2026 Blue Cross Blue Shield of Michigan

Quality Improvement Program Description

January 21, 2026

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Conflict of Interest

Blue Cross Blue Shield of Michigan (Blue Cross) is committed to conducting business with integrity and in accordance with all applicable federal, state, and local laws and any accompanying regulations thereto. Corporate compliance policies have been established which demonstrate the Blue Cross commitment to identifying and preventing misconduct and treating our customers, as well as all our constituents, with fairness and integrity. Ethical business practices are essential to gaining and keeping stakeholder's trust as Blue Cross strives to make the corporate vision and mission a reality. All employees are required to review and attest to a conflict of interest policy. Human Resources maintains the statement, signed annually by all employees.

1. Purpose

The purpose of the Quality Improvement Program is to establish a planned, systematic, and comprehensive approach to measure, assess and improve organization-wide performance. The focus is on the identification of important aspects of care and services; the assessment of the level of care and services being delivered, the continuous improvement of the quality and safety of clinical care, and the quality of services. The plan is developed in accordance with our corporate vision and mission. The Quality Improvement Program outlines the structure, processes, and methods Blue Cross uses to determine activities and influence outcomes related to the improvement of care and treatment of its members. This program description document applies to Commercial PPO and Exchange PPO products. The Federal Employee Program is included with the Commercial PPO product line.

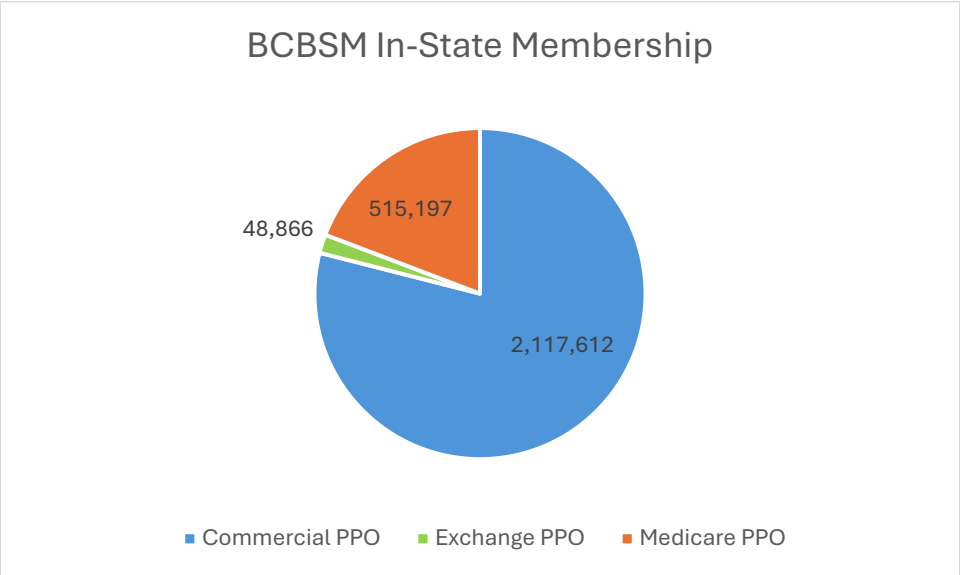
2. Health Plan Mission

We commit to being our members' trusted partner by providing affordable, innovative products that improve their care and health.

We aspire to be clear and simple, to help our customers make the right choices, to offer valuable coverage, and to help them get quality health care for themselves and those they love. Our social mission is that we commit to increasing access to affordable health care; enhancing the quality of care patients receive; and improving the health of Michigan's citizens and communities.

3. Health Plan Membership

Blue Cross Blue Shield of Michigan Mutual Insurance Company (Company or BCBSM) was originally founded in 1939. Headquartered in Detroit, Blue Cross Blue Shield of Michigan (Blue Cross) is the state's largest Preferred Provider Organization health plan, serving over 2.6 million members in the state of Michigan. The in-state population consists of 2,117,612 (79 percent) Commercial PPO, 515,197 (19 percent) Medicare PPO and 48,866 (2 percent) Exchange PPO members.



**Data reflects BCBSM members as of 12/31/2025.*

4. Quality Improvement Philosophy

The Blue Cross quality improvement philosophy is to organize and finance best-in-class health services for optimum member health status improvement, efficiency, accessibility, and satisfaction. This is accomplished through strong collaborative partnerships with practitioners, providers, purchasers, and communities. Blue Cross uses the scientific methods of continuous quality improvement to design, implement, operate, evaluate, and improve services for our members.

Through the efforts of the Quality Improvement Program, Blue Cross strives to improve the quality and safety of clinical care and services that members receive which meet or exceed all stakeholder expectations for satisfaction and improved health status. Blue Cross strives to conduct its business in a prudent and efficient manner and to maintain a work environment that is exciting, challenging and rewarding. The goal is to empower employees to accomplish their work within a friendly atmosphere of teamwork and mutual respect.

Blue Cross embraces the Institute of Healthcare Improvement's Triple Aim framework which includes:

- Improving the health of the population
- Improving the patient experience of care, including quality and satisfaction
- Reducing or at least controlling the per capita cost of care

5. Scope

The scope of the program is comprehensive, and activities are focused on access, clinical quality, satisfaction, service, qualified providers, and compliance. Activities are designed to:

- Address all health care settings (inpatient, outpatient, ambulatory, and ancillary)
- Evaluate the quality and appropriateness of care and services provided to members
- Pursue opportunities for improvement
- Resolve identified problems

The program indicators relate to structure, process and outcomes of health care services provided. The Quality Improvement Program covers Blue Cross (Commercial and Exchange) members. The Quality Improvement Program activities are categorized by the following: Quality of service, clinical quality, member experience, continuity and coordination, member safety, pharmacy, inclusion and diversity, qualified providers, delegation, compliance, and communications.

6. Goals and Objectives

The overall goals (refer to work plan for performance measurement/measurable objectives) of the Blue Cross Quality Improvement Program are:

Quality Improvement Program Structure and Operations

- Revise, review, approve and implement the 2026 Quality Improvement Program Description and Work Plan with all activities based on the 2025 annual QI evaluation findings and recommendations.
- Evaluate the 2025 quality improvement program description and implement findings in the 2025 annual QI Evaluation into the 2026 QI Program and Work Plan.
- Maintain minutes that demonstrate the health plan's QI Committee develops and implements the QI program and oversees the QI functions within the organization.

Quality of Service

- Maintain an adequate network of primary care, behavioral healthcare and specialty care practitioners and monitors how effectively this network meets the needs and preferences (cultural, ethnic, racial, and linguistic) of its membership.
- Provide and maintain appropriate access to primary care services, behavioral health care services (prescribers and non-prescribers) and specialty care (high volume and high impact) services.
- Ensures communication with members correctly and thoroughly represents the benefits and operating procedures of the health plan.
- Provide members with the information they need to easily understand and use their health plan and pharmacy benefits via phone.
- Provide members with the information they need to easily understand and use their health plan benefits via phone or Email.

Clinical Quality

- Work collaboratively to ensure compliance with HEDIS® reporting requirements and participate in initiatives that improve rates.
- Support utilization management activities for medical and behavioral health care.
- Support pharmacy utilization management activities for medical and behavioral health care.
- Outline the population heath management strategy for meeting the care needs of the member population.
- Assess the needs of the population and determine actionable categories for appropriate intervention.
- Coordinate services for members with complex conditions and help them access needed resources.
- Measure the effectiveness of the population health management strategy.
- Deliver market leading, innovative, whole-person solutions focused on integration of behavioral and physical health care in order to meet member and customer needs.
- Demonstrate continuity and coordination of care across the health care network and between medical and behavioral health care.
- Work with practitioners and their physician organizations to better manage patients through various value partnerships programs.

Member Experience

- Evaluates member experience with nonbehavioral and behavioral health care and services and identifies opportunities for improvement.
- Monitor members experience in access to health care services and act to improve network adequacy where indicated.
- Assess physician directory accuracy.

Member Safety

- Participate in collaborative workgroups on patient safety programs to maximize safety of clinical practices.
- Support health plans safety initiatives related to pharmacy.

Inclusion and Workplace Engagement

- Promote employee trainings to improve care or service delivery.
- Address Member Health Care Gaps

Qualified Providers

- Consistently implement a process for the credentialing and recredentialing of practitioners and organizational providers.
- Demonstrate that health care services are provided in a manner consistent with effective professional practice and continuous quality improvement.

Delegation

- Maintain accountability for delegated functions and conduct annual oversight assessments on all delegates.

Compliance

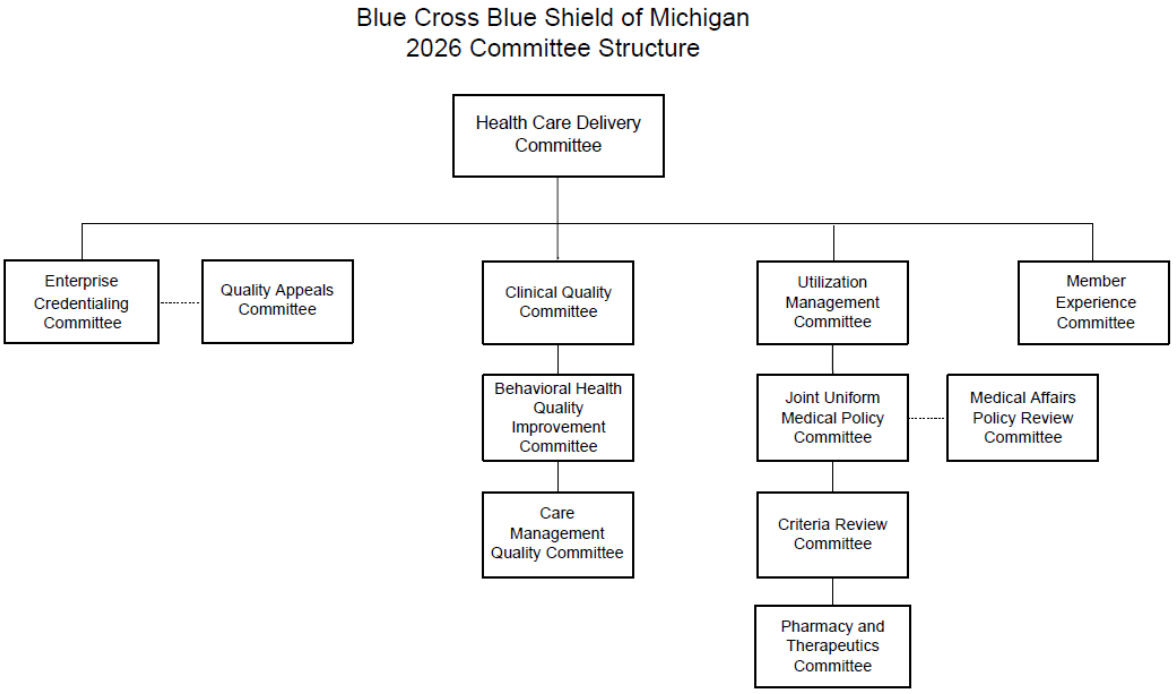
- Prepare for NCQA Single Site Multiple Entity Resurvey in 2028.
- In collaboration with the Compliance Officer, ensure compliance with local, state and federal regulatory requirements and accreditation agency standards.

Communication

- Maintain communication plan to ensure compliance with regulatory requirements.

7. Organizational Structure

The Blue Cross Board of Directors, program committees, operational departments, and employees all work together to promote quality throughout the Blue Cross organization, as described on the following pages. Blue Cross committees provide oversight and implementation of all quality improvement activities.



7.1. Program Committees

To promote quality throughout the Blue Cross organization, specific relationships and linkages between health care delivery, program committees, operational departments and key professional staff are described below. The quality improvement committees are designed and

designated to provide oversight for the Quality Improvement Program activities, including access, quality of service, clinical quality, satisfaction, continuity and coordination, qualified providers, compliance, and communication.

7.1.1. Health Care Delivery Committee

The Board of Directors is responsible for overall governance of Blue Cross and has designated the Health Care Delivery Committee, a board subcommittee, to perform board- level oversight of the Quality Improvement Program. The Health Care Delivery Committee reviews and approves the Quality Improvement Program Description, Work Plan and Evaluation annually.

Responsibilities:

- Review provider reimbursement strategies.
- Review health care value trends, delivery, and product strategies.
- Consider input from Participating Hospital Agreement and Professional Provider Relations Advisory Committees, based on the specific scope of their responsibilities as set forth in their charters.
- Review and approve quality plans required for accreditation.
- Render decisions on provider appeals regarding financial audits, reimbursement matters, de-participation, and utilization matters (other than medical necessity), unless stipulated otherwise in provider contracts or other legally binding documents.
- Accept input from the Participating Hospital Agreement Advisory Committee on policies to address conflicts of interest that may arise when the Contract Administration Process Committee representatives affiliate with hospitals that own a preferred provider organization or other managed care products and are asked to consider issues related to Blue Cross PPOs and other managed care products. The policies shall include provisions for disclosure of potential conflicts by committee members, as well as provisions for abstention from discussions and providing input and recommendations on particular matters.

Composition:

- Chairperson: Appointed
- Vice Chairperson: Appointed
- Committee composed of three or more members from the Board of Directors. Determinations as to whether a particular board member satisfies the requirements for membership on the committee is made by the Nominating and Governance Committee.

Term:

- Committee members serve terms appointed by the chairperson and Chief Executive Officer and as the board may determine, or until their earlier resignation, death, or removal.

Meetings:

- Meetings held at such frequency and intervals as determined necessary to fulfill its duties and responsibilities.
- Committee meeting minutes are provided to the Board of Directors for review and approval.

7.1.2. Clinical Quality Committee

The Clinical Quality Committee is a subcommittee of the Health Care Delivery Committee. The committee has oversight responsibilities for quality improvement studies, utilization management activities, behavioral health, chronic condition management, patient safety, health promotion and wellness activities.

Responsibilities:

- Reviews and makes recommendations to approve, annually, the Quality Improvement Program Plan, work plan and annual evaluation of effectiveness.
- Reviews annually, the UM Descriptions and Evaluation.
- Reviews and approves, annually, the Care Management Program Descriptions and Evaluation.
- Recommends policy decisions.
- Analyzes and evaluates the results of QI activities.
- Ensures practitioner participation in the QI program through planning, design implementation or review.
- Provides oversight for delegated quality improvement, utilization management, chronic condition management including wellness and education, and case management services.
- Reviews quality peer review activities, determines interventions and monitors the interventions, as needed.
- Submits written reports on clinical quality management activities to the Health Care Quality and Service Improvement Committee.
- Ensures the quality improvement programs are compliant with regulatory and licensing requirements.
- Reviews and evaluates the results of quality improvement activities, determines action for improvement and ensures follow-up.
- Evaluates and monitors clinical coordination of care activities and recommends opportunities for improvement.
- Reviews and approves activities to improve patient safety related to medical care.
- Reviews quality indicators and related activities for the Performance Recognition Program.
- Reviews and approves collaborative quality improvement activities performed by the organization.
- Reviews and recommends activities to make performance data publicly available for members and practitioners.

Composition:

- Chairperson: Senior Medical Director & Associate Chief Medical Officer
- Medical Director, Quality Management
- Medical Director, Behavioral Health
- Eight external practitioners who represent a cross section of both primary care physicians and specialists
- Director, Quality Management

The committee membership may be changed upon recommendation of the committee chairperson and approval by the Senior Vice President and Chief Medical Officer.

Term:

- Physician members serve for an initial term of two years.

- Reappointment is at the discretion of the Senior Vice President and Chief Medical Officer.

Meetings:

- A quorum is defined as a majority of voting members including a minimum of two external practitioners. All committee members are voting members. Only physician members are voting members for peer review cases and practitioner appeals.
- Minutes are taken to record actions and recommendations.
- Minutes are maintained in a confidential manner.
- Meetings are held six times per year at a minimum.

7.1.3. Utilization Management Committee

The Utilization Management Committee is a subcommittee of the Health Care Delivery Committee for BCBSM PPO. The committee has oversight responsibilities for utilization management activities, including behavioral health.

Responsibilities:

- Review and approve the Utilization Management Program Description annually which includes the program structure, scope, processes and information sources used to make UM determinations.
- Review the below UM rates:
  - Over-all approval rate
  - Over-all denial rate
  - Over-all timeliness of notification rate for denials
  - Timeliness of notification rate for urgent concurrent denials
  - Timeliness of notification rate for urgent pre-service denials
  - Timeliness of notification rate for non-urgent pre-service denials
  - Timeliness of notification rate for post-service denials
- Review and approve the UM program evaluation annually to assess over and under-utilization.
- Identify needed actions based on the evaluation.
- Review and approve the UM policies and procedures at least annually.
- Provides oversight for delegated utilization management services.
- Designation of a senior physician who is actively involved in implementation, supervision, oversight and evaluation of the UM programs as a member of this committee.
- Designation of a behavioral health practitioner who is actively involved in implementing behavioral healthcare aspects of the UM program as a member of this committee.
- Ensures the utilization management programs are compliant with regulatory and licensing requirements.
- Review and approve subcommittee meeting minutes.
- Review and provide feedback on criteria and medical policies used to make utilization decisions and procedures used to apply the criteria including annually adopting criteria sets and guidelines for program components ensuring unform application.
- Designation of representatives from subcommittees who are actively involved in developing criteria used to make utilization decisions.

Composition:

- Chairperson: Chief Medical Officer, Utilization Management/Clinical Affairs
- Co-Chairperson: Vice President, Clinical Decision Support
- BCN and BCBSM Medical Directors
- Seven practitioners who represent a cross section of both primary care physicians and specialists.

The committee membership may be changed upon recommendation of the committee chairperson and approval by the Senior Vice President and Chief Medical Officer.

Term:

- Physician members serve for an initial term of two years.
- Reappointment is at the discretion of the Senior Vice President and Chief Medical Officer.

Meetings:

- A quorum is defined as a majority of voting members with a minimum of two participating external physicians. All committee members do not have voting rights. The chair will only vote if it is to break a tie. A motion is set and seconded during the meeting discussion(s) by a minimum of two external physicians.
- Minutes are taken to record actions and recommendations; and are maintained in a confidential manner.
- Meetings are held four times per year at a minimum.
- Clinical Criteria Policies are distributed electronically via email to the external physicians approximately 14 days prior to the UM Committee meeting with information associated to each policy that may include the information listed below. The external physicians are asked to send questions or comments ahead of the UM Committee meeting about 3-5 days before the meeting in order for BCBSM/BCN to have time to review feedback.
  - A summary of changes applicable to the new/updated clinical criteria policy.
  - Redline guidelines reflecting the changes to the clinical criteria policy.
  - Coversheet(s) highlighting criteria with significant changes that require review.

7.1.4. Behavioral Health Quality Improvement Committee

The Behavioral Health Quality Improvement Committee reports to the Clinical Quality Committee and is a subcommittee of the Blue Cross Quality Improvement Committee. Its goals is to create and maintain a comprehensive and integrated approach to behavioral and medical management. Blue Cross Behavioral Health is responsible for oversight of the white labeled vendor program and participates in the BH QIC. The purpose of the committee is to provide oversight of corporate wide quality improvement initiatives related to behavioral health. The committee recommends improvement strategies for programs, policies, and processes with the objective of continuously improving the behavioral health status of Blue Cross members.

Responsibilities:

- Provide input/consultation on Behavioral Health development, clinical, vendor and quality program components with focus on program review, recommendations, and improvements.

- Support the alignment of quality goals and activities.
- Facilitate objective and systematic program measurement as outlined in the Delegation Agreement.
- Monitor program implementation.
- Identify opportunities to increase program efficiency, effectiveness and alignment through measurement(s) based on the program results.
- Approve behavioral health-related clinical policies and procedures and program components.
- Review and approve clinical guidelines.
- Monitor behavioral health-related HEDIS measures.
- Provide oversight and direction for clinical program activities.
- Provide oversight and direction for vendor management activities.
- Provide oversight and direction for quality improvement activities.
- Monitor program performance measures (dashboard).
- Review and monitor annual program evaluations.
- Ensure compliance with regulatory and accreditation standards.
- Monitor customer/client satisfaction with the program.
- Review market expectations/acceptance.

Composition:

- Chairperson: Blue Cross Manager, Behavioral Health Strategy and Planning
- Senior Analyst, Blue Cross Behavioral Health Strategy and Planning
- Medical Director, External Physician
- Medical Director, Blue Cross Clinical Quality
- Director, Quality Management
- Manager, Quality Management
- Senior Health Care Analyst, Blue Cross Value Partnership Programs
- Manager, FEP Care Coordination/Managed Care
- Senior Account Executive, for Blue Cross Behavioral Health

Term:

- BH QIC memberships are assigned in accordance with SME needs, enterprise-wide input and NCQA requirements. Terms are open-ended.

Meetings:

- Meetings held at least quarterly.
- Ad hoc meetings held more frequently, as needed.
- Committee members expected to attend all meetings within reason; members may send alternate if circumstances warrant.
- A quorum consisting of 50 percent of voting members is required.

7.1.5. Care Management Quality Committee

The Care Management Quality Committee has been established to provide oversight and guidance for the development, implementation, maintenance, evaluation and quality improvement of CM internal and vended programs. This committee will set strategy aligned with corporate goals, review market expectations and seek differentiation from competitors. The committee will deliver high quality CM programs consistent with current evidence-based standards and practices to improve member health, thereby decreasing benefit spend. The Care Management Quality Committee will report to the Clinical Quality Committee.

Responsibilities:

- Develop program strategy based on corporate goals, and market and segment input
- Oversight of CM program development, implementation, delivery and evaluation with particular focus on program review, recommendations and improvements
- Support the alignment of CM's quality goals and activities
- Ensure integration with clinical guidelines and outcome measures
- Identification and alignment of opportunities to increase program efficiency and effectiveness and alignment through measurement

The committee will share its recommendations/plans with the Clinical Quality Committee. The committee will also share observations and recommendations with program leadership.

In order to achieve the goals outlined in the mission, the committee will be responsible for the following objectives:

- Develop and monitor program strategy
- Review and approve CQI and CAPs and recommend actions
- Recommend program goals/measures
- Provide oversight and direction for operational and clinical program activities
- Provide oversight and direction for vendor management activities
- Provide oversight and direction for quality improvement activities
- Monitor program performance measures (dashboard)
- Recommend program improvements based on evaluations(outcome)
- Implement action plans to improve or correct performance measures
- Ensure compliance with regulatory and accreditation standards
- Review and monitor customer/client program satisfaction

Composition:

- Co-Chairperson: Enhanced Care Values Business Consultant, Care Management Quality
- Co-Chairperson: Supervisor, CM Quality
- Vice President, Care Management
- Senior Medical Directors, Care Management
- Director II, Coordinated Care Operations and Analytics
- Directors, CM Program Delivery
- ECV Business Consultant
- Health Care Manager, CM Performance Management
- Manager, Training
- Operational Managers ad hoc
- Team Leaders, CM Quality
- Health Care Analyst, CM Quality
- Training/Quality RNs – CM Performance Management

Term:

- Not applicable.

Meetings:

The Committee will meet annually. A quorum of 2/3 of participating membership is required to vote and conduct business. If a committee member is unable to attend the committee member must send a proxy. The CM Quality Committee agenda and handouts are prepared and distributed to attendees in advance of the meeting. Written minutes are taken

by a designated scribe and will be sent out for email approval. Once the minutes are approved by the committee, the meeting facilitator formally signs the meeting minutes. The minutes are retained for a minimum of one year or as otherwise required by external regulatory/accrediting entities.

Committee Oversight
The CM Quality Committee will provide oversight of the Care Management Program and its components. The Committee will receive updates/reports and will provide recommendations and guidance on the program.

In addition, the CM Quality Committee often collaborates with other BCBSM corporate areas including, but not limited to:

- Behavioral Health
- Blue Care Network
- Blue Cross Blue Shield Association
- Center of Excellence
- Group Business and Corporate Marketing
- Corporate Communications
- IT
- Office of General Counsel (Legal/Compliance)
- Medical Policy
- Pharmacy
- Product Development
- Value Partnership
- Accreditation organizations
- Medicare Advantage

7.1.6. Joint Uniform Medical Policy

The Joint Uniform Medical Policy Committee is a joint corporate committee representing Blue Cross and BCN that evaluates new technologies, devices, and healthcare services, as well as new uses of existing technologies, devices, and healthcare services. Evaluations may result in the development or revision of medical policy statements that describe the technologies, devices, and healthcare services as investigational or established.

Responsibilities:
The JUMP Committee reviews documentation compiled by clinical team members comprised of physicians and registered nurses within Blue Cross and BCN. Documentation for review will include, but is not limited to:

- Medical Policy Position Document
- Appropriate peer reviewed literature
- Documentation/recommendations from appropriate professional organizations and/or independent medical consultants, with expertise in the area under review
- Regulatory, legislative and research documentation, (e.g., Blue Cross Blue Shield Association ([BCBSA] policies*, Technology Evaluation Center [TEC] assessments, Center for Medicare, and Medicaid Services [CMS] documentation, Federal Drug Administration [FDA] documentation, AHRQ, ECRI and Hayes, Inc. technology assessment reports). ** It is noted that most medical policies adopted from BCBSA have been vetted by clinical subject*

matter experts in national academic medical centers as well as by relevant national provider organizations
- Provider communication(s), as indicated.

Upon review of the information the JUMP Committee will vote to:
- Recommend the technology, device or healthcare service as established (non-investigational) or to deny it as investigational. Additionally, a new technology, device, procedure, or service may be considered "Not Medically Necessary" if a comparable alternative exists which provides equivalent outcomes but is less expensive. The more expensive service with equivalent outcomes would be considered "not medically necessary."
- Request additional information or data for review, with the potentially revised medical policy statement and additional information being presented at a subsequent committee meeting.

Composition:
- The Joint Uniform Medical Policy Committee is comprised of physician representatives of varying specialties and responsibilities. Physician representatives comprise the voting membership. Physician membership consists of the following:
  - Chairperson: Senior Medical Director of Medical Policy/Quality Management
  - Medical Directors
  - Network Physician Representatives
- Team members at both BCN and BCBSM provide ongoing support to the JUMP Committee. While these team members are not voting members, they have responsibility for meeting coordination, presentations, and documentation. Supporting membership consists of:
  - Manager, Medical Policy
  - Medical Policy Coordinators
  - Senior Analysts
  - Administrative Support
- Representatives from various departments at BCBSM and BCN may also attend the Joint Uniform Medical Policy Committee meeting and provide resource support as needed. These representatives may vary from meeting to meeting, depending on the meeting agenda.
- Behavioral Medicine specialists will be involved in the development of policies addressing mental health related services, devices, and procedures.
- Representatives may also include, but are not limited to:
  - Customer Services
  - Business Product Development
  - Marketing
  - Account Representation
  - Claims Payment/Processing
  - Legal
  - Program Planning and Implementation
  - Reimbursement and Payment Policy
  - Pharmacy Administration
  - Other department representation, as appropriate.

The committee membership may be changed upon recommendation of the committee chairperson and approval by the Senior Vice President and Chief Medical Officer.

Term:

- Not applicable.

Meetings:

- Decisions shall be by majority vote unless there are two dissenting votes from either Blue Cross or BCN in which case the BCN Senior Vice President and Chief Medical Officer and the Blue Cross Chief Medical Officer review the policy.
- Physician representatives have voting authority.
- Minutes are taken to record actions and recommendations.
- Minutes are maintained in a confidential manner.
- Meetings are held quarterly at a minimum.

7.1.7. Criteria Review Committee

The CRC reviews clinical criteria used in the utilization management process for the Traditional, PPO, MAPPO, POS, and BCN/BCNA lines of business as well as in specialty areas such as substance abuse, foot surgery and psychiatric care. The committee reports to the Utilization Management Committee.

Responsibilities:

- Receives inquiries regarding criteria.
- Reviews and monitors clinical criteria.
- Advises corporate medical director in areas related to corporate policy for clinical criteria.

Composition:

- Chairperson: Associate CMO, Clinical Decision Support
- Medical Directors, Clinical Decision Support

Term:

- Permanent appointment until position is vacated.

Meetings:

- Ad hoc as needed to review and approve clinical criteria throughout the year.

7.1.8. Medical Affairs Policy Review Committee

The Medical Affairs Policy Review Committee coordinates the review and approval of Blue Cross Blue Shield of Michigan and Blue Care Network only policies and Interim Medical Policies on an annual basis. The review of these documents is reported to the Joint Uniform Medical Policy Committee. These policies are included in the JUMP Committee's report to the Corporate Utilization Management Committee.

Responsibilities:

- Presentation and discussion of policy statement drafts and supporting rationale.
- Interim Medical Policies will represent emerging technologies as Investigational/Experimental or Established to support the handling of inquiries and appeals for services where there is no standing JUMP medical policy.

- Policies under consideration are developed by Medical Directors using evidence-based literature, proprietary technology assessment reports, Medicare Policy documentation, with benchmarking of other national health plan medical policy.
- Policies are signed by the Senior Medical Director for Quality and Medical Policy, the designee of the Chief Medical Directors of BCBSM and BCN.
- Policies are reviewed annually.
- When appropriate, Interim Medical Policies may be referred to the JUMP Committee for full review.
- Interim Medical Policies will be replaced when a JUMP medical policy is in place.
- Interim Medical Policies May be retired if and when the technology is determined to be obsolete, no longer available or when requests for the service are no longer being made.

Composition:
The Medical Affairs Policy Review Committee is comprised of employed Blue Cross/BCN physician representatives of varying specialties and responsibilities, clinical and non-clinical team members. Physician representatives comprise the voting membership. Supporting and Optional Support members provide ongoing support to the committee. While these team members are not voting members, they have responsibility for meeting coordination, presentations, and documentation.

Voting Membership:
- Chairperson: Senior Medical Director, Quality Management
- Three or more Medical Directors, Medical Affairs Support/Quality Management
- Additional Physician support as assigned.

Supporting Staff:
- Director, Medical Affairs
- Manager, Medical Policy
- Manager, Medical Review & Appeals
- Medical Policy Coordinators
- Senior Analysts, Medical Policy

Meetings:
- Meets a minimum of two times per year.
- Quorum consists of one-half of the voting members.
- Minutes shall be taken to record actions and recommendations of the committee.

7.1.9. Enterprise Credentialing Committee

The Credentialing Committee is an enterprise peer review committee representing Blue Cross Blue Shield of Michigan and Blue Care Network. The committee has oversight responsibility for credentialing and recredentialing activities (including utilization management and quality) for all practitioners. The committee also has oversight responsibility for credentialing and recredentialing organizational providers including but not limited to hospitals, home health agencies, skilled nursing facilities, nursing homes, freestanding surgical centers, and behavioral health facilities.

Responsibilities:

- Reviews credentialing, quality and utilization information and makes determinations on initial and recredentialing applications for practitioners.
- Reviews and makes determinations on initial and recredentialing applications for health care delivery organizations including (but not limited to) hospitals, home health agencies, skilled nursing facilities, nursing homes, freestanding surgical centers and behavioral health facilities.
- Reviews credentialing, quality and utilization information for practitioners and providers. Credentialing decisions are based on the enterprise credentialing criteria, utilization information is based on utilization information from each product and quality information includes quality of care and service issues and is based on information from each product.
- Reviews and approves credentialing and recredentialing policies, as applicable.
- Reviews and makes recommendations on operational/administrative procedure related to practitioner affiliation and quality performance.
- Provides oversight for delegated credentialing and recredentialing activities.
- Makes decisions on reporting to the National Practitioner Data Bank.
- Maintains confidentiality of proceedings and related documentation to support confidentiality of peer review information.
- For BCN and MA PPO serves as the review board for selected first level administrative practitioner appeals.
- Submits written reports to required committees/workgroups. BCBSM submits reports to the Health Care Quality and Service Improvement Committee and PPO TRUST submits reports with appropriate excerpts of ECC minutes to Network Action Team.
- Reviews and evaluates annually the credentialing program plan, work plan, annual activity report and annual nondiscriminatory audit report.

Composition:

Voting Members:

- Chairperson: Appointed by the Senior Vice President and Chief Medical Officer.
- Vice Chairperson: Medical Director, who has direct responsibility and participation in the credentialing program.
- Four BCBSM/BCN Medical Directors
- Primary care practitioners (two external). The practitioners will represent internal medicine or family practice and pediatrics.
- Specialists (six external): The practitioners will represent the specialties including but not limited to: general surgery or a surgical subspecialty, Obstetrics and Gynecology, behavioral health, Oral Surgery and Pathology, Anesthesiology, Radiology or Emergency Medicine.
- Chiropractor
- BCBSM/BCN approved Physician Consultants are utilized at the request of the committee or Medical Directors to review cases requiring additional specialty expertise.

Non-Voting Members:

- Director or Manager, Quality Management
- Manager and representative from CCPS
- BCBSM Network Management Representative
- Corporate Financial Investigation Representative

- BCBSM Corporate Office of General Counsel

Term:

- Physician members serve for an initial term of two years.
- Committee membership will be reviewed annually by the Senior Vice-President and Chief Medical Officer.
- Reappointment is at the discretion of the Senior Vice-President and Chief Medical Officer.

Meetings:

- A quorum is defined as three voting practitioners being present with a minimum of two external physicians.
- Minutes are taken to record actions and recommendations.
- Minutes are maintained in a confidential manner. The confidentiality of information and documents discussed and disseminated at the meetings are governed by the confidentiality and indemnification agreements signed by the members.
- Minutes are forwarded to the appropriate committee as required. BCBSM forwards minutes to the Health Care Quality and Service Improvement Committee.
- Meetings are held at least ten times per year.

7.1.10. Pharmacy and Therapeutics Committee

The Blue Cross Blue Shield of Michigan and Blue Care Network Joint Pharmacy and Therapeutics Committee is a joint committee representing both Blue Cross and BCN. The P & T Committee evaluates the clinical use of drugs available under the pharmacy and medical benefit, determines the appropriate formulary placement of drugs, ensures that the formulary is appropriately revised to adapt to both the number and types of drugs on the market, and advises in the development of policies for managing drug use, drug administration, and the formulary system.

The Committee is a subcommittee of the BCN Health Care Quality and Service Improvement Committee. The Committee meeting minutes will be reviewed by the BCN Health Care Quality and Service Improvement Committee and shared with the BCBSM Utilization Management Committee and Quality Improvement Committee.

Responsibilities:

- Provides a thorough, critical review of the pharmaceutical and medical literature in the evaluation of criteria for drug usage and for inclusion on the formularies. The selection of items to include in the formularies shall be based on objective evaluation of their relative therapeutic merit and safety. The committee will approve inclusion or exclusion of the therapeutic classes in the formulary on an annual basis. Decisions must be based on available scientific evidence and may also be based on economic considerations that achieve appropriate, safe, and cost-effective drug therapy. Therapeutic advantages in terms of safety and efficacy must be considered when selecting formulary drugs and when reviewing placement of formulary drugs into formulary tiers.
- Provides oversight for delegated pharmacy activities.
- Approves policies regarding formulary management activities, such as prior authorizations, step therapies, quantity limitations, generic substitutions and other drug utilization activities that affect access.

- Serves in an evaluative, educational, and advisory capacity to the affiliated medical community and BCBSM/BCN administration in all matters pertaining to the use of drugs.
- To provide final decisions as it relates to the development of Medicare Part D and Qualified Health Plan formularies of drugs accepted for use within BCBSM/BCN and to ensure that the Medicare Part D and QHP formularies are appropriately revised to adapt to both the number and types of drugs on the market. The Committee will have an advisory role in decisions related to all other BCBSM/BCN commercial formularies.
- Advises in the establishment of quality clinical programs and procedures that help ensure safe and effective drug therapy.

Composition:

- Co-Chairperson: Director of BCBSM Pharmacy Benefit Clinical Services
- Co-Chairperson: Director of BCBSM Medical Benefit Drug Management
- Co-Chairperson: BCBSM Pharmacy Services Medical Director
- The committee consists of 15 total standing members.
  - 9 external representatives: 7 practicing physicians and 2 practicing pharmacists
  - 6 internal representatives: 2 BCBSM pharmacy directors and 4 BCBSM physicians
- The committee members will come from various clinical specialties that adequately represent the needs of BCBSM/BCN enrollees.
- At least one P&T committee practicing pharmacist and at least one practicing physician must be an expert in the care of elderly or disabled persons.
- The majority of members must be practicing physicians, practicing pharmacists or both, and must meet the following minimum criteria:
  - Must be an active licensed healthcare professional in the state of Michigan.
  - Must be a participating provider with Blue Cross and BCN in good standing.

Term:

- Members of the Committee are selected for two-year terms that can be renewed by approval of the Committee co-chairs, BCBSM Chief Medical Officer and BCBSM Chief Pharmacy Officer or their designees. No member of the Committee shall appear on the Excluded Entity or Individual lists maintained by the HHS Office of the Inspector General or the General Services Administration. Any member that appears on either list shall be immediately removed from the Committee.

Meetings:

- A quorum is defined as eight members, including at least one external physician and one external pharmacist.
- Minutes are taken to record actions and recommendations.
- Minutes are maintained in a confidential manner.
- Meetings are held quarterly at a minimum.

7.1.11. Member Experience Committee

The primary purpose of the Member Experience Committee is to provide oversight for all member and prospective member interactions to include member communications, satisfaction, protected health information, grievances and appeals in order to improve the

quality and consistency of services for members, practitioners, providers (including facilities), and purchasers across channels, functions, and touch points.

Responsibilities:

- Review a variety of available information related to member, provider and purchaser satisfaction and make recommendations to improve the experience.
- Review results from member surveys, including but not limited to CAHPS and Behavioral Health Services, to see if activities designed to improve the experience are effective or need to be further modified based on survey outcomes.
- Review and monitor materials for all stakeholder communications across channels.
- Review and monitor website and print materials for member health (pre-enrollment and enrollment).
- Occasionally recommend and create content for member and provider communication content.
- Review and provide feedback on external and internal member communication channels across the enterprise.
- Reviews trends related to stakeholder complaints, appeals and primary care physician change requests; and approves recommendations for improvement.
- Review member complaints and appeals, primary care physician change request; and make recommendations for improvement.
- Review and approve BCBSM, BCN and BCNA policies relevant to this committee, at least annually.
- Submit written reports to Health Care Quality and Service Improvement Committee and the Clinical Quality Committee and to the Executive Committee of Officers Committee on request.
- Analyze data on member complaints and appeals for both medical and behavioral services and identify opportunities for improvement in the following areas: Quality of Care, Access, Attitude and Service, Billing and Financial Issues, Quality of Practitioner Office Site.
- Scope includes the BCBSM commercial PPO, Exchange, and Federal Employee Program product lines and BCN commercial, Exchange, Medicare product lines.

Composition:

- Co-Chairperson: Vice president, Service Operations
- Co-Chairperson: Vice president, Experience
- Director, Customer Experience
- Director, Pharmacy Services
- Director, Digital Experience
- Director, Executive Services
- Director, Federal Employee Program
- Director, Provider Engagement and Transformation
- Manager, Behavioral Health Strategy and Planning
- Director, Quality Management
- Senior Analyst, Pharmacy Services
- Director, SHS Operations Administration

Term:

- Not applicable.

Meetings:

- In-person or virtual meetings conducted at least quarterly.
- A voting quorum is defined as the majority of the voting membership.
- Committee members may request to send a delegate with approval from one committee chair.
- Meeting minutes will be stored on the Blue Cross Blue Cross ENT- Member Exp Committee Microsoft Teams site.

7.1.12. Quality Appeals Committee

The Quality Appeals Committee has responsibility for reviewing practitioner quality of care appeals for the enterprise. Cases are referred from the Enterprise Credentialing Committee. The committee reports its finding back to the Corporate Credentialing and Program Support department for reporting.

Responsibilities:

- Serves as review board for practitioner appeals.
- Recommends reporting of appropriate peer review or disciplinary actions to the state regulatory agency and the National Practitioner Data Bank.

Composition:

- Chairperson: Associate CMO
- Medical Director, Behavioral Health
- Medical Director, Quality Management
- Eight external practitioners who represent a cross section of both primary care physicians and specialists
- Director, Quality Management
- Nurse practitioner(s)
- Social worker(s)

Term:

- Practitioners serve for an initial term of two years.
- Reappointment is at the discretion of the Senior Vice President and Chief Medical Officer.

Meetings:

- A quorum is defined as a majority of voting members. All practitioners on the committee are voting members for peer review cases and practitioner appeals.
- Minutes are taken to record actions and recommendations.
- Minutes are maintained in a confidential manner.
- Meetings are held when necessary.

8. Reporting Relationships

8.1. Blue Cross Blue Shield Board of Directors

The Blue Cross Board of Directors has ultimate authority and responsibility for oversight of the Blue Cross Quality Improvement Program. The President and Chief Executive Officer, the Executive Vice President, Health Care Value, and the EVP, Clinical Affairs and Chief Medical Officer provide oversight and coordination of the Quality Improvement Program and act subject

to and on the board's behalf in the review and approval of policies, procedures, and activities of the Quality Improvement Program.

8.2. President and Chief Executive Officer

The board has designated the President and Chief Executive Officer as its agent in making provisions for quality improvement. The President and Chief Executive Officer is the board's principal agent to assure establishment and maintenance of effective quality programs. The President and Chief Executive Officer works with senior leadership to establish a planned, systematic, and comprehensive approach to measure, assess and improve organization-wide quality improvement performance, and ensures sufficient resources are allocated to allow the Quality Improvement Program to meet its objectives and to accomplish the tasks established in the annual work plan.

8.3. Executive Vice President, Health Care Value

The Executive Vice President, Health Care Value is the corporate executive responsible for broad operational oversight of the corporate Quality Improvement Program. The Executive Vice President reports to the President and Chief Executive Officer.

8.4. Executive Vice President, Clinical Affairs and Chief Medical Officer

The BCBSM Executive Vice President, Clinical Affairs and Chief Medical Officer is the physician executive charged with broad quality improvement program clinical oversight, including: the quality and safety of clinical improvement activities and reports clinical quality, behavioral health quality and safety of clinical care improvement activities to the Health Care Delivery Committee, The responsibility for clinical quality, behavioral health quality and safety of clinical care improvement activities includes, but isn't limited to the following:

- Communication of information and the results of quality improvement activities to affiliated practitioners, Michigan Department of Insurance and Financial Services, Michigan Department of Community Health, and Centers for Medicare & Medicaid services.
- Review and adjudication of selected peer review cases, as applicable.
- Oversight of the practitioner discipline, suspension and/or termination process.
- Oversight of applicable policies and procedures.
- Review and adjudication of practitioner appeals.
- Oversight of actions implemented to improve the quality of medical care and behavioral health care delivered by the plan.
- Oversight of the patient safety activities.
- Review and approve all benefit changes.
- Review and approve all medical policies.

8.5. Senior Medical Director & Associate Chief Medical Officer

The Senior Medical Director and Associate Chief Medical Officer reports to the Executive Vice President, Clinical Affairs & CMO and is responsible for providing clinical guidance, input and leadership oversight for healthcare improvement related activities including utilization management, medical management, credentialing, quality improvement, behavioral health, and pharmacy services. Responsibilities include the following:

- Leads the Clinical Quality Committee.
- Assist in ensuring compliance with legal requirements and regulatory and accrediting agencies' standards and procedures by providing clinical oversight and input into regulatory and accreditation reviews related to utilization and quality management programs.

- Provide leadership, support, and direction for development of clinical and cost-effective programs which improve member access, reduce gaps in care, enhance customer satisfaction, lower medical costs, and maximize positive health outcomes.
- Provide clinical and operational oversight for pharmaceutical management programs including establishment of policies, procedures, and protocols to support the appropriate and cost-effective use of pharmaceuticals.
- Improve clinical support and relationships with network providers, leading to opportunities to improve care and outcomes for members.
- Assist in the education of providers and facilitate the integration of managed care knowledge, clinical and cost-effective practices into network policy.
- Assist the medical directors in working closely with providers to improve their performance related to member satisfaction, clinical outcomes, and appropriate use of clinical resources, access, effectiveness, and cost.
- Participate in and provide leadership to clinical committees as required.
- Represent Blue Cross at state and national meetings and partner with internal and external groups to identify and contribute to ongoing improvement opportunities.
- Work collaboratively with other corporate areas to increase effectiveness of medical administration programs and promote the integration of other corporate clinical programs.

8.6. Medical Directors

The medical directors provide clinical expertise for quality improvement, credentialing and recredentialing activities, chronic condition management and health promotion and wellness programs. Responsibilities include the following:

- Provides direct clinical guidance, support, and oversight for the credentialing and recredentialing daily processes including file review approval and denial designations.
- Participates in providing direction for health promotion and wellness initiatives and chronic condition management programs.
- Participates in the development of internal quality improvement policies and procedures.
- Reviews identified quality of care concerns and determines corrective action required.

8.7. Behavioral Health Medical Director

The BCBSM Behavioral Health Medical Director in collaboration with a board-certified psychiatrist with Optum (NCQA accredited MBHO) are responsible for oversight of the Blue Cross Behavioral Health program and are members of the Behavioral Health Quality Improvement Committee. This committee ultimately reports to the Clinical Quality Committee.

8.8. Senior Health Care Value Operations and Execution Excellence

The Senior Director Health Care Value Operations and Execution Excellence is responsible for QI Program Oversight. The Senior Director reports to the Executive Vice President, Health Care Value.

8.9. Director, Quality Management

The Director of Quality Management is responsible for Quality Improvement Program oversight with broad responsibility for program development and organizational integration. The Director, Quality Management reports to the Senior Director, Health Care Value Operations and Execution Excellence who reports to the Executive Vice President, Health Care Value. The Director, Quality Management, is responsible for Quality Improvement Program operations including accreditation processes, focused quality studies and quality initiatives.

8.9.1. Quality Management Department

The department is responsible for activities related to monitoring and evaluation of the quality of care and service delivered. This department performs the following functions:

- Develops and submits for approval the annual Quality Improvement Program Plan, Quality Improvement Work Plan, and the annual Quality Improvement Program Evaluation.
- Prepares and submits quality improvement reports and proposals to the Clinical Quality Committee.
- Conducts ongoing monitoring activities as directed by the Clinical Quality Committee.
- Coordinates accreditation surveys for the enterprise.
- Maintains clinical guidelines and protocols related to patient care, patient safety and services. Submits guidelines, as needed, for review and revision at required intervals and communicates revisions to practitioners.
- Identifies clinical activities for the year with Clinical Quality Committee input.
- Conducts required facility site and medical records reviews.
- Develops and maintains internal quality improvement policies and procedures.
- Initiates corrective action for identified problems as recommended by the Clinical Quality Committee. Monitors the results of actions taken and follow-up activities.
- Performs annual evaluation of delegated quality management entities, as applicable.
- Develops and distributes to members and practitioners upon request a written annual summary of the Quality Improvement Program.
- Develops and implements programs to enhance coordination of care between medical care and behavioral health services across all levels of care.
- Develops and implements patient safety programs, monitors programs, and provides reports to purchasers and the Clinical Quality Committee.
- Coordinates collaborative quality activities with designated organizations.

9. Program Activities

The program activities are designed to continuously monitor the quality and safety of care and services to identify opportunities for improvement. The demographic and epidemiological characteristics of the member population are analyzed to assist in the selection of studies and improvement projects. The Clinical Quality Committee approves the quality improvement activities.

Measurement (data collection) is the basis for determination of the existing level of performance and the outcomes from those processes. Quantitative measures are established to evaluate the most critical elements of care and services provided. The selected indicators include structure, process, and outcome indicators. Structure measures are used to assess the availability of organized resources. Process measures focus on using the expected steps in the course of treatment. Outcome measures assess the extent to which care provided resulted in the desired or intended effect.

The assessment of the captured data determines the actual level of performance and the need for action to improve performance. The assessment process includes trending performance over time and comparison to established benchmarks. Action taken is primarily directed at improving outcomes, as well as processes.

Blue Cross conducts quality improvement studies to systematically evaluate the quality and safety of clinical care and service delivered to members. Blue Cross relies on its policy and procedure which provides for the consideration of many factors in the identification, selection, and prioritization of study topics, including the following:

- Volume of services
- Cost of services
- Availability of data
- Regulatory requirements
- Replicability
- Amenability to intervention

The Medical Informatics department under HCV Business Analytic Services provides assistance with clinical study design, statistical analysis, and evaluation. The activities are described below.

9.1. Quality of Service

9.1.1. Availability of Practitioners

Blue Cross ensures that its networks are sufficient in numbers and types of practitioners to meet the needs of its members. In creating and maintaining the delivery system of practitioners, Blue Cross acknowledges and values the key role of cultural, racial, ethnic, gender, linguistic needs, and personal preferences in the effective delivery of health care services.

Blue Cross implements mechanisms designed to ensure the availability of hospitals, primary care, obstetrical/gynecological, behavioral health (prescribers and non-prescribers), ancillary, high volume specialty care and high impact practitioners. Other specialty care practitioners as identified by regulatory agencies are also reviewed.

Some of the tools used to monitor network access include the practitioner availability study, analysis of member complaints and appeals, appointment accessibility, population assessments and Consumer Assessment of Healthcare Providers and Systems surveys. A year over year comparison is done using the current and previous practitioner availability studies to identify changes that may negatively impact access.

In addition, the plan has special enterprise initiatives focused on meeting members' cultural, ethnic, racial and linguistic needs and finding long-term solutions to barriers in receiving care. The Health Disparities Action Team provides analysis and recommendations on programs annually.

Goals:
At least annually, Blue Cross monitors network access based on the following three standards:

- For at least 90% of Blue Cross members in Large Metro and Metro, 85% in Micro, Rural and Counties with Extreme Access Considerations should have access to the following, based on time and distance from the member's home:

Practitioner/Provider	Large	Metro	Micro	Rural	CEAC
PCPs	10/5	15/10	30/20	40/30	70/60
OB/GYN	30/15	45/30	80/60	90/75	125/110
Dermatology*	20/10	45/30	60/45	75/60	110/100
Ophthalmology*	20/10	30/20	50/35	75/60	95/85
Cardiovascular Disease*	20/10	30/20	50/35	75/60	95/85

Oncology (med/surg)**	20/10	45/30	60/45	75/60	110/100
Oncology (radiation)**	30/15	60/40	100/75	110/90	145/130
BH and Substance Abuse	20/10	45/30	60/45	75/60	110/100

**High Volume Specialty*
***High Impact Specialty Note: The list contained in this grid in not all inclusive.*

- The ratio of PCP, Specialty Care Practitioners (including high volume and high impact specialists), as well as other specialty care practitioners), and behavioral health practitioners (prescribers and non-prescribers) to members should be:
  - Family practice to members: 1:1,000 or less
  - Pediatrics to pediatric members: 1:1,000 or less
  - Internal medicine to adult members: 1:1,000 or less
  - PCP to adult members: 1:1,000 or less
  - PCP to pediatric members: 1:1,000 or less
  - OB/GYN to female members: 1:10,000 or less
  - High Volume (excluding OB/GYN) to members: 1:10,000 or less
  - High Impact to members: 1:10,000 or less
  - Behavioral Health to members: 1:10,000 or less

- The percent of practitioners who are board certified or board eligible should be.
  - PCPs: at least 85 percent
  - All contracted specialists: at least 90 percent

The outcomes are reported to the Network Policy Council for input and to the Clinical Quality Committee for review and approval annually.

9.1.2. Accessibility of Service

Blue Cross has established mechanisms to provide access to appointments for primary care services, behavioral health services and specialty care services. Appointment access standards are assessed annually for primary care physicians (general practitioners/family practice practitioners, internists, pediatricians), top four high volume specialists including obstetricians and gynecologists, high impact specialists (oncologists) and behavioral health care providers (prescribers and non-prescribers).

The Quality Management department provided multiple options for providers to complete the survey (i.e., phone, email and fax). Blue Cross assesses standards for primary care physicians, high volume specialists and high impact specialists as follows:

Primary Care Provider:

Appointment Types	Standard	Target
Emergency Care	Immediately	100 percent of the appointments are completed within the standard time frame.
Urgent Medical Care	Immediately	
Not urgent, but requires medical attention	Within seven days	
Regular and Routine Care	Within 30 days	
After-Hours Care	24 hours a day, seven days a week for medically necessary situations	

Specialists:

Appointment Types	Standard	Target
Regular and Routine Care	Within 30 days	90 percent of the appointments are completed within the standard time frame.

Blue Cross also assesses standards for its Behavioral Health providers, consisting of both prescribers and non-prescribers, to include:

Appointment Types	Standard	Target
Emergency Life Threatening	Immediately	100 percent of the appointments are completed within the standard time frame.
Emergency Care Non-Life Threatening	Immediately	
Urgent Care	Immediately	97 percent of the appointments are completed within the standard time frame.
Not urgent, but requires medical attention	Seven days	
Initial visit for Routine Care	10 days	
Follow-up Routine Care	30 days	
After-Hours Care	24 hours a day, seven days a week for medically necessary situations	100 percent of the appointments are completed within the standard time frame.

The outcomes are reported to the Clinical Quality Committee annually for review and approval.

9.1.3. Monitoring for Quality and Accuracy of Information to Members

NCQA Program and Standard			
NCQA Measurement	**Type**	**Program**	**Target Rating**
NCQA Accuracy Measurements	Member 1st Provider 1st Quality Program	The Member 1st Provider 1st Quality Program is designed to assess the accuracy and completeness of service delivery through telephone and written (email) work in the call center.	85% of CSRs receive a Pass on the evaluations.
	Accuracy of Email Response Time	Email inquiries receive a response within one business day Turn-Around-Time.	85% of emails received a response within one business day.
NCQA Quality Measurements	Interactive Voice Response Survey	Survey responses with member feedback based on experience with the customer service representative based on the following two questions; You understood the information received and the information you received was useful.	85% of CSRs receive a pass on the surveys.
	Quality of Email Response	Responses to emails assessing member understanding and usefulness of information provided based on contacts to the service center within seven days of email response.	85% of emails sent did not have a member callback within seven days.

All communications with members and providers are delivered with accuracy regardless of whether it is via telephone, letter, email, or any other form of communication. The Member 1st

Provider 1st Quality Program contains methodology for performing oversight and monitoring functions on service delivery via telephone and written communications. This program is designed to supply ongoing assessment information to operational leaders and staff to be used to drive continual improvement in service delivery and outcomes. Data collected from individual evaluations is used to track and trend overall performance to goal. Interactive Voice Response Surveys and email resolution response data are used to evaluate the members' understanding and usefulness of the information received.

Accuracy Measurement
The Member 1st Provider 1st Quality Program for member and provider servicing includes the following program components:

A randomized methodology sampling of inquiries managed by Customer Service Representatives is reviewed for quality, accuracy, and completeness. Evaluations are scored based on a five-point system of the following attributes: HIPAA verification, accuracy, completeness, proper claim handling, and completion of any applicable promised actions. Accuracy and completeness are evaluated based on the member or provider receiving correct and complete information. If the CSR does not provide accurate and complete information for each attribute, then the CSR will not pass the evaluation.

Each evaluation includes scoring one point for each attribute for a total of five points possible for each evaluation.

1. HIPAA violations
2. Promised action
3. Claim adjustments
4. Accuracy
5. Completeness

- To reach a passing Quality level, the minimum pass rate is 95 percent.
  - CSR can miss one attribute on one evaluation and pass quality for the month.
  - The maximum score for the month is 20, if the CSR misses one attribute the score will be 19 out of 20 or 95% and the CSR will pass quality for the month.
- This information is compiled and utilized to assess performance at all levels.
  - Quality evaluations are entered and captured in the Verint and Genesys systems.
  - Monthly samples can consist of phone only, written only (including email) or a combination of phone and written.
  - Targeted sampling goal is four evaluations (on average) per CSR per month.

Monitoring Email Responses and Turnaround Time
A monthly report is pulled to review and ensure the turnaround timeframes are met. All data is pulled, and an analysis is completed. The analysis includes but is not limited to a review of:

- Overall performance to goal.
- The aggregate inquiry reasons to identify global issues.
- Prevalence of issues and appropriateness of resolution.
- Effective language and quality of communication.
- Process and performance opportunities to improve customer experience.

Quality Measurement
Interactive Voice Response Surveys: Targeted sampling goal is three surveys (on average) per CSR per month. Members are specifically asked to select how much they agree with each

statement based on their experience with the customer service representative who managed their call.

Each survey includes scoring of 1 point for each attribute for a total of 5 points possible for each survey. Scale of 1-5: 1 is strongly disagree, 2 is somewhat disagree, 3 is neither agree nor disagree, 4 is somewhat agree and 5 is strongly agree.

1. You understood the information received.
2. The information you received was useful.

Note: CSR must score 4 or better to pass to meet the target rating

Quality of Email Responses: Responses to emails assessing member understanding and usefulness of information provided based on contacts to the service center within seven days of email response. The target is 85% of emails sent did not have a member callback within seven days.

Quality and Accuracy Target Rating

1. Telephone and Email Accuracy Target: 85 percent of CSRs will pass monthly evaluations.
2. Telephone Quality Target: 85 percent of surveys will pass monthly evaluations.
3. Email Timeliness Target: 85 percent of email inquiries receive a response within one business day.
4. Email Quality Target: 85 percent of email responses will not result in an additional call to the service center.

A quarterly data analysis is performed against the target rating and action plans are created to identify improvement activities to address deficiencies. A full analysis including interventions and recommendations is shared with Service Operations leadership and the Member Experience Committee. The committee is responsible for approval, feedback, and recommendations are incorporated into the final report.

9.2. Clinical Quality

9.2.1. Healthcare Effectiveness Data and Information Set

HEDIS is a tool Blue Cross uses to measure performance as it relates to important dimensions of care and service. Because so many health plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an equivalent basis. Blue Cross uses HEDIS results to analyze where improvement efforts should be focused.

Blue Cross complies with the HEDIS reporting requirements established by the National Committee of Quality Assurance, the Office of Financial and Insurance Regulations, Centers for Medicare and Medicaid Services, and Michigan Department of Community Health. Activities focused on improving gap closure rates for select HEDIS measures are integrated with the Physician Group Incentive Program and also targeted provider and member outreach strategy. Blue Cross implements interventions based on the reporting year results. The impact of the interventions is monitored in the subsequent year. HEDIS activities and results are audited by an NCQA-certified auditor and submitted for public reporting annually.

Commercial measures for focus are:

- Breast Cancer Screening

- Controlling High Blood Pressure
- Hemoglobin A1c Control for Patients with Diabetes
- Kidney Health Evaluation for Patients with Diabetes
- Colorectal Cancer Screening
- Immunization Measures (Childhood Immunization Status – Combo 10, Immunizations for Adolescents – Combo 2)

Performance goals for HEDIS MY2025 are focused on increasing lower performing measures to the next percentile while increasing or maintaining measures that are currently performing well. For MY2024, 75 percent of the PPO accreditation measures performed in the 50th percentile or higher. Health Plan Ratings result for MY2024 for Commercial is 4 Stars.

Goal:

- Health Plan Rating of 3.5 Stars or better

9.2.2. Utilization Management

The Utilization Management Program includes medical, behavioral health and pharmacy utilization activities. Pharmacy Services is responsible for review of all pharmaceutical services that require clinical review/benefit interpretation, and they follow their own pharmacy program policies.

Utilization Management strives to ensure the appropriate delivery of care at the right time and place and reduce costs to improve quality according to established criteria or guidelines. Each business area evaluates the appropriateness, medical need and/or efficiency of health care services across the care continuum. Utilization management decision making is based only on appropriateness of care, service, setting and existence of coverage. The utilization management process includes prior authorization/precertification, concurrent and peer reviews along with clinical case appeals and appeals introduced by the provider, payer, or patient.

Appropriate practitioners are involved in adopting and reviewing criteria applicability. The criteria used for the evaluation and monitoring of health care services are annually reviewed and approved. New criteria and updates to existing criteria are distributed to all network facilities. Post-acute local rules for commercial business only are developed with input from appropriate practitioners to supplement approved criteria.

Blue Cross maintains a consistent process for the development, review, and revision of its pharmaceutical utilization management program, including but not limited to prior authorization criteria, step therapy requirements, and quantity limits. Drug criteria are based on current medical information and reviewed and approved annually by the Blue Cross and BCN Pharmacy & Therapeutics Committee.

Refer to the annual Utilization Management Program Description for additional information about the health plans programs and goals.

9.2.3. Population Health Management

Population Health Management consists of a comprehensive plan of action for addressing member care needs across the continuum of care. The strategy is based on outcomes from an annual PHM assessment that identifies member characteristics, services based on claims, and social determinants of health. Additionally, the strategy

describes programs and services offered to members, activities that support practitioners, providers or community-based organizations, how member programs are coordinated, how members and practitioners are informed about available PHM programs, and the promotion of health equity.

Interactive member programs selected for the strategy focus on keeping members healthy, managing members with emerging risk, patient safety or outcomes across settings, and managing multiple chronic illnesses.

An evaluation is conducted annually on select programs in the strategy to determine its impact based on one clinical measure, one cost or utilization measure, and one member feedback measure from two different programs:

Focus area	Program/cohort	Measure	Goal
Managing members with emerging risk	Blue Cross Coordinated Care complex case management: Chronic future risk	Clinical	Managed members will have a higher percentage for overall gap closure rate as compared to members not managed in the program. This includes the closure of all care gaps that may be open for a member and include gaps related to medication adherence, managing their treatment for their condition, provider visits, and prevention/screening guidelines
Managing multiple chronic illness	Blue Cross Coordinated Care complex case management: Highly comorbid conditions	Cost/utilization	Members managed will have a higher rate of physician follow-up visits within seven days of discharge from medical admission over members not managed in the program.
Patient safety or outcomes across settings	Blue Cross Coordinated Care complex case management: At risk for readmissions	Cost/utilization	Members managed will have a higher rate of physician follow-up visits within seven days of discharge from medical admission over members not managed in the program.
Managing multiple chronic illness	Blue Cross Coordinated Care complex case management: Highly comorbid conditions	Member survey	Achieve 90 percent overall member satisfaction rate
Patient safety or outcomes across settings	Blue Cross Coordinated Care complex case management: At risk for readmissions	Member survey	Achieve 90 percent overall member satisfaction rate
Keeping members healthy	Tobacco Coaching		Achieve 50th NCQA percentile for CAHPS Smoking Cessation

Overall outcomes of the annual assessment and evaluation are presented to the Clinical Quality Committee for review and approval. Refer to the BCBSM Population Health Management Strategy & Program Description for additional information.

9.2.4. Care Management

The Blue Cross Coordinated Care program has an integrated care management approach designed to help reduce the complexity of the healthcare system by giving members access to a comprehensive care team that will help them better manage their health. BCCC is designed to effectively manage the healthcare resources for members with various healthcare needs and in multiple care settings. The program provides coordination of care and services for members who have experienced an acute event or diagnosis that requires extensive resources and need help navigating the system. BCCC uses a collaborative process and case management principles that assess, plan, implement, and evaluate options and services to meet an individual's health needs. Case managers handle the day-to-day clinical management of program members. Case managers are assigned to dedicated geographical regions. The use of regional assignments improves the care manager/ relationship with local providers and community resources and fosters an understanding of the socioeconomic conditions of that region.

Goals:

- Managed members will have a higher percentage for overall gap closure rate as compared to members not managed in the program. This includes the closure of all care gaps that may be open for a member and include gaps related to medication adherence, managing their treatment for their condition, provider visits, and preventative/screening guidelines.
- Members managed will have a higher rate of physician follow-up visits within seven days of discharge from a medical admission over members not managed in the program.
- Achieve 90 percent overall member satisfaction rate.

Refer to the Blue Cross Coordinated Care program description for additional information about care management.

9.2.5. Behavioral Health

9.2.5.1. Optum Behavioral Health Program

In 2024, Optum Behavioral Health assumed behavioral health management of Blue Cross Blue Shield of Michigan members. Optum Behavioral Health is accredited by the National Committee for Quality Assurance and has extensive experience managing Behavioral Health benefits for other insurers across the nation. Services included in the contract with Blue Cross Blue Shield of Michigan include utilization management and case management services for all members who receive behavioral health through BCBSM.

Behavioral Health vendor oversight is provided by the BCBSM Behavioral Health Strategy and Planning department and is approved by the Utilization Management Committee.

The program goals are:

- Manage and engage 15,000 members across all lines of business in Behavioral Health Care Management.
- Improve follow-up care after inpatient psychiatric and substance use admissions related to HEDIS FUH 7 performance with the intent of 75% or higher, or +5% year-over-year improvement.
- Improve coordination and continuity of care between behavioral health and primary care providers.

- Maintain a 9% or lower 30-day readmission rate for Commercial behavioral health admissions and 11% or less for Medicare mental health admissions.
- Maintain a 15% or lower 30-day readmission rate for substance use admissions.
- Develop and execute HEDIS-related interventions to support Antidepressant Medication Management (AMM; discontinued in 2025), Management of Treatment Access and Follow-Up with Members with Diabetes and Schizophrenia (SMD), and Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD).
- Maintain a minimum of 85% member satisfaction with Behavioral Health customer service and case management services.
- Participate in the quarterly Behavioral Health – Quality Improvement Committee to examine opportunities to improve any of the above areas.

9.2.5.2. Blue Cross Behavioral Health™ Program

Services provided to manage the behavioral health members include utilization management of prior authorizations, and case management services through programs accredited by the National Committee for Quality Assurance. The program is titled *Blue Cross Behavioral Health™.* The behavioral health programs are overseen by the Quality Management department and reviewed and approved by the Utilization Management Committee.

The Blue Cross Behavioral Health™ program vision is to deliver market leading, innovative, whole person solutions focused on integration of behavioral and physical health care in order to meet member and customer needs. We deliver this by implementing a number of plan-based, provider and network strategies.

Blue Cross Behavioral Health™ continues to demonstrate its commitment to behavioral health through inclusion of mental health and substance use programs in both its long-term strategy and its enterprise goals. Blue Cross Blue Shield Michigan has a dedicated behavioral health strategy team to continuously review its behavioral health programs and procedures and create a robust, long-term strategy to better serve our members.

Goals:

1. Enhance the quality, consistency, and value of inpatient psychiatric care by continuing to promote and expand the Alternative Payment Model for inpatient psychiatric pilot program launched in 2025.
    - Deliver more coordinated, person-centered care for members through evidence-based treatment pathways.
    - Align incentives that promote recovery, reduce readmissions, and optimize overall behavioral health outcomes.
    - Leverage program outcomes to explore opportunities for broader implementation, reinforcing commitment to sustainable, value-based behavioral health delivery.

Having experienced successful treatment and discharge planning quality with Pine Rest Christian Mental Health Services, a pilot program was initiated in 2025 which will evaluate treatment outcomes and quality using an Alternative Payment Model rather than fee-for-service arrangement for Blue Cross Blue Shield members.

Data available through Q2 2025 indicate that this program has resulted in:

- A lower average length of stay in 2025 compared to Pine Rest admissions in 2024 (7.90 days average LOS in 2025 vs. 8.43 days average LOS in 2024).

- A lower average LOS than 4 of 5 large inpatient behavioral health facilities in Michigan with low 30-day readmission rates.
- A lower 30-day readmission rate (11.72%) than 5 large inpatient behavioral health facilities in Michigan with high readmission rates (average 13%).
- While Pine Rest's 30-day readmission rate of 11.72% through Q2 2025 is higher than the average of 5 large inpatient behavioral health facilities with low rates (average 8.15%, highest – 9.35%), Pine Rest has a much higher number of admissions by just over 250 compared to the next highest facility (563 through Q2 2025 compared to 310 – Michigan BH JV/Beaumont).

2. Evaluate the Behavioral Health Case Management program to identify opportunities for enhancing quality, efficiency, and member outcomes.

   Goals:
   - Evaluate current-state performance across access, quality, and industry best practices.
   - Evaluate opportunities for greater engagement in care management programs to improve transitions in care.
   - Measure the performance and success of customized care pathways and refine for greater improvements in engagement and outcomes.

   An annual quality audit of the BH CM program was completed in September 2025 and a summary report sent to Optum Behavioral Health in October. Areas of improvement identified included clear and simple case documentation; clinical assessments being fully completed and documented; documentation of member acceptance of CM services aligning with documented members accepting or declining these services; and proper documentation of plans and goals related to members' needs.

   Optum Behavioral Health's response to this annual audit and summary report is forthcoming as of this writing.

   The impact of BH CM services on HEDIS and CMS Stars quality performance is underway with the creation of a Behavioral Health Dashboard which will collect monthly quality data for reporting up to executive leadership.

3. Promote and expand Crisis Services by closing gaps in awareness and streamlining access.

   Behavioral health crises are serious events that require trained clinical intervention. Unfortunately, police are often called in to manage the situation and the individual in crisis is transferred to the emergency room. Despite work in this area, many emergency rooms do not have full-time behavioral health staff to immediately assess and start treatment. This can lead to longer wait times and delays in treatment initiation.

   Blue Cross is working with the State of Michigan and local community agencies to establish crisis services to support our members. These services have been available for more than 20 years in the public sector (e.g., Medicaid), but have only recently become accessible to the broader commercially insured population. Crisis services are not standard across Michigan or across the country so contracting requires considerable time. Certain counties have rather robust crisis services and

others have very few available. Blue Cross' ideal crisis continuum would contain the following:

- Psychiatric urgent care
- Mobile crisis
- Crisis stabilization
- Crisis residential

Further expansion took place in 2025 across the state, particularly in rural counties and in the Upper Peninsula. All 83 counties in Michigan now have access to mobile, virtual, or in-person crisis care services. A publicly-available website, https://www.bcbsm.com/behavioral-mental-health/support/crisis-care/, was launched where members and providers can quickly find crisis care providers in a member's area through a simple drop-down menu. This website also links members to the nationwide 988 Suicide and Crisis Lifeline where trained crisis counselors are available 24/7/365.

Individuals who call 988 are linked to a behavioral health expert who can triage the member and refer to appropriate crisis, community, or hospital (if needed) resources to reduce law enforcement involvement. These tactics also aim to reduce the need for individuals in a psychiatric crisis to sit in an untherapeutic medical emergency room.

Goals:

- Equip our provider community and members with clear, accessible resources.
- Promote crisis services through a dedicated communication strategy to ensure members are aware of crisis care services and know how to locate them.
- Continue to expand the number of contracted crisis providers to allow improved access to community-based services.

The goal to expand the number of contracted crisis providers to allow improved access to community-based crisis services continued in 2025; crisis services are now available in all counties in Michigan and the provider network for this continues to grow. Main goal areas comprised increasing the number of available providers across the state and improving awareness of these services to our provider network and membership.

4. Expand and strengthen the Behavioral Health Outpatient Quality Initiative

   On September 1, 2024, Blue Cross partnered with two large virtual therapy provider groups, Headway and Grow Therapy, to expand telehealth services to members across the state as part of an Outpatient Quality Pilot Program. These groups combined have over 700 therapists and prescribers, and the aim of the program is to provide prompt, efficacious treatment to members.

   Metrics for program success include low-latency of time to first appointments, improvement on measures such as the PHQ-9 for depression and GAD-7 for anxiety, and provider demographics which match those of members (Spanish- and Arabic-speaking providers, BIPOC providers, and those who specialize in the treatment of children and adolescents).

   The goal of the Outpatient Quality Pilot Program is to improve access to evidence-

based care to treat the two most common behavioral health conditions, anxiety and depression. Behavioral Health Strategy will evaluate the success of the two groups noted above that will help bring virtual therapy services to members in a quick and efficacious manner.

Efforts are currently underway to complete an annual data review, which will be finalized after the submission of this report. However, initial evaluation indicates that both MSO provider groups have met the performance quality metrics in 2025 for access to initial and 14-day follow-up appointments as well as improved symptoms of anxiety and depression as shown by improved GAD-7 (anxiety) and PHQ-9 (depression) screenings.

Goals:

- Maintain a provider group size of at least 300 behavioral health providers representing specific provider demographics (e.g., specialties, languages spoken, etc.).
- Participate in the Michigan Health Information Network Shared Services for clinical quality data sharing.
- Increase access to outpatient providers and prescribers.
- Reduce appointment wait times.
- Enhance quality of services and clinical outcomes through use of consistent, evidence-based care.
- Improve member experience and satisfaction related to BH access while ensuring symptom reduction through patient reported outcome measures.

5. Promote member access to self-guided behavioral health care to support stress and anxiety reduction.

Virtual care remains an important was that Blue Cross is expanding access to behavioral health services. Between 2021 and 2022 there was a 53% increase in virtual care visits and overall, 65% of visits delivered virtually (for any specialty), were behavioral health visits.

Blue Cross has partnered with AbleTo to expand national access to evidence-based behavioral health care. AbleTo is a best-in-class, high-quality, technology enabled virtual solution approved by the Blue Cross Blue Shield Association with measurable outcomes that provide a structured eight session Cognitive Behavior Therapy intervention, which is the recommended treatment for anxiety and depression. Anxiety and depression are the two most prevalent mental health conditions members struggle with nationally and ensuring access to evidence-based treatment will improve well-being and outcomes. In 2023, Blue Cross expanded messaging to customers and members to increase awareness of the program. This program continued through 2025.

In Q3 2025, the Blue Cross Coordinated Care program began to provide free access to the Calm app for anxiety and stress relief. This makes available to members a quick and readily available way to help decrease anxiety, manage stress, and improve sleep through guided offerings such as meditation, music tracks to help with focus and relaxation, and a library of audio stories to help members sleep. This smartphone app can assist members with building habits to improve sleep quality

and focus and can also be set to automatically remind members to take time for meditation and stress relief. Efforts going forward will focus on improving member awareness of this application as a free benefit and looking at symptom improvement for members.

Goals:

- Increase member awareness and adoption of digital tools across the eligible population to promote early intervention, resilience, and overall well-being.
- Strengthen member experience and promote preventive care by encouraging early self-management before behavioral health needs escalate.
- Connect members to additional support for those who need it.
- Improve member experience and align with whole-person health strategy.

In addition to the initiatives above, Blue Cross has built a robust program and is expanding, and additional behavioral health capabilities are highlighted below:

Integrated Health Expansion Efforts

Continued Expansion of the Collaborative Care Designation Program

PGIP has developed a Collaborative Care Designation Program that builds off our strong Patient-Centered Medical Home foundation using the CoCM model developed by the AIMS Center at the University of Washington.

Collaborative Care adds a behavioral health component to the partnership between a patient and their primary care provider or OB/GYN. It allows patients to connect to appropriate behavioral medicine quickly and right from their doctor's office. A Collaborative Care team consists of the treating physician, who remains the head of the care team, and adds two new team members: a behavioral health care manager and a consulting psychiatrist. The behavioral health care manager meets with the patient often to make sure treatment is going well. The behavioral health care manager also consults with a psychiatrist regularly to discuss treatment progress and make recommendations when needed. The behavioral health care manager connects the dots between the patient, the psychiatrist, and the patient's doctor. The treating physician makes the final decisions about the patient's treatment.

The Collaborative Care Designation Program:

- Improves patient care and brings more patients to depression-free days and to remission.
- Creates a strong care team that allows for the provision of behavioral health care in a primary care setting.
- Stretches limited psychiatric resources to allow more patients to receive psychiatrist-influenced care, while reserving face-to-face psychiatrist time for high complexity patients.
- Improves self-management for patients with behavioral health and other chronic conditions.
- Reduces member stigma.

To receive the Collaborative Care designation a primary care practice must be PCMH designated and must have all ten of the CoCM capabilities fully in place. The

capabilities selected are the basic elements a practice needs to have fully in place to effectively deliver Collaborative Care. Members in BCBSM plans can receive services at a CoCM practice within the context of their primary care.

Goals:

- 100 percent of POs and their designated practices will receive rewards as described above.
- There are currently 970 practitioners (PCP and OB/GYN) across 338 different practices, up from 519 practitioners across 275 practices in 2024. These include 249 Advanced Primary Care practices (up from 218 the previous year) which provide advanced treatment and collaborative care management.
  - BCBSM has exceeded the corporate goal of CoCM practice growth between 2023-2025.
- To retain current designated practices, recruit additional adult and pediatric practices, expand OB/GYN specialty practices and using CoCM with those with substance use disorders.
  - Value-based reimbursement incentives will remain in place for participating providers and clinics in 2026.
  - Oncology and Addiction Medicine are being considered as specialty practices to expand the CoCM program in 2026.
  - Expanding Behavioral Health integration to Advanced Primary Care practices is also being considered for 2026.
- Further opportunities to care team members to both hone skills and to target specific populations. Additional training will focus on specialty populations – substance use disorders, OB/GYN, pediatric/adolescent care.
  - All learning modules have been revised in 2025 based on user feedback.
  - Base training has been condensed from 3 to 2 days.
  - Perinatal and substance use trainings are now 1 day.
  - The type and number of topics has also been expanded.
- Additional suggestions for changes to this program are also being considered:
  - Caseload size – being able to identify how many BCBSM members CoCM practices are managing and setting thresholds for caseload and billing based on this.
  - Incentives may also be based on patient attribution as practices can vary significantly in size (number of PCPs per practice; number of members that can be managed based on number of PCPs).

Collaborative Quality Improvement Initiative – MI MIND

Blue Cross partnered with Henry Ford Health System to roll out a state-wide quality improvement initiative to implement the Zero Suicide Model across the provider community starting with four Physician Organizations to pilot in 2022. In 2024, MI MIND had 11 physician organizations participating, representing 737 primary care physicians, psychiatrists and psychologists across Michigan. In 2025, these numbers were:

- Three new physician organizations (total of 14).
- A decrease in the total number of practices, 95 in 2025 down from 124 in 2024.
- A decrease in total practitioners, 519 in 2025 down from 737 in 2024.
- While there have been decreases in number of practices and practitioners in

2025, BCBSM's Behavioral Health Strategy and Planning have worked to increase the number of participating providers and groups who deliver crisis care across the state of Michigan to further address both suicide prevention and overall access to care.

The MI MIND Zero Suicide was developed at Henry Ford and adopted nationally as part of a National Strategy for Suicide Prevention as well as globally in over 20 countries. This is an opportunity for health care entities to work together and take a systematic clinical approach to suicide prevention through this well-researched model. The overall aim of MI MIND is to improve suicide prevention and access to behavioral health across all providers within the State of Michigan.

In 2024 this program helped to lessen the increase of suicides in Michigan to 2% lower than the national average. Participating providers have helped with this by using effective suicide prevention protocols with their patients. There have been significant increases in participating providers' knowledge of such procedures and protocols, support of staff when suicide does occur, and providing safety planning to patients.

In 2025, the scope of this project continued to expand across the state and also reinforced the use of mobile crisis services in practices where a patient screens positive on question #9 of the PHQ-9 ("[Have you had] thoughts that you would be better off dead or of hurting yourself in some way").

Continuing to add providers and provider organizations remains an ongoing initiative.

Goals:
This CQI will continue, encouraging collaboration with Blue Cross associated physician organizations and their affiliated providers to:

- Refine the Zero Suicide elements that will be implemented in each practice and health system.
- Implementation of Zero Suicide training protocol across all participating providers.
- Initiate QI cycle of evidence-based suicide prevention components across all participating providers.
- Continue to expand the program to include additional physician organizations and their affiliated providers.

Expanding Access to Behavioral Health Services

Certified Community Behavioral Health Clinics (CCBHCs)

A program was slated to begin in 2025 to collect data on members with certain severe and persistent mental illness (SPMIs) across the state, and with that information help outreach to these members to help them locate participating clinics at which to obtain treatment.

CCBHCs are facilities which will provide targeted treatment services to these members in nine core treatment areas (medical, behavioral, care management, medications, etc.) which will provide integrated care to members rather than receiving separate treatment modalities at separate locations, which may be difficult for members.

In 2025, this initiative remains in development and is projected for a 2026 go-live. There have been meetings with external stakeholders to develop contracting and funding specifics.

Data and Screening:

Postpartum depression screening VBR:

Obstetrician/Gynecologists who perform Postpartum Depression (PPD) screenings for new mothers PPD Screening Metric Logic:

- Mothers will be assigned to an OB/GYN using the attribution logic in the women's health dashboard.
- Screenings and deliveries will be attributed to the PO of the OB/GYN for a PO-level rate calculation.
- PPD Screening Rate:
  - Denominator: In-state female commercial PPO member (ages 15-44), attributed to an OB/GYN, with a live birth during measurement period.
  - Numerator: Members from denominator with a claim including a code for PPD screening within 90 days post IP admit date of birth episode.
- OB/GYNs in POs meeting or exceeding the PPD screening threshold will be rewarded.

Behavioral Health Screening Data Collection

150 providers are currently receiving value-based reimbursement for administering these screening measures to members. This initiative is being retired at the end of 2025; one more VBR payment will be made in 2026 to cover the final 2025 measurement year.

The objective of the initiative is to increase the amount of behavioral health screening data submitted via Physician Payer Quality Collaborative (PPQC) and/or EMR feeds. Incentives will be available for submission of data for each of the three screening types listed below.

PO Incentive:

- Incentive dollars will be allocated for each of these screening measures separately.
  - Edinburgh Postnatal Depression Scale (EPDS)
  - Generalized Anxiety Disorder (GAD-7)
  - Patient Health Questionnaire-9 (PHQ-9)
- POs will earn a percent of the allocated incentive, per screening type, based on their contribution to the data relative to all PO data submissions.
- Each screening measure will be evaluated independently from the other screening tools.
- Example: If a PO submits 4,000 GAD screenings, and Blue Cross receives a total of 100,000 GAD screenings in the measurement year, the PO will earn 4% of the funding available from the GAD screening.

Goal:

- Increase the level of behavioral health data available to inform program evaluation and evolution.

Education and Messaging to our Members

Educational Campaign

Beginning in 2021 and continuing through 2023, Blue Cross launched a multi-channel member engagement campaign to provide guidance, education and support members and group customers with behavioral health care resources.

In 2025, the focus continued with educating members on where and how to get care, including crisis care, behavioral health navigation, virtual and in-person services. The campaign also continues to help reduce the stigma around behavioral health and getting behavioral health care.

Efforts to advance member education in 2025 include:

- Blue Cross Behavioral Health has worked to inform both behavioral health and medical providers about the statewide availability of crisis services through articles in Provider News and Hospital and The Record as well as a Lunch and Learn webinar for providers.
- A Statewide Partners Meeting was held on March 5, 2025, and included a presentation on Advancements in Behavioral Health including:
  - Specialty Care Management for substance use disorders; LGBTQIA+ members; geriatric members; maternity care; eating/feeding disorders; and autism spectrum disorders
  - Care options across the risk continuum including virtual treatment options; high risk care management; and urgent and crisis services
  - The Blue Cross Behavioral Health Outpatient Quality pilot program
- A Substance Use Impact Conference was held on April 17, 2025, to educate both employers and providers on available options for substance use treatment including:
  - Buprenorphine treatment for opioid use disorder
  - Transitional Care Management for members discharging from high levels of substance use treatment
  - The Collaborative Care Model
  - Adult Intensive Services
  - Crisis Services
- Quarterly Behavioral Health Summits for providers included information on the availability of specialty Behavioral Health programs including:
  - Crisis Services
  - Adult and Child Intensive Services
  - First Episode Psychosis intervention and treatment
  - Feeding and Eating Disorders
  - In-state residential treatment facilities
  - Blue Cross' Employee Assistance Program (EAP)
- The public-facing BCBSM Behavioral Health site was updated with links to assist members with finding in-person and virtual/telehealth therapists and prescribers as well as crisis intervention services based on the county in which they reside.
- A text-based messaging campaign was created which focused on members with Opioid Use Disorder (OUD). Identified members received text messages warning them of the dangers of OUD as well as risks associated with combining opioid use with alcohol and/or benzodiazepine use.

- A new television and streaming service ad campaign was released in Q3 2025, “Ready to Help”, which encourages member to take steps to access care for comprehensive medical and behavioral health needs.
- The “A Healthier Michigan Podcast” delivered several episodes targeted toward members to help address behavioral health needs:
  - How Positive Self-Talk Reduces Stress – August 13, 2025
  - How to Recover from Burnout – July 16, 2025
  - How to Know When Stress Becomes Chronic – July 2, 2025
  - How to Reduce Stigma Around Mental Health – June 4, 2025

Goals:

- Increase awareness of available programs.
- Inform members of where to go to find available BH care options.

9.2.6. Continuity and Coordination of Care

BCBSM is committed to improving quality of care delivered to members. Coordinated care is a critical element in achieving this goal. Coordination involves communication among multiple providers, each providing individual expertise, knowledge and skills working toward the goal of reducing inefficiencies and responding to patients’ unique care needs.

The health plan monitors continuity and coordination by assessing the facilitation of medical care and behavioral health services across transitions and setting of care, of members getting the care or services they need, and practitioners or providers getting the information they need to provide the care patients need.

In 2026, BCBSM will demonstrate continuity and coordination of care through performance on required Health Plan Ratings HEDIS measures. The health plan will use its most recent Health Plan Ratings scoresheet to demonstrate that it met the scoring threshold. If the health fails to meet the threshold, an improvement plan is implemented. The following Health Plan Ratings measures are included in the calculated average for the Commercial product line brought forward for Accreditation:

Commercial Measure List	
• Eye Exam for Patients With Diabetes • Prenatal and Postpartum Care—Prenatal Rate • Prenatal and Postpartum Care—Postpartum Rate • Coordination of Care • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics • Follow-Up After Emergency Department Visit for Mental Illness—7 days—Total Rate	• Follow-Up After Emergency Department Visit for Substance Use—7 days—Total Rate • Follow-Up After Hospitalization for Mental Illness—7 days—Total Rate • Follow-Up After High Intensity Care for Substance Use Disorder—7 Days—Total Rate • Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total Rate

In 2026, BCBSM will annually monitor performance and act on one required continuity and coordination of care QRS measure and documents an improvement plan for any of the following measures that are required QRS reporting:

Exchange Measure List	
• Prenatal and Postpartum Care—Prenatal Rate • Prenatal and Postpartum Care— Postpartum Rate	• Coordination of Care • Follow-Up After Hospitalization for Mental Illness—7 days

• Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment • Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment	• Follow-Up After Hospitalization for Mental Illness—30 days • Depression Screening and Follow-Up for Adolescents and Adults*

*Per the Final 2024 Call Letter for the QRS and QHP Enrollee Survey, CMS is finalizing the addition of the Depression Screening and Follow-Up for Adolescents and Adults to the QRS measure set, beginning with the 2025 ratings year, as proposed in the Final 2023 Call Letter. CMS will begin collecting measure data in 2025, and will not include the measure in scoring until the at least the 2026 ratings year. Organizations are required to show evidence of reporting the measure for Element D, but not required to include the measure in the improvement plan.

The outcomes are reported to the Clinical Quality Committee for review, input, and approval annually.

9.2.7. Identification and Documentation of Quality of Care Concerns

Blue Cross established a mechanism to assess and report potential quality of care concerns to ensure identification, review, and timely resolution of quality issues. Concerns regarding quality of care may be identified by all areas of the corporation, as well as external sources.

Blue Cross conducts ongoing monitoring of complaints and serious adverse events. Reports are pulled at least biannually related to quality of care concerns and SAEs for three or more complaints in a year per provider. Cases are reviewed to determine severity and level of intervention. When a potential quality of care concern is identified, the case is referred to the plan medical director for recommendations.

Goals:

- Cases that don't require additional outreach are reviewed and closed within 7 business days.
- Cases that require additional information from the practitioner but don't require medical director review are reviewed and closed within 45 days.
- Cases that require a medical director review are reviewed and closed within 90 days.

9.2.8. Value Partnerships – Quality Programs

Blue Cross works with practitioners, physician organizations and acute-care hospitals in the state to improve the health care for Michigan residents. This purposeful, innovative approach to transforming health care forms partnerships and uses technology to improve health care quality, experience and affordability. These partnerships allow us to:

- Enhance the quality of care
- Manage costs
- Improve health outcomes
- Decrease health complications
- Eliminate errors

9.2.8.1. Physician Group Incentive Program

Launched more than 20 years ago, the Physician Group Incentive Program includes over 20,000 primary care physicians and specialists throughout Michigan in provider-led quality improvement efforts. PGIP initiatives are aimed at improving quality, utilization and costs. The program connects 34 physician organizations (representing these 20,000 physicians) statewide to collect data, share best practices and collaborate on initiatives that improve the health care system in Michigan.

PGIP includes the Patient-Centered Medical Home program, which helps facilitate transformation of health care delivery in physician practices. Additionally, it includes the PCMH designation program, which recognizes those practices that have implemented a significant number of PCMH capabilities and have delivered high quality and cost-effective care. Majority of the PCMH-designated practices have expanded their services to provide personalized care management services for patients with chronic conditions or multiple, ongoing health needs through Provider-Delivered Care Management. Building on the foundation of the award-winning PCMH model, is the Collaborative Care designation program – the first of its kind in the nation – providing additional support to members who are struggling with behavioral health issues. The combination of these three standalone PGIP programs (PCMH, PDCM and CoCM), along with the implementation of PCMH capabilities focusing on at-risk populations, forms the basis of the Advanced Primary Care designation. The APC designation recognizes providers who have transformed their practices for serving at-risk members.

Goals:

- Be the market leader among state and national health plans for exceptional provider partnerships, transformational health care delivery, and innovative provider payment models with an emphasis on programs that support population health management, primary care, hospital and ancillary providers, specialty care, and system integration.
- Drive provider change to clinical care models through reimbursement; drive increased opportunities for differentiation amongst providers; and drive system transformation by developing initiatives to support continued transformation of clinical models.

9.2.8.2. Patient-Centered Medical Home

In partnership with PGIP physicians and physician organizations, Blue Cross developed the Patient-Centered Medical Home program in 2008. This program is based on the Joint Principles of the Patient-Centered Medical Home issued in March 2007 by the American Academy of Family Practice, American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association. Blue Cross' PCMH program supports physicians in implementing patient-centered information systems and care processes. Some elements of the PCMH model that specifically address patient safety include:

- Electronic patient registries incorporating evidence-based guidelines and information from other care settings – giving providers a comprehensive view of the care patients have received and ensuring treatment is appropriate and safe.
- Written and jointly developed goal planning and patient education and self-management support that uses the teach-back method to ensure patient comprehension.
- Provisions for 24/7 telephone availability of clinical decision-makers with access to patient's medical record or patient registry information.
- Tracking system with safeguards in place to ensure patients receive needed tests, timely and accurate results, and follow-up care.
- Electronic prescription systems that ensure accurate information is transmitted to the pharmacy and alerts providers to any prescribing errors, patient allergies and potential adverse outcomes or drug interactions.
- Timely response to urgent patient needs and proper patient guidance about emergency situations and seeking care.
- Care coordination and care transition protocols that ensure patient care is

efficiently coordinated across all settings and patients receive timely, appropriate care. An example of care coordination is Blue Cross' Health Information Exchange initiative which reports admissions, discharges and transfers notifications to the Michigan Health Information Network, a statewide health information exchange.
- Specialist referral processes that provide the specialist with detailed information regarding the patient's needs and past medical history to avoid exposing patients to duplicative or unnecessary testing or treatment and include a feedback loop to the primary care provider.

Note: Although there are two PCMH capabilities related to HIE, the HIE Initiative is not part of the PCMH program. It is a part of the Physician Group Incentive Program.

Goals:
- Increase overall PCP PCMH capability participation.
- Strengthen the role of the PCP in the delivery and coordination of health care.

9.2.8.3. Clinical Quality Initiative

At Blue Cross, the Physician Group Incentive Program administers the Clinical Quality Initiative, a reward-based program incorporating Healthcare Effectiveness Data and Information Set® measures aimed to driving improvement among PGIP participating physician organizations. This initiative strives to promote clinical quality improvement by driving best practice behaviors among PGIP physicians. Value-based reimbursement is provided at the population level for POs who can achieve high performance and improve over time.

Throughout this initiative, Blue Cross has worked with a subset of physician organizations identified by total Blue Cross membership attribution and quality scores. Physician organizations with the greatest opportunity to improve quality participate in discussions with the Blue Cross PGIP Clinical Quality team at regular intervals during each program year. Regular meetings are designed to discuss quality, process improvement opportunities, best practices, and to provide analytic support as needed. Activities, for each year, start in the summer when the previous year's data is finalized and continue throughout the performance year.

The overall objective of the Clinical Quality Initiative is to improve the performance of all PGIP physician organizations by providing key ad-hoc data analysis, guidance, coaching and regular feedback about initiative performance. To achieve rewards physician organizations must be able to complete the following activities:
- Identify opportunities for improvement in measures by conducting data analysis and continuous quality improvement processes.
- Induce and deploy best practices among their physician community that result in safe and effective care.
- Support innovation and constructive change in processes for the delivery of care.
- Promote better outcomes and coordination of care across provider settings.
- Develop and implement strategies for population health management.
- Only measures where the Physician Organizations meet the NCQA 75th or 90th percentile are eligible to earn a performance reward.

Blue Cross internal subject matter experts, annually review measures of care to determine which measures should continue as part of the initiative and which should be retired. Measures selected for the Clinical Quality Initiative include childhood and adolescent well visits, adult screenings, heart disease, diabetes, medication

management and appropriate use of services measures. Blue Cross provides commensurate reporting to PGIP participating physician organizations that includes population performance, practice performance, relative performance to other PGIP PO, and performance against applicable benchmarks.

Goals:

- Better care for members that lead to healthier members and communities.
- Improve selected HEDIS measure compliance to NCQA 75th or 90th percentile at the PGIP PO level.

9.2.8.4. Value Partnerships Strategic Engagement Program

The objective of the Value Partnerships Strategic Engagement Incentive is to commit to our Physician Organizations to implement a strategic program that aligns with departmental and enterprise key strategies. Value Partnerships Strategic Engagement Incentive strives to improve engagement in the following areas:

- Quality of Care (Healthcare Effectiveness Data and Information Set/Stars)
- Provider Delivery Care Management
- Patient-Centered Medical Home
- Health Information Exchange
- Addressing the opioid epidemic

The goal of the program is to catalyze physician organizations to deliver optimal patient-centered care, and, to ensure focus on clinical quality, adoption of the PCMH, PDCM and leadership and engagement in population management and Physician Group Incentive Programs. All existing physician organizations participate in the program. New physician organizations are not eligible in their first year. (An organization is considered new to PGIP if at least 51 percent of their physician members were not participants in PGIP during the most recent twelve-month period). Each physician organization receives a scorecard annually, showing their performance and ratings on each of the individual measures.

Goals:

- Deliver scorecards to 40 physician organizations by year-end.
- Evaluate if a physician organization is performing well overall on PGIP programs.

9.2.8.5. Hospital Pay-for-Performance Program

The Blue Cross Hospital Pay-for-Performance programs provide incentives to acute care provider who improve health care quality, cost efficiency and population health. The program for large and medium-sized hospitals encompasses the following program components:

- A mandatory prequalifying condition that ensures hospitals take basic steps to demonstrate a commitment to building a culture of patient safety.
- A mandatory prequalifying condition that requires hospitals to place focus on third-party industry quality ratings such as CMS stars and Leapfrog patient safety ratings.
- Participation in the Blue Cross Hospital Collaborative Quality Initiatives
- Service-line efficiency within the Michigan Value Collaborative.
- Health Information Exchange requirements to help physicians better manage patient care across the entire continuum.
- Plan All-cause Readmission (PCR) performance and readmissions-related initiatives.

The program for small and rural hospitals, including critical access hospitals, has been overhauled to reduce the workload on rural hospitals, so they can deliver the most value to the unique communities they serve. The program includes the following components:

- High-level health information exchange efforts to align with large and medium-sized hospitals programs.

Goals:

- Continue to require 100 percent of hospitals to fully comply with the program's patient-safety prequalifying condition, including conducting regular patient safety walk-rounds with hospital leadership and assessing and improving patient safety performance by fully meeting one of the following options:
  - Complete and submit the National Quality Forum Safe Practices section of the Leapfrog Hospital Survey at least once every 18 months.
  - Complete the Joint Commission Periodic Performance Review of National Patient Safety Goals at least once every 18 months.
  - Review Compliance with the Agency for Healthcare Research Patient Safety Indicators at least once every 18 months.
  - Participate in a federally qualified patient safety organization.
- Ensure results of the patient safety assessment and improvement activities are shared with the hospital's governing body and incorporated into a board- approved, multidisciplinary patient safety plan that is regularly reviewed and updated.
- Increase the number of hospitals demonstrating favorable year-over-year improvements or maintaining top quartile performance in their own hospital-specific readmission rate from the previous program year.
- Continued in 2026, hospitals are assessed using the hospital Plan All-Cause readmission (PCR) rate for their Blue Cross commercially insured PPO population.
- Observe year-over-year improvements in hospital-selected Michigan Value Collaboration service lines, including:
  - Episode Spending Condition options:
    - Chronic obstructive pulmonary disease (COPD)
    - Congestive heart failure (CHF)
    - Coronary artery bypass graft (CABG)
    - Pneumonia
  - Value Metric options:
    - Cardiac rehabilitation within 90 days after CABG
    - Cardiac rehabilitation within 90 days after percutaneous coronary intervention (PCI)
    - Follow-up within 7 days after CHF
    - Follow-up within 14 days after COPD
    - Preoperative testing before low-risk surgeries
    - Follow-up within 14 days after Sepsis
- Engage all P4P-participating acute care providers in more robust Health Information Exchange.

9.2.8.6. Hospital Value-Based Contracting

In 2013, Blue Cross began a value-based contracting initiative designed to transition providers away from traditional fee-for-service toward a value-based system that rewards collaboration and improvements in population health.

Initially, Blue Cross VBK efforts were intended to serve as a glide path for acute care providers to build the necessary infrastructure and partnerships with partnering physician organization partners needed to be successful in this new reimbursement environment. Presently, seventy-four Michigan hospitals, representing just over 80 percent of the total Blue Cross commercial hospital payout, have signed a Value Based Contract.

Goals:

- Move from an industry standard practice of negotiated rate increases, toward increases earned based on performance, continuing to focus on managing an overall population health through physician and hospital collaboration.
- Measure PMPM trend and point in time relative performance.
- Measure hospital-based utilization quality metrics to support hospital/physician collaboration.
  - Hospital all-cause readmissions.
  - Primary care sensitive emergency room visits.
  - Ambulatory care sensitive inpatient admissions.
- Continue to evolve VBK construct to move into alignment with broader Blue Cross value contracting and risk-based arrangements.

9.2.8.7. Blueprint for Affordability

Blueprint for Affordability is Blue Cross' value-based physician contracting program. In the Blueprint physician partnerships, Blue Cross works closely with health care providers to manage their patient populations to reduce the overall cost of care trend while maintaining the highest quality standards. Commercial PPO Blueprint for Affordability performance is measured based on a retrospective relative cost of care trend with quality requirements aligned to HEDIS.

Medicare Advantage Blueprint for Affordability performance is measured based on a prospective Medical Loss Ratio target and includes Stars (clinical quality and Clinician and Group Consumer Assessment of Healthcare Providers and Systems) performance requirements. Providers who successfully manage the cost of care share in the savings generated and those who do not share in the losses.

Combined, these partnerships cover more than 50% of the instate PPO primary care-attributed membership and have saved over ~$70M in avoided medical cost trend.

Goal:

- In 2026, Blue Cross will launch our next generation of our Commercial PPO and Medicare Advantage PPO shared risk models. During such time, the physician contracting team will develop and contract a brand-new HMO shared risk model (effective 2027).

9.3. Member Experience

9.3.1. Consumer Assessment of Healthcare Providers and Systems Survey

Blue Cross surveys its members using the CAHPS survey instrument conducted annually by Press Ganey, an NCQA-certified vendor. The CQC and Member Experience Committees evaluate survey results, combining them with other member feedback surveys to determine areas in which BSCSM can improve service to members. CAHPS survey results are reported to NCQA, and other governmental and regulatory agencies as required.

Goals:

- Perform at or above the 66.67th NCQA Percentile for Commercial.
- Perform either same as or above the national average of all Qualified Health Plans.

The results are reported to the CQC and MEC annually.

9.3.2. ECHO Behavioral Health Survey

Blue Cross Blue Shield of Michigan surveys members using the ECHO CAHPS behavioral health survey tool, which is conducted annually by Press Ganey, an NCQA-certified vendor. This survey is designed to support efforts to measure, evaluate, and improve the experiences of members with various aspects of mental health and substance abuse treatment and counseling services. The ECHO survey is considered a primary measure of customer service and satisfaction with the health plan and is conducted yearly to drive ongoing improvement in the overall member experience.

Goal:

- The goal is for each measure to increase two percentage points year over year up to 90%. The goal is met for measures equal to or greater than 90%.

The results are reported to the Clinical Quality Committee annually.

9.3.3. Voice of the Customer

The *Voice of the Customer* program encompasses member and provider feedback across multiple channels and touchpoints across the Enterprise. Leveraging a dynamic text analytics platform which refreshes daily, the VoC team monitors feedback to identify emerging member and provider pain points and synthesizes insights illuminating company-wide member and provider experience improvement initiatives. Stakeholders and leadership rely on ongoing outputs produced by the VoC team and platform users across the Enterprise to keep a pulse on member and provider experiences and inform their decision-making. Further, text analytics functionality enabling direct listening to member and provider voices fosters empathy and an enhanced level of understanding and ability to relate to their experiences with Blue Cross at all levels within the organization.

9.3.4. Digital Experience

The Digital Experience team supports the enterprise by delivering experiences that help prospective members, current members, and group customers at their moments of need. The DX team currently manages:

- bcbsm.com – Destination for prospective members to evaluate plan options and for existing members to learn more about their health care journey.
- Member Portal – Secured and personalized experience that helps members manage their coverage and explore care options.
- Member Mobile Application – Smartphone application that puts members' plan information at their fingertips – available anytime, anywhere.
- Consumer Transparency – Supports enterprise efforts involving member transparency and is the Business Owner for the enterprise Provider Directory and cost transparency solutions such as estimate your cost solution.

As part of their human-centered design practice, the DX team actively engages users in the testing of new features and content. They gather feedback from their own initiatives

and combine it with those from partnering business units to ensure that every person coming to our site or app has an exceptional health care experience.

Goal:

- Delivering of an online experience that is “simple, useful and personal” through a combination of educational content and self-service tools for our users that are monitored based on annual satisfaction scores collected from our stakeholders.

9.3.5. Consumer Transparency

The Consumer Transparency team, an organization within Digital and Automation Business Strategy, focuses strategically and tactically on the management of the Enterprise Provider Directory which is also known as Provider Search or Find a Doctor Tool. This organization also owns and maintains cost transparency solution (Estimate Your Cost Tool).

Provider Directory

Provider Directory is an enterprise solution and one of the most utilized business functions by our membership as it allows members to search for care referencing many providers demographic components.

Goal:

- Create and maintain a “best in class” directory that our membership can leverage to search for care within their provider network. The Enterprise directory contains key provider demographic and transparency information for our members including office locations, contact information, and the plans they accept to name a few that are key for decision making.

Cost Transparency

Cost Transparency, via the Estimate Your Cost Tool, is an enterprise solution and a key business function used by our members. It allows members to search for costs related to various medical services and procedures, helping them plan and manage their healthcare expenses efficiently.

Goal:

- Create and maintain a “best in class” cost transparency tool that empowers members to make informed decisions about healthcare costs. The tool includes detailed pricing information for medical services, which is critical for members as they plan their healthcare journeys and manage out-of-pocket expenses.

9.3.6. Member Complaints, Inquiry and Grievance Resolution

The member complaint data is utilized to improve services and increase overall member satisfaction. All member complaints regarding medical, contractual, or administrative concerns are received, categorized, reviewed, and analyzed. Clinical complaints involving quality of care are forwarded to Quality Management for investigation, resolution, tracking and trending. These service trends are considered in the provider recredentialing process.

Blue Cross Executive Services maintains a consistent process in compliance with federal and state regulations for handling member urgent preservice appeals, standard preservice appeals, post-service appeals, denial of/rescission of coverage appeals and managing the federal external review process.

Goal:

- The goal for both complaints and appeals are for the total rate per 1,000 members to be equal to, or less than 0.15 percent.

9.3.7. Network Adequacy

Blue Cross Blue Shield of Michigan provides its members with adequate network access for needed healthcare services. Analysis of network adequacy enables health plan organizations to identify aspects of performance that do not meet member expectations and initiate actions to improve performance. Blue Cross monitors multiple aspects of network adequacy including:

- Complaints, appeals, and member experience about network adequacy for non-behavioral healthcare services.
- Complaints, appeals, and member experience about network adequacy for behavioral healthcare services.
- Requests for and utilization of out-of-network cost share services for non-behavioral health and behavioral healthcare services.

The compiled data is analyzed to determine if there are gaps in the network specific to geographical areas or to types of practitioners or providers. The analysis performed relates to the Commercial PPO (including the Federal Employee Program) and Exchange PPO memberships.

Goals:

- Complaint rate: ≤0.15/1000 members
- Appeal rate: ≤0.15/1000 members
- Annually completes an analysis of OON cost share and identifies opportunities for improvement, if applicable.
- OON Cost share appeals: ≤0.15/1000 members
- For CAHPS:
  - The NCQA 66.67th percentile benchmark is used to determine the Commercial PPO performance outcomes.
  - Exchange PPO is to perform either the same as or above the national average of all Qualified Health Plans.
- For ECHO: The target for access measures is to increase two percentage points year over year up to 90 percent. The target is met for measures scoring greater than or equal to 90 percent.

The analysis describes the monitoring methodology, results and analysis for each network access data source, and actions are initiated to improve member satisfaction. The outcomes are reported to the Clinical Quality Committee and Member Experience Committee for review and input annually.

9.4. Member Safety

Blue Cross implements programs to improve processes and systems that impact patient safety. Activities are focused on identification and reporting of safety concerns, reduction of medical errors and collaboration with delivery systems, hospitals and physicians/clinicians in order to develop improvement plans when member safety issues are recognized, develop performance measures on patient safety, maximize safe clinical practices and improve patient safety and clinical outcomes.

Member safety efforts are designed to work in collaboration with other Michigan managed care plans, hospitals, purchasers and practitioners to identify safety concerns, develop action plans with measurable outcomes and implement plans with the goal of improved patient safety and fewer medical errors.

Member safety standards are developed and communicated in key areas that have been documented as potential patient safety concerns, such as reduction of medical errors and improving patient outcomes, computer physician order entry system, intensive care unit physician staffing and an evidence-based hospital referral standard.

9.4.1. Collaborative Quality Initiatives

Collaborative Quality Initiatives support efforts to work collaboratively with physicians, physician organizations, hospital partners, and community leaders to develop programs and initiatives that save lives and reduce health care costs. CQIs are developed and administered by Michigan physician, physician organization, and hospital partners, with funding and support from Blue Cross and BCN. CQIs seek to address some of the most common, complex and costly areas of surgical and medical care.

CQIs support continuous quality improvement and development of best practices for areas of care that are highly technical, rapidly evolving and associated with scientific uncertainty. Given that valid, evidence-based, nationally accepted performance measures are only established for a narrow scope of health care, Blue Cross leverages collaborative, inter-institutional, clinical data registries to analyze links between processes and outcomes of care to generate new knowledge, define best practices and guide quality improvement interventions across Michigan.

The CQI Program supports:

- Data Collection: Timely feedback of robust, trusted, consortium-owned performance data to hospitals and providers.
- Collaborative Learning: Collaborative, data-driven learning fostered in a non-competitive environment (most meetings are held in person, typically three times a year).
- Improvement Implementation: Systematic development, implementation, and testing of hospital-specific and Michigan-wide quality improvement interventions.

Goal:

- Empower providers to self-assess and optimize their processes of care by identifying opportunities to bring care into closer alignment with best practices, which leads to improved quality and lower costs for selected, high cost, high frequency, and/or highly complex procedures. The CQI model has proven remarkably effective in raising the bar on clinical quality across a broad range of clinical conditions throughout Michigan.

9.4.2 CQI Coordinating Centers

Each CQI is led by a Blue Cross-commissioned, provider-led coordinating center, that is independent of Blue Cross. Dedicated coordinating centers are responsible for ensuring the validity of the CQI program data and for managing quality improvement activities focused on improving outcomes, increasing efficiencies, and reducing patient care costs. Coordinating centers guide the development of quality improvement plans and generate new knowledge about best practices. The CQIs focus on areas where:

- Identifiable and clear variations in practices of care exist throughout the health care

continuum.
- An opportunity to positively influence outcomes is evident.
- Knowledge about optimal practices are not widely implemented or scientific uncertainty exists.

The coordinating center is staffed by individuals whose primary function is the activities of the consortium—with the exception of the project director (a practicing physician/clinician, usually between a 0.25 to 0.40 FTE). Typically staffed by quality improvement, nursing, and epidemiological personnel (usually based within an academic medical center), the coordinating center's role is to engage the provider community in all aspects of the consortium.

In most, CQIs participants submit disease or procedure-specific data to a centralized data registry. The coordinating center conducts risk-adjusted analyses to identify best practices and opportunities for improvement. Reports are then shared with participating hospitals or practices where systematic implementation of the recommendations result in improved outcomes, increased efficiencies and cost avoidance associated with reduction in adverse outcomes. Within the three population health CQIs, data is generally collected via health information exchange and electronic data transmission.

Quality improvement interventions include:
- Selected processes that have been proven by registry-based analyses to be effective and appropriate for the vast majority of patients.
- Aspects of clinical care that are generally known to be evidence-based, with significant variability across providers, and known to yield improved outcomes.

As of 2025, Blue Cross is providing funding and active leadership for 20 CQIs addressing one or more of the following clinical areas/conditions:

Hospital CQIs	Professional CQIs
• Anesthesiology (ASPIRE) • Cardiovascular (BMC2) • Anticoagulation (MAQI2) • Bariatric surgery (MBSC) • Cardiac surgery (MSTCVS) • Emergency department care (MEDIC) • General surgery (MSQC) • Hospital efficiency (MVC) • Hospitalist care (HMS) • Radiation oncology (MROQC) • Spine surgery (MSSIC) • Total knee and hip replacement (MARCQI) • Trauma (MTQIP) • Obstetrics Initiative (OBI)	• Urology (MUSIC) • Oncology (practice and treatment) (MOQC) Chronic Care/Population Health CQIs • Diabetes (MCT2D) • Suicide prevention (MIMIND) • Asthma and COPD (INHALE) • Whole Health (MSHIELD)

Goals:
- Continue to develop additional best practices for CQI programs to demonstrate improved patient outcomes and share lessons learned locally, nationally, and internationally.
- Evaluate each CQI's program performance to identify opportunities for strengthening, revamping, and consolidating, and to assure efficiency within and sustainability of the CQI portfolio.
- Focus on whole health addressing both medical and non-medical factors within the CQI

portfolio and within individual CQIs.

9.4.3 Blue Distinction Centers for Specialty Care®

Blue Distinction® Specialty Care recognizes health care facilities and providers that demonstrate proven expertise in delivering high-quality, effective, and cost-efficient care for select specialty areas. The goal of the program is to assist members in finding quality specialty care on a consistent basis nationwide while encouraging health care providers to improve the overall quality and delivery of specialty care. The program currently includes the following eleven areas of specialty care:

- Bariatric surgery
- Cancer care
- Cardiac care
- Cellular immunotherapy- CAR-T
- Fertility care
- Gene therapy- Ocular disorders
- Knee and hip replacement
- Maternity care
- Spine surgery
- Substance Abuse Treatment and Recovery
- Transplants

Blue Cross awards facilities and providers with two levels of designation:

- Blue Distinction Centers are providers recognized for their expertise in delivering safe, effective, high-quality specialty care.
- Blue Distinction Centers+ are providers recognized for their expertise and cost- efficiency in delivering specialty care. Only those providers that first meet Blue Distinction Centers' nationally established, objective quality criteria are considered for designation as a Blue Distinction Center+.

Blue Distinction Center and Blue Distinction Center+ designations are awarded to facilities and providers based on a thorough, objective evaluation of their performance in the areas that matter most, including quality of care, treatment expertise and overall patient results. Selection criteria are developed with the help of expert physicians and medical organizations. Blue Distinction Centers and Blue Distinction Centers+ have a proven history of delivering better quality and results, such as fewer complications and lower readmission rates, than those without these recognitions. Overall, Blue Distinction Centers+ are also more cost-efficient than non-Blue Distinction Centers+, with episode savings of more than 20 percent on average.

The Blue Distinction Specialty Care program provides broad national access to facilities and providers delivering better quality specialty care, making them easy to find wherever you work and live across the U.S. You can easily locate a Blue Distinction Center at bcbs.com/blue-distinction-center-finder or by using our Find a Doctor feature at bcbsm.com. Today, more than 5,800 Blue Distinction Center and Blue Distinction Center+ designations have been awarded to more than 2,500 health care providers across the U.S.

Goals:

- Complete final designation activities, including de-designation of providers no longer eligible, for the renewed Knee & Hip Replacement and Spine Surgery programs.
- Complete bi-annual maintenance activities for the Solid Organ and Bone Marrow Transplant programs.

- Begin designation activities for launch of renewed Bariatric Surgery program.

9.4.4 Total Care℠

Blue Cross Blue Shield plans participate in a national designation that helps members and employers identify doctors and hospitals who are a part of value-based programs, including Patient-Centered Medical Home and Accountable Care Organization programs. This designation is called the Total Care designation, and it allows Blue Cross members to find health care providers that meet nationally consistent criteria for quality, efficiency, and patient outcomes in the online provider directory.

Value-based Programs Delivery Platform:
BCBS Commercial PPO members are attributed to a provider responsible for managing their care based on visit history. The Value-Based Program Delivery Platform allows for the sharing of member, attribution and reimbursement information that is essential to supporting more coordinated, efficient and quality-driven healthcare for National Accounts.

Inter-Plan Financial Settlement:
Provider reimbursement is a critical component in making value-based programs available to national accounts. Providers that participate in Total Care and other value-based programs receive reimbursement based on outcomes and coordination of care for attributed members. There are two main types of expenses in the Plan-to-Plan financial settlement process:

- **Incentive and Shared Savings Payments** – Payments negotiated with providers based on defined quality and cost targets above and beyond fees associated with specific services.
- **Care Coordination Fees** – The negotiated amounts paid on a per member basis to reimburse providers for additional care coordination services. Attribution is required.

PaMPM (Per-attributed Member Per Month) rates are used to calculate non-claims expenses for national accounts through Capitated-Bulk Billing Format (CBF). CBF is used to transmit administrative billing, settlements, and capitation billing between Host and Home Plans.

Local programs must meet the following criteria to be Total Care designated:

- The program focuses on managing care for a population of Blue Cross members.
- The program attributes Blue Cross members to the provider responsible for managing care.
- The program provider contracts contain value-based incentives associated with both cost and quality outcomes.
- Providers, in collaboration with Blue Cross Plans, are responsible for utilizing additional data and analytics to support activities including at least three of the following five practices to improve quality and affordability.
  - Practice Referral Pattern Management – assessing provider referral patterns to enhance quality and affordability.
  - Labs and Imaging Practice Management – assessing lab and imaging patterns to enhance quality and affordability.
  - Readmissions Practice Management – assessing patterns for quality and affordability that reduce avoidable readmissions.
  - Medication Practice Management – assessing patterns for quality and affordability that enhance medication management.
  - Emergency Room Practice Management – assessing patterns for quality and affordability that reduce ambulatory-sensitive ER visits.

- The program is available to Blue Cross members through a PPO-based product.
- The program is available to Blue Cross members covered by administrative services only (ASO) and fully insured products.

In Michigan, Total Care providers are part of the BCBSM PCMH program.

Goals:

- Ensure the BCBSM National Value-based Programs (VBP) (Total Care) delivery platform and inter-plan financial settlement process are aligned with Blue Cross Blue Shield Association's program policies and software updates.
- Continue monitorization of the National Value-based Programs (VBP) (Total Care) delivery platform and inter-plan financial settlement process to identify & fix process gaps.
- Improve Total Care reporting based on needs from leadership and sales teams/customer reps.
  - Gather insight from leadership and sales teams/customer reps to determine what common questions they are getting about their out of area (OOA) Total Care membership and attribution.
  - Enhance the Attributed Monthly Summary and Detail Trend (2D OOA Attribution) report from Cognos Analytics based on feedback.

9.4.5 Health Information Exchange

The Health Information Exchange component is designed to ensure caregivers have the data they need to effectively manage the care of their patient population. The HIE component is focused on improving the quality of data transmitted through the Michigan Health Information Network statewide service, expanding use of the statewide shared infrastructure, and developing capabilities that help facilitate data exchange across the healthcare continuum.

Since the HIE component was introduced in 2014, hospitals have significantly improved the availability and quality of data available to caregivers across the state. In addition, the MiHIN service supports Physician Group Incentive Program physician organizations by providing practitioners with a single access point to obtain daily admit-discharge-transfer notifications including Emergency Department, Inpatient notifications, as well as discharge medication information for all their patients—regardless of whether they have an affiliation with the hospital. The service uses existing health information exchange infrastructure to receive hospital Admit Discharge Transfer notifications including ED and IP visit data, identify which physician has a care relationship with each patient and transmit a notification to the relevant physician organization.

In January 2016, Blue Cross introduced a skilled nursing facility Pay-for-Performance program into the HIE continuum to build upon the previously established hospital-based data exchange. The Skilled Nursing Facility P4P program provides freestanding and hospital-based SNFs the opportunity to earn an incentive for submitting all-payer admission, discharge, transfer notifications through the MiHIN statewide service.

Overall participation in the statewide service provides foundational support to the Patient-Centered Medical Home model of care and is designed to improve care by ensuring practitioners have the information they need to address patient health care needs more quickly. This is expected to result in a better care transition, an improved health outcome and reduced likelihood of an unplanned readmission. Blue Cross also participates with MiHIN as a health plan qualified organization, which allows it to transmit and receive data for its members. In addition, a Blue Cross representative serves as a member of the MiHIN board.

9.4.5.1. Peer Group 1-4 Hospitals Engagement in HIE Initiative

The HIE Initiative was introduced in 2014. As of Fall 2025, all PG 1-4 hospitals participate in MiHIN's statewide notification service. Within 5 years, 78% of hospitals participated and all hospitals have been participating for 5 consecutive years. Hospitals have significantly improved the availability and quality of admission, discharge, transfer, and medication data available to caregivers across the state. Participating hospitals are currently sending notifications for approximately 99 percent of all admissions statewide. These efforts will continue to be recognized with hospitals earning a portion of their Blue Cross P4P HIE points through continued data quality conformance standards for the ADTs with the common key, Exchange Consolidated Clinical Document Architecture (formerly Medication Reconciliation), Ambulatory C-CDA, and Statewide Labs use cases.

9.4.5.2. Peer Group 5 Hospitals Engagement in HIE Initiative

Blue Cross designates small, rural acute care facilities that provide access to care in areas where no other care is available as peer group 5 facilities. Additionally, many of these hospitals are also classified as Critical Access Hospitals by Medicare. The Blue Cross PG5 Hospital P4P program provides these hospitals with an opportunity to demonstrate value to their communities and customers by meeting expectations for access, effectiveness, and quality of care.

Beginning with the 2016-2017 program year, hospitals began participating in the MiHIN statewide service by implementing the Admission-Discharge-Transfer use case. Currently, all PG 5 hospitals have implemented the ADT use case. Starting in 2020, hospitals also earned a portion of their Blue Cross P4P HIE points by meeting data quality conformance standards for ADTs and for transmitting Exchange C-CDA data to MiHIN to support rural providers in improving care transitions and reducing readmissions. In 2021, hospitals were also incentivized to start sending their lab data.

9.4.5.3. Skilled Nursing Facility Engagement in HIE Initiative

Blue Cross introduced a skilled nursing facility Pay-for-Performance program into the HIE continuum beginning in January 2016. In 2021, the SNF P4P program provides freestanding and hospital based SNFs the opportunity to earn an additional four percent of their commercial Blue Cross payment for transmitting all-payer all patient admission, discharge, transfer notifications through the MiHIN statewide service. As of the last measurement date (August 2025), 296 of 420 SNFs currently meet this requirement which represents a 31% increase since the previous reporting period.

9.4.5.4. Physician Organizations Engagement in HIE Initiative

All PGIP POs are participating in MiHIN' s statewide notification service through implementation of the Active Care Relationship Service, Admission-Discharge-Transfer, and Exchange C-CDA use cases. Participation in the statewide service offers providers a single access point to obtain daily ADT and medication information for all their patients, regardless of hospital affiliation. Participating POs currently receive daily ADT notifications including ED and IP encounters for more than 7 million Michigan patients.

Introduced in 2019, the EHR vendor initiative leverages PGIP funds to engage IT vendors, on behalf of all participating physician organizations and practices. Vendors extract and submit clinical data to MiHIN using the All-Payer Supplemental specification. This has increased participation in MiHIN's QMI use cases and

expanded clinical data transmission and quality reporting capabilities for participating physician organizations. The original method of vendors extracting and submitting data for POs has reached a maintenance state and a new method of accessing data through API interfaces has been introduced. This method builds on requirements for vendors to develop these interfaces and can be more efficient and cost effective for the PO. It also allows data to be accessed from vendors with less market saturation.

The HIE initiative also supports physician organizations to appropriately and consistently incorporate ADT messages and discharge medication information into the processes of care. A new transitions of care medication reconciliation post-discharge outcomes measure was rolled out in 2021 and will be retired after the 2024 program year. Physician organizations have worked to improve overall medication reconciliation rates.

In response to the COVID-19 public health crisis, PGIP implemented a new telehealth incentive to support rapid deployment of telehealth resources across the provider community to help reduce the spread of the virus, ease the burden on hospitals, provide urgent assistance to practices facing financial challenges, and expand the adoption of telehealth to support members. The phased incentive offered providers the opportunity to focus on meeting immediate needs, while promoting telehealth solutions that support ongoing patient centered care. Within a five-week period, adoption rates increased from under 10 percent of providers using telehealth to over 85 percent of primary care and behavioral health providers using telehealth. Currently, all physician organizations offer telehealth options and will continue to offer these services.

9.4.5.5. Physician Organizations Engagement in Supplemental Data Initiatives

Data exchange and interoperability are the foundation to continued progress in healthcare delivery. Timely information can provide the building blocks for improved health outcomes. POs can earn rewards for submitting key data elements via MIHIN use cases. Currently rewards are available for the Quality Measure Information use case which allows for data submission for a wide variety of clinical data including social needs screening, test results, procedures completed and much more. The QMI use case has a broad incentive as well as more narrow incentives that focus on specific measures and the ability to submit new data elements.

Goals:

- Increase the representation of practices included in QMI data submissions
- Focus on data submission for relevant HEDIS measures

9.5. Pharmacy

The Pharmacy Services' Quality Improvement Plan describes various programs and initiatives that are designed to help improve the health and safety of our members. These programs and initiatives may include collaboration with other departments across the company.

Pharmacy Services' quality goals are as follows:

- Offer innovative programs to enhance quality of care through partnerships with physicians and pharmacists.
- Promote safe and appropriate medication use.
- Improve medication adherence to help ensure members stay healthy.
- Provide education to physicians.

9.5.1. Commercial and Exchange Pharmacy

Some programs and initiatives that are designed to help improve the health and safety of our Commercial and Exchange members include:

9.5.1.1. Doctor Shopper Program

The Doctor Shopper program addresses the issue of members who obtain controlled substances from multiple providers without the prescribers' knowledge of other prescriptions. The goal of the program is to reduce the number of members who abuse their prescription drug benefit, reduce the risk of opioid overdose, and improve coordination of care among physicians.

Through this ongoing program, in 2026 we will continue to monitor claims data to identify members who meet specific criteria for filling opioid prescriptions from multiple prescribers and multiple pharmacies. Pharmacy Services will fax a letter to each prescriber identified in the analysis. The letter encourages the prescriber to use their state prescription drug monitoring program to determine whether patients are receiving controlled substances from other providers. This information gives the physician a better picture of the patient's-controlled substances profile.

Goal:

- Maintain 1% or below for members meeting Doctor Shopper Program criteria.

9.5.1.2. Academic Detailing: Use of Statin Therapy in Patients with Diabetes or Cardiovascular Disease

Cardiovascular disease is the leading cause of death in the United States. Statins are recommended in patients with diabetes or cardiovascular disease for atherosclerotic cardiovascular disease risk reduction. A clinical pharmacist will provide telephonic consultations with provider offices for members identified as needing statin therapy initiated. Member lists will be provided to prescribers with gaps in care to be closed, along with statin prescribing guidelines to assist prescribers.

Goal:

- Academic detailers will outreach twice to providers in 2026. The total target amount is 1,200 providers representing approximately 17,000 members in the SPC/SPD measure.

9.5.1.3. Academic Detailing: Pediatric Flu Vaccination

Influenza is one of the deadliest vaccine-preventable diseases in America. Flu vaccines can significantly reduce the chances of getting sick with the flu. Even if you still get sick, people who are vaccinated have less severe symptoms and are less likely to be hospitalized or die from flu-related complications. Everyone 6 months or older with rare exceptions should get a flu vaccine. Children under the age of five, especially those under the age of two, are at a higher risk of developing potentially serious flu-related complications.

A clinical pharmacist will provide telephonic consultations with provider offices for members under the age of two needing to complete their influenza vaccinations. Member lists will be provided to providers with gaps in care to be closed.

Goal:

- Academic detailers will outreach to at least 600 providers representing at least 10,000 members who are less than 2 years old in 2026.

9.5.1.4. Academic Detailing: Controller Inhaler for Patients with COPD

Appropriate medication management for patients with COPD could reduce the need for as well as the costs associated with ER visits, inpatient admissions, and missed days of work. Treatment guidelines recommend using a controller or maintenance inhaler to reduce exacerbation risk. A clinical pharmacist will provide telephonic consultations with provider offices for members having a COPD exacerbation event and needing a controller inhaler initiated. Member lists will be provided to prescribers with gaps in care to be closed, along with prescribing guidelines to assist prescribers.

Goal:

- Academic detailers will outreach to 100% of providers whose members are in the PCE measure and without bronchodilator therapy in 2026.

9.5.1.5. High Dose Opioid 90 Morphine Milligram Equivalent Edit

Prior authorization will be required for the first time a member's opioid dosage exceeds 90 morphine milligram equivalents per day. Higher opioid dosages have not been shown to reduce long-term pain and are associated with a higher risk of overdose and death. Dosages at or above 100 morphine milligram equivalents per day are associated with a nearly nine-fold increase in overdose risk compared to dosages of 20 morphine milligram equivalents per day or less. This edit addresses the HEDIS measure Use of Opioids at High Dosage which identifies the proportion of members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days during the measurement year.

Goal:

- Ensure that the HDO rate does not increase by more than one percent throughout 2026.

9.5.1.6. Academic Detailing: HPV Vaccination

Vaccines are a safe and effective way to protect adolescents against potential deadly diseases. The HEDIS IMA measure assesses adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap vaccine, and the complete human papillomavirus vaccine (HPV) series by their 13th birthday. HPV vaccination prevents cancer-causing infections and precancers, however, vaccination against HPV among adolescents remains significantly lower than meningococcal and Tdap. A clinical pharmacist will provide telephonic consultations with provider offices for members ages 9 to 13 identified as needing to complete the HPV vaccination series. Member lists will be provided to providers with gaps in care to be closed.

Goal:

- Academic detailers will outreach to at least 700 providers representing approximately 20,000 members in 2026.

9.5.1.7. Value Partnerships Pharmacy Forum

Value Partnerships, HCV Data Analytics & Insights, and Pharmacy Services developed a forum in 2013 to collaborate internally and externally with providers and other healthcare stakeholders to generate ideas, prioritize efforts, determine, and implement success

measures and evaluate efforts in providing value to members. The collaboration is designed to further strengthen Blue Cross' efforts to improve quality measure performance. Pharmacy-related topics related to medication safety, quality, and cost-effectiveness are identified and presented to pharmacy representatives and administrators at provider organizations. Example topics addressed through the forum include, but are not limited to, the following: opioids, medication adherence, antibiotics, vaccines, and pharmacy costs. In addition, the forum facilitates the use of clinical data by physician organizations to address gaps in clinical care and to improve prescribing.

Goal:

- In 2026, the forum will identify further opportunities to work with pharmacists in physician organizations. Goals for the Value Partnerships Pharmacy Forum include hosting at least four meetings with PGIP physician organizations and sustaining physician organization interest and engagement on pharmacy issues.

9.6. Inclusion and Workplace Engagement

Blue Cross Blue Shield of Michigan is committed to helping to improve the health care outcomes of its members. Through its multi-year healthy communities strategy and other initiatives to improve health care quality and access, Blue Cross assessed member needs and partners with providers and community organizations to address health care needs; recognizing the unique health and non-medical needs of members.

Blue Cross offers language assistance to individuals who have limited English proficiency and/or other communication needs, evaluates network adequacy to help meet the needs of members, and ensures compliance with Meaningful Access and Non-Discrimination requirements.

Through the Patient-Centered Medical Home program, core capabilities that support addressing health care quality and access for members include open access same day appointments and extended hours; quality reporting and test tracking; and care coordination and case management.

PCMH capabilities that relate to addressing health care needs and gaps include:

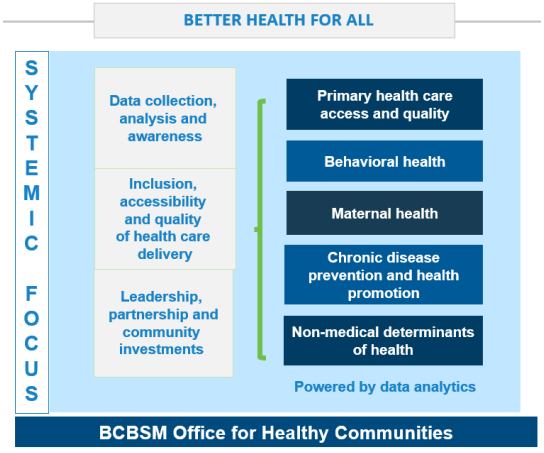
Guideline number	PCP and Specialist Guideline	Definition
2.20	Registry contains advanced patient information that will allow the practice to identify and address gaps in care	Primary/preferred language, race, ethnicity, measures of social support (e.g., disability, family network), disability status, health literacy limitations, type of payer (e.g., uninsured, Medicaid), relevant behavioral health information
2.21	Registry contains advanced patient demographics	Gender identity, sexual orientation, sexual identity
2.25	Registry used to identify patients with concerns related to non-medical drivers of health	Transportation limitations, housing instability, interpersonal violence, food insecurity
2.26	Non-medical drivers of health data shared with Michigan Institute for Care Management and Transformation	Data must be shared routinely and electronically
5.9	Practice unit has telephonic or other access to interpreter(s) for all languages common to practice's established patients	Languages common to practice are defined as languages identified as primary by at least 5 percent of the established patient population

Guideline number	PCP and Specialist Guideline	Definition
		Language services may consist of 3rd-party interpretation services or multi-lingual staff Asking a friend or family member to interpret does not meet the intent of the capability
5.10	Patient education materials and patient forms are available in languages common to practice's established patients	Languages common to practice are defined as languages identified as primary by at least 5 percent of the established patient population Patient education materials and forms are clear and simple and written at an appropriate reading grade level
10.6	Practice has a systematic approach in place for referring patients to community resources	Patients should have access to national and local resources that are appropriate for their ethnicity, gender orientation, ability unique health care needs, including resources that are available in other languages such as Spanish, Arabic, and American Sign Language

Advancing Healthy Communities

Building upon the foundational work of the Health Improvement, a healthy communities strategy has been developed with a vision of better health for all and a current focus on five focus areas: primary care access and quality of care, behavioral health, maternal health, chronic disease prevention (and Management) and health promotion, and non-medical drivers of health. More than 15 initiatives have been completed, are underway or being planned.

On an annual basis, the goal is to execute initiatives in at least three out of the five focus areas.



Blue Cross is executing on a maternal health strategy to improve health outcomes for members. It includes a focus on providing information to help members navigate the maternal journey, connecting members to community resources and providing guidance and support through care

management's high-risk pregnancy program.

Trainings to Improve Care or Service Delivery
The health plan will offer at least one training or education to employees focused on improving the quality of or experience with health care or services or reducing disparities. The organization will offer training or education to employees on at least one of the following topics:

- Culturally and linguistically appropriate practices
- Unique health or health care needs of relevant subgroups
- Improving the impartiality of care or services
- Reducing ableism in care or services
- Inclusive, non-stigmatizing or respectful data collection practices
- Trauma-informed practices

10. Qualified Providers

10.1. Credentialing and Recredentialing

The credentialing and recredentialing process is designed to establish the quality and competency of practitioners and other providers. Credentialing is conducted prior to affiliation and repeated on a three-year cycle. It ensures that each practitioner maintains the appropriate level of clinical competency and professional conduct necessary to deliver high-quality care to members.

Goals:

- To ensure healthcare professionals and organizational providers meet specific health standards and qualifications to provide quality care to patients.
- To provide written notification within thirty (30) days of the credentialing decision.
- To ensure recredentialing files are completed every three (3) years.

10.2. Ongoing Monitoring

The Quality Management department conducts ongoing monitoring of complaints and serious adverse events. Reports are pulled at least biannually related to quality of care concerns and SAEs for three or more complaints in a 24 month period per provider. Cases are reviewed to determine severity and level of intervention. When a quality of care concerns is identified, the case is referred to the plan medical director for recommendations.

10.3.Facility Site Review

The Quality Management department sets acceptable standards for provider offices including physical accessibility, physical appearance, examining room space, availability of appointments and adequacy of medical record keeping for the enterprise.

Office site visits are conducted based on member complaints, member surveys, staff visits, and other criteria as determined periodically by the plan.

Goals:

- Conduct site reviews within 30 calendar days of request related to complaints or reassessments.
- Conduct site reviews within 14 business days of request that are not complaint related.

10.4. Physician Participation

All practitioners are expected to participate in the Quality Improvement Program. The practitioners agree to this through written consent in their contract with the health plan.

Participation may include serving on committees, involvement in the development and implementation of quality improvement activities, involvement in actions to improve care and service, review of clinical guidelines and peer review.

Practitioners are provided information regarding their performance in relation to quality indicators through written communication. When deficiencies in quality of care or service are identified, a corrective action plan is requested to monitor ongoing improvement. Physician discipline, suspension or terminations are done in accordance with the practitioner screening, discipline, termination, and appeal process policy. In compliance with the Health Care Quality Improvement Act of 1986, the National Practitioner Data Bank is informed of any disciplinary actions required to be reported by the Act. Disciplinary actions are also reported to the Healthcare Integrity Protection Data Bank as required.

10.5. Peer Review Process and Implementation of Corrective Action Plan

The Peer review process is mechanism whereby all potential quality of care and service issues are identified, investigated, analyzed, monitored, and resolved timely. Sources of potential quality of care and service issues include, but aren't limited to the following:

- Participating physicians
- Member complaints
- Quality management tracking processes
- Concurrent review
- Content of medical record review
- Referral from internal departments or committees
- Risk management
- Medical directors and medical staff members

A corrective action and/or quality improvement plan is initiated, as necessary, to address and resolve confirmed physician related quality of care and service issues. Quality of care and service issues are assigned a severity category. The corrective action and/or quality improvement plan is implemented and monitored in accordance with the medical director's recommendations. When quality of care issues is severe enough to warrant contractual termination rather than corrective action, the physician termination process is followed.

Practitioners and Organizational Providers that do not meet criteria may be requested to submit a Corrective Action Remediation Plan to denote their compliance with requirements within an allotted timeframe established by the Enterprise Credentialing Committee or plan Medical Director.

10.6. Physician Discipline and Termination

There is an established procedural process for initiating disciplinary actions or terminating affiliated physicians. Disciplinary action, non-renewal, or termination of a contract with an affiliated practitioner may occur for a number of reasons. Such action may be prompted by quality of care concerns, lack of cooperation, behavior inconsistent with managed care objectives, failure to comply with recredentialing standards, or other appropriate reasons. Termination may be preceded by one or more instances of discipline but is not required.

The appropriate State Licensing Board is notified of cases that involve quality of care issues that will restrict or regulate a practitioner's practice for more than fifteen (15) days. The National Practitioner Data Bank is notified of quality-of-care actions that restrict or regulate a practitioner's practice for more than thirty (30) days.

A practitioner may be terminated for any reason not prohibited by law (e.g., unlawful discrimination). The health plan may terminate its contractual relationship with an affiliated practitioner by declining to recredential, failing to renew a time-limited contract, or by providing appropriate notification to the physician at any time during the term of the contract.

Goals:

- To provide written notice to the practitioner at least thirty (30) days before termination of the contract.
- To complete the National Practitioner Data Bank Adverse Action Report within fifteen (15) days of the final decision for a quality denial.
- To notify the appropriate State Licensing Board within fifteen (15) days of any action taken by Blue Cross for a quality denial.

10.7. Physician Appeal Process

A physician is offered an appeal process when the relevant corporate committee and/or a plan medical director has taken, or recommended, action based on concerns related to selected administrative issues or quality of patient care. This includes at least one of the following:

- Denial of a physician's application for affiliation or continued reaffiliation for reasons related to the quality of care provided.
- Restriction or regulation of a physician's clinical practice for more than fifteen (15) days due to quality-of-care concerns.
- Termination of a physician's contract for reasons related to administrative or quality-of-care issues.

Goals:

- Process first-level written appeals within thirty (30) days of receiving all relevant documentation.
- Process second-level written appeals within thirty (30) days of receiving all relevant documentation.

11. Delegation Activities

The health plan may elect to delegate the performance of select functions to qualified provider organizations and retains sole responsibility for assuring that these functions are performed according to established standards, regulatory and accreditation requirements. Organizations, which are granted delegated status, are expected to demonstrate compliance with all standards, monitoring, and reporting requirements. A process is in place to ensure the delegate meets or exceeds performance requirements and to define oversight activities associated with these requirements, and as required by regulatory and accrediting agencies.

The Quality Management department oversees NCQA requirements for all delegates and receives input from business areas and contract administrators to complete the following:

- NCQA delegation agreements are written and outline the specific responsibilities being delegated in accordance with NCQA requirements. Updates are made, as necessary, to reflect changes to NCQA requirements. All delegation agreements state the delegate must remain compliant, ongoingly, with all changes to the NCQA Standards for which they have delegation responsibility.
- Prior to implementation, the Quality Management department works with the contract administrator to conduct pre-delegation evaluations. Findings are presented to the appropriate oversight committee (e.g., Clinical Quality Committee, Utilization Management Committee, Member Experience Committee, Pharmacy and Therapeutics

Committee, and Care Management Quality Committee). Annual delegation oversight evaluations are completed and presented to the appropriate oversight committee for approval and recommendations for continued delegation.
- For all credentialing delegates, the Corporate Credentialing and Program Support area writes delegation agreements, conducts pre-delegation and annual delegation oversight evaluations, and presents to the Enterprise Credentialing Committee.

The FEP Director's Office maintains oversight for all their delegates.

12. Compliance

12.1. Review by External Entities

Blue Cross is committed to conducting business with integrity and in accordance with all applicable federal, state and local laws, regulations, guidelines, and standards.

The compliance program policies and procedures support and promote the seven elements of an effective compliance program as specified by the Office of Inspector General and U.S Federal Sentencing Guidelines.

Compliance is an integral part of our business. Every workforce member is responsible for understanding and following the rules that help protect customers' health information, enterprise assets, and data.

The enterprise promotes a culture of compliance that builds trust with our stakeholders: customers and clients, providers, regulators, community, and workforce to name a few. It maintains an effective compliance program by leveraging the three lines governance model, which outlines well-defined roles and responsibilities. This model promotes a strong risk management culture and establishes accountability at all levels of the organization.

The model includes the following three tiers of oversight:

1. The business areas are the first line. They help manage the organization's risks by implementing and maintaining effective internal control procedures while providing transparency to their day-to-day operations. Compliance liaisons are first line team members who receive heightened training regarding compliance topics and help to reinforce key compliance topics with their business areas.
2. The Compliance Office provides second-level oversight of compliance controls, helps confirm accuracy and completeness of reporting, collaborates with various business areas to evaluate compliance with laws and regulations, and oversees timely remediation of issues. The Enterprise Compliance Officer reports directly to the CEO with a dotted line to the Audit Committee of the Board. Other areas residing in the second line include Enterprise Risk Management, Enterprise Financial Advisory, Enterprise Information Security, Human Resources, and the Office of the General Counsel.
3. Enterprise Audit comprises the third line and conducts independent risk-based services. These services range from conducting financial, performance, compliance, system security and due diligence audits; to participating on committees, to select new systems, and teaching training courses in internal controls to new managers.

12.2. Confidentiality

All documented peer review activities are maintained in a confidential manner and in compliance with legal requirements and state regulatory standards. The records, data and information collected for or by individuals or committees assigned a professional review function are

confidential and shall be used only for the purposes of professional review, aren't public records and aren't subject to court subpoena. Disclosure of quality assessment information is protected under the Federal Health Care Quality Improvement Act of 1986.

Names of members, health care practitioners and providers are removed from documents and coded so as not to identify the individual. Dissemination of practitioner or provider specific information is limited to the involved practitioner or provider, or to those individuals requiring the data to perform recommended corrective action. Quality improvement documents not protected under the auspices of peer review are maintained in accordance with internal policies and procedures.

Confidentiality of member and patient personal and medical information is required and expected of all workforce members. Strict standards are adhered to concerning patient and fellow workforce member medical information, and all other information that is of a confidential nature.

Workforce confidentiality requirements are part of an acknowledgement form employees sign that includes a commitment to value confidentiality and safeguard corporate and member information. The acknowledgement form is maintained by Human Resources. Annual conflict of interest disclosures are maintained by the Compliance department. All participants in the Quality Improvement Program are expected to respect the confidential information as such. External committee members are required to sign a confidentiality statement annually.

12.3. Fraud, Waste, and Abuse

Health care fraud may be defined as an intentional act to defraud a health care benefit program or to obtain through false representations, money or other property owned by a health care benefit program. Stakeholders are educated on health care fraud and how to report fraud and abuse through member and provider newsletters, handbooks, and manuals. Anyone can choose to report fraud, waste, or abuse anonymously and confidentially, without retaliation.

FWA Identification:

- Facility site and medical record reviews for member complaints and/or provider issues.
- Proactive analytics, early detection monitoring, and artificial intelligence to discover outlier behavior.
- Audits conducted on a random or targeted basis to identify, refer, investigate, resolve FWA and quality of care concerns.

When potential fraud, waste or abuse is suspected, the issue should be reported to one of the following:

- Employee's supervisor
- Medicare Compliance Officer
- Corporate Compliance Officer
- Blue Cross Corporate and Financial Investigations Unit (1-844-STOP-FWA)
- Blue Cross Government Programs Investigation Unit (1-888-650-8136)
- Health and Human Services Office of the Inspector General for suspected cases of Medicare/Medicaid fraud

13. Annual Work Plan

An annual work plan is developed to document the Quality Improvement Program objectives, planned projects, responsible person, and targeted time frames for completion. The work plan is initiated by the Quality Management department and is forwarded to the Clinical Quality Committee for review and recommendations. Annual approval by the Board of Directors and the Health Care

Delivery Committee is obtained. An evaluation regarding completion of the work plan is included in the annual summary report.

The work plan provides a mechanism for tracking quality activities over time and is updated throughout the year and as new issues are identified. The work plan is based on both the Quality Improvement Program and the previous year's activities and identified opportunities. The work plan includes the following elements:

- Measurable objectives for the quality improvement activities associated with important aspects of quality of clinical care, quality of service, safety of clinical care and member experience.
- Follow-up monitoring of activities previously identified from quality improvement initiatives.
- Ongoing monitoring of activities.
- Time frame which each activity is to be achieved.
- Person, department, or committee responsible for activities.
- Schedule of delegated activities.
- Evaluation of the Quality Improvement Program.

14. Evaluation of the Quality Improvement Program

An annual evaluation is a component in the assessment of the overall effectiveness of the Quality Improvement Program. Evaluation criteria include the following:

- Evaluation of the effectiveness of activities performed with an emphasis on the identification of improvements in the quality and safety of clinical care and quality of services delivered.
- Assessment, trending, and documentation of measurable improvements in the quality and safety of clinical care and quality of service.
- Analysis of the results of quality improvement initiatives including barrier analysis.
- Evaluation of the effectiveness of the quality improvement processes and structure.
- Adequacy of resources for the Quality Improvement Program.
- Recommendations for changes to improve the effectiveness of the Quality Improvement Program.
- Analysis of the progress made on influencing safe clinical practices.

The evaluation is initiated by the Quality Management department. The evaluation is submitted to the Clinical Quality Committee review and recommendations. The Health Care Delivery Committee approves and submits the evaluation to the Blue Cross Board of Directors for final approval.

15. Resources

Efficient and appropriate use of internal resources, including facilities, equipment, staffing, personnel, and data systems are continuously monitored and adjustments made as required.

The resources dedicated to the supporting the QI program include but are not limited to:

- President and Chief Executive Officer
- EVP, Clinical Affairs and Chief Medical Officer
- EVP, Health Care Value
- EVP, President Commercial Markets
- SVP, Provider Partnerships and Network Management
- SVP, Community Relations
- SVP, Office of the General Auditor and Corporate Compliance's
- VP, Advanced Analytics
- VP, Digital and Automation Business Strategy
- VP, Care Delivery Transformation and Affordability

- VP, Clinical Decision Support
- VP, Clinical Partnerships & Associate Chief Medical Officer
- VP, Core Operations
- VP, Corporate Communications
- VP, Experience
- VP, Enrollment, Billing and FEP Operations
- VP, Care Management
- VP, Pharmacy Services and Chief Pharmacy Officer
- VP, Product Development and Market Solutions
- VP, Provider Contracting
- VP, Service Operations
- VP, Quality
- Sr Director Community Responsibility & Social Mission
- Sr Director Corporate Counsel
- Sr Medical Director and Associate CMO, Quality and Experience
- Sr Medical Director, Associate CMO, Clinical Policy
- Sr Medical Director, Utilization Management
- Medical Director, Behavioral Health
- Medical Director, Utilization Management/Quality Management
- Medical Directors
- Sr Director, HCV Operations and Execution Excellence
- Director, Quality Management

Leadership evaluates staffing on an ongoing basis to ensure adequate and skilled personnel are in place to complete the activities delineated in the Quality Improvement Program Plan. Refer to the Quality Management Department organizational chart for staffing found in ***Appendix A***.

16. Analytical Support

The QI program is further supported by the Health Care Value division with IT. Analytic outcomes include identifying eligible population for accreditation, developing dashboards for reporting HEDIS metrics to providers, ascertaining racial/ethnic disparities in quality metrics and understanding variation in quality across the Blue Cross statewide network. The Quality Department analyzes data to understand what is driving gaps in care and identify areas for provider improvements in order to improve overall quality of care. The Quality Department also performs the following:

- Conducts analytics to create HEDIS quality metrics for our physician organization partners in addition to public reporting.
- Provides analytic support to IT groups responsible for data submission to the HEDIS analytic vendor and analytics to support audit and medical chart review process.

Following are a few more examples of data analytic outcomes in support for quality improvement:

- Map vision claims for inclusion in the data mart to enhance relevant metrics.
- Enhance PGIP Clinical Quality Initiative report to include HEDIS Health Plan Rating measures.
- Partner with Member Marketing and Engagement for member outreach efforts.
- Manage supplemental data and laboratory results for HEDIS and physician quality reporting.
- Manage customer-specific performance guarantee reports on HEDIS metrics to help monitor performance.

17. Federal Employee Program

The Federal Employee Program Quality Improvement Program is consistent with the Commercial PPO/ Exchange PPO program with the following exceptions:

NCQA Standard		FEP Exception
Member Experience (ME)		
ME 1A	Statement of Member's Rights and Responsibilities Statement	FEP members access rights and responsibilities by accessing fepblue.org/memberrights. Web content and member digital experience are managed and monitored by the Director's Office, not Blue Cross Blue Shield of Michigan.
ME 1B Factors 1, 2	Distribution of Rights Statement	The FEP Director's Office distributes its member rights and responsibilities statement to members.
ME 2A Factors 1-14 and 16	Subscriber Information	The FEP Director's Office maintains responsibility for the distribution written information to its subscribers about benefits and access to medical services for Factors 1-14 and 16. Factor 15 is NA for FEP products.
ME 3A	Marketing Information- Materials and Presentations	The FEP Director's Office ensures that communication with prospective members correctly and thoroughly represents the benefits and operating procedures of the organization.
ME 3B Factors 1-4	Communicating with Prospective Members	The FEP Director's Office maintains responsibility for using easy-to-understand language in communications to prospective members about its policies and practices regarding collection, use and disclosure of PHI for Factors 1-4. Factor 5 is NA for product lines sponsored by state or federal government, including FEP products.
ME 3C	Assessing Member Understanding	The FEP Director's Office maintains responsibility for assessing member understanding, implementing procedures to maintain accuracy of marketing communications, and acting on opportunities of improvement.
ME 4A	Functionality of Claims Processing (Website)	The FEP Director's Office maintains responsibility for web content and member digital experience for claims processing information at fepblue.org/myblue.
ME 5A-C	Pharmacy Benefit Information (Website)	The FEP Director's Office contracts with CVS Caremark, an NCQA-Accredited UM organization, to provide pharmacy services to FEP members. The FEP Director's Office maintains this contract at a national level and is responsible for the oversight of the delegated activities.
ME 6A	Personalized Information on Health Plan Services-Functionality: Website	The FEP Director's Office provide members with the information they need to easily understand and use health benefits at fepblue.org/myblue. The web content and member digital experience are managed and monitored by the FEP Director's Office, not Blue Cross of Michigan.
ME 6B	Personalized Information on Health Plan Services-Functionality: Telephone	Blue Cross FEP employees utilize the FEP Service Benefit Plan Brochure and Blue Cross of Michigan local fee schedules to determine which services require authorization and to determine benefit and financial responsibility for specific services and treatment for members over the telephone.
ME 6C	Quality and Accuracy of Information for Web and Telephone	The FEP Director's Office maintains responsibility for assessing the quality and accuracy of the functionality it provides to members via the Web, e.g., for requesting and reordering ID cards. Blue Cross FEP is responsible for assessing the quality and accuracy of the functionality it provides to members via the telephone for determining when to obtain referrals and authorizations, as well as determining benefit and financial responsibility for a specific service or treatment.
ME 6D	E-mail Response Evaluation	Blue Cross FEP maintains responsibility for responding to member e-mail inquiries submitted through fepblue.org.

ME 8A-D	Delegation of ME	The FEP Director's Office contracts with CVS Caremark, an NCQA-Accredited UM organization, to provide pharmacy services, WebMD for Health appraisals, Livongo for chronic care management, and Teladoc for medical and behavioral health services for FEP members. The FEP Director's Office maintains this contract at a national level and is responsible for the oversight of the delegated activities.
Utilization Management (UM)		
UM 2B	Clinical Criteria for UM Decisions- Availability of Criteria	FEP Medical Policies are accessed from fepblue.org. Web content and member digital experience are managed and monitored by the Director's Office, not Blue Cross Blue Shield of Michigan.
UM 2C	Consistency Applying Criteria	The FEP Director's Office contracts with CVS Caremark, an NCQA-Accredited UM organization: to evaluate the consistency in which health care professionals involved in UM apply criteria in decision making and acts on opportunities to improve consistency.
UM 3A	Communication Services-Access to Staff	The FEP Director's Office maintains responsibility for the distribution of written communication with information related to how members can access staff to discuss UM issues. Written content, web content and member digital experience are managed and monitored by the FEP Director's Office, not Blue Cross Blue Shield of Michigan. The FEP Director's Office contracts with CVS Caremark, an NCQA-Accredited UM organization, for pharmacy-related services for Factors 1-3.
UM 4F	Appropriate Professionals-Use of Board-Certified Consultants	The FEP Director's Office contracts with CVS Caremark, an NCQA-Accredited UM organization; to ensure written procedures are in place for using board-certified consultants to assist in making medical necessity determinations and provides evidence that board-certified consultants are used for medical necessity determinations.
UM 10A Factors 1-3	Procedures for Pharmaceutical Management	The FEP Director's Office contracts with CVS Caremark, an NCQA-Accredited UM organization, to provide pharmacy services to FEP members. Evidence for Factor 4 will be surveyed at the local organization level for FEP and non-FEP memberships.
UM 10B-E	Procedures for Pharmaceutical Management	The FEP Director's Office contracts with CVS Caremark, an NCQA-Accredited UM organization, to provide pharmacy services to FEP members.
UM 11A-C	UM Information Integrity	The FEP Director's Office contracts with CVS Caremark, an NCQA-Accredited UM organization, to include new information integrity requirements for delegation of pharmacy services. The FEP Director's Office maintains responsibility for information integrity for non-pharmacy services.
UM 11D and F Factor 1 only	UM Information Integrity	The FEP Director's Office contracts with CVS Caremark, an NCQA-Accredited UM organization, to include new information integrity requirements for delegation of pharmacy services. UM 11D and 11F Factor 2, 11E, and 11G are NA since the organization did not identify any inappropriate documentation and updates to UM denial receipt and decision notification dates.
UM 12A-D	Delegation of UM	The FEP Director's Office contracts CVS Caremark, an NCQA-Accredited UM organization, to provider pharmacy services and includes new information integrity requirements for delegation to FEP members. The FEP Director's Office contracts One Touchpoint, a mail vendor responsible for the annual mailing of member postcards. FEP members may request mail order for their prescriptions, and CVS Caremark fills and mails the prescriptions to the member.
Credentialing and Recredentialing (CR)		
CR 2A	Credentialing Committee	The FEP Director's Office contracts with Teladoc Physicians, P.A. to provide Telehealth services to FEP members. The FEP Director's Office maintains this contract at a national level and is responsible for the oversight of the delegated activities.

CR 5A	Ongoing Monitoring and Interventions	The FEP Director's Office contracts with Teladoc Physicians, P.A. to provide Telehealth services to FEP members. The FEP Director's Office maintains this contract at a national level and is responsible for the oversight of the delegated activities.
CR 8A-B, D	Credentialing Information Integrity	The FEP Director's Office contracts with Teladoc Physicians, P.A. to provide Telehealth services to FEP members. The FEP Director's Office maintains this contract at a national level and is responsible for the oversight of the delegated activities.
CR 8C Factor 1 only	Credentialing Information Integrity	The FEP Director's Office contracts with Teladoc Physicians, P.A. to provide Telehealth services to FEP members. The FEP Director's Office maintains this contract at a national level and is responsible for the oversight of the delegated activities. Factor 2 is scored NA since Teladoc did not identify any inappropriate documentation and updates.
CR B, D	Delegation of CR	The FEP Director's Office contracts with Teladoc Physicians, P.A. to provide Telehealth services to FEP members. The FEP Director's Office maintains this contract at a national level and is responsible for the oversight of the delegated activities.
CR 9C Factors 1-5	Delegation of CR	The FEP Director's Office contracts with Teladoc Physicians, P.A. to provide Telehealth services to FEP members. The FEP Director's Office maintains this contract at a national level and is responsible for the oversight of the delegated activities. Factors 6-7 are NA because there were no corrective actions regarding information integrity.
Network Management (NET)		
NET 5A, E, G and H Factor 1	Physician and Hospital Directories	The FEP Director's Office contracts with HealthSparq to provide vendor directories for fepblue.org. The FEP Director's Office maintains this contract at a national level and is responsible for the oversight of the delegated activities.
NET 6A-D	Delegation of NET	The FEP Director's Office contracts with HealthSparq to provide vendor directories for fepblue.org. The FEP Director's Office maintains this contract at a national level and is responsible for the oversight of the delegated activities.
Population Health Management (PHM)		
PHM 4A-B	Wellness and Prevention	The FEP Director's Office contracts with WebMD Health Services Group, Inc., an NCQA-Accredited WHP organization that provides self-management tools related to information on wellness and promotion.

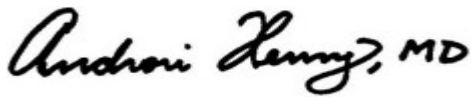
Goals:

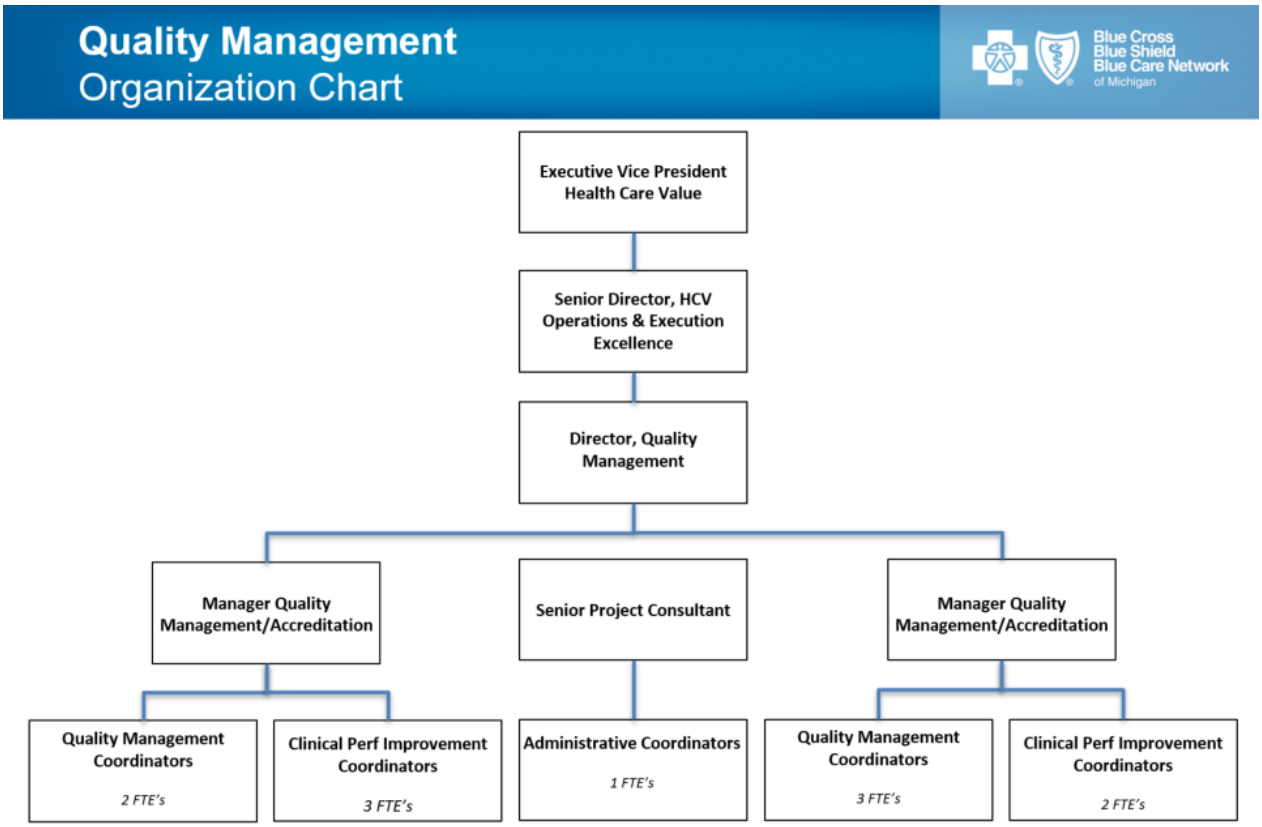
1. To provide members with the information they need to use their benefits via phone and written inquiries.
2. To achieve 100% on the FEP Corporate Survey annually.

The 2026 Quality Improvement Program Plan has been reviewed and approved.

APPROVED BY:

Clinical Quality Committee on 01/21/2026:



Androni Henry, MD
Senior Medical Director & Associate Chief Medical Officer
Clinical Quality Committee

18. Appendix A