2019 Blue Care Network of Michigan
Quality Improvement Program Description

January 16, 2019
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Conflict of Interest

Blue Care Network of Michigan 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 Care Network is 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 Care Network 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 Plan 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 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 Care Network uses to determine activities and influence outcomes related to the improvement of the care and treatment of members.

2. Health Plan Mission

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

3. Health Plan Overview

In 2018, the health plan celebrated 20 years of service. Headquartered in Southfield Michigan, Blue Care Network serves over 889,000 total members. The in-state population consists of 686,291 (77 percent) Commercial HMO, 89,962 (10 percent) Medicare HMO and 113,388 (13 percent) Marketplace members.

BCN has been the largest HMO in Michigan for 20 years. BCN is the only HMO in Michigan to cover the Upper Peninsula. Our network includes almost 6,000 primary care physicians, over 23,000 specialists and most of the state's leading hospitals.

In 2002, BCN became the first commercial HMO in the nation to receive National Committee for Quality Assurance accreditation for disease management programs addressing adult diabetes, adult and child asthma and congestive heart failure. BCN currently holds a Commendable NCQA health plan accreditation rating for its Commercial HMO and Medicare HMO products. The Marketplace HMO accreditation rating is Accredited. Blue Care Network will undergo an NCQA Renewal Survey in 2020.
This program plan document applies to HMO Commercial, Marketplace and Medicare products. In 2018, the health plan restructured its business and as a result, a Memorandum of Understanding was implemented to share specified services between Blue Cross or BCN.

3.1. Background

BCN is a mixed-model health maintenance organization that was legally formed in February 1998. Prior to February 1998, four BCN health maintenance organizations existed across the state: BCN Southeast, BCN Mid-Michigan, BCN East and BCN Great Lakes. The four plans were merged to form one statewide organization. BCN Advantage (a Medicare Advantage product) was implemented in January 2006. MyBlue Medigap (a Medicare supplement product) was implemented in November 2009. MyBlue, which is licensed to sell in the state of Michigan, is offered to Medicare beneficiaries 65 years or older.

BCN purchased M-Care and M-Caid, owned by the University of Michigan, on December 31, 2006. M-Care was a commercial HMO and M-Caid was a Medicaid HMO. During 2007, the M-Care membership was transitioned to BCN. In October 2007, the ownership of the Medicaid HMO was transferred to BCN and the corporation was renamed BlueCaid of Michigan. In April 2012, BlueCaid changed its name to Blue Cross Complete of Michigan.

Effective January 1, 2016 Blue Cross Complete of Michigan, became a joint venture between Blue Cross and AmeriHealth Caritas. It provides coverage to thousands of lower-income Michigan residents with Medicaid and Healthy Michigan Plan coverage. It is no longer included in this program document.

BCN began to provide services on behalf of its subsidiary, BCN Service Company, to self-funded customers in 2007. Starting Jan. 1, 2018, all employer groups administered through BCN Service Company were transitioned to Blue Care Network. BCN Service Company no longer administers self-funded employer benefit plans and BCN health reimbursement arrangement (HRA) plans.

Due to the Affordable Care Act, BCN began to provide care to Individual Business Unit members (including Marketplace) in 2014. The Health Insurance Marketplace allows individuals purchasing health care for themselves as well as small groups with 50 or fewer employees to compare prices and coverage among plans.

As a subsidiary of Blue Cross Blue Shield of Michigan and with the largest health maintenance organization membership in the state, BCN plays a significant role in shaping future health care delivery, servicing and financing strategies regionally and in the state of Michigan.

BCN has arrangements with physicians, major hospitals, home care agencies, skilled nursing facilities, urgent care centers, laboratories and ancillary vendors to meet the health care needs of our members.

4. Quality Improvement Philosophy

BCN’s 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. BCN uses the scientific methods of continuous quality improvement to design, implement, operate, evaluate and continuously improve services for our members.

Through the efforts of the Quality Improvement Program, BCN 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. BCN strives to conduct its business in a prudent and efficient manner and to maintain a work environment that is exciting, challenging and rewarding. It’s Blue Care Network’s goal to empower employees to accomplish their work within a friendly atmosphere of teamwork and mutual respect.

BCN embraces the Institute of Healthcare Improvement’s Triple Aim framework which includes:

- Improving of 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 the health care services provided. The Quality Improvement Program activities are categorized by the following: quality of service, clinical quality, satisfaction, continuity and coordination, member safety, cultural and linguistic, qualified providers, delegation, compliance and communications.

6. Goals and Objectives

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

**Quality Improvement Program Structure**

- Revise, review, approve and implement the 2019 Quality Improvement Program Description and Work Plan with all activities based on the 2018 annual QI evaluation findings and recommendations.
- Evaluate 2018 improvements and areas for improvement. Implement findings of the 2018 annual QI Evaluation into the 2019 QI Program and Work Plan.

**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 and specialty care (high volume and high impact) services.
- Monitor member experience with customer service and identifies areas of potential improvement.
- Monitor provider experience with behavioral health services and identifies areas of potential improvement.
- Collect and evaluate member complaints and appeals.

**Clinical Quality**

- Coordinate services for members with complex conditions and help them access needed resources.
- Adopt and use clinical practice guidelines relevant to health plan population for the provision of prevention, acute or chronic medical services and behavioral health care services.
- Work collaboratively to ensure compliance with HEDIS® reporting requirements and participate in initiative around improving rates.
- Support utilization management activities for medical and behavioral health care.
- Outline the population health management strategy for meeting the care needs of the member population.
- Measure the effectiveness of the population health management strategy.
- Promote data, comparative cost and quality, information sharing and value-based arrangements with providers.
- Integration of public health goals into the quality improvement program through health education, participation in community public health forums, and collaboration with state and local public health agencies.
- Facilitate continuity and coordination of medical care across the health plans delivery system.
- Collaborate with behavioral health care practitioners to monitor and improve coordination between medical care and behavioral health care.

**Satisfaction**

- Assess satisfaction with care and services through surveys of members, practitioners and providers.

**Member Safety**

- Support health plans safety initiatives (for example, controlled substance workgroup).
- Participate on collaborative workgroups on patient safety programs to maximize safety of clinical practices.

**Serving Culturally and Linguistically Diverse Populations**

- To meet the cultural and linguistic needs of the population.
- To create a culturally competent workforce.

**Qualified Providers**

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

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

**Compliance**
- 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 Care Network Board of Directors, program committees, operational departments and employees all work together to promote quality throughout the BCN organization, as described on the following pages. BCN committees provide oversight and implementation of all quality improvement activities.

**7.1. Program Committees**

To promote quality throughout the Blue Care Network organization, specific relationships and linkages between the board, program committees, operational departments and key professional staff are described below (see appendix – committee structure). The quality improvement committees are designed and designated to provide oversight for the Quality Improvement Program activities (access, quality of service, clinical quality, satisfaction, continuity and coordination, qualified providers, compliance and communication).

**7.1.1. Blue Care Network Board of Directors**
The Board of Directors has ultimate authority and responsibility for oversight of the BCN and BCN Advantage Quality Improvement Program. The BCN board delegates the responsibility for the design, implementation and management of the QI Program to the Health Care Quality and Service Improvement Committee.

**Responsibilities**

- Reviews and acts upon the recommendations of the Health Care Quality and Service Improvement Committee.
- Reviews and approves annually, the Quality Improvement Program, work plan and annual evaluation of effectiveness.
- Makes recommendations to the Clinical Quality Committee, Utilization Management Committee, Credentialing Committee, Customer Service and Satisfaction Committee, Pharmacy and Therapeutics Committee, Internal Review and Confidentiality Committee through the Health Care Quality and Service Improvement Committee and the senior vice president and chief medical officer.
- Monitors the ongoing activities of the Quality Improvement Program through the regular review of committee and management reports.
- The board may appoint an Ad Hoc Oversight Committee to oversee or intensify a focus on one or more attributes of quality of care or service, or related administrative activities.

**Composition**

- Fifteen members
- Directors are appointed by the shareholder, Blue Cross. At least one (1) member of the Board shall represent the Corporation's membership
- **Chairperson:** Board Member
- **Vice Chairperson:** Board Member

**Term**

- The term office of each Director shall be one (1) year and until his or her successor is selected and qualified, or until his or her resignation or removal.

**Meetings**

- A quorum is a majority as defined by the bylaws of the Board.
- Minutes are taken to record actions and recommendations.
- Minutes are maintained in a confidential manner.

**7.1.2. Health Care Quality and Service Improvement Committee**

The Health Care Quality and Service Improvement Committee is a standing committee of the Board of Directors and provides oversight for quality improvement activities related to health care delivery and service and makes recommendations to the board based on matters reviewed. The committee has the authority to review decisions made by its subcommittees. The BCN retains ultimate authority and responsibility for oversight of BCN’s Quality Improvement Program, BCN’s board delegates the responsibility for the design, implementation and management of the Quality Improvement Program to the Health Care Quality and Service Improvement Committee.
Responsibilities
- Provides oversight for quality improvement activities related to health care delivery and service.
- Receives, reviews and makes recommendations to the Board of Directors on quality improvement documents received from the reporting committees.
- Reviews and evaluates the results of quality and service improvement activities.
- Reviews and approves, annually, the Quality Improvement Program Plan, work plan and annual evaluation of effectiveness.
- Submits quality improvement reports to the Board of Directors.
- Reviews and monitors reports, findings of evaluations, actions and results of program activities conducted through the subcommittees.
- Reviews and approves selected policy issues as requested by senior management.
- Provides reports to the Blue Care Network Board of Directors.

Composition
- Board members, minimum of three (includes chairperson)
- President and chief executive officer
- Senior vice president and chief medical officer
- Vice president, Utilization Management
- Vice president, Provider Network Evaluation and Management
- Senior medical director, Clinical Affairs
- Three BCN practitioners
- Chairperson: Board Member
- Vice Chairperson: Board Member

Committee membership changes require Board approval.

Term
- Annual appointment.

Meetings
- A quorum is defined as the majority of the membership.
- Minutes are taken to record actions and recommendations.
- Minutes are maintained in a confidential manner.
- Meetings are held quarterly at a minimum.

7.1.3. BCN Medical Leadership Advisory Council

The Medical Leadership Advisory Council is a forum for practitioners and their representatives to provide input on network policies and programs that affect clinical care, service and access.
Responsibilities

- Reviews and comments on medical policies and programs related to clinical care, service and access.
- Provides input to the Health Care Quality and Service Improvement Committee and senior leadership on health care delivery related issues.
- Reviews and recommends activities to make performance data publicly available for members and practitioners.
- Provides reports to Health Care Quality and Service Improvement Committee and Blue Care of Michigan Inc. Board of Directors.

Composition

- Medical leadership of affiliated groups (statewide)
- Members are appointed by the senior vice president and chief medical officer after reviewing nominations by the regional medical directors and vice president of Provider Outreach
- BCN medical directors
- BCN leadership as designated by the senior vice president and chief medical officer
- **Chairperson:** Senior vice president and chief medical officer
- **Vice Chairperson:** Senior medical director

The committee membership may be changed upon recommendation of the senior vice president and chief medical officer.

Term

- Not applicable.

Meetings

- Minutes are taken to record actions and recommendations.
- Minutes are maintained in a confidential manner.
- Meetings are held a minimum of two times per year.

7.1.4. Health Care Quality and Service Improvement Committee

The Behavioral Health Leadership Advisory Council is a forum for practitioners and their representatives to provide input on network policies and programs that impact behavioral health.

Responsibilities

- Reviews and comments on medical policies and programs related to behavioral health care service and access.
- Provides input to the Health Care Quality and Service Improvement Committee and senior leadership on behavioral health related issues.
- Provides reports to Health Care Quality and Service Improvement Committee and Blue Care of Michigan Inc. Board of Directors.
**Composition**

- Behavioral health providers of affiliated groups (statewide)
- Members are appointed by the senior vice president and chief medical officer after reviewing nominations by the medical director of behavioral health
- BCN medical directors (optional)
- BCN leadership as designated by the senior vice president and chief medical officer
- The committee membership may be changed upon recommendation of the senior vice president and chief medical officer
- **Chairperson:** Medical Director, Behavioral Health
- **Vice Chairperson:** Director, Clinical Review

**Term**

- Not applicable.

**Meetings**

- Minutes are taken to record actions and recommendations.
- Minutes are maintained in a confidential manner.
- Meetings are held a minimum of two times per year.

### 7.1.5. Clinical Quality Committee

The Clinical Quality Committee is a subcommittee of the Health Care Quality and Service Improvement Committee. The committee has oversight responsibilities for quality improvement studies, utilization management activities, behavioral health, chronic condition management, patient safety, medical management, 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.
- Reviews, updates and approves clinical practice and preventive health guidelines and standards of care, related to medical care and oral health.
- 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 and utilization 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 practitioner.
- Reviews developed criteria and guidelines annually.

**Composition**

- Senior Medical Director, Quality Management
- Associate Medical Director, Behavioral Health
- Six Associate Medical Directors, Medical Health
- Nine external practitioners who represent a cross section of both primary care physicians and specialists
- Vice President, Provider Network Evaluation and Management
- Vice President, Clinical Strategies
- Director, Quality and Population Health
- Director, Quality Management
- Director, Utilization Management
- Manager, Pharmacy Services
- Director, Medical Informatics
- Director, Value Partnerships Program
- **Chairperson:** Senior Medical Director, Quality Management
- **Vice Chairperson:** Associate Medical 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.

7.1.6. Utilization Management Committee

The Utilization Management Committee is a subcommittee of the Health Care Quality and Service Improvement Committee. The committee has oversight responsibilities for utilization management activities, including behavioral health.

**Responsibilities**

- Reviews and approves, annually, the Utilization Management Program Descriptions and annual program evaluations.
- Provides oversight for delegated utilization management services.
- Reviews the consistency with which clinical staff involved in UM decision making apply criteria.
- Submits written reports on utilization management activities to the Health Care Quality and Service Improvement Committee.
- Ensures the utilization management programs are compliant with regulatory and licensing requirements.
- Reviews and evaluates the results of utilization management activities, determines action for improvement and ensures follow-up.
- Reviews and approves utilization management activities for behavioral health.
- Integrates clinical pharmacy activities in utilization management activities.
- Reviews data and information regarding the appropriate use of medical services.
- Reviews and recommends approval for medical policies.
- Reviews and approves utilization management guidelines for use by medical practitioners.
- Reviews data and information that addresses member and practitioner satisfaction with the utilization management process, determines opportunities and makes recommendations for improvement.
- Adopts annually criteria sets and guidelines for program components and ensures uniform application.
- Reviews developed criteria and guidelines annually.
- Monitors utilization data to detect potential underutilization and overutilization of services and recommends programs to address both as necessary.

**Composition**

- Senior medical director, Clinical Affairs
- Vice president, Utilization Management
- Medical director, Behavioral Health
- BCN medical directors
- Associate medical director, Preferred Provider Organization and Care Management Programs
- Director, Utilization Management
- Director, Clinical Review
- Manager, Pharmacy Services
- Twelve practitioners who represent a cross section of both primary care physicians and specialists
- Chairperson: Senior medical director, Clinical Affairs

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.

### 7.1.7. Quality Appeals Committee

The Quality Appeals Committee is a subcommittee of the Health Care Quality and Service Improvement Committee that has responsibility for reviewing practitioner quality of care appeals.

**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**
- Senior Medical Director, Quality Management
- Associate Medical Director, Behavioral Health
- Six Associate Medical Directors, Medical Health
- Nine external practitioners who represent a cross section of both primary care physicians and specialists
- Nurse practitioner(s)
- Psychologist
- Social worker(s)
- **Chairperson:** Senior medical director, Quality Management
- **Vice Chairperson:** One regional medical director

The committee membership may be changed upon recommendation of the committee chairperson and approval by the senior vice president and chief medical officer.
**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.

**7.1.8. Enterprise Credentialing Committee**

The Enterprise Credentialing Committee is an enterprise wide peer review committee representing Blue Cross and BCN. The ECC 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. These include but are 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 and organizational providers.
- Reviews credentialing and recredentialing policies as needed.
- Reviews and makes recommendations on operational/administrative procedures 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.
- Serves as the review board for first level administrative appeals or reconsiderations, as applicable.
- Submits written reports included in committee minutes to the Health Care Quality and Service Improvement Committee and TRUST.
- Reviews and evaluates annually the Credentialing Program Plan, work plan, annual activity report and annual nondiscriminatory audit report.
- Demonstrates annually that the committee and program objectives are being fulfilled with identification of opportunities for improvement.
- Reviews credentialing, quality and utilization information and makes determinations on initial and recredentialing applications for practitioners and organizational providers.

**Composition**

**Voting Members**

Created 12/15/2018 Reported to CQC 1/16/2019
- Chairperson
- Vice chairperson
- Four Blue Cross/BCN medical directors
- Two external primary care practitioners who represent internal medicine or family practice and pediatrics
- Six external specialists who represent specialties including but not limited to general surgery or a surgical subspecialty, obstetrics and gynecology, behavioral health, oral surgery, pathology, anesthesiology, radiology or emergency medicine specialty
- Chiropractor
- Chairperson: Appointed by the vice president of health and clinical affairs and BCN senior vice president, and chief medical officer
- Vice Chairperson: Regional medical director (southeast region), who has direct responsibility and participation in the credentialing program

Non-Voting Members

- Blue Cross director or manager, Quality and Population Health
- Blue Cross director, Provider Operations
- Blue Cross Representative from Corporate Credentialing and Program Support
- Blue Cross network management representative
- Blue Cross Corporate Financial Investigation representative
- Blue Cross corporate Office of General Counsel

Term

- Physician members serve for an initial term of two years.
- Committee membership is reviewed annually by the vice president health and clinical affairs and BCN senior vice president and chief medical officer.
- Reappointment is at the discretion of the vice president health and clinical affairs and BCN senior vice president and chief medical officer.

Meetings

- A quorum is defined as three voting practitioners being present with a minimum of two external practitioners.
- 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 agreements signed by the members.
- Minutes are forwarded to the appropriate committee as required. BCN forwards minutes to the Health Care Quality and Service Improvement Committee.
- Meetings are held at least ten times per year.

7.1.9. Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics Committee is a joint committee representing both Blue Cross and BCN. The Pharmacy and Therapeutics Committee has oversight responsibility for the clinical quality aspects of the pharmacy program. The committee reports to the Utilization Management Committee.
Responsibilities

- Reviews and approves criteria for drug usage annually.
- Approves policies regarding the evaluation, selection and therapeutic uses of drugs, biologics and related devices.
- Reviews and approves pharmaceutical program policies and procedures.
- Establishes educational programs to practitioners on drug utilization.
- Establishes quality clinical programs and procedures that help ensure safe and effective drug therapy.
- Initiates and directs drug use review and evaluation of programs and studies, review results and makes recommendations to optimize drug use and clinical value.
- Evaluates drug usage patterns of individual practitioners and of members. Makes recommendations regarding identified practitioner problems to the Clinical Quality Committee, as appropriate.
- Provides education and advice to the medical community and administration on issues related to the use of drugs.
- Develops formularies based on objective evaluation of drugs’ clinical merit, safety and cost.
- Provides oversight for delegated pharmacy activities.
- Submits written reports to the Utilization Management Committee.

Composition

- Two Blue Cross directors, Pharmacy
- Four Blue Cross physicians
- Seven participating external physicians
- Two participating external pharmacists
- 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 committee will consist of 15 (fifteen) total standing members
- The Committee members will come from various clinical specialties that adequately represent the needs of Blue Cross /BCN enrollees
- 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.
- Co-Chairperson: Director, Medical Benefit Drug Management, Blue Cross
- Vice Chairperson: Director, Clinical Pharmacy Services, Blue Cross

Term

- Members of the Committee are selected for two-year terms that can be renewed by approval of the Committee co-chairs, Blue Cross and BCN Chief Medical Officers or their designees and the Blue Cross Vice President of Pharmacy Services. 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.

### 7.1.10. Customer Service and Satisfaction Committee

The Customer Service and Satisfaction Committee provides oversight for the service quality provided to members, practitioners, providers (including facilities), and purchasers for all commercial and Medicare lines of business for BCN and its subsidiaries. The committee is a subcommittee of the Health Care Quality and Service Improvement Committee.

**Responsibilities**
- Reviews member, practitioner, provider (including facility) and purchaser satisfaction survey results and performance indicators and determines actions for improvement. Appoints workgroups and approves and monitors goals, work plans and performance measures.
- Provides oversight of corporate programs which relate to evaluating and monitoring the quality and appropriateness of service and satisfaction.
- Reviews and determines service quality indicators used for assessment and stakeholder experience improvement activities.
- Evaluates the service quality programs on an annual basis and refocuses direction as necessary.
- Reviews trends related to stakeholder complaints, appeals and primary care physician change requests; and approves recommendations for improvement. Monitors and evaluates effectiveness of improvement plans.
- Reviews trends related to significant stakeholder servicing issues, member access requirements and the quality of information. Appoints workgroups to address issues and approves and monitors remediation plans.
- Reviews and approves member related satisfaction policies and procedures, including complaint and appeal procedures after the approval by the highest-ranking leader of the responsible department.
- Identifies strategies to improve service performance and satisfaction.
- Provides oversight for delegated Customer Service and Claims activities.
- Submits written reports to the Health Care Quality and Service Improvement Committee.

**Composition**
- Senior Director, Corporate Performance and Administration
- Director, Medical Management Behavioral Health
- Director, Senior Health Services
- VP, Claims Operations
- Senior Director, Customer Service
- Manager, Key Accounts
- Director, Member Engagement & Satisfaction
- VP, Business & Program Development Regional Executive
- Director, Provider Outreach
- Director, Quality Management
- Director, BCN Operations Performance & Member Engagement
- VP, Utilization Management
- Market Research Analyst
- Director Customer Service, Director- BCN Commercial and Medicare Advantage
- Manager Pharmacy Administration
- Chairperson: Senior Director, Customer Service
- Vice Chairperson: Director, BCN Customer Service and Member Engagement

The committee membership may be changed upon approval of the senior vice president and chief medical officer.

**Term**
- Not applicable.

**Meetings**
- A quorum is defined as a majority of voting members.
- Minutes are taken to record actions and recommendations.
- Minutes are maintained in a confidential manner.
- A minimum of six meetings are held each year.

**7.1.11. Joint Uniform Medical Policy Committee (JUMP)**

The Joint Uniform Medical Policy Committee is a joint corporate committee representing Blue Cross and BCN with the vision of a uniform medical policy as a basis for business decisions. The committee has oversight responsibility to evaluate existing and new technologies, devices and healthcare services. The committee is a subcommittee of the Utilization Management Committee. The committee uses both internal and external practicing physicians as consultants, as necessary.

**Responsibilities**
- Reviews and recommends policy statements describing the status of health care services, technologies or devices (established, investigational, not medically necessary or inclusive to another procedure).
- The committee recommends, as appropriate, medical criteria for the established and non-established uses of healthcare services, technologies or devices.
- Reviews and recommends, as appropriate, coding revisions for specific services.
- Conducts research on areas under review and makes medical policy recommendations.
- Submits recommendations for medical policy approvals or changes to the BCN senior vice president and chief medical officer and chief medical officer for Blue Cross.
- Submits written reports to the Utilization Management Committee.

**Composition**
- Two BCN medical directors
- Two Blue Cross medical directors
- One or two external BCN physicians (must be par with Blue Cross and BCN)
- **Co-chairperson:** Medical director, BCN
- **Co-chairperson:** Senior associate medical director, Blue Cross

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.

### 7.1.12. Care Management Quality Committee

The Care Management (CM) 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 sets strategy aligned with corporate goals, reviews market expectations and seeks differentiation from competitors. The committee delivers high quality CM programs consistent with current evidence-based standards and practices to improve member health thereby decreasing benefit spend. The committee reports 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.
**Composition**
- Vice President, Care Management
- Senior Medical Directors and Care Management
- Directors, Care Management Leadership
- Director, Care Management Development
- Manager, Care Management Development
- Health Care Manager, Care Management Operations
- Manager, Quality Accreditation and Training
- Operational Managers, ad hoc
- **Co-chairperson:** Health Care Manager, Care Management Development
- **Co-chairperson:** Manager, Quality Accreditation & Training

**Term**
- Not applicable.

**Meetings**
The Committee meets quarterly. 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 Care Management Quality Committee meeting 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.

8. Reporting Relationships

8.1. Blue Care Network Board of Directors
The BCN Board of Directors has ultimate authority and responsibility for oversight of the BCN Quality Improvement Program. The president and chief executive officer and the senior vice president 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. Senior Vice President and Chief Medical Officer

The senior vice president and chief medical officer is the corporate officer responsible for the quality and safety of clinical improvement activities and reports clinical quality, behavioral health quality and safety of clinical care improvement activities to the president and chief executive officer, the Health Care Quality and Service Improvement Committee, the BCN Board of Directors and the Blue Care of Michigan Inc. Board of Directors. The responsibility for clinical quality, behavioral health quality and safety of clinical care improvement activities includes, but aren’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.
- 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.
- Serves as chairperson for the Clinical Quality Committee, the Medical Leadership Advisory Council and the Internal Review and Confidentiality Committee.
- Review and approve all benefit changes.
- Review and approve all medical policies.

8.4. Senior Medical Director, Quality Management

The senior medical director of Quality Management 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:

- 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 for both the commercial HMO and Medicare Advantage products, 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 BCN 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 BCN 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.

8.5. 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.

8.6. Behavioral Health Medical Director

The behavioral health medical director provides behavioral health care expertise for Quality and Population Health including health promotion and wellness programs and utilization management including chronic condition management programs.

8.7. Directors, Quality and Population Health

The directors of Quality and Population Health are responsible for oversight of the daily operations for Quality and Population Health, regulatory requirements, Stars and HEDIS data management and operations.

Responsibilities include the following:

- Provides direction for Stars and HEDIS Data Management and Operations.
- Allocates adequate resources to promote the successful completion of quality improvement activities and programs.
- Provides support for clinical performance improvement activities and programs.
- Ensure adherence to all regulatory requirements.
8.7.1. Quality and Population Health 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:
- 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/Utilization Management 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 and Health Care Quality and Service Improvement 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.

BCN conducts quality improvement studies to systematically evaluate the quality and safety of clinical care and service delivered to members. BCN 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 provides assistance with clinical study design, statistical analysis and evaluation.

The 2019 activities are described below.

**9.1. Quality of Service**

**9.1.1. Availability of Practitioners**

BCN 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, BCN acknowledges and values the key role of cultural, racial, ethnic, gender, linguistic needs and personal preferences in the effective delivery of health care services.

BCN implements mechanisms designed to ensure the availability of hospitals, primary care, obstetrical, gynecological, behavioral health, ancillary, high volume specialty care and high impact practitioners. BCN also reviews availability of other specialty care practitioners as identified by regulatory agencies.

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 CAHPS surveys. A year over year comparison is done using the current and previous practitioner availability studies to identify changes that may negatively impact access.

**Goals:** At least annually, BCN monitors network access based on the following four standards:

1. For at least 90 percent of the population, members should have access to at least one of the following practitioner/provider types, based on time and distance from the member’s home for:
Practitioner/Provider Type | 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
Orthopedic Surgery* | 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
Ophthalmology* | 20/10 | 30/20 | 50/35 | 75/60 | 95/85
BH and Substance Abuse | 20/10 | 45/30 | 60/45 | 75/60 | 110/100
BH Inpatient Facility | 30/15 | 70/45 | 100/75 | 90/75 | 155/140
Acute Care Hospital | 20/10 | 45/30 | 80/60 | 75/60 | 110/100

*High Volume Specialty
**High Impact Specialty

2. The ratio of PCP, SCP (including high volume and high impact), OB/Gyn, and behavioral health practitioners to members should be:
   - General/family practice to members: 1:1000 or less
   - Pediatrics to pediatric members: 1:1000 or less
   - Internal medicine to adult members: 1:1000 or less
   - PCP to adult members: 1:1000 or less
   - PCP to pediatric members: 1:1000 or less
   - OB/GYN to female members: 1:10,000 or less
   - SCP to members: 1:10,000 or less
   - Behavioral Health to members: 1:10,000 or less

3. The percent of PCPs accepting new patients should be at least 80 percent and the percent of PCPs accepting new or current patients (for the purpose of new members transitioning from another health plan) should be at least 97 percent.

4. 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 Management Committee for approval and to the Clinical Quality Committee and Customer Service and Satisfaction Committee for review and input annually.

**9.1.2. Accessibility of Service**

BCN 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).
Using valid methodology, BCN assesses standards for the following primary care physicians, high volume specialists and high impact specialists:

- Regular and routine care appointments within 30 calendar days
- Urgent care appointments within 48 hours
- Access to after-hours care (24 hours/7 days a week)

**Goals:**

1. Primary Care Providers at 100 percent
2. High Volume and High Impact at 90 percent

BCN also assesses standards for its behavioral health providers to include:

- Emergency care (life threatening or requiring rapid intervention to prevent rapid deterioration of the member’s health) within six hours.
- Urgent care within 48 hours.
- Initial visit for routine care within 10 calendar days.
- Follow up routine care within 30 days of the initial visit.

**Goals:**

1. Initial Routine Visit at 95 percent
2. Urgent and Emergent Non-Life Threatening at 100 percent
3. Follow-up Routine Care within 30 days of Initial Visit
   - **Prescribers:** 10 percent
   - **Non-Prescribers:** 45 percent

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

**9.1.3. Telephone Service**

Blue Care Network member and provider call centers evaluate performance by measuring the average speed of answer, self-service (IVR containment) capabilities and abandonment rates on live calls. These metrics are considered primary components of customer service and satisfaction measures for contact centers and are monitored throughout the year to drive ongoing improvement in the overall member experience.

Interactive voice response system (IVR) containment: The IVR system is an automated telephone-based service which allows BCN members to obtain coverage information (for example, benefit information and claims status) 24 hours a day. Containment is defined as any call that doesn’t opt out of IVR for assistance from a customer service representative. When the IVR can provide the necessary information based on caller’s needs and there is no human intervention, the call is considered contained.

- **Rate of abandoned calls:** This metric identifies the percentage of callers who reach the queue but disconnect prior to being serviced. The longer a caller must wait in a queue, the greater the likelihood they will terminate the call before reaching a representative. For this metric, a lower number indicates a better performance.
• **Average speed of answer:** This metric captures the average length of time a caller waits in a queue before they reach a representative. For this metric, a lower number indicates a better performance.

**Goals:**

1. Average speed of answer: 30 seconds or less
2. Rate of abandoned calls: 5 percent or less

The data also includes the total number of calls received and is reported quarterly to the Customer Service and Satisfaction Committee with a full analysis conducted annually.

**9.1.4. Monitoring for Quality and Accuracy of Information to Members**

All communications with members are delivered with accuracy regardless of whether it is via telephone or email. The BluExpert Quality Program is a tool containing 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.

Each random quality sample is reviewed for accuracy and completeness based on the criteria and process outlined in desk level procedures for the inquiry call type/reason. Servicing quality evaluations are scored pass/did not pass based on accuracy and completeness criteria (including a review of claim adjustment and any promised action, if applicable). This information is compiled and utilized to assess performance at the all levels.

Identified deficiencies are reviewed and improvement efforts are executed on a consistent basis. Depending on the scope of the deficiency, remediation efforts may include but are not limited to:

- Ongoing coaching and development with individual customer service representatives.
- Development and training for operational staff and/or leaders.
- Staffing changes.
- Systems and knowledgeware modifications and updates.

**Goals:**

1. The CSR Performance Standard Range minimum is 80 percent.

The outcomes are reported to the Customer Service and Satisfaction Committee annually for review and approval.

**9.1.5. Monitoring Email Turnaround**

BCN has a process for responding to email inquiries and evaluating the quality of email response. The BluExpert Quality Program tool is used to perform oversight and monitoring functions on service delivery via telephone and written (email) communications.
A monthly report is run to ensure the turnaround timeframes are being 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 the customer experience.

**Goals:**

1. 95 percent of email inquiries receive a response within one business day with ongoing review for improvement and enhancement to ultimately achieve the 100 percent turnaround time expectation.
2. CSR Performance Standard Range minimum of 80 percent.

A quarterly data analysis and review of the timeliness is conducted and shared with the Customer Service and Satisfaction Committee with full analysis annually. Improvement activities associated with email inquiries are identified and outlined in the quarterly email status reports. Quality analysis and review is conducted on an ongoing basis and reported monthly for tracking purposes.

**9.2. Clinical Quality**

**9.2.1. Healthcare Effectiveness Data and Information Set**

BCN complies with all the HEDIS® reporting requirements to the National Committee for Quality Assurance, Department of Insurance and Financial Services and Centers for Medicare and Medicaid Services.

Commercial measures for focus are:

- Pharmacy Measures (medication management for people with asthma 75 percent; statin therapy for patients with CVD or Diabetes – 80 percent adherence)
- Comprehensive diabetes care – all submeasures
- Antidepressant Medication Management – Continuation Phase
- Well care visits for children ages 3-6

Medicare measures for focus are:

- Pharmacy measures (pharmacotherapy management of COPD – bronchodilators; statin therapy for patients with CVD or diabetes-adherence)
- Medication reconciliation post-discharge
- Comprehensive diabetes care – all submeasures
- Osteoporosis management in women who had a fracture

QHP measure for focus are:

- Pharmacy measures (annual monitoring for patient on persistent medications; proportion of days covered – ACE/ARBS + Statins)
• Colorectal cancer screening
• Comprehensive diabetes care – all submeasures
• Well care visits for children ages 3-6

Interventions are implemented based on the reporting year results and prospective results for the current year. The impact of the interventions is monitored in the subsequent year.

Performance goals for 2019 are focused on increasing lower performing measures to the next percentile with a goal of increasing or maintaining measures that perform in the 90th percentile. BCN achieved 20 measures in the 90th percentile in 2018. The 2019 goal is to maintain the number of measures performing in the 90th percentile.

The HEDIS activities and results are audited by a National Committee for Quality Assurance certified auditor and submitted for public reporting annually.

9.2.2. Utilization Management

The BCN utilization management program includes medical and behavioral health utilization activities across the health care continuum.

Each area addresses the evaluation of the appropriateness, medical need and/or efficiency of health care services, procedures and facilities according to established criteria or guidelines and under BCN provisions. Utilization management decision making is based only on appropriateness of care, service, setting and existence of coverage. Utilization management is a process which includes, precertification, concurrent review, clinical case appeals and peer reviews, which include 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. Local rules are developed with input from appropriate practitioners to supplement approved criteria.

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

9.2.3. Population Health Management

BCN’s Population Health Management Strategy is designed to meet the care needs of its membership. It is the plan of action for addressing member needs across the continuum of care. Components include but are not limited to the following:

The strategy description has goals and populations targeted for each of the focus areas listed below:

• Keeping members healthy
• Managing members with emerging risk
• Patient safety or outcomes across settings
• Managing multiple chronic illnesses
• Programs or services offered to members
• Activities that aren't direct member interventions
• How member programs are coordinated
• How members are informed about available PHM programs

Assessment of the needs of its population and actionable categories for appropriate interventions:
• Integrating data such as claims/encounter (medical, behavioral health and pharmacy), laboratory results, health risk appraisals and others to use for population health management functions.
• Conducting a population assessment.
• Using assessment results to review and update its PHM structure, strategy (including programs, services, activities) and resources (for example, staffing ratios, clinical qualifications, job training, external resource needs and contacts, cultural competency) to meet member needs and correlate community resources.
• Segmenting its entire population for targeted interventions.

Comprehensive analysis of the impact of its PHM strategy for the following relevant clinical, cost/utilization and experience measures:

<table>
<thead>
<tr>
<th>Focused Areas</th>
<th>Program</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keeping members healthy</td>
<td>Postpartum Program</td>
<td>Achieve 90th NCQA percentile</td>
</tr>
<tr>
<td></td>
<td>Osteoporosis in women with a fracture</td>
<td>Achieve 90th NCQA percentile</td>
</tr>
<tr>
<td>Managing members with emerging risk</td>
<td>Diabetes Outreach Program</td>
<td>Increase by 1% members who have had an HbA1c test over baseline</td>
</tr>
<tr>
<td>Patient safety or outcomes across settings</td>
<td>Care Transitions Program</td>
<td>Increase by 1% members who attend a physician visit within 7 days post discharge over baseline</td>
</tr>
<tr>
<td>Managing multiple chronic illnesses.</td>
<td>Complex Case Management Program</td>
<td>Increase by 1% members who attend a physician visit within seven days post discharge over baseline</td>
</tr>
</tbody>
</table>

Overall outcomes are reported to the Clinical Quality Committee for review, input and approval. Refer to the annual PHM Strategy document for additional information.

9.2.4. Case Management (including Complex Case Management)

BCN has a shared services agreement with Blue Cross Blue Shield of Michigan (an NCQA Accredited Health Plan) to conduct its complex case management program. The program is an opt-out, voluntary member centric program that is supported by clinical and nonclinical staff. The Blue Cross case management program is aligned with NCQA, CMSA and BCBSA recommendations and standards for best practice for case management.

Referrals into the case management program come from multiple sources such as: Physicians, facilities, members, member family/representatives, employer groups, Blue Cross internal units, prenotification or precertification systems,
predictive model and high cost claims. Blue Cross also uses segmentation and stratification referral criteria.

The case management program identifies, and addresses members’ needs and provides member-centered care plans. Members, especially those with complex catastrophic injuries or chronic illness that can lead to high cost health care services, are evaluated for case management. Trigger diagnoses for case management include, but are not limited to: Cellulitis, chemotherapy, complex wound care, congestive heart failure, ketoacidosis, myocardial infarction, respiratory failure, sepsis, spinal cord injury, stroke and trauma/injury and transplants.

Care plans are member-centered with mutually agreed upon goals that allow stewardship of resources for the member through the health care system. The case managers utilize telephonic outreach to work in collaboration with the member, their families/representatives, physicians and other key members of the health care team to assist in developing member self-management plans and ongoing education about their complex complicated health care needs. This collaborative process includes assessment, planning, facilitation and advocacy for options and services to meet a consumer’s health needs through communication and available resources to promote quality cost-effective outcomes.

Case management focuses on assisting members in achieving health and maintaining wellness. Collaboration with the physician, providers, and member increases adherence to a care plan and promotes successful outcomes. The case manager can enhance a member's safety, well-being, and quality of life while reducing health care costs. Case management promotes the following:

- Using available resources to achieve clinical and financial outcomes.
- Ensuring appropriate access to care in a timely and cost-effective manner.
- Interjecting objectivity, health care choice, and promotion of self-care where it is lacking.
- Assisting member to appropriately self-direct care, self-advocate and make informed health care decisions, as appropriate.

Blue Cross administers the program for all lines of business. The individual case management program focuses on a target population of members with acute, chronic and complex medical conditions. It serves as a collaborative effort to provide support and coordination of care to the member.

Refer to the specific complex case management program descriptions for additional information about the health plans program and goals.

9.2.5. Health Promotion

BCN has well established health promotion programs. Worksite wellness programs, seminars and other health promotion initiatives provide information and support for lifestyle behaviors that positively influence member health status.
The Healthy Blue Living\textsuperscript{SM} product is designed to reward the healthy behaviors of members. BCN offers health promotion programs through WebMD for:

- Tobacco cessation
- Weight management

9.2.6. Behavioral Health

BCN offers comprehensive behavioral health services. Activities are focused on practitioner and member education, screening programs, clinical practice guidelines, treatment, continuity and coordination of care, chronic condition management, case management and utilization management. The medical director of Behavioral Health provides medical expertise and clinical oversight for the Behavioral Health program. Refer to the Utilization Management Program for additional program information and goals.

9.2.7. Continuity and Coordination of Care

BCN 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.

BCN monitors continuity and coordination by assessing the facilitation of continuity and coordination of medical care 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. The health plan identifies multiple areas, or measures, for improvement based on its analysis. Four opportunities for improvement are selected to improve coordination of medical care by conducting a quantitative and qualitative analysis on medical care coordination data.

The health plan annually collects data about opportunities for collaboration between medical care and behavioral healthcare for the following areas:

- Exchange of information
- Appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care
- Appropriate use of psychotropic medications
- Management of treatment access and follow-up for members with coexisting medical and behavioral disorders
- Prevention programs for behavioral health care
- Severe and persistent mental illness

BCN acts as necessary to improve continuity and coordination of care across the healthcare network and collaborates with behavioral health care practitioners to monitor and improve coordination between medical care and behavioral health care. The goals are listed in the table below.
<table>
<thead>
<tr>
<th>Topics</th>
<th>Goal or Benchmark</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Movement Across Settings: Cardiology</td>
<td>Health Plan Goal</td>
<td>100% for all lines of business</td>
</tr>
<tr>
<td>Movement Between Practitioners: Pulmonology</td>
<td>Health Plan Goal</td>
<td>100% for all lines of business</td>
</tr>
<tr>
<td>Movement Between Practitioners: Diabetic Eye Exams</td>
<td>NCQA Benchmark</td>
<td>90th percentile for all lines of business.</td>
</tr>
<tr>
<td>Movement Across Settings: Use of Opioids at High Dosages</td>
<td>Health Plan Goal</td>
<td>1-point increase for all lines of business</td>
</tr>
<tr>
<td>Exchange of information between behavioral health and medical providers</td>
<td>Health Plan Goal</td>
<td>100% for all lines of business</td>
</tr>
<tr>
<td>Appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care: Antidepressant Medication Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute phase</td>
<td>NCQA Benchmark</td>
<td>90th percentile for all lines of business.</td>
</tr>
<tr>
<td>Continuation phase</td>
<td>NCQA Benchmark</td>
<td>90th percentile for all lines of business.</td>
</tr>
<tr>
<td>Appropriate use of psychotropic medications: Follow up care for children prescribed ADHD medications</td>
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<td></td>
</tr>
<tr>
<td>Initiation phase</td>
<td>NCQA Benchmark</td>
<td>90th percentile for Commercial and Marketplace</td>
</tr>
<tr>
<td>Continuation/maintenance phase</td>
<td>NCQA Benchmark</td>
<td>90th percentile for Commercial and Marketplace</td>
</tr>
<tr>
<td>Management of treatment access and follow-up for members with coexisting medical and behavioral disorders: Diabetes monitoring for People with Diabetes and Schizophrenia</td>
<td>Health Plan Goal</td>
<td>80% for Commercial and Marketplace and 85% for Medicare</td>
</tr>
<tr>
<td>Prevention programs for behavioral health care: Postpartum Depression Screening</td>
<td>Health Plan Goal</td>
<td>25% for Commercial and Marketplace</td>
</tr>
<tr>
<td>Severe and persistent mental illness: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are using Antipsychotic Medications</td>
<td>Health Plan Goal</td>
<td>87% for all lines of business</td>
</tr>
</tbody>
</table>

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

9.2.8. Identification and Documentation of Quality of Care Concerns

BCN 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.

BCN 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 potential quality of care concerns are identified, the case is referred to the plan medical director for recommendations.

**Goals:**

1. Cases that don’t require medical director review are reviewed within 45 days.
2. Cases that require a medical director review are reviewed within 90 days.

**9.2.9. Clinical Practice Guidelines**

BCN promotes the development, approval, distribution, monitoring and revision of uniform evidence-based clinical practice guidelines and preventive care guidelines for practitioners. BCN utilizes the Michigan Quality Improvement Consortium guidelines to support these efforts. These guidelines facilitate the delivery of quality care and facilitate the reduction in variability in physician practice and medical care delivery. Evidence based guidelines are known to be effective in improving health outcomes.

In addition to the MQIC guidelines, BCN maintains one clinical practice guideline for Chronic Obstructive Pulmonary Disease.

**Goals:**

1. Review and approve guidelines annually.

**9.3. Satisfaction**

**9.3.1. Consumer Assessment of Healthcare Providers and Systems Survey**

BCN surveys members using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tool. The survey results are reported to the National Committee of Quality Assurance, Department of Insurance and Financial Services, and Centers for Medicare & Medicaid Services. This survey is conducted annually by a National Committee for Quality Assurance certified vendor.

**Goals:**

1. NCQA Quality Compass 75th percentile.

The results are reported to the Clinical Quality Committee annually.

**9.3.2. ECHO Behavioral Health Survey**

BCN surveys members using the ECHO behavioral health survey tool. 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 treatments, as well as counseling services.

**Goals:**

1. The overall goal is 90 percent or higher for the customer service and getting needed care measures.
2. For those measures with a rate less than 90 percent the goal is to increase by two percentage points year over year up to 90 percent.

The results are reported to Clinical Quality Committee annually.

### 9.3.3. Digital Experience

BCN has a centralized web and mobile development team that manages content across the enterprise and the member digital experience. This team works extensively with each part of the organization that has an online presence to ensure consistency, simplicity and ease of understanding.

### 9.3.4. Member Complaint, Inquiry and Grievance Resolution

The review process is performed through a cooperative effort between the Quality and Population Health and the Customer Service departments. All member complaints regarding medical, contractual or administrative concerns are processed by Special Inquiries. Complaints involving quality of care are forwarded to Quality and Population Health for investigation, resolution, and tracking and trending.

**Goals:**

1. Decrease complaints by the ratio of 0.06 complaints per 1000.

### 9.3.5. Practitioner and Provider Satisfaction Survey

BCN may conduct an annual practitioner and provider satisfaction survey to assess levels of satisfaction with specific areas of care delivery. Survey results are used to determine satisfaction and opportunities for improvement with contracted practitioners.

**Goals:**

1. The health plan goal is set at 75 percent.

The provider satisfaction survey results are reported to the Clinical Quality Committee annually.

### 9.3.6. Network Adequacy for BCN and BCN Advantage

BCN conducts an analysis of network adequacy to identify aspects of performance that don’t meet member expectations and initiate actions to improve performance. BCN monitors multiple aspects of network adequacy performance, including:

- Member complaints about network adequacy for nonbehavioral and behavioral health care services.
• Member appeals about network adequacy for nonbehavioral and behavioral health care services.
• Member requests for and utilization of out-of-network services.
• Determining if there are gaps in the network specific to particular geographic areas or practitioner or provider types based on complaints, appeals, out of network requests and utilization data.
• Annual member satisfaction survey results specific to access (CAHPS).

Goals:
1. Complaint rate to be ≤0.5/1000 members.
2. Appeal rate to be ≤0.5/1000 members.

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

9.3.7. Marketplace Network Transparency and Experience

BCN analyzes of member satisfaction information helps managed care organizations identify aspects of performance that don’t meet member expectations and initiate actions to improve performance. BCN monitors multiple aspects of Marketplace member satisfaction, including:

• Member complaints based on quality of care, access, attitude and service, billing and financial issue, and quality of practitioner office site categories.
• Member appeals based on quality of care, access, attitude and service, billing and financial issues and quality of practitioner office site categories.
• Member requests for and utilization of out-of-network services.
• Annual member satisfaction survey results specific to access (CAHPS).

Goals:
1. Complaint rate to be ≤0.5/1000 members.
2. Appeal rate to be ≤0.5/1000 members.

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

9.4. Member Safety

BCN 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 to develop improvement plans when member safety issues are recognized, develop performance measures on patient safety and maximize safe clinical practices. Information is distributed to physicians and members to increase their knowledge about clinical safety.

The patient 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.

9.4.1. Collaborative Quality Initiatives

Collaborative Quality Initiatives (CQIs) support Blue Cross efforts to work collaboratively with physicians, 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 and hospital partners, with funding and support from Blue Cross and Blue Care Network. 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 (meetings are held in person, typically on a quarterly basis).
- **Improvement Implementation**: Systematic development, implementation, and testing of hospital-specific and Michigan-wide quality improvement interventions.

The goal is to 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 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.

As of 2019, Blue Cross is providing funding and active leadership for 14 CQIs addressing one or more of the following clinical conditions:

<table>
<thead>
<tr>
<th>Hospital CQIs</th>
<th>Hospital CQIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiology (ASPIRE)</td>
<td>Hospitalist care (HMS)</td>
</tr>
<tr>
<td>Cardiovascular (BMC2)</td>
<td>Radiation oncology (MROQC)</td>
</tr>
<tr>
<td>Anticoagulation (MAQI2)</td>
<td>Spine surgery (MSSIC)</td>
</tr>
<tr>
<td>Bariatric surgery (MBSC)</td>
<td>Total knee and hip replacement (MARQI)</td>
</tr>
<tr>
<td>Cardiac surgery (MSTCVS)</td>
<td>Trauma (MTQIP)</td>
</tr>
<tr>
<td>Emergency department care (MEDIC)</td>
<td>Obstetrics (OBI)</td>
</tr>
<tr>
<td>General surgery (MSQC)</td>
<td></td>
</tr>
<tr>
<td>Hospital value (MVC)</td>
<td></td>
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</tbody>
</table>

9.4.2. MHA Keystone Center for Patient Safety and Quality
Blue Cross provides considerable funding to the Michigan Health and Hospital Association (MHA) to support the MHA Keystone Center, a collaborative effort among Michigan hospitals – along with state and national patient safety experts – to improve patient safety and reduce health care acquired infections. The primary goal of the Blue Cross funding for the MHA Keystone Center is to remove participation barriers for hospitals.

Over the past several years, the MHA Keystone Center has focused on initiatives related to care transitions, catheter-associated urinary tract infections, emergency rooms, intensive care units, obstetrics, sepsis, surgery and pain management. The center was also a co-leader in three national projects aimed at eliminating specific hospital-associated infections and serves as a Partnership for Patients Hospital Engagement Network.

In 2016, the Keystone Center partnered with both the Illinois Health & Hospital Association and the Wisconsin Hospital Association to form the Great Lakes Partners for Patients Hospital Improvement Innovation Network (HIIN). The focus of the HIIN is to implement person and family engagement practices, enhance antimicrobial stewardship, build cultures of high reliability and address the following types of inpatient harm:

- Adverse drug events
- Central line-associated blood stream infections
- Catheter-associated urinary tract infections
- Clostridium difficile bacterial infection, including antibiotic stewardship
- Injury from falls and immobility
- Pressure ulcers
- Sepsis and septic shock
- Surgical site infections
- Venous thromboembolism
- Ventilator-associated events
- Readmissions

**Goals:**

1. The primary goal of the Blue Cross funding for the MHA Keystone Center is to remove participation barriers for hospitals.
2. In addition, the 2017 Blue Cross Hospital Pay-for-Performance Program rewards hospitals for the following HIIN-related activities:
   - Submission of outcome data
     - **Goal:** At least 90 percent of outcome data submitted across 12-month period
   - Performance on outcomes for Falls, Sepsis and Opioid Adverse Drug Events
     - **Goal:** Improvement from HIIN baseline on 2 of 3 measures (3 of 3 earns 10 bonus points)
   - Safety Improvement Activity Project
     - **Goal:** Develop and implement a plan to drive improvement and share results around the areas of Falls, Health Disparities, Opioids, Pressure Ulcers, Readmissions, Sepsis, Surgical Site Infections or Ventilator Associated Events, and create a storyboard to display improvement activity.
Create a storyboard to display improvement activity.

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 ten areas of specialty care:

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

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 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 nearly 20 percent on average.

The Blue Distinction Specialty Care program provides broad national access to facilities and providers by 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 3,600 Blue Distinction Center and Blue Distinction Center+ designations have been awarded to more than 1,900 health care facilities in 48 states.
**Goals:**

2. Develop strategy for recruitment for new Substance Use Treatment and Recovery program. Also develop Local Plan Criteria to align with internal Blue Cross behavioral health initiatives.

**9.4.4. Health Information Exchange**

Health Information Exchange (HIE) is designed to ensure caregivers have the data they need to effectively manage the care of their patient population. Blue Care Network participates with MiHIN as a health plan qualified organization, which allows it to transmit and receive data for its members.

Overall participation in the statewide service provides foundational support, by ensuring practitioners receive timely notification when one of their patients has an Admission, Discharge, Transfer (ADT) or Emergency Department event. Blue Care Network case management utilizes ADT and ED event messages through the HIE to identify and outreach members for services. This is expected to result in a better care transition, an improved health outcome and reduced likelihood of an unplanned readmission.

**9.5. Pharmacy**

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 department across the company.

**Goals:**

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

Some of the programs and initiatives that are designed to help improve the health and safety of our members can be found below.

**9.5.1. Asthma Medication Adherence Pilot**

This pilot is an incentive-based program to improve adherence among members diagnosed with asthma. Members meeting criteria for the program are enrolled and notified on a quarterly basis January 1, 2017 – December 31, 2017.

All members enrolled in the program are eligible for $25 Visa gift card based on medication adherence. On a quarterly basis, pharmacy claims are evaluated for each member and members adherent to therapy receive a gift card. Member incentives are available April 1, 2017 – December 31, 2019.

The goal in 2019 is to improve medication adherence to asthma controller medications by three percent over the course of the pilot program (by December 31, 2019).
9.5.2. Mending MI Hearts Program

The Mending MI Hearts (MMH) Program helps members adhere to their medications by removing potential financial barriers. Following a heart attack doctors prescribe several drugs to help prevent complications and a future heart attack. Out-of-pocket costs can add up making it hard for a patient to afford his or her medications.

Members who recently had a heart attack are automatically enrolled to receive select medications at no cost. These medications include most ACE inhibitors, angiotensin receptor blockers, antiplatelet agents, beta-blockers and statins. In addition, beta-blockers are available at a six-month supply per fill.

Goals:

1. Improve medication adherence to beta-blocker therapy by two percent.

9.5.3. 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 to improve coordination of care among physicians.

Through this ongoing program, in 2019 we will continue to monitor claims data to identify members who meet specific criteria for filling controlled substance prescriptions from multiple prescribers or multiple pharmacies. Pharmacy Services will fax a letter to each prescriber identified in the analysis. The letter encourages the prescriber to use their state’s prescription drug monitoring program (PDPM) 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. In addition, if the prescriber is associated with a physician organization, a report is sent to their leadership.

Goals:

1. Decrease the number of members meeting Doctor Shopper Program criteria by 5 percent.

9.5.4. Triple Threat Initiative

The ‘Triple Threat’ is a drug regimen consisting typically of an opioid analgesic, a benzodiazepine and Soma® (carisoprodol). This combination of controlled substances has no medical purpose but it’s used recreationally and is associated with an increased risk of overdose.

Members who receive this high-risk combination are identified through prescription claims. Providers who have written at least one prescription in that drug combination for an identified member are notified. Prescribers receive a fax letter to provide education on this dangerous drug combination and to encourage use of the state’s Prescription Drug Monitoring Programs (e.g. MAPS). In addition, if the prescriber is associated with a physician organization, a report is sent to their leadership. Members who are
repeatedly identified are referred to a Controlled Substance Workgroup to improve coordination of care.

**Goals:**

1. Decrease the number of members receiving the ‘Triple Threat” drug combination by 20 percent.

**9.5.5. 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 (ASCVD) risk reduction. A clinical pharmacist will provide in-person and 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.

**Goals:**

1. Reduce the number of gaps in care related to statin therapy among patients with diabetes or cardiovascular disease by 1 percent each by December 31, 2019.

**9.5.6. High Dose Opioid 90 Morphine Milligram Equivalent (MME) Edit**

Prior authorization will be required the first time a member’s opioid dosage exceeds 90 morphine milligram equivalents per day, effective February 2019. 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 (UOD) which identifies the proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year at a high dosage (average milligram morphine dose [MME] >120 mg).

**Goals:**

1. Ensure that the UOD rate does not increase by more than one throughout 2019.

**9.5.7. Electronic Prescribing of Controlled Substances (EPCS) Initiative**

The EPCS initiative focuses on the adoption and use of EPCS-enabled solutions. The goal of this initiative is to increase electronic prescribing of controlled substances to improve patient safety and health outcomes. The baseline measurement period for the initiative was fourth quarter 2015. At that time, 6.5 percent of controlled substance prescriptions were sent electronically.

The focus is to work with primary care providers and specialists who prescribe controlled substances to support adoption of EPCS and help break down existing barriers. Blue Cross provides each physician organization with opportunity reports and physician organizations are eligible for an incentive based on improved EPCS rates.
**Goals:**

1. Increase the percentage of electronically-prescribed controlled substances by 10 percent through the end of 2019.

**9.6. Cultural and Linguistic Diversity**

BCN seeks to be responsive to all segments of the population. Culture and language have considerable impact on how members access and respond to health care services. To ensure quality health care by diverse populations BCN:

- Offers language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
- Ensures network adequacy to meet the needs of underserved members.
- Ensures compliance with Meaningful Access and Non-Discrimination.
- Continue the initiatives related to focus group outcomes in August 2015.
- Participates in the organization-wide diversity and inclusion initiatives:
  - Cultural competency training
  - Health Disparities Action Team
  - Diversity and inclusion learning sessions
  - Employee resource networks

While activities to address disparities have been occurring across the company, in 2016, an enterprise workgroup was formed with the following purpose:

- Create a shared vision.
- Understand disparities in our member population – Commercial HMO, Marketplace and Medicare.
- Build upon and leverage existing Blue Cross and BCN policies and programs to effectively address health disparities.
- Collect and analyze member data on an annual basis.
- Implement the Continuous Quality Improvement Model – Plan, Do, Act and Evaluate.

The Health Disparities Action Team is comprised of employees from Diversity and Inclusion, Health Care Value, Social Mission, Pharmacy Services, Sales and Marketing, Medicare and Human Performance meets every other month and has worked to catalog all existing activities and initiatives across the organization and define measures that are critical to success across products and stakeholders.

Our vision includes:

- Detecting and monitoring known health and health care disparities and distinguish what can be addressed.
- Implementing policies and programs that help to address the health and health care disparities among African American members and other ethnicities.
- Influencing members to make healthy lifestyle choices and engage in regular preventive screenings.
- Partnering with stakeholders to provide education and information to members.
10. Qualified Providers

10.1. Credentialing and Recredentialing

The credentialing and recredentialing process is designed to establish the quality of practitioners and other providers. Credentialing is conducted prior to affiliation and repeated on a three-year cycle. It's designed to ensure that each practitioner has the level of clinical competency and professional conduct necessary to provide quality care to members.

BCN 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 potential quality of care concerns are identified, the case is referred to the plan medical director for recommendations.

10.2. Facility Site Review

BCN sets acceptable standards for provider offices including physical accessibility, physical appearance, adequacy of waiting and examining room space, availability of appointments and adequacy of medical record keeping.

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

Goals: Conduct reviews within 30 days of request.

10.3. Medical Record Review

BCN reviews medical record keeping practices for primary care physicians, obstetricians and gynecologists, high volume behavioral health specialists and non-board-certified physicians prior to initial credentialing. The review includes confidentiality of medical records, documentation standards and an organized medical record keeping system.

Goals:

1. Conduct reviews within 30 days of request.

Practitioner Profiles

Practitioner profiles consist of a compilation of multiple indicators of practitioner performance designed to continually monitor patterns of practice and provision of care. Data are reviewed from a variety of sources including, but not limited to the following:

- Member complaints
• Medical record review
• Appointment access results
• After-hours access results
• PEERiodical composite scores
• Quality improvement activities

Unacceptable practitioner profiles are forwarded to Quality and Population Health to obtain the plan medical director or designee recommendations prior to the Enterprise Credentialing Committee review.

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 BCN and BCN Advantage. 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 physician discipline and termination policy and procedure. 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

BCN has a peer review 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 BCN internal departments or committees
• Risk management
• BCN medical directors and medical staff members

BCN initiates corrective action and quality improvement plans, 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 quality improvement plan is implemented and monitored in accordance with the medical director’s recommendations. When quality of care issues are severe enough to warrant contractual termination rather than corrective action, the physician termination process is followed.

10.6. Physician Discipline and Termination
BCN has a procedure for initiating disciplinary actions or terminating affiliated physicians. Disciplinary action, nonrenewal of a contract or termination of a contract with an affiliated physician may be appropriate for several reasons. Discipline or termination may be prompted by quality of care concerns, lack of cooperation, unsatisfactory utilization management, behavior inconsistent with BCN managed care objectives, failure to comply with recredentialing standards or for other appropriate reasons. Termination may be preceded by one or more instances of discipline but isn’t required.

A physician may be terminated by BCN for any reason other than a reason prohibited by law (for example, discrimination). BCN may terminate its contractual relationship with an affiliated physician by declining to recredential, failing to renew a time limited contract or by appropriate notification to the physician at any time during the term of the contract. For physicians participating in the Medicare Advantage and Medicaid plans, termination procedures comply with all applicable state and federal regulations.

10.7. Physician Appeal Process

BCN offers a physician 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 provided by the physician. That action 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 by the physician.
- Restriction or regulation of a physician’s clinical practice for more than 15 days for reasons related to the quality of care provided by the physician.
- Termination of a physician’s contract for reasons relating to selected administrative concerns or the quality of care provided by the physician.

11. Delegation Activities

Blue Care Network may elect to delegate the performance of selected Quality Management functions to qualified provider organizations. BCN retains sole responsibility for assuring that these functions are performed according to established standards. Organizations, which are granted delegated status, are expected to demonstrate compliance with all standards, monitoring and reporting requirements, set forth by BCN. A process is in place to insure the delegate meets or exceeds BCN’s performance requirements and to define BCN’s oversight activities associated with these requirements. All requests for delegation made by contracted providers must be submitted to and approved by BCN the relevant BCN committee (Clinical Quality Committee, Utilization Management Committee. Customer Service and Satisfaction Committee, Pharmacy and Therapeutics Committee or Credentialing Committee).

12. Compliance

12.1. Review by External Entities

Reviews by external entities are conducted in collaboration with the Corporate Compliance office. The reviews validate compliance with regulatory agency standards and determine the effectiveness of the Quality Improvement Program to continually improve the care and services provided to BCN members. Examples of external entities are as follows:
• Department of Insurance and Financial Service: Requires an annual evaluation of BCN’s operations and selected aspects of the Quality Improvement Program.
• National Committee for Quality Assurance: Voluntary review of the Quality Improvement Program is conducted by the National Committee for Quality Assurance, which is the leading external review organization for the managed care industry.
• Centers for Medicare & Medicaid Services: Require an annual evaluation of the Medicare Advantage program.

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 BCN employees. Strict standards are adhered to concerning patient and fellow employee medical information, and all other information that is of a confidential nature.

Staff confidentiality requirements include an annual review and signing of a BCN confidentiality statement and annual conflict of interest disclosure. The signed statements are maintained by Human Resources. 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, waste and abuse is the intentional misrepresentation of health care services by a provider, employer group or member with the intention of personal or financial gain. Employees, members and providers are educated on health care fraud and how to report fraud and abuse through member and provider newsletters, handbooks and manuals. An employee, member or provider can choose to report fraud, waste or abuse anonymously.

BCN staff identifies potential abuse by providers or members through facility site and medical record reviews for member complaints and/or provider issues. Audits may be conducted on a random or targeted basis to identify, refer, investigate, resolve and trend quality of care/service concerns as well as any FWA.
When potential fraud, waste or abuse is identified, the issue is promptly reported to one of the following:

- Employee’s supervisor
- Compliance officer
- Director of corporate ethics and compliance
- Blue Cross Corporate and Financial Investigations Unit
- Blue Cross Government Programs Investigation Unit
- Health and Human Services Office of the Inspector General for suspected cases of Medicare 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 and Population Health department and is forwarded to the Clinical Quality Committee for review and recommendations. Annual approval by the Board of Directors and the Health Care Quality and Service Improvement 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 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.
- Planned 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 and Population Health department. The evaluation is submitted to the Clinical Quality Committee review and recommendations. The Health Care Quality and Service Improvement Committee approves and submits the evaluation to the BCN Board of Directors for final approval.

15. Resources and Analytical Support

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 Quality and Population Health, and Utilization Management departments include:

- President and chief executive officer
- Senior vice president and chief medical officer
- Senior medical director, Quality Management
- Vice president of Provider Network Evaluation and Management
- Senior director of Customer Service
- Vice president of Utilization Management
- Director of Quality and Population Health
- Director of Utilization Management (medical)
- Director of Utilization Management (behavioral health)
- Director of Clinical Review

The staffs in the west, southeast, mid and east regions include a medical director. One medical director oversees the mid and east regions. The regions maintain sufficient staff to support regional functions and the corporate plan.

BCN 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 BCN’s Quality and Population Health Department organizational chart for staffing found in Appendix A.
The 2019 Quality Improvement Program Plan has been reviewed and approved.

APPROVED BY:

Clinical Quality Committee: 01/16/2019

Health Care Quality and Service Improvement Committee:

Blue Care Network Board of Directors: