BlueCross BlueShield Association

BlueDistinction®
Specialty Care

Program Selection Criteria: Substance Use Treatment and Recovery

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Document Overview

The Program Selection Criteria document outlines the Selection Criteria and evaluation process used to determine eligibility for the Blue Distinction Centers (BDC) for Substance Use Treatment and Recovery program.

This document is organized into the following sections:

Blue Distinction Centers for Substance Use Treatment and Recovery

The BDC for Substance Use Treatment and Recovery program aims to improve patient outcomes and value by addressing the fragmented delivery of substance use disorder treatment. This program will be offered to facilities delivering substance use treatment programs in one or more of the following settings: residential, inpatient, intensive outpatient, or partial hospitalization services.

All providers must offer programs for opioid use disorder treatment within the broader substance use disorder diagnosis. Additionally, when an opioid use disorder is treated, at minimum, medication-assisted treatment (MAT) must be available to all patients admitted to the treatment program.

Designation as a BDC for Substance Use Treatment and Recovery differentiates providers locally, as well as nationally. This highly respected designation acknowledges the expertise providers have demonstrated and their commitment to improving quality and affordability. Designations are awarded based on quality and value criteria that supports delivery of timely, coordinated, multidisciplinary, evidence-based care with a focus on quality improvement and patient-centered care. To be considered for the BDC for Substance Use Treatment and Recovery designation, applicant providers must meet **all** of the following:

- Quality and Value Criteria,
- Business Criteria; and
- Local Blue Plan Criteria *(if applicable)*.

Evaluation Process

Blue Distinction Specialty Care programs establish nationally consistent and continually evolving approaches to evaluating quality and value of care. The measurement framework for this, and other Blue Distinction value-based initiatives, were developed using the following guiding principles:

- Align with credible, transparent, nationally established measures with an emphasis on proven outcomes, where available, appropriate, and feasible.
- Utilize nationally consistent measurement approaches, which recognize the value added by local market initiatives.
- Apply a fair and equitable evaluation approach that consistently identifies providers with meaningfully differentiated quality and (where relevant) cost of care.

- Achieve competitive geographic access with footprints that can advance over time.
- Create a nationally consistent, market viable solution, which is operationally feasible and scalable over time.

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

Data Sources

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

Evaluation Components	Evaluation Source
Quality and Value (Provider Survey)	• Quality and Value data supplied by applicant provider in the Provider Survey • Local Blue Plan Quality Criteria (*if applicable*)
Value (Claims Data)	• Cost of care episode measurements using Claims Data • Local Blue Plan Cost Criteria (*if applicable*)
Business	• Data supplied by Plan in the Plan Survey • Review of Blue Brands Evaluation • Review of Office of the Inspector General's Exclusion Database[1] • Local Blue Plan Business Criteria (*if applicable*)

[1] *BCBSA also compared each applicant facility and Related Providers against the Office of the Inspector General's Exclusion Database which identifies individuals or entities excluded from federally funded healthcare programs.*

Quality and Value (Provider Survey) Selection Criteria

Quality and Value criteria were 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. Its framework aligns with a chronic care treatment model, addressing the delivery, quality, utility, and affordability of care. Providers are evaluated for quality and value in the following categories for the Substance Use Treatment and Recovery program, based on the responses they submit in the Provider Survey.

The table below outlines the Quality and Value (Provider Survey) Selection Criteria and approach to scoring. Applicant Provider must achieve all 4 required points **and** at least 13 (out of 18) flexible points to meet the Program's Quality and Value Selection Criteria.

Evaluation Component	Metric Name	Selection Criteria Description	Approach to Scoring
Must achieve ALL 4 required points			
Quality	**Level of Care**	Level of Care available includes at least inpatient, residential, intensive outpatient or partial hospitalization services	**Required:** At least one in-scope level of care selected in Q14
Quality	**MAT for OUD**	Medication-assisted treatment (MAT) for opioid use disorders (OUD) is available at the applicant facility	**Required:** 'Yes' to Q49
Quality	**Multidisciplinary Care Available**	Delivers or facilitates coordinated multidisciplinary care to patients	**Required:** 'Yes' to Q22
Quality	**Accreditation**	Facility must be fully accredited by at least one of the following organizations: • The Joint Commission (TJC) – Hospital or Behavioral Health Care Programs • Commission on Accreditation of Rehabilitation Facilities (CARF) • Healthcare Facilities Accreditation Program (HFAP) of the Accreditation Association for Hospital and Health Systems (AAHS) • DNV GL Healthcare in the National Accreditation for Healthcare Organizations (NIAHO) • Hospital Accreditation Program, National Committee for Quality Assurance (NCQA) in Case Management Accreditation Program • Council on Accreditation (COA) in the Private Organization or the Public Agency Program • Center for Improvement in Healthcare Quality (CIHQ) in the Hospital Accreditation Program	**Required :** At least one accreditation selected in Q15
Quality	**Local Plan Criteria**	An individual Blue Plan, at its own independent discretion, may establish and apply local quality requirements as additional Selection Criteria for eligibility in a Blue Distinction Centers program, for providers located within its Service Area.	**Required**, *if applicable*
Must achieve at least 13 (out of 18) flexible points. Each scored item is worth 1 point.			
Quality	**Evidence- Based Therapies**	Implements evidence-based care aligned with established guidelines/clinical pathways, as appropriate.	At least one evidence-based therapy as 'Always or Often' in Q25

Quality	**Patient and Family Centered Long-Term Goal Planning**	Implements patient-centered care by including patient/family in long-term treatment planning and goal setting, as well as managing patients with dual diagnoses (e.g., substance abuse combined with other mental health issues), with the goal to improve the quality of life for both patient and family.	'Yes' to Q46
Quality	**Quality Measurement**	Commits to monitoring and reporting of quality measures throughout provider's entire system of care.	'Yes' to Q63
Quality	**Quality Improvement Program**	Incorporates quality measurement results into feedback and improvement of provider's entire system of care.	'Yes' to Q65
Quality	**Multidisciplinary Care Discipline Types**	Facilitates multidisciplinary care (either within an integrated delivery system or through coordination within a virtually organized delivery system of a medical neighborhood) to ensure that the patient has access to key disciplines: • Addiction Medicine • Primary Care • Counseling Services • Psychotherapy • Case Management • Rehabilitation • Referral Services	'Available Onsite' or 'Coordinated' for **at least 4** of the following 7 key disciplines in Q23.
Quality	**Multidisciplinary Care Coordinated throughout Continuum of Care**	Delivers coordinated multidisciplinary care to patients requiring clinically managed care, and facilitates timely access to quality medical and psychosocial care in all phases of substance use treatment (including withdrawal/detox management) through long-term maintenance/support.	'Yes' to Q24
Quality	**Industry Standard Assessment/ Screening Tool**	Executes an industry standard assessment (e.g., CONTINUUM, The American Society of Addiction Medicine [ASAM] Criteria Decision Engine™) on all patients to determine the appropriate level of care prior to admitting patients to that provider's facility.	'Yes' to Q38
Quality	**Individualized Care Planning**	Delivers individualized care planning, by managing patients from diagnosis through all stages of substance use treatment (including withdrawal/detox) through long-term maintenance/support (e.g., treatment plan).	'Yes' to Q45
Quality	**Coordination of MAT following Discharge**	For all patients admitted for OUD, MAT is available and the provider coordinates follow-up care (including MAT services) as part of discharge planning.	'Yes' to Q51

Quality	**Transition and Discharge Planning at Time of Admission**	Begins discharge and transition planning for each patient at time of admission, with involvement of applicable physicians/staff and the patient (and family/caregiver, if indicated).	'Yes' to Q52
Quality	**Engagement of Patient and Family in Discharge Planning**		'At time of admission' to Q53
Quality	**Local Community Resource Identification**	Prior to discharge, outpatient providers and services are identified within that organization and the patient's local community.	'Yes' to Q54
Quality	**Flow of Necessary Information**	Delivers efficient, appropriate, and effective flow of necessary patient care information to providers and patients (e.g., through use of Electronic Health Records and/or patient portal).	Q36: <u>At least one</u> of the selections including: • Electronic Health Record • Use of Patient Portal • Coordination with Health Plan
Quality	**Shared Decision Making Model**	Engages patient (and family/caregiver, if indicated) in shared decision-making (SDM) process for goal-setting and treatment planning that provides information on realistic expectations and impacts of treatment options, through the use of appropriate SDM tools, so that care delivers utility to the patient (and family/caregiver, if indicated).	'Yes' to Q40
Quality	**Standardized Patient Satisfaction and Experience Surveys**	Participates in a standardized Patient Experience Survey to evaluate and inform care delivery.	'Yes' to Q59
Value	**Notification of Patient's Portion of Treatment Costs**	Notifies patients of their portion of all costs prior to their admissions into provider's treatment program.	'Yes' to Q34
Value	**Drug Testing Aligned with Best Practices and Standards of Care**	Follows established best practices and standards of care for drug testing (ASAM, Appropriate Use of Drug Testing in Clinical Addiction Medicine).	'Yes' to Q48
Value	**Participation in Value-Based or Alternative Payment Program**	Engages or is willing to have future engagement in contracts that contain value-based incentives associated with both cost and quality outcomes.	'Yes' or 'considering' to Q66

Value (Claims Data) Selection Criteria

The Value (Claims Data) Selection Criteria is designed to provide a nationally consistent, equitable, and objective evaluation. The claims-based value evaluation is focused on identifying providers with outlier cost of care relative to the Claims Dataset.

Value Criteria Category	Selection Criteria
Value (Claims)	The Composite Cost Index must be **below** the 95th percentile based on the Claims Data. *Applicant providers with insufficient data will not be penalized for this Program's initial evaluation cycle, due to claims identification and episode sample sizes.*
Local Blue Plan Value Criteria *(if applicable)*	An individual Blue Plan, at its own independent discretion, may establish and apply local value requirements as additional Selection Criteria for eligibility in a Blue Distinction Centers program, for providers located within its Service Area.

Business Selection Criteria

The Business Selection Criteria consists of the following components:

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

A provider must meet **all** components listed below to meet the Business Selection Criteria for the Blue Distinction Centers for Substance Use Treatment and Recovery designation.

Business Criteria Category	Selection Criteria
Facility Participation [2]	All facilities are required to participate in the local Blue Plan's BlueCard PPO Network.
Related Provider Participation [2, 3]	All persons and entities that bill patients separately (i.e., whose charges are not bundled and included as part of this Provider's billed charges) on any products or services in connection with Provider's substance use, treatment, and recovery program (with examples including, but not limited to, professional providers, drug testing and/or lab services, etc., as described generally in the most recent Provider Survey) ("Related Providers") are also required to be participating providers in the local Blue Plan's BlueCard PPO Network.
Blue Brands Criteria	Provider and its corporate family meet BCBSA criteria for avoiding conflicts with BCBSA logos and trademarks.
Local Blue Plan Business Criteria *(if applicable)*	An individual Blue Plan, at its own independent discretion, may establish and apply local business requirements as additional Selection Criteria for eligibility in a Blue Distinction Centers program, for providers located within its Service Area.

[2] BCBSA also compared each applicant facility and Related Providers against the Office of the Inspector General's Exclusion Database which identifies individuals or entities excluded from federally funded healthcare programs.

[3] Providers listed in question 68 of the Provider Survey.

Informational Quality (Claims Data) Evaluation

The quality measures applied to the national Claims Data set are for **informational purposes only.** While these measures were evaluated (where data was available), results from these measures **did not** factor into the scoring model for this designation evaluation. Claims-based quality measures will continue to evolve and inform future designation evaluations. Below is a list of the informational measures used in the quality (Claims Data) evaluation:

Measure	Measure Description	National Quality Forum (NQF) #	Measure Developer and Notes
Process Measures			
MAT Prescribed for Alcohol Use Disorder (AUD)	MAT prescribed for AUD (MAT During Episode)	N/A	ASAM with modifications to fit Claims Data
MAT Prescribed for OUD	MAT prescribed for OUD (MAT During Episode)	N/A	ASAM with modifications to fit Claims Data
MAT Continuation of Care for AUD	MAT prescribed for AUD 30, 60 and 90 days after episode	N/A	Extension of ASAM MAT for AUD prescribed measure with additional follow up data points
MAT Continuation of Care for OUD	MAT prescribed for OUD 30, 60 and 90 days after episode	N/A	Extension of ASAM MAT for OUD prescribed measure with additional follow up data points
Follow-up After Withdrawal Management in an inpatient setting	Follow-up care for a behavioral health service 7 and 90 days after inpatient detox for alcohol use disorder and opioid use disorder	N/A	ASAM with modifications to fit Claims Data
Follow-up After Hospitalization for Substance Use Disorder (SUD)	Follow-up care for a behavioral health service 7 and 30 days after hospitalization for substance use disorder	0576	NCQA Mental Health measure has been repurposed for SUD
Outcome Measure			
All Cause Readmission	All cause readmission 90 days after episode (excluding admissions within 30 days to the same or lower level of care)	N/A	ASAM with modifications to fit Claims Data

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.