BlueCross BlueShield Association

BlueDistinction®
Specialty Care

Program Selection Criteria: Cardiac Care

Released August 2018

About This Document

The Program Selection Criteria outlines the selection criteria and evaluation process used to determine eligibility for the Blue Distinction Centers for Cardiac 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 2018, local Blue Plans invited 2,400+ providers across the country to be considered for the Cardiac Care designation under this Program; over 800+ providers applied and were evaluated on objective, transparent selection criteria with Quality, Business, and Cost of Care components. This Program focuses on Percutaneous Coronary Interventions (PCI), Coronary Artery Bypass Graft (CABG), and cardiac valve surgery episodes of care performed at comprehensive inpatient acute care hospitals. The applicant provider must perform both PCI and cardiac surgery procedures (CABG and valve), for patients ages 18 years and older, to be considered for designation. Table 1 outlines the Cardiac 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 (*see* Table 4)
Provider types considered for this Program	• Comprehensive Inpatient Acute Care Hospitals
Evaluated Procedures	• Percutaneous Coronary Interventions (PCI) • Coronary Artery Bypass Graft (CABG) • Aortic Valve Replacement (AVR) • Mitral Valve Repair and Replacement (MVR, MVRR)
Data Sources	• Quality: Provider Survey and Third Party Registry Data from the American College of Cardiology (ACC), Society of Thoracic Surgeons (STS), and publicly available Provider Compare data from Centers of Medicare and Medicaid (CMS) • Business: Plan Survey and Blue Brands evaluation; plus Local Blue Plan Criteria (if applicable) • Cost: Blue Plans' healthcare claims data
Quality Data	• Third Party Registry Data: o ACC NCDR® CathPCI® Institutional Outcomes Report, Released October 2017 o STS Adult Cardiac Surgery Database 2017 Quarter 3 Report, Released October 2017 o Hospital Compare, Publicly Available Data as of January 2018
Cost Data	• Blue Plans' healthcare claims data, with services occurring between January 1, 2014 through December 31, 2016 and paid through March 31, 2017. • Blue Patients ages 25 - 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 providers 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.

Data Sources

Objective data from detailed Provider Survey, Third Party Registry Data, Plan Survey and Blue Plans' healthcare claims data information were used to evaluate and identify providers that meet the Program's Selection Criteria. Table 2 below outlines the data sources used for evaluation under this Program.

Table 2: Data Sources

EVALUATION COMPONENT	DATA SOURCE	BLUE DISTINCTION CENTERS (BDC)	BLUE DISTINCTION CENTERS+ (BDC+)
Quality	Information obtained from a provider in the Provider Survey Publicly available data from Hospital Compare, www.hospitalcompare.hhs.gov	✓	✓
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 continue to evolve through each 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

Providers 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 provider responses to the Provider Survey and publicly available Hospital Compare data.

The Quality Selection Criteria includes structure, process, and outcome metrics specific to Cardiac Care. Most provider metrics were analyzed using a confidence interval (CI) of 90 percent around the point estimate (e.g., observed rate). "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) or upper confidence limit (UCL) was then compared to the national Selection Criteria thresholds, depending on whether lower results or higher results represent better performance (e.g., lower mortality is better, but higher adherence to medication is better). Other metrics, where a CI was not calculated, were compared against the Selection Criteria threshold.

Tables 3a and 3b below translate CI results into "meets criteria" or "does not meet criteria" categories. Additionally, interpretation into three statistical categories of performance is provided for comparison ("statistically better," "no different," or "statistically worse" than the threshold).

Table 3a –Lower Confidence Limit (LCL) Evaluation: Lower Results are Better

LOWER RESULTS ARE BETTER		
FACILITY EVALUATION RESULT	**FACILITY'S LOWER CONFIDENCE LIMIT (LCL)**	**FACILITY'S PERFORMANCE CATEGORY**
MEETS CRITERIA	LCL is **Below** or **Equal** to the Threshold	**Statistically Better** or **No Different** than the Threshold
DOES NOT MEET CRITERIA	LCL is **Above** the Threshold	**Statistically Worse** than the Threshold

Table 3b – Upper Confidence Limit (UCL) Evaluation: Higher Results are Better

HIGHER RESULTS ARE BETTER		
FACILITY EVALUATION RESULT	**FACILITY'S UPPER CONFIDENCE LIMIT (UCL)**	**FACILITY'S PERFORMANCE CATEGORY**
MEETS CRITERIA	UCL is **Above** or **Equal** to the Threshold	**Statistically Better** or **No Different** than the Threshold
DOES NOT MEET CRITERIA	UCL is **Below** the Threshold	**Statistically Worse** than the Threshold

Quality Selection Criteria

Table 4 below identifies the Quality Selection Criteria used in the evaluation of each provider. A provider must meet **all** Quality Selection Criteria requirements, as well as all Business Selection Criteria (outlined below in Table 5) to be considered eligible for the Blue Distinction Centers for Cardiac Care designation.

Table 4 – Quality Selection Criteria

ALL SELECTION CRITERIA MUST BE MET FOR ELIGIBILITY CONSIDERATION		
DOMAIN	**SOURCE**	**QUALITY SELECTION CRITERIA**
National Accreditation*	Provider Survey Q#7	The provider 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 American Association for Hospital and Health Systems (AAHHS) as an acute care hospital. • DNV GL Healthcare in the National Integrated Accreditation Program (NIAHO®) Hospital Accreditation Program. • Center for Improvement in Healthcare Quality (CIHQ) in the Hospital Accreditation Program. **NOTE: To enhance quality while improving BCBS 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 provider's local Blue Plan.*
Comprehensive Provider	Provider Survey Q#8	The provider is a comprehensive acute care provider that offers **ALL** of the following services on site: • Intensive care unit; • Emergency Room or Emergency Services that include plans or systems for onsite emergency admission of post-operative patients with 24/7 availability of onsite medical response teams; • 24/7 availability of in-house emergency physician coverage; • Diagnostic radiology, including MRI and CT; • 24/7 availability of inpatient pharmacy services (may include alternative night-time access when pharmacy is closed); • Blood bank or 24/7 access to blood bank services; **AND** • 24/7 availability of Clinical Laboratory Improvement Amendments (CLIA) accredited laboratory services.
Percutaneous Coronary Intervention (PCI) Volume	Provider Survey Q#13a	The provider reports a PCI minimum sample size of **100 or greater** for outcome reliability.

ALL SELECTION CRITERIA MUST BE MET FOR ELIGIBILITY CONSIDERATION		
DOMAIN	**SOURCE**	**QUALITY SELECTION CRITERIA**
ACC NCDR CathPCI Registry Executive Summary Measures	The following NCDR CathPCI Executive Summary Measures are calculated, using a **Lower Confidence Limit (LCL):**	
	Provider Survey Q#13b	• Executive Summary Measure #1: PCI In-Hospital Risk Adjusted Mortality (All Patients) 90% Lower Confidence Limit is **at or below 1.70.**
	Provider Survey Q#13j	• Executive Summary Measure #30: Proportion of PCI Procedures Not Classifiable for Appropriate Use Criteria (AUC) Reporting 90% Lower Confidence Limit is **at or below 11.60.**
	Provider Survey Q#13k	• Executive Summary Measure #36: Patients WITHOUT Acute Coronary Syndrome: Proportion of Evaluated PCI Procedures that were Inappropriate 90% Lower Confidence Limit is **at or below 36.50.**
	Provider Survey Q#13l	• Executive Summary Measure #37: PCI In-Hospital Risk Adjusted Rate of Bleeding Events 90% Lower Confidence Limit is **at or below 5.4.**
	The following NCDR CathPCI Executive Summary Measures are calculated, using a **Upper Confidence Limit (UCL):**	
	Provider Survey Q#13c	• Executive Summary Measure #4: Proportion of STEMI Patients Receiving Immediate PCI w/in 90 Minutes 90% Upper Confidence Limit is **at or above 90.00.**
	Provider Survey Q#13d	• Executive Summary Measure #9: Proportion of Patients with a P2Y12 Inhibitor Prescribed at Discharge 90% Upper Confidence Limit is **at or above 90.00.**
	Provider Survey Q#13e	• Executive Summary Measure #10: Statins Prescribed at Discharge 90% Upper Confidence Limit is **at or above 90.00**.
	Provider Survey Q#13m	• Executive Summary Measure #38: Composite Discharge Medications in Eligible PCI Patients 90% Upper Confidence Limit is **at or above 90.00.**
STS Adult Cardiac Surgery Database Registry*	Provider Survey Q#16c, 17c	Provider's STS Isolated CABG Mortality Star Rating is **at least 2 Stars.** **NOTE: Providers with more than 1 STS Participant must meet this Cardiac Care Selection Criteria **for each STS Participant.***

ALL SELECTION CRITERIA MUST BE MET FOR ELIGIBILITY CONSIDERATION		
DOMAIN	**SOURCE**	**QUALITY SELECTION CRITERIA**
Star Ratings	Provider Survey Q#16c, 17c	Provider's STS Isolated CABG Morbidity Star Rating is **at least 2 Stars.** **NOTE: Providers with more than 1 STS Participant must meet this Cardiac Care Selection Criteria **for each STS Participant.***
	Provider Survey Q#16e, 17e	Provider's STS Isolated Aortic Valve Replacement (AVR) Mortality Star Rating is **at least 2 Stars.** **NOTE: Providers with more than 1 STS Participant must meet this Cardiac Care Selection Criteria **for each STS Participant.***
	Provider Survey Q#16e, 17e	Provider's STS Isolated Aortic Valve Replacement (AVR) Morbidity Star Rating is **at least 2 Stars.** **NOTE: Providers with more than 1 STS Participant must meet this Cardiac Care Selection Criteria **for each STS Participant.***
Hospital Compare Measures	Publicly Available (Data from January 2018)	Coronary Artery Bypass Graft (CABG) 30 day risk adjusted mortality rate is reported as **"better than** or **no different than the national rate."**
		Coronary Artery Bypass Graft (CABG) 30 day risk adjusted readmission rate is reported as **"better than** or **no different than the national rate."**
		Acute Myocardial Infarction (AMI) 30 day risk adjusted mortality rate is reported as **"better than** or **no different than the national rate."**
		Acute Myocardial Infarction (AMI) 30 day risk adjusted readmission rate is reported as **"better than** or **no different than the national rate."**

Business Selection Criteria

The Business Selection Criteria (Table 5) consists of the following components:

1. Provider Participation;
2. Physician and Surgeon Participation;
3. Blue Brands Criteria; and
4. Local Blue Plan Criteria (if applicable)

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

Table 5: Business Selection Criteria

BUSINESS SELECTION CRITERIA	
Provider Participation	All providers are required to participate in the local Blue Plan's BlueCard Preferred Provider Organization (PPO) Network.
Physician Medical and Surgical Specialists Participation	All physician medical and surgical specialists identified in the Provider Survey are required to participate in the local Blue Plan's BlueCard PPO Network.
Blue Brands Criteria	Provider and its corporate family 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 providers located within its Service Area.

Note: *De Minimis Rule may be applied to the Physician Specialists Participation criteria, at the local Blue Plan's discretion.*

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+ providers. The inputs and methodology used in the cost evaluation are explained below.

> ***Quality is key:*** only those providers 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:

- Claims were evaluated using adjusted allowed amounts derived from Blue Plan healthcare claims data from January 1, 2014 through December 31, 2016, and paid through March 31, 2017.
- Cardiac Care episodes with commonly used and clinically comparable primary diagnoses and most typical MS-DRGs are included within each clinical category.
- Cardiac Care episodes were identified through a trigger procedure (or index event) for each clinical category by CPT, HCPCS, or ICD-10/ICD-9 procedure codes and were placed in one of three clinical categories:
  - Percutaneous Coronary Intervention (PCI)
  - Coronary Artery Bypass Graft (CABG)

  - Cardiac Valve Surgery

- A hierarchy was used to place episodes that include multiple trigger procedures into a single clinical category for analysis (i.e., Cardiac Valve Surgery > CABG > PCI). So for example, a patient with Cardiac Valve Surgery and CABG performed at the same time would be classified based on the Cardiac Valve Surgery procedure.
- Adjusted allowed amounts for professional and in-network provider claims were included, using specific Cardiac Care clinical categories—PCI, CABG, and Cardiac Valve Surgery—for actively enrolled commercial BCBS members.
- Exclusion criteria: No data was evaluated for members under 25 and over 64 years of age; members whose primary payer is not a Blue Plan; or members with a discharge status of Left Against Medical Advice (AMA) or Death.
- The episode window for Cardiac Care begins 30 days prior to the date of the admission for the index admission (look back period) and ends 90 days following discharge from the index admission (look forward period). The episode window includes services from provider, physician, other professional, and ancillary providers.
  - The **30 day look back** period includes relevant services (a service presumed related to the episode, regardless of diagnosis) and relevant diagnoses (other conditions and symptoms directly relevant to the episode).
  - The **index admission** includes all costs during the inpatient admission and subsequent outpatient stay (i.e., provider, physician, other professional, and ancillary costs).
  - The **90 day look forward** period includes relevant services (a service presumed related to the episode, regardless of diagnosis), relevant diagnoses (other conditions and symptoms directly relevant to the episode), and complications (identified based on relevant diagnosis).
- For providers located in overlapping areas served by more than one local Blue Plan, the same method for cost evaluation was used but the claims data and results were evaluated separately for each of those local Blue Plans, except in limited cases where the more expensive result takes precedence.

Adjusting Episode Costs

Provider episode costs were analyzed and adjusted separately for each clinical category (i.e., Cardiac Valve Surgery, CABG, and PCI), as follows:

A geographic adjustment factor (CMS Geographic Adjustment Factors [GAF]) was applied to the episode cost, **to account for geographic cost variations in delivering care.**

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:

- Identified patient severity levels, using the MS-DRG risk stratification system.
- Created separate risk bands within episodes, based on patient severity level, case mix, and gender. Only one age band, 25-64 years, was used for all patients. Case mix category distinctions were made for both the CABG clinical category and the PCI clinical category, separating when the trigger procedure was associated with an acute myocardial infarction (AMI) versus when the trigger procedure was not associated with AMI. Outpatient cases for PCI without AMI were also included as a separate case mix category. Cardiac valve procedures were divided into 3 case mix categories: Aortic Valve Replacement, Mitral Valve Repair, and Mitral Valve Replacement.
- 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 provider's geographically adjusted provider 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 Cardiac Care episode was attributed to the provider where the procedure/surgery occurred, based on trigger events that occurred at that provider for each clinical category. Clinical Category Provider Cost (CCPC) was calculated separately for Cardiac Valve Surgery, CABG, and PCI, based on the median value of the adjusted total episode costs.

Confidence intervals (90 percent) were calculated around each Clinical Category Provider Cost (CCPC) measure; the Upper Confidence Limit of the CCPC for a specific Clinical Category was divided by the national median episode cost for the Clinical Category to become the Clinical Category Provider Cost Index (CCPCI).

Using each of the Clinical Category Provider Cost Index (CCPCI) values, an overall Composite Cost Index (CompCI) was calculated for the provider. Each CCPCI was weighted by that provider's own volume and provider costs to calculate a composite measure of cost called the Composite Cost Index (CompCI). The CompCI was then rounded down to the nearest 0.025 for each provider to give the 'benefit of the doubt' to providers whose evaluation falls close to the threshold. The CompCI was then divided by the national median to normalize/standardize the values. While this does not change the results in any way, it allows for greater transparency by having a CompCI of 1.0 equivalent to the national median with values greater than 1.0 indicating more expensive providers and values less than 1.0 indicating more efficient providers. In the final step, the CompCI was compared to the National Cost Selection Criteria to achieve the final cost evaluation

decision.

Minimum Case Volume Requirement

A provider must have five or more episodes in a Clinical Category to consider the Clinical Category Provider Cost valid. All valid Clinical Category Provider Costs are included in the final calculations. If the Clinical Category Provider Cost is not valid, it will not be used in further calculations. A provider must have 5 or more episodes in the percutaneous coronary intervention (PCI) clinical category **AND** must have 5 or more episodes in either the coronary artery bypass graft (CABG) or cardiac valve clinical categories for a valid Composite Provider Cost Index to be calculated. Any provider that did not meet these episode minimums did not meet the cost of care Selection Criteria

Cost Selection Criteria

In addition to meeting the nationally established, objective quality and business measures for Blue Distinction Centers, a provider also must meet **all** of the following cost of care Selection Criteria (Table 6) requirements to be considered eligible for the Blue Distinction Centers+ (BDC+) designation.

Table 6 – Cost of Care Selection Criteria

COST OF CARE SELECTION CRITERIA
Provider must meet Minimum Case Volume Requirement for each Clinical Category: • **Minimum case volume of 5** for Percutaneous Coronary Interventions (PCI), ***AND*** • **Minimum case volume of 5** for Coronary Artery Bypass Graft (CABG) surgery, ***OR*** a **minimum case volume of 5** for Valve Repair/Replacement
Composite Provider Cost Index must be **below 1.125**

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.