BlueCross BlueShield Association

BlueDistinction®
Specialty Care

Program Selection Criteria: Bariatric Surgery

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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 Bariatric Surgery program (this 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 healthcare nationwide, and providing a credible foundation for local Blue Cross and/or Blue Shield Plans (Blue Plans) to design benefits tailored to meet employers' 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 delivering specialty care.

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

Executive Summary

In late 2016, local Blue Plans invited 1,775 facilities across the country (consisting of comprehensive acute care inpatient facilities and ambulatory surgery centers) to be considered for the Bariatric Surgery designation under this Program; over 750 facilities applied and were evaluated on objective, transparent selection criteria with quality, business, and cost of care components.

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

The Program uses updated Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) accreditation levels, which focus on site of service. With this design change, each facility can apply to achieve the BDC or BDC+ designation, as either a Comprehensive Center (including outpatient capability) or an Ambulatory Surgery Center (ASC).

PROGRAM HIGHLIGHTS	
Designation Levels	• BDC • BDC+
Accreditations Considered	• National accreditation organizations • Bariatric-specific program accreditations
Facility types considered for this Program	• Comprehensive, Acute Care, Inpatient Facility • Ambulatory Surgery Center
Evaluated Procedures	• Laparoscopic Sleeve Gastrectomy • Laparoscopic Roux-en-Y Gastric Bypass • Laparoscopic Adjustable Gastric Band
Data Sources	• Quality: Provider Survey • Business: Plan Survey, Blue Brands evaluation, and Local Blue Plan Criteria (if applicable) • Cost: Blue Plans' healthcare claims data
Quality Data	• Cases occurring between Jan. 1, 2015 and Dec. 31, 2015 • October 2016 Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) Semiannual Report (SAR)
Cost Data	• Blue Plans' Preferred Provider Organization (PPO) healthcare claims data, with cases occurring between Jan. 1, 2013 and Dec. 31, 2015. • Blue Patients ages 18 - 64

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 the Program's specific selection criteria, defined by the following evaluation components (Table 1), to be eligible for the BDC or BDC+ designation:

Table 1: 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

This Program evaluates facility performance on one or more of the following procedures: Laparoscopic Sleeve Gastrectomy, Laparoscopic Roux-en-Y Gastric Bypass and/or Laparoscopic Adjustable Gastric Band as either a Comprehensive Center (including outpatient capability) or an Ambulatory Surgery Center (ASC). Both Comprehensive Centers and ASCs 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, quality metrics obtained from the facility's Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) Semiannual Report (SAR) from the October 2016 release (for procedures performed from 1/1/2015 to 12/31/2015).

The quality selection criteria includes general facility structure metrics, plus accreditation and patient outcome metrics that are specific to bariatric surgery.

Table 2 and Table 3 identify all domains used in the quality evaluation.

- Comprehensive Center designation: the facility must meet **all** requirements in Table 2 to meet the Quality evaluation portion of the eligibility decision.
- Ambulatory Surgery Center designation: the facility must meet **all** requirements in Table 3 to meet the Quality evaluation portion of the eligibility decision.

Quality criteria in Table 2a and Table 3a are not used to determine eligibility status under this Program's current selection criteria, but are shared with facilities as *informational feedback* to raise internal awareness and stimulate quality improvement.

Table 2: Quality Selection Criteria for Comprehensive Centers

DOMAIN	SOURCE	QUALITY SELECTION CRITERIA
National Accreditation*	Provider Survey Q#6	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.*
Bariatric Surgery Program Accreditation	Provider Survey Q#5	Facility is accredited as a Comprehensive Center by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).
Primary Bariatric Surgery Volume	Provider Survey Q#7	**At least 25** primary bariatric surgery procedures were performed at the facility between 1/1/2015 and 12/31/2015 in **at least one** of the following primary procedure categories: • Laparoscopic Sleeve Gastrectomy • Laparoscopic Roux-en-Y Gastric Bypass • Laparoscopic Adjustable Gastric Band
Patient Outcome Measures • **Patient outcome measures were evaluated if the analytic case volume reported was greater than or equal to 5. If the reported analytic case volume was less than 5, then the patient outcome measure was not evaluated due to insufficient data.** • **All patient outcome measures within a given procedure group (LSG, LRYGB and/or LAGB) must meet criteria in order to pass for that procedure group. If a procedure group was evaluated (had at least 5 cases), then the criteria for that procedure group must be met.** • **Facility must meet all scored patient outcome measures within at least one of the procedure groups (LSG, LRYGB and/or LAGB). A facility will not meet quality if 1) ALL evaluated procedure group(s) do not meet all of the scored patient outcome measures or 2) if they have insufficient volume in ALL 3 procedure groups.**		
Laparoscopic Sleeve Gastrectomy (LSG) Patient Outcomes		
Surgical Site Infection	Provider Survey Q#8	Facility's LSG Surgical Site Infection Rate's Lower Confidence Level (LCL) is **less than or equal to 1.00.**

DOMAIN	SOURCE	QUALITY SELECTION CRITERIA
All Occurrence Morbidity	Provider Survey Q#8	Facility's LSG All Occurrence Morbidity Rate's Lower Confidence Level (LCL) is **less than or equal to 1.00.**
Laparoscopic Roux-en-Y Gastric Bypass (LRYGB) Patient Outcomes		
Surgical Site Infection	Provider Survey Q#9	Facility's LRYGB Surgical Site Infection Rate's Lower Confidence Level (LCL) is **less than or equal to 1.00.**
All Occurrence Morbidity	Provider Survey Q#9	Facility's LRYGB All Occurrence Morbidity Rate's Lower Confidence Level (LCL) is **less than or equal to 1.00.**
Laparoscopic Adjustable Gastric Band (LAGB) Patient Outcomes		
Morbidity	Provider Survey Q#10	Facility's LAGB Morbidity Rate's Lower Confidence Level (LCL) is **less than or equal to 1.00.**
Related Readmissions	Provider Survey Q#10	Facility's LAGB Related Readmissions Rate's Lower Confidence Level (LCL) is **less than or equal to 1.00.**
Related Reoperation	Provider Survey Q#10	Facility's LAGB Related Reoperation Rate's Lower Confidence Level (LCL) is **less than or equal to 1.00.**

Table 2a (INFORMATIONAL (ONLY): Quality Criterion for Comprehensive Centers

DOMAIN	SOURCE	QUALITY SELECTION CRITERIA
Patient Satisfaction	Provider Survey Q#12	Facility collects a patient satisfaction survey that is specific to the bariatric surgery service line.

Table 3: Quality Selection Criteria for Ambulatory Surgery Centers

DOMAIN	SOURCE	QUALITY SELECTION CRITERIA
National Accreditation*	Provider Survey Q#15	Facility is fully accredited by **at least one** of the following national accreditation organizations*: • The Joint Commission (TJC), in its Ambulatory Care Accredited Program. • Healthcare Facilities Accreditation Program (HFAP) of the Accreditation Association for Hospitals and Health Systems (AAHHS) as an Ambulatory Surgical Center. • American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) Surgical. • Accreditation Association for Ambulatory Health Care (AAAHC) as an Ambulatory Surgery Center. • Institute for Medical Quality (IMQ), in its Ambulatory 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.*
Bariatric Surgery Program Accreditation	Provider Survey Q#14	Facility is accredited as an Ambulatory Surgery Center by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).
Primary Bariatric Surgery Volume	Provider Survey Q#16	**At least 25** primary bariatric surgery procedures were performed at the facility between 1/1/2015 and 12/31/2015 in **at least one** of the following primary procedure categories: • Laparoscopic Sleeve Gastrectomy • Laparoscopic Roux-en-Y Gastric Bypass • Laparoscopic Adjustable Gastric Band

DOMAIN	SOURCE	QUALITY SELECTION CRITERIA
Inpatient Facility(ies) BDC Designated	Provider Survey Q#23	All inpatient facility(ies) with transfer agreement(s) to receive that ASC's bariatric patients is/are currently designated as a Blue Distinction Centers for Bariatric Surgery Comprehensive Center.
Patient Outcome Measures • **Patient outcome measures were evaluated if the analytic case volume reported was greater than or equal to 5. If the reported analytic case volume was less than 5, then the patient outcome measure was not evaluated due to insufficient data.** • **All patient outcome measures within a given procedure group (LSG, LRYGB and/or LAGB) must meet criteria in order to pass for that procedure group. If a procedure group was evaluated (had at least 5 cases), then the criteria for that procedure group must be met.** • **Facility must meet all scored patient outcome measures within at least one of the procedure groups (LSG, LRYGB and/or LAGB). A facility will not meet quality if 1) ALL evaluated procedure group(s) do not meet all of the scored patient outcome measures or 2) if they have insufficient volume in ALL 3 procedure groups.**		
Laparoscopic Sleeve Gastrectomy (LSG) Patient Outcomes		
Surgical Site Infection	Provider Survey Q#17	Facility's LSG Surgical Site Infection Rate's Lower Confidence Level (LCL) is **less than or equal to 1.00.**
All Occurrence Morbidity	Provider Survey Q#17	Facility's LSG All Occurrence Morbidity Rate's Lower Confidence Level (LCL) is **less than or equal to 1.00.**
Laparoscopic Roux-en-Y Gastric Bypass (LRYGB) Patient Outcomes		
Surgical Site Infection	Provider Survey Q#18	Facility's LRYGB Surgical Site Infection Rate's Lower Confidence Level (LCL) is **less than or equal to 1.00.**
All Occurrence Morbidity	Provider Survey Q#18	Facility's LRYGB All Occurrence Morbidity Rate's Lower Confidence Level (LCL) is **less than or equal to 1.00.**
Laparoscopic Adjustable Gastric Band (LAGB) Patient Outcomes		
Morbidity	Provider Survey Q#19	Facility's LAGB Morbidity Rate's Lower Confidence Level (LCL) is **less than or equal to 1.00.**
Related Readmissions	Provider Survey Q#19	Facility's LAGB Related Readmissions Rate's Lower Confidence Level (LCL) is **less than or equal to 1.00.**
Related Reoperation	Provider Survey Q#19	Facility's LAGB Related Reoperation Rate's Lower Confidence Level (LCL) is **less than or equal to 1.00.**

Table 3a (INFORMATIONAL ONLY): Quality Selection Criteria for Ambulatory Surgery Centers

DOMAIN	SOURCE	QUALITY SELECTION CRITERIA
Patient Satisfaction	Provider Survey Q#24	Facility collects a patient satisfaction survey that is specific to the bariatric surgery service line.

Business Selection Criteria

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

- Facility Participation;
- Surgeons Participation;
- Blue Brands Criteria; and
- Local Blue Plan Criteria (if applicable)

A facility must meet **all** components listed in Table 4 to meet the Business evaluation for the Blue Distinction Centers for Bariatric Surgery designation.

Table 4: Business Selection Criteria

BUSINESS SELECTION CRITERIA	
Facility Participation	All facilities are required to participate in the local Blue Plan's BlueCard Preferred Provider Organization (PPO) Network.
Surgeons Participation	All surgeons (identified in the Provider Survey as those who perform the Bariatric Surgical procedures at that facility) are required to participate in the local Blue Plan's BlueCard PPO Network.[2]
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.

[2] De Minimis Rule may be applied, 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 were 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 analysis of Blue Plan claims data. To provide validity for comparisons, cost analytics for the BDC Bariatric Surgery program focus on commonly performed bariatric procedures. Specifically, the program focuses on three clinical categories, Laparoscopic Roux-En Y Gastric Bypass (LYRGB), Laparoscopic Sleeve Gastrectomy (LSG) and Laparoscopic Adjustable Gastric Band (LAGB). All revisions are excluded. The scope of this analysis includes:

- The cost of care was calculated using adjusted allowed amounts for specific total bariatric surgery episodes of care for actively enrolled Blue members, derived from Blue Plans' PPO claims data with cases occurring between Jan. 1, 2013 through Dec. 31, 2015, and paid through Feb. 29, 2016.
- Episodes were identified through a trigger procedure (or index event) for each clinical category by identifying Current Procedural Terminology (CPT) codes. An ICD-9 Diagnosis Code[3] (ICD-9 CM) must be present along with the CPT code. Only those episodes categorized using the following CPTs were included in further analysis:
  - CPT 43775 (Laparoscopic Sleeve Gastrectomy)
  - CPT 43644, 43645 (Laparoscopic Roux-en-Y Gastric Bypass)
  - CPT 43770 (Laparoscopic Adjustable Gastric Band)
- To enhance the comparability of cost comparisons, each clinical category includes only episodes with commonly used and clinically comparable primary diagnoses within each clinical category. Episodes that display primary diagnosis codes for atypical or infrequent diagnoses, or those that are not clinically relevant to the Program's cost evaluation (such as trauma, neoplasm or infection), are not included in the analyses. Episodes with the most typical primary diagnoses are selected and the remaining atypical primary diagnoses are excluded.

[3] All claims using ICD-10 codes were mapped to ICD-9 codes allowing claims from both before and after 10/1/2015 to be analyzed using the ICD-9 code system.

- Episodes will be included when there is a primary diagnosis of obesity:
  - ICD-9 CM 278.0 (Overweight and Obesity)
  - ICD-9 CM 278.00 (Obesity Unspecified)
  - ICD-9 CM 278.01 (Morbid Obesity)
  - ICD-9 CM 278.02 (Overweight)
  - ICD-9 CM 278.03 (Obesity Hypoventilation)
  - ICD-9 CM 278.1 (Localized Adiposity)
- Members are excluded if they meet any of the following 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
- Each surgery episode type has time windows before and after the episode trigger event within which relevant services may be included. The episode window for bariatric procedures begins 30 days before the index event (look-back period) and ends 90 days after index event (look-forward period). For an index event lasting more than a single day (e.g., inpatient stay), the post-period is measured from the last date of the index event (e.g., the discharge date for an inpatient stay). The episode window includes services from facility, physician, and other professional, and ancillary providers.
- The 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 admission (i.e., facility, physician/professional, and ancillary costs).
- The 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).
- Cost methodology took the sum of all costs incurred during the episode (including facility, physician, other professional, and ancillary costs) for each individual member, including the specified days before and after the trigger for the episode.
- For facilities 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.

Adjusting Episode Costs

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

- 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 88 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:
  - Identified patient severity levels, using the MS-DRG risk stratification system.
  - Created separate risk bands within the clinical category episodes, based on patient severity level and gender. Only one age band, 18-64 years, was used for all patients because there was no meaningful variation in cost based on age subgroups.
  - 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 Facility Cost (CCFC) was calculated separately, 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).

Using each of the Clinical Category Facility Cost Index values, an overall Composite Facility Cost Index (CFCI) 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.

A minimum of 5 episodes was required in at least one clinical category in order to consider the Clinical Category Facility Cost Index valid.

Cost Selection Criteria

In addition to meeting the nationally established, objective quality and business measures for BDC, 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 have a **minimum of 5 episodes** of cost data in at least one of the clinical categories (LYRGB, LSG, LAGB).
The Composite Facility Cost Index must be **below 1.500**.

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

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.