Proposed Benefit Changes for 2020/21 Plan Year

- Dental Coverage Enhancements
  - Proposed major revamp of currently offered Dental Benefits to bring it in line with industry norms
- Vision Coverage Enhancement – New Option
  - Details Enclosed
- Diabetes Early Detection Eye Scan
  - Details Enclosed
- Enhanced Stop Loss/Reinsurance Coverage
- Rx Connect 360
  - Details Enclosed
- HAS – Health Advocacy Solutions from BCBSOK
  - An enhanced version of our current Benefits Value Advisor (BVA) Full-Service Member Services Unit
  - Increases Fixed Costs $12.50 per member per month
  - Estimated savings of $42 per member per month
  - Guaranteed ROI of 1:1
  - Estimated ROI of 2:1
- Blue Distinction - Centers of Excellence
  - Blue Distinction Centers offer quality care, treatment expertise and better overall patient results. Blue Distinction Centers+ offer more affordable care in addition to quality care, treatment expertise and better overall patient results.
  - Plan would cover Out-of-Pocket costs (Co-Pays, Co-Insurance & Deductible) for treatment of the following care categories received at Blue Distinction Centers:
    - Cardiac Care
      - Details Enclosed
      - Hillcrest Medical Center – Tulsa
      - Many more throughout the country
    - Cellular Immunotherapy
    - Fertility Care
    - Gene Therapy
    - Knee & Hip Replacement
    - Maternity Care (Complex Pregnancies)
    - Spine Surgery
    - Transplants
  - More information can be found online: https://www.bcbsok.com/find-a-doctor-or-hospital/find-a-hospital/blue-distinction
- Member Out-of-Pocket Coverage – Optional Enhancement
- $25 Insulin (1/1/2020)

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OPEH&W

Effective Date: 01/01/20

MONTHLY Participation Requirement Rates
Exam Fee at Time of Service: $15
Materials Fee at Time of Service: $15
Polycarbonate for Kids Fee at Time of Service: $0

130 PLAN *$130 frame or $130 contact lens*	ALLOWANCE FREQUENCY	EMPLOYEE ONLY	EMPLOYEE +1	EMPLOYEE w/CHILDREN	EMPLOYEE w/FAMILY
Silver Exam + Materials 130 PK **PLUS**	12 / 12 / 24	$10.22	$16.36	$18.88	$32.10

150 PLAN *$150 frame or $150 contact lens*	ALLOWANCE FREQUENCY	EMPLOYEE ONLY	EMPLOYEE +1	EMPLOYEE w/CHILDREN	EMPLOYEE w/FAMILY
Silver Exam + Materials 150 PK **PLUS**	12 / 12 / 24	$11.06	$17.68	$20.40	$34.70

* Allowance Frequency is shown as Exam/Lenses/Frames in month increments

Thank you for your business!

JAMES ASHFORD
Oklahoma Sales Director

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VCD PLUS+

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ALLOWANCE SUMMARY

EXAM	PLAN ALLOWANCE	MEMBER RESPONSIBILITY	OPEN ACCESS MAXIMUM
Comprehensive eye-health vision examination includes refraction and dilation	100% after exam fee	$15	$50
FLEXIBLE EXAM OPTION: In the event that a member has an eye exam included with another plan, Vision Care Direct applies a credit to be used for other services or materials in lieu of a Vision Care Direct eye exam. An explanation will be provided to you by your provider at time of service in regards to the amount and how it was applied to your additional services or materials.			$0

SPECTACLE LENSES	PLAN ALLOWANCE	MEMBER RESPONSIBILITY	OPEN ACCESS MAXIMUM
Standard Single Vision in CR-39 plastic	100% after materials fee	$15	$50
Lined Bi-focal (FT28) in CR-39 plastic	100% after materials fee	$15	$75
Lined Tri-focal (FT7x28) in CR-39 plastic	100% after materials fee	$15	$100
Progressive (no-line multi-focal) in CR-39 plastic	Up to retail price of lined tri-focal	$15 + Overage above allowance	$100
Upgrades and/or add-ons (anti-reflective coating, high-index, photochromic, etc.)	$0	Standard retail price	$0
POLYCARBONATE FOR KIDS (PK): Polycarbonate lenses for dependent children up to age 18	100% after PK fee	$0	$0

FRAMES	PLAN ALLOWANCE	MEMBER RESPONSIBILITY	OPEN ACCESS MAXIMUM
Frame allowance as indicated by desired plan toward standard retail price of any frame in the provider's office.	Up to $130 or $150	Overage above $130 or $150 allowance	$60

VCD PLUS LENS OPTION (In lieu of spectacle lens option above)	PLAN ALLOWANCE	MEMBER RESPONSIBILITY	OPEN ACCESS MAXIMUM
Standard Single Vision in CR-39 plastic with premium anti-reflective coating	100% after materials fee	$15	$0
Lined Bi-focal (FT28) in CR-39 plastic with premium anti-reflective coating	100% after materials fee	$15	$0
Lined Tri-focal (FT7x28) in CR-39 plastic with premium anti-reflective coating	100% after materials fee	$15	$0
Progressive (up to a digital free form full back surface) in CR-39 plastic with premium anti-reflective coating	100% after materials fee	$15	$0
Upgrades and/or add-ons (high-index, photochromic, tint, etc.)	$0	Standard retail price	$0

CONTACT LENS (In lieu of glasses)	PLAN ALLOWANCE	MEMBER RESPONSIBILITY	OPEN ACCESS MAXIMUM
ELECTIVE: Equal to frame allowance of desired plan, in lieu of frames and spectacle lenses. Can be used toward multi-focal contacts and contact lens fitting fees.	Up to $130 or $150	Overage above $130 or $150 allowance	Up to $80
MEDICALLY NECESSARY: Requires prior authorization from your Doctor to the Vision Care Direct Medical Director. Medically necessary is defined as 1) Keratoconus; or 2) monocular aphakia and/or binocular aphakia.	Up to $250	Overage above $250 allowance	Up to $80

GENERAL LIMITATIONS AND EXCLUSIONS:

This vision plan is designed for routine eye care and materials expense incurred while the membership is in force. Plan allowances cannot be combined with any other discounts, promotional offers or other advertised specials including, but not limited to, discounts, coupons, or two-for-one materials specials offered by the providers at their individual offices. Members must choose between using their Vision Care Direct allowances or the provider's special offers. Unused allowances do not roll over into next allowance period. We do not provide allowances for the following:

- Services and materials not included on Allowance Summary including cosmetic items and add-ons
- Orthoptics or vision training and any associated supplemental testing
- Subnormal vision aids, non-prescription or aniseikonia lenses
- Contact lenses for cosmetic enhancement such as changing eye color except as included in the Allowance Summary
- Oversized 61 and above lens or lenses
- Additional charge may apply for Rx above +/- 6 sphere and/or 6 cylinder
- Experimental or non-conventional treatment or device
- Medical or surgical treatment of the eyes
- Any injury or illness covered by Workers Compensation or similar law
- Two pairs of glasses in lieu of bifocals, trifocals, or progressives
- Care for services or materials received while traveling in a foreign country without a detailed receipt in English
- Charges incurred after membership ends

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At last, you finally have the freedom to use your materials allowance the way you want without all the surprise out of pocket expenses. With VCD PLUS™, you'll have access to high definition (single vision, bifocal, trifocal or premium progressive) lenses, premium anti-reflection coating, scratch resistant coating and UV protection all for one low price!

		STANDARD VCD	VCD PLUS
FRAME	Up to $130 or $150	✓	✓
LENSES	Single Vision	✓	✓
	Bifocal	✓	✓
	Trifocal	✓	✓
	Progressive		✓
EXTRAS	Non-Glare Coating		✓
	Scratch Resistance		✓
	Water Repellent		✓
	Oil Repellent		✓
PROVIDER NETWORK		Any provider listed on www.VisionCareDirect.com VISION CARE DIRECT	Any provider listed on www.VisionCareDirect.com with this logo: VCD PLUS

* Progressive lens allowance on the Standard VCD option is equal to doctor's retail cost of standard trifocal lens. Difference between retail cost of progressive and trifocal lens is patient responsibility.

** Lens enhancements not listed as included options above (polycarbonate, high-index, photochromic, etc.) can be added at doctor's usual and customary rate.

*** Contact lens allowance of $130 or $150 may be used in lieu of the frame/spectacle lens allowance options listed above.

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130 PLAN *$130 frame or $130 contact lens*	ALLOWANCE FREQUENCY	EMPLOYEE ONLY	EMPLOYEE +1	EMPLOYEE w/CHILDREN	EMPLOYEE w/FAMILY
Gold Exam + Materials 130 PK **PLUS**	12 / 12 / 12	$13.16	$21.04	$24.28	$41.30

150 PLAN *$150 frame or $150 contact lens*	ALLOWANCE FREQUENCY	EMPLOYEE ONLY	EMPLOYEE +1	EMPLOYEE w/CHILDREN	EMPLOYEE w/FAMILY
Gold Exam + Materials 150 PK **PLUS**	12 / 12 / 12	$14.82	$23.72	$27.36	$46.54

* Allowance Frequency is shown as Exam/Lenses/Frames in month increments

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VCD PLUS+

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Lined Tri-focal (FT7x28) in CR-39 plastic	100% after materials fee	$15	$100
Progressive (no-line multi-focal) in CR-39 plastic	Up to retail price of lined tri-focal	$15 + Overage above allowance	$100
Upgrades and/or add-ons (anti-reflective coating, high-index, photochromic, etc.)	$0	Standard retail price	$0
POLYCARBONATE FOR KIDS (PK): Polycarbonate lenses for dependent children up to age 18	100% after PK fee	$0	$0

FRAMES	PLAN ALLOWANCE	MEMBER RESPONSIBILITY	OPEN ACCESS MAXIMUM
Frame allowance as indicated by desired plan toward standard retail price of any frame in the provider's office.	Up to $130 or $150	Overage above $130 or $150 allowance	$60

VCD PLUS LENS OPTION (In lieu of spectacle lens option above)	PLAN ALLOWANCE	MEMBER RESPONSIBILITY	OPEN ACCESS MAXIMUM
Standard Single Vision in CR-39 plastic with premium anti-reflective coating	100% after materials fee	$15	$0
Lined Bi-focal (FT28) in CR-39 plastic with premium anti-reflective coating	100% after materials fee	$15	$0
Lined Tri-focal (FT7x28) in CR-39 plastic with premium anti-reflective coating	100% after materials fee	$15	$0
Progressive (up to a digital free form full back surface) in CR-39 plastic with premium anti-reflective coating	100% after materials fee	$15	$0
Upgrades and/or add-ons (high-index, photochromic, tint, etc.)	$0	Standard retail price	$0

CONTACT LENS (In lieu of glasses)	PLAN ALLOWANCE	MEMBER RESPONSIBILITY	OPEN ACCESS MAXIMUM
ELECTIVE: Equal to frame allowance of desired plan, in lieu of frames and spectacle lenses. Can be used toward multi-focal contacts and contact lens fitting fees.	Up to $130 or $150	Overage above $130 or $150 allowance	Up to $80
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		STANDARD VCD	VCD PLUS
FRAME	Up to $130 or $150	✓	✓
LENSES	Single Vision	✓	✓
	Bifocal	✓	✓
	Trifocal	✓	✓
	Progressive		✓
EXTRAS	Non-Glare Coating		✓
	Scratch Resistance		✓
	Water Repellent		✓
	Oil Repellent		✓
PROVIDER NETWORK		Any provider listed on www.VisionCareDirect.com VISION CARE DIRECT	Any provider listed on www.VisionCareDirect.com with this logo: VCD PLUS

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*** Contact lens allowance of $130 or $150 may be used in lieu of the frame/spectacle lens allowance options listed above.

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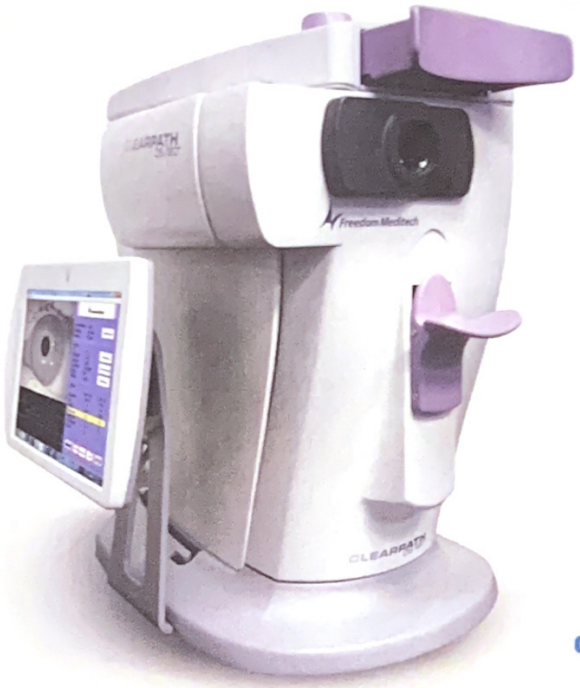
Non-Invasive Early Diabetes Detection



- **Preventative**
  Can identify diabetes 7 years prior to complications*
- **Noninvasive**
  No blood and no fasting required
- **Rapid Results**
  Instant results provides actionable information

CLEARPATH DS 120™

FDA Claim: ClearPath DS-120 detects auto-fluorescence of the crystalline lens.

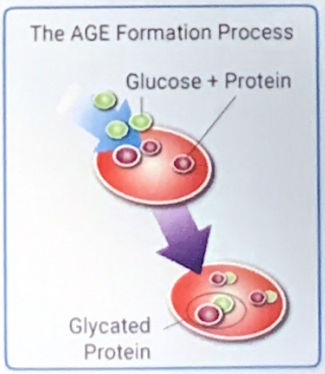
* References available upon request

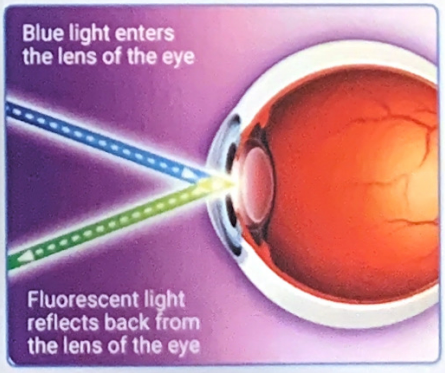
OUR MISSION: Our mission is to transform current blood-based standards to non-invasive screening, diagnosis and monitoring of chronic disease - to significantly improve the quality of life.

How does it work?

FM's technology platform detects fluorescence caused by Advanced Glycation End products (AGEs) in ocular structures.

Clinical Data shows strong correlation between AGEs and the progression of diabetes.





Diabetes: A Chronic Epidemic

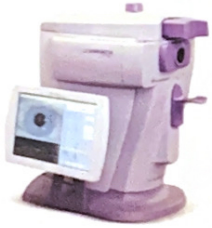
Early Detection of Diabetes Risk Is Cost-Effective

People with diagnosed diabetes incur average medical expenditures of about $13,700 per year, of which about $7,900 is attributed to diabetes. People with diagnosed diabetes, on average, have medical expenditures approximately 2.3 times higher than what expenditures would be in the absence of diabetes.

For the cost categories analyzed, care for people with diagnosed diabetes accounts for more than 1 in 5 health care dollars in the U.S., and more than half of that expenditure is directly attributable to diabetes.
Indirect costs include:

- increased absenteeism ($5 billion) and
- reduced productivity while at work ($20.8 billion) for the employed population,
- reduced productivity for those not in the labor force ($2.7 billion),
- inability to work as a result of disease-related disability ($21.6 billion), and
- lost productive capacity due to early mortality ($18.5 billion).

Lens Auto-fluorescence



- Lens Auto-fluorescence using the DS-120 is more effective than an A1c blood draw test for early diabetes detection
- DS-120 can detect diabetes 7 years or more before the onset of complications – catch diabetes before costs sky-rocket
- Non invasive – no blood draw, no fasting required
- Test takes less than 2 minutes, results are immediate
- DS-120 measure of the patient's long term metabolic state vs. A1c narrow window of approximately the last 90 days
- Significantly less expensive than a blood drawn A1c test
- DS-120 does not eliminate the need for blood testing

50%
of global diabetes population is undiagnosed

1 in 3 Kids
born today are projected to get diabetes in their life

8.1 Million
People with undiagnosed diabetes in the U.S.

86 Million
People with pre-diabetes in the U.S.

$250 Billion
Total cost of diabetes per year in the U.S.

" Diabetes is like a time bomb with a long fuse.
I can't believe that this technology isn't already available in every primary care practice, pharmacy, and supermarket!"

Robert H. Osher, MD
Medical Director Emeritus of Cincinnati Eye Institute,
Recipient of Kelman Award from American Academy of Ophthalmology
FM Advisor

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VCD Diabetic Wellness Program

The VCD Diabetic Wellness program has a positive ROI and is a massive advancement in the ability to prevent and control the increasing costs of diabetes. Every dollar spent comes back in substantial health care cost savings to employers.

Diabetes is currently the number one most expensive health care cost. Here are just a few diabetic facts:

- Employees diagnosed with diabetes cost an additional $9,600 + in claims per year
- 30% of the US is prediabetic, but only 1 in 9 know it.
- 9.4% of the population is already diabetic, 1 in 4 (7.5 million) doesn't know
- Diabetes is the leading cause of Heart Disease, Liver Disease, Kidney issues, and Hypertension.
- If left undetected, diabetes can not only make employees very ill, but push their claims cost much higher than the average of $9,600 listed above.

VCD's Diabetic Wellness Program uses FDA approved diabetic scanners which are 97% accurate. The scans:

- Can be done there at the employer's location and requires minimal space. (We bring our scanning equipment to the employer's location.)
- Are painless and provide instant results (unlike blood work which can take weeks)
- Take 6-8 seconds per per person with no fasting required
- Enable early detection of diabetes for employees that have never been diagnosed, which has a 77% success rate of prevention
- Remove the hassle of having to go to a doctor's office
- Measure the amount of autofluorescence on the crystalline lens.
- Detects diabetes up to 10 years before it shows up in the blood and is less expensive than a A1c test
- Can detect most employees who have Type 2 Diabetes that have never been diagnosed.

Specific results with similar groups using our remote engagement program and glucometer readings have been:

- $3,086 saved annually per employee completing program
- A1c reduction from 11.3% to 8.3% in 90 days
- 77% reduction in all-cause hospitalizations
- 70% decrease in ER visits
- 379% ROI for municipality
- 40% decrease for employee hospital stay claims
- Sustained population reduction in blood glucose of 51.5mg/dL (1 year)

The program is not a one-size-fits-all program, like most wellness programs, but allows us to identify those employees who are diabetic and prediabetic and put them into the proper program to lower claims and premium costs.

BlueCross BlueShield Association

BlueDistinction®
Specialty Care

Selection Criteria and Program Documentation: Cardiac Care

Released October 2015

About This Document

This Selection Criteria and Program Documentation document outlines the Selection Criteria and evaluation process used to determine eligibility for the Blue Distinction® Centers for Cardiac Care program.

About the Blue Distinction Specialty Care Program

Blue Distinction Specialty Care is a national designation program recognizing healthcare facilities 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 Blue Shield (BCBS) 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 facilities recognized for their expertise in delivering specialty care.
- **Blue Distinction Centers+ (BDC+):** Healthcare facilities recognized for their expertise and cost efficiency in delivering specialty care.

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

Facilities are evaluated on objective, transparent Selection Criteria with quality, business, and cost of care components. This Program focuses on cardiac valve surgery, coronary artery bypass graft (CABG), and percutaneous coronary interventions (PCI) episodes of care performed at acute care inpatient facilities. Facilities considered for this Program are defined as comprehensive, acute care, inpatient facilities. Early in 2015, local BCBS Plans invited facilities to be considered for the Blue Distinction Centers (BDC) or the Blue Distinction Centers+ (BDC+) designations. Of over 2,100 facilities invited across the country, over 800 facilities applied for the designation.

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

Understanding the Evaluation Process

Selection Process

The selection process balances quality, cost, and access considerations to offer consumers meaningful differentiation in 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 Blue Distinction Centers+ was used to address market and consumer demand for cost savings and affordable healthcare.

Access

- BCBS members' access to Blue Distinction Centers was considered, as needed, 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 a detailed Provider Survey, publicly available quality data, BCBS Plan healthcare claims data, and Plan Survey 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	1. Information obtained from facility in the Provider Survey. 2. Publicly available data from Hospital Compare's December 2014 release. www.hospitalcompare.hhs.gov	✓	✓
Business	1. Information obtained from the local BCBS Plan, for facilities within its Service Area, on: • Facility's and Physician Specialists' participation status in the local BCBS Plan's BlueCard PPO Network. • Local BCBS Plan Criteria, if applicable. 2. Information obtained by BCBSA on whether the facility meets BCBSA criteria for avoiding conflicts with BCBSA logos and trademarks.	✓	✓
Cost of Care	BCBS Plan healthcare claims data.		✓

Measurement Framework

The Blue Distinction Centers for Cardiac Care program established a nationally consistent approach to evaluating quality and safety by incorporating quality measures with meaningful impact, with criteria that will evolve over time through future evaluation cycles, consistent with medical advances and measurement in this specialty area. Measurement framework for this and other Blue Distinction value-based initiatives were developed using the following guiding principles:

1. Utilize a credible process and produce credible results with meaningful differentiated outcomes.
2. Align with other national efforts using established measures, where appropriate and feasible.
3. Simplify and streamline measures and reporting processes.
4. Enhance transparency and ease of explaining program methods.
5. Utilize existing resources effectively to minimize costs and redundancies.
6. Meet existing and future demands from BCBS Plans, national accounts, and BCBS 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 from objective, publicly available sources.

The quality evaluation for facilities was based on objective, publicly available quality metrics obtained from Hospital Compare and facility responses to the Provider Survey. The quality Selection Criteria includes general facility structure metrics and cardiac specific process and outcome metrics.

General facility metrics were obtained from the Provider Survey. Cardiac specific metrics were obtained from the Provider Survey (with measure results from the facility's National Cardiovascular Disease Registry® [NCDR] CathPCI Registry® 2014 Q2 Report, and the Society of Thoracic Surgeons [STS] Harvest 3 Report for cardiac bypass and valve surgeries), as well as publicly available national data from the Hospital Compare database (December 2014 release).

Facility results for percutaneous coronary intervention metrics were analyzed using a confidence interval (90 percent) around the point estimate from either the reported:

- numerator and denominator events or
- denominator events and rates.

"Confidence Interval" is a term used in statistics that measures the probability that a result will fall between two set values. Evaluation of the Confidence Interval (CI) depends on whether lower results or higher results represent better performance (e.g., lower mortality is better, but higher adherence to medication is better). Tables 2a and 2b 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 2a – Confidence Interval Results for PCI Measures: Lower Results are Better

PCI MEASURES WHERE 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 2b – Confidence Interval Results for PCI Measures: Higher Results are Better

PCI MEASURES WHERE 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

Other metrics, where a CI was not calculated, were compared against the Selection Criteria threshold. Specific details on the Cardiac Care quality Selection Criteria are outlined below in Table 3.

Facilities were evaluated for quality in the following domains for the Blue Distinction Centers for Cardiac Care program. A facility must meet **all** requirements in Table 3 to meet the Quality evaluation of the overall designation decision.

Table 3 – Quality Selection Criteria

ALL SELECTION CRITERIA MUST BE MET FOR ELIGIBILITY CONSIDERATION		
DOMAIN	**SOURCE**	**QUALITY SELECTION CRITERIA**
National Accreditation*	Provider Survey Q#3	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 American Osteopathic Information Association (AOIA) as an acute care hospital. • National Integrated Accreditation Program (NIAHOSM)—Acute Care of DNV GL Healthcare. • 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 BCBS Plan Criteria; for details, contact the facility's local BCBS Plan.*
Comprehensive Facility	Provider Survey Q#4	The facility is a comprehensive acute care facility 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.

ALL SELECTION CRITERIA MUST BE MET FOR ELIGIBILITY CONSIDERATION		
DOMAIN	**SOURCE**	**QUALITY SELECTION CRITERIA**
NCDR CathPCI Registry® Participation & Report	Provider Survey Q#5, 6	Facility reports to the National Cardiovascular Data Registry® (NCDR) CathPCI Registry® and has reported on ALL adult Percutaneous Coronary Intervention (PCI) procedures performed at the facility from July 1, 2013 through June 30, 2014. Facility has the CathPCI Registry® 2014 Q2 Institutional Outcomes Report (including 4 consecutive quarters of data, which have passed all CathPCI Registry® data quality report checks).
STS Registry Participation & Report	Provider Survey Q#5, 8	All cardiothoracic surgeons with cardiac surgical privileges at the facility participate in the Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database and submit data on all coronary artery bypass graft (CABG) surgeries and valve surgeries performed at the facility from July 1, 2013 through June 30, 2014. Facility has the Society of Thoracic Surgeons (STS) Adult Cardiac Database 2014 Harvest 3 Report (period ending June 30, 2014).
Percutaneous Coronary Intervention (PCI) Volume for Outcome Reliability	Provider Survey Q#6a	PCI **Minimum Sample Size:** The facility reports a minimum sample size of **100 or greater**.

ALL SELECTION CRITERIA MUST BE MET FOR ELIGIBILITY CONSIDERATION		
DOMAIN	**SOURCE**	**QUALITY SELECTION CRITERIA**
NCDR® CathPCI – Executive Summary Measures	Provider Survey Q#6b	Facility's calculated **Lower Confidence Limit (LCL)** for the following NCDR CathPCI Executive Summary Measures: • Executive Summary Measure #1: PCI In-Hospital Risk Adjusted Mortality (All Patients) 90% Lower Confidence Limit is **at or below 1.70.** • Executive Summary Measure #37: PCI In-Hospital Risk Adjusted Rate of Bleeding Events 90% Lower Confidence Limit is **at or below 5.4.** • 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.** • 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.** Facility's calculated **Upper Confidence Limit (UCL)** for the following NCDR CathPCI Executive Summary Measures: • 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.** • Executive Summary Measure #38: Composite Discharge Medications in Eligible PCI Patients 90% Upper Confidence Limit is **at or above 88.4.**
STS Overall Composite Star Ratings*	Provider Survey Q#10c, 14c	Facility's Overall STS Isolated CABG Composite Star Rating is **at least 2 Stars.** **NOTE: Facilities with more than 1 STS Participant must meet this Cardiac Care Selection Criteria **for each participant.***
	Provider Survey Q#11b, 15b	Facility's Overall STS Isolated Aortic Valve Replacement (AVR) Composite Star Rating is **at least 2 Stars.** **NOTE: Facilities with more than 1 STS Participant must meet this Cardiac Care Selection Criteria **for each participant.***
	Provider Survey Q#12b, 16b	Facility's Overall STS CABG + AVR Combined Composite Star Rating is **at least 2 Stars.** **NOTE: Facilities with more than 1 STS Participant must meet this Cardiac Care Selection Criteria **for each participant.***
Hospital Compare Measures	Publicly Available Data from Dec. 2014 Release	Acute Myocardial Infarction (AMI) 30 day risk adjusted mortality rate is reported as **"better than** or **no different than the national rate."** 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 4) consists of four components: Facility Participation; Physician Specialists Participation; Blue Brands Criteria; and Local BCBS Plan Criteria (if applicable). A facility must meet **all** requirements to be considered eligible for the Blue Distinction Centers for Cardiac Care designation.

Table 4 – Business Selection Criteria

BUSINESS SELECTION CRITERIA	
Facility Participation	All facilities are required to participate in the local BCBS Plan's BlueCard Preferred Provider Organization (PPO) Network.
Physician Specialists Participation	All physician specialists (identified in the Provider Survey as those who perform the Cardiac Care procedures at that facility) are required to participate in the local BCBS Plan's BlueCard PPO Network[2].
Blue Brands Criteria	Facility meets BCBSA criteria for avoiding conflicts with BCBSA logos and trademarks.
Local BCBS 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 Blue Distinction Centers+.

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

Cost Data Sources and Defining the Episodes

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

- Claims were evaluated using adjusted allowed amounts derived from BCBS Plan claims data from July 1, 2010 through June 30, 2014, and paid through August 31, 2014 for Cardiac Care trigger procedures (defined below) occurring between April 1, 2011 and March 31, 2014.
- Cardiac Care episodes were identified through a trigger procedure (or index event) for each clinical category by CPT, HCPCS, or ICD9 codes and were placed in one of three clinical categories:
  - Cardiac Valve Surgery
  - Coronary Artery Bypass Graft (CABG)
  - Percutaneous Coronary Intervention (PCI)
- 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).
- Episodes with commonly used and clinically comparable primary diagnoses and most typical MS-DRGs are included within each clinical category. (Approximately 2% of episodes were excluded as atypical MS-DRGs.)
- Adjusted allowed amounts for professional and in-network facility claims were included, using specific Cardiac Care clinical categories—Cardiac Valve Surgery, CABG, or PCI for actively enrolled commercial BCBS members. Members under 25 and over 64 years were excluded from the cost analysis.
- Medicare/Medicaid and secondary claims were excluded.
- 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 facility, 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., facility, 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).
- 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 Cardiac Care episode.
- For facilities located in overlapping areas served by more than one local BCBS Plan, the same method for cost evaluation was used but the claims data and results were evaluated separately for each of those local BCBS Plans.

Adjusting Episode Costs

Facility 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 was applied to the episode cost, **to account for geographic cost variations in delivering care.** Episode costs were adjusted using the 2012 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), 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 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 Cardiac Care episode was attributed to the facility where the procedure/surgery occurred, based on trigger events that occurred at that facility for each clinical category. Clinical Category Facility Cost (CCFC) was calculated separately for Cardiac Valve Surgery, CABG, and PCI, 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 (CompFCI) 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 facility must have 5 or more episodes in at least 2 of the 3 Cardiac Care clinical categories for a valid Composite Facility Cost Index to be calculated. Any facility that did not meet this episode minimum did not meet the cost of care Selection Criteria. If the Clinical Category Facility Cost is not valid, it cannot be used in the Composite Facility Cost Index calculation. If a facility met the episode minimum for only 2 of the 3 clinical categories, then the other clinical category, for which the episode minimum was not met, was not included in the formula numerator and denominator. For example, if a facility had at least 5 episodes for CABG and 5 episodes for PCI, then it would have a two-part formula, as Cardiac Valve Surgery would not be included in the Composite Facility Cost Index calculation.

Cost Selection Criteria

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

Table 5 – Cost of Care Selection Criteria

COST OF CARE SELECTION CRITERIA
Facility must have a **minimum of 5 episodes** of cost data for **at least 2 clinical categories.**
Composite Facility Cost Index must be **below 1.400.**

Questions

Contact your local BCBS Plan for 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 facilities 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 facility's cost of care is evaluated using data from its Local Blue Plan. Facilities 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.