DRG risk stratification system.
  - Created separate risk bands within episodes, based on patient severity level and age (18-39 and 40-64).
  - Managed outliers through winsorization within risk bands. Outliers were identified in each risk band as those values for which geographically adjusted costs were the top 2 percent and bottom 2 percent of episode costs. Outlying cost values were truncated to these points, to preserve their considerations in calculating the overall episode cost estimate, while moderating their influence.
  - The national expected cost for each clinical category/risk level combination is divided by the national mean cost for the clinical category, to calculate the Risk Ratio for each clinical category/risk level combination.
  - The Risk Adjustment Factor (which is the inverse of the Risk Ratio) is multiplied by each facility's geographically adjusted and winsorized facility episode costs for each clinical category/risk level combination, to normalize for risk, resulting in a final episode cost that is both geographically adjusted and risk adjusted.

Establishing the Cost Measure

Each Maternity Care episode was attributed to the facility where the delivery occurred based on trigger events that occurred at that facility for each of the two clinical categories (i.e., Vaginal Deliveries and Cesarean Deliveries). Clinical Category Facility Cost (CCFC)

was calculated separately for Vaginal Delivery and Cesarean Delivery, based on the median value of the adjusted episode costs.

Confidence intervals (90 percent) were calculated around each Clinical Category Facility Cost measure; the Upper Confidence Limit of the measure was divided by the National median episode cost to become the Clinical Category Facility Cost Index (CCFCI). A minimum of five episodes was required for each Maternity Care clinical category, in order to be included in the calculation of a Composite Facility Cost Index (CompFCI) for a facility. Any facility that did not meet this episode minimum did not meet the cost of care Selection Criteria.

Using each of the Clinical Category Facility Cost Index values, an overall Composite Facility Cost Index was calculated for the facility. Each Clinical Category Facility Cost Index was weighted by that facility's own volume and facility costs to calculate a composite measure of cost called the Composite Facility Cost Index. The Composite Facility Cost Index was then rounded down to the nearest 0.025 for each facility and compared to the National Cost Selection Criteria.

Cost Selection Criteria

In addition to meeting the nationally established, objective quality and business measures, a facility also must meet **all** of the following cost of care selection criteria (Table 5) requirements to be considered eligible for the BDC+ designation.

Table 5 – Cost of Care Selection Criteria

COST OF CARE SELECTION CRITERIA
Facility must meet Minimum Case Volume Requirement for each clinical category: • Vaginal Delivery: **minimum case volume of 5**; and • Cesarean Section: **minimum case volume of 5**
The Composite Facility Cost Index must be **below 1.150**.

Questions

Contact your local Blue Plan with any questions.

Blue Distinction Centers (BDC) met overall quality measures for patient safety and outcomes, developed with input from the medical community. A Local Blue Plan may require additional criteria for providers located in its own service area; for details, contact your Local Blue Plan. Blue Distinction Centers+ (BDC+) also met cost measures that address consumers' need for affordable healthcare. Each provider's cost of care is evaluated using data from its Local Blue Plan. Providers in CA, ID, NY, PA, and WA may lie in two Local Blue Plans' areas, resulting in two evaluations for cost of care; and their own Local Blue Plans decide whether one or both cost of care evaluation(s) must meet BDC+ national criteria. National criteria for BDC and BDC+ are displayed on www.bcbs.com. Individual outcomes may vary. For details on a provider's in-network status or your own policy's coverage, contact your Local Blue Plan and ask your provider before making an appointment. Neither Blue Cross and Blue Shield Association nor any Blue Plans are responsible for non-covered charges or other losses or damages resulting from Blue Distinction or other provider finder information or care received from Blue Distinction or other providers.