BlueCross BlueShield Association

BlueDistinction®
Specialty Care

Program Selection Criteria: Maternity Care

Released October 2020

Document Overview

The Program Selection Criteria outlines the Quality, Business, and Cost of Care Selection Criteria and evaluation processes used to determine eligibility for the Blue Distinction® Centers (BDC) for Maternity Care program (this Program).

Sections of this document include:

Blue Distinction Centers for Maternity Care

The BDC for Maternity Care program (Program) evaluates facilities with maternity care services that treat adult patients 18 years or older, in acute care hospitals as well as children's hospitals that offer maternity services for adults. This Program evaluates patient outcomes and additional measures collected in the 2020 Maternity Care Provider Survey.

Designation as a BDC for Maternity Care differentiates providers locally, as well as nationally, and includes two levels of designation:

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

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

Designations are awarded to individual facilities (i.e., unique bricks-and-mortar facilities with unique addresses). Any facility with multiple locations (different addresses) was evaluated separately for each location. Health systems and other groups of multiple facilities/clinics are not designated collectively.

Evaluation Process

Blue Distinction Specialty Care programs establish nationally consistent and continually evolving approaches to evaluating quality and value of care. The evaluation 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.

Data Sources

Objective data from the Provider Survey, Plan Survey, and National Blue Claims Dataset (Claims Data) information were used to evaluate and identify facilities that meet the Program's Selection Criteria. Table 1 below outlines the data sources used for evaluation of this Program.

Table 1: Data Sources

Selection Criteria Components	Data Source	Blue Distinction Centers (BDC)	Blue Distinction Centers+ (BDC+)
Quality	• Quality data supplied by applicant facility in the Provider Survey • Local Blue Plan Quality Criteria *(if applicable)*	✓	✓
Business	• Data supplied by Blue Plan in the Plan Survey • Review of Blue Brands Evaluation • Local Blue Plan Business Criteria *(if applicable)*	✓	✓
Cost of Care	• Claims Data • Local Blue Plan Cost Criteria *(if applicable)*		✓

Note: Due to challenges presented by the COVID-19 pandemic, BCBSA reserves the right to make necessary accommodations to this Program's Selection Criteria. Accommodations, if any, will be made on a nationally consistent basis and communicated through your local Blue Plan.

Quality Evaluation

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 programs were developed using the following guiding principles:

- Utilize a credible process and produce credible results with meaningfully differentiated outcomes
- Align with other national efforts using established measures, where appropriate and feasible
- Simplify and streamline measures and reporting process
- Enhance transparency and ease of explaining program methods

Quality Methodology

The measures used in the quality evaluation were selected through a process that included input from the medical community and quality measurement experts, and review of medical literature. This process also included an analysis of national quality and safety initiatives; and a thorough analysis of meaningful quality measures.

The Quality Selection Criteria includes general facility structure and process measures, and patient outcome measures specific to maternity care. Evaluation was based on facility responses to the Provider Survey for cases performed from January 1, 2019 through December 31, 2019.

The selected measures are joined into the final aggregate scoring model for evaluating facilities. The goal of the program is to create a final aggregate model that provides differentiated performance on quality (at least 10% better than the comparison group) while still providing Blue Member access.

Furthermore, the scoring of quality outcome measures was based on the lower confidence limits (LCL) of these outcome measures, not on the actual point estimate of the quality outcome measures. This benefits the facility by taking potential measurement error into account, based upon statistical confidence predictions. If a facility's LCL is above the threshold, that indicates that the facility performance is worse than the threshold and they will fail the quality scoring threshold for that measure; but if a facility's LCL is equal to or below the threshold, then that facility's performance is the same or better than the threshold and that facility would meet the quality scoring threshold for that measure.

Patient outcome measures were evaluated only if the analytic measure volume (measure denominator) reported was greater than or equal to 11. If the reported analytic measure volume was less than 11, then that patient outcome measure was not evaluated due to insufficient data.

Quality Selection Criteria

The Quality Selection Criteria are outlined below. The structure and process measures are outlined in Table 2. The patient outcome measures are outlined in Table 3. **Applicant Facilities must meet requirements in Table 2 and Table 3 to meet the Quality Evaluation portion of the eligibility decision.**

Structure and Process Measures

Table 2: Structure & Process Selection Criteria

Quality Selection Criteria: Structure and Process Measures		
Measure Name	**Data Source**	**Selection Criteria Description**
National Accreditation*	Provider Survey Question #6	The facility is fully accredited by **at least one** of the following national accreditation organizations: • The Joint Commission (TJC) (without provision or condition) in the Hospital Accreditation Program. • Healthcare Facilities Accreditation Program (HFAP) of the Accreditation Association for Hospital and Health Systems (AAHHS) and is an acute care hospital. www.hfap.org • National Integrated Accreditation Program (NIAHO℠)—Acute Care of DNV GL Healthcare. • 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.*
Quality Improvement Program	Provider Survey Question #45	The applicant facility has an internal quality improvement program to assess maternity care.
Data Collection	Provider Survey Question #38	The applicant facility has an established system to accurately document self-identified race, ethnicity, and primary language.
Hypertension Management	Provider Survey Question #28, #30, or #31	The applicant facility **must have one** of the following: • Facility-wide standard protocols (with checklists and escalation policies) for management and treatment of severe hypertension, eclampsia, seizure prophylaxis, and magnesium over-dosage, and postpartum presentation of severe hypertension/preeclampsia. ('Yes' to Q#28) **OR** • Facility implemented (or in the process of implementing) the Council on Patient Safety's Severe Hypertension safety bundle. ('Yes' to Q#30) **OR** • Facility indicated that they have implemented **6 or more** elements from the Severe Hypertension safety bundle. (Checked 6 or more boxes in Q#31)
Hemorrhage Management	Provider Survey Question #24 or 25	The applicant facility **must have one** of the following: • Facility implemented (or in the process of implementing) the Council on Patient Safety's hemorrhage safety bundle. ('Yes' to Q#24) **OR** • Facility indicated that they have implemented **6 or more** elements from the Severe Hypertension safety bundle. (Checked 6 or more boxes in Q#25)
Drills for Serious Maternal Adverse Events	Provider Survey Question #40	The applicant facility hold drills or simulations for serious maternal adverse events.
Local Plan Quality Criteria (if applicable)	Plan Survey	An individual Blue Plan, at its own independent discretion, may establish and apply local quality requirements as additional Selection Criteria for eligibility in a Blue Distinction Centers Program, for facilities located within its Service Area.

Patient Outcome Measures

Applicant facilities must meet the patient outcome measures for the Maternity Care procedures, as reported in the Provider Survey. The patient outcome measure evaluation requirements and details are outlined below and in Table 3.

1) To be evaluated, a facility must meet the minimum analytic measure volume (measure's denominator).
- **a)** If the analytic measure volume is greater than or equal to 11, the patient outcome measure will be evaluated.
- **b)** If the analytic measure volume is less than 11, the patient outcome measure cannot be evaluated, and the facility will not meet this criteria.

Table 3. Patient Outcome Selection Criteria

Quality Selection Criteria: Patient Outcome Measures		
Measure Name	**Data Source**	**Selection Criteria Description**
Analytic Measure Volume	Provider Survey Question #10, #11, and #13	Facility's analytic measure volume is **greater than or equal to 11** for the following measures: • PC-01 Early Elective Delivery Denominator • PC-02 Cesarean Section Denominator • Episiotomy Denominator
Episiotomy Rate	Provider Survey Question #13	Percent of women who received an episiotomy during a vaginal birth **must be less than or equal to 14%**
PC-01 (Elective Delivery)	Provider Survey Question #17	Rate of patients delivering newborns with >=37 and <39 weeks gestation completed **must be less than or equal to 5%.**
PC-02 (Caesarean Section)	Provider Survey Question #18	Rate of Nulliparous Patients who delivered a live term singleton newborn in vertex presentation via cesarean section **must be less than or equal to 24.7%**

Quality Informational Measures

The following informational measures were reported by applicant facilities in the Provider Survey and through Blue Claims data. These measures were not scored and are to be used as an educational tool for quality improvement. In future designation cycles, these informational measures may become selection criteria (and required to be eligible for the Maternity Care designation).

Table 4. Informational Measures

Informational Measures		
Measure Name	**Source**	**Evaluation Component Description**
Severe Maternal Morbidity	Blue Claims	• Cesarean Section Severe Maternal Morbidity (SMM) • Vaginal Severe Maternal Morbidity (SMM)
Adverse Event Drills and simulations	Provider Survey Questions #28 and #60	• Facility performs adverse event drills and simulations on a regular basis • Facility mandates physicians participate in drills and simulations
Physician Performance- PC-02	Provider Survey Questions #46	• Facility Reports PC-02 Rates to physicians annually • Facility Reports PC-02 Rates to physicians quarterly • Facility Reports PC-02 Rates to physicians monthly • Facility Reports PC-02 Rates to physicians- None (i.e., no reporting)

Informational Measures		
Measure Name	**Source**	**Evaluation Component Description**
Patient Reported Outcomes	Provider Survey Questions #46	• Facility uses Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) to measure patient satisfaction • Facility uses HCAHPS and other patient satisfaction survey tool to measure patient satisfaction • Facility uses other patient satisfaction survey tool to measure patient satisfaction

Business Selection Criteria

The Business Selection Criteria consists of the following components:

1. Facility Performs Services
2. Facility Preferred Provider Organization (PPO) Participation;
3. Blue Brands Criteria; and
4. Local Blue Plan Business Criteria (if applicable)

A facility must meet **all** components listed below in Table 5 to meet the Business Selection Criteria for the Blue Distinction Centers for Maternity Care designation.

Table 5. Business Selection Criteria

Business Selection Criteria	
Facility Performs Services	Facility must perform Maternity Care services.
Facility PPO Participation	Facility must participate in the local Blue Plan's BlueCard® Preferred Provider Organization (PPO) network.
Blue Brands Criteria	Facility and its corporate family meets BCBSA criteria for avoiding conflicts with BCBSA logos and trademarks.
Local Blue Plan Business 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 providers 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 the Program at this time but **will become a requirement in the next evaluation cycle**. Additionally, Blue Cross Blue Shield believes that all patients should be protected from surprise medical bills. We are strongly committed to working with policy makers, hospitals and physicians on solutions to better protect consumers while preventing unintended costs and disruptions to the healthcare system. For that reason, the Blue Distinction Specialty Care program is currently evaluating a new national selection criteria requirement – for the next evaluation cycle – that the applicant provider, plus all hospital-based physicians must participate in the local Blue Plan's Preferred Provider Organization (PPO) Network, in order for that applicant provider to receive a Blue Distinction designation.

Cost of Care Selection Criteria

In addition to meeting the nationally established, objective Quality and Business Selection Criteria for BDC, Facilities must meet all of the following Cost of Care Selection Criteria (Table 6) requirements to be considered eligible for the BDC+ designation.

Table 6. Cost of Care Selection Criteria

Cost of Care Selection Criteria	
Measure Name	**Selection Criteria Description**
Episode Volume	The facility has **greater than or equal to 5** matched episodes of cost data in both of the clinical categories: • Vaginal Birth • Cesarean Birth
Composite Cost Index	Composite Cost Index must be **less than** the nationally established threshold of 1.09.
Local Plan Cost Criteria (If Applicable)	An individual Blue Plan, at its own independent discretion, may establish and apply local cost requirements as additional Selection Criteria for eligibility in a Blue Distinction Centers program, for providers located within its Service Area.

Cost of Care Evaluation

Cost of care measures were designed to address market and consumer demand for cost savings and affordable healthcare. The Cost of Care Selection Criteria were used to provide a consistent and objective approach to identify BDC+ facilities. The inputs and methodology used in the cost of care evaluation are explained below.

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

Defining the Episodes

Cost of care evaluation was based on a nationally consistent analysis of Claims Data. To provide validity for comparisons, cost analytics for the BDC Maternity Care program focus on vaginal and cesarean births.

Cost Data Sources

Each facility's cost of care is calculated using adjusted allowed amounts for specific maternity care episodes of care for actively enrolled Blue members, derived from Blue Plans' PPO claims data from January 1, 2017 through December 31, 2018, and paid through February 28, 2019, with case trigger dates occurring between January 1, 2017 and December 31 2018.

Clinical Category Identification Criteria

To provide validity for comparisons, cost analytics for the BDC Maternity Care program focus on commonly performed procedures. Specifically, the program focuses on two Maternity Care events:

- Vaginal Birth
- Cesarean Birth

Maternity episodes are triggered by inpatient deliveries – either vaginal or cesarean, using the Blue Claims data. Maternity episodes are identified and triggered by MS-DRGs (DRGs are assigned by Blue Health Intelligence® (BHI) to ensure consistency of approach), and are listed in Table 7.

Table 7. Maternity Care MS-DRG Trigger Codes

Trigger Category	Code Type	Code	Code Description
Vaginal Deliveries	MS-DRG	774	Vaginal Delivery with Complicating Diagnoses
	MS-DRG	775	Vaginal Deliveries without Complicating Diagnoses
Cesarean Deliveries	MS-DRG	765	Cesarean Section with CC/MCC
	MS-DRG	766	Cesarean Section without CC/MCC

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) are excluded from the cost analysis, due to very low volume of cases.

Member Exclusion Criteria

- Exclude age <18 or >64 years
- Exclude discharge status Left Against Medical Advice (LAMA)
- Exclude in-hospital death
- Exclude when primary payer is not a BCBS Plan
- Exclude members not continuously enrolled for the duration of the episode
- Exclude multiple delivery (e.g., twins)
- Exclude gender equal to male or unknown

Clinical category costs are adjusted for the impact of significant patient co-morbidities, via risk adjustment methods. No other clinical exclusions are applied.

Episode Duration: Each delivery episode type has time windows before and after the episode trigger event within which relevant services may be included. The trigger start date is the First Service Date from the facility header claim identified, as the trigger claim. The episode window for maternity begins 280 days prior to date of admission of the index admission and ends 90 days following discharge from the index admission. Episodes are included in the analysis only if the member is continuously eligible for relevant (primarily PPO) BCBS benefits throughout the episode duration. Incomplete episodes (such as gaps in member eligibility during the look-back and look-forward windows and a lack of both facility and professional claims) are excluded.

- Episode begin: Date of index admission – 280 days
- Episode end: Date of index discharge + 90 days
- Continuously enrolled: Episode begin and end dates are between eligibility begin and end dates, and member does not have any gaps in eligibility between episode begin and end dates
- Trigger event: first service date from facility header

Adjusting Episode Costs

Facility episode costs were analyzed and adjusted separately for each clinical category, as follows:

- Adjustments in episode costs are needed for both the validity and fairness of cost comparisons among providers. Two types of adjustment include:
  1) Factor adjustment which adjusts for factors known to have a predictable impact on costs of care. These include:
     - Adjustments for predictable cost differences related to geography
     - Adjustments for predictable cost differences due to risk (or, more specifically, due to differences in the clinical characteristics of patients and age that have a measurable and predictable impact on costs)
  2) Outlier management – which protects against rare, unpredictable high-cost and very low events that could have a dramatic impact on average costs for a provider.
- A geographic adjustment factor was applied to the episode cost**,** to account for geographic cost variations in delivering care. Adjustments made for predictable cost differences related to geography, using Geographic Adjustment Factors (GAFs) for 89 Geographic Practice Cost Index (GPCI) localities level, as defined by CMS.
- Risk adjustment was used to adjust for variation in cost that may relate to differences in patient severity (with or without comorbidity), as well as case mix, using the following steps: Adjustment for differences in patient risk is needed to support credible comparison of episode costs for different providers.
  - Identified patient severity levels, using the MS-DRG risk stratification system.
  - Three separate age-bands (18-34 years, 35-39 years and 40+ years) were created for better risk assessment within each broad clinical category. As a result, there will be a total of 9 sub-categories to calculate 9 risk adjustment factors under both vaginal and cesarean deliveries.
  - 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.
  - Calculated a Risk Ratio for each risk band by taking the mean of the episode costs within each risk band and dividing it by the overall mean episode cost for the relevant clinical category.
  - The Risk Adjustment Factor (which is the inverse of the Risk Ratio) is multiplied by each facility's geographically adjusted 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 episode was attributed to the facility where the primary procedure/surgery occurred, based on trigger events that occurred at that facility for each clinical category. Each Clinical Category Cost (CCC) was calculated separately, based on the median value of the adjusted episode costs. Confidence intervals (90 percent) were

calculated around each Clinical Category Cost measure; the Upper Confidence Limit of the measure was divided by the National median episode cost to become the Clinical Category Cost Index (CCCI).

Using each of the Clinical Category Cost Index values, an overall Composite Cost Index (CCI) was calculated for the facility. Each Clinical Category Cost Index was weighted by that facility's own volume and facility costs to calculate a composite measure of cost called the Composite Cost Index. The Composite Cost Index was then rounded down to the nearest 0.025 for each facility and compared to the National Cost Selection Criteria. A minimum of 5 episodes was required in at least one clinical category in order to consider the Clinical Category Cost Index valid.

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.