

An abstract graphic consisting of several overlapping, flowing blue waves that create a sense of movement and depth. The waves are rendered in various shades of blue, from light to dark, and are set against a white background. The overall effect is clean, modern, and professional.

2021 Blue Care Network of Michigan Quality Improvement Program Description

January 13, 2021

Table of Contents

1.	Purpose	6
2.	Health Plan Mission	6
3.	Health Plan Overview	6
3.1.	Background	7
4.	Quality Improvement Philosophy	8
5.	Scope	8
6.	Goals and Objectives	8
7.	Organizational Structure	10
7.1.	Program Committees	11
7.1.1.	Blue Care Network Board of Directors	11
7.1.2.	Health Care Quality and Service Improvement Committee	12
7.1.3.	BCN Medical Leadership Advisory Council	13
7.1.4.	Behavioral Health Leadership Advisory Council	14
7.1.5.	Clinical Quality Committee	14
7.1.6.	Utilization Management Committee	16
7.1.7.	Quality Appeals Committee	17
7.1.8.	Enterprise Credentialing Committee	18
7.1.9.	Pharmacy and Therapeutics Committee	19
7.1.10.	Customer Service and Satisfaction Committee	21
7.1.11.	Joint Uniform Medical Policy Committee	22
7.1.12.	Care Management Quality Committee	24
7.1.13.	Senior Health Services Care Management Quality Committee	25
8.	Reporting Relationships	26
8.1.	Blue Care Network Board of Directors	26
8.2.	President and Chief Executive Officer	26
8.3.	Vice President, Health Care Value Performance and Execution Excellence	26
8.4.	Senior Vice President of Health and Chief Medical Officer	26
8.5.	Medical Director, Quality Management	27
8.6.	Medical Directors	27
8.7.	Behavioral Health Medical Director	28
8.8.	Director, Quality Management	28
8.8.1.	Quality Management Department	28
9.	Program Activities	29
9.1.	Quality of Service	29
9.1.1.	Availability of Practitioners	29

9.1.2.	Accessibility of Service.....	31
9.1.3.	Monitoring for Quality and Accuracy of Information to Members.....	32
9.1.4.	Monitoring Email Turnaround.....	33
9.2.	Clinical Quality.....	33
9.2.1.	Healthcare Effectiveness Data and Information Set.....	33
9.2.2.	Utilization Management.....	34
9.2.3.	Population Health Management.....	34
9.2.4.	Case Management (including Complex Case Management).....	36
9.2.5.	Health Promotion.....	40
9.2.6.	Behavioral Health.....	40
9.2.7.	Quality Incentive Programs.....	41
9.2.8.	Continuity and Coordination of Care.....	44
9.2.9.	Identification and Documentation of Quality of Care Concerns.....	46
9.2.10.	Clinical Practice Guidelines.....	46
9.3.	Satisfaction.....	46
9.3.1.	Consumer Assessment of Healthcare Providers and Systems Survey.....	46
9.3.2.	ECHO Behavioral Health Survey.....	47
9.3.3.	Voice of the Customer.....	47
9.3.4.	Digital Experience.....	47
9.3.5.	Consumer Transparency.....	48
9.3.6.	Member Complaint, Inquiry and Grievance Resolution.....	48
9.3.7.	Network Adequacy for BCN and BCN Advantage.....	48
9.4.	Member Safety.....	49
9.4.1.	Collaborative Quality Initiatives.....	49
9.4.2.	Blue Distinction Centers for Specialty Care®.....	50
9.4.3.	MHA Keystone Center for Patient Safety & Quality.....	51
9.4.4.	Health Information Exchange.....	52
9.5.	Pharmacy.....	54
9.5.1.	Doctor Shopper Program.....	55
9.5.2.	Academic Detailing: Use of Statin Therapy in Patients with Diabetes or Cardiovascular Disease.....	55
9.5.3.	Academic Detailing: Controller Inhaler for Patients with Asthma or COPD.....	55
9.5.4.	High Dose Opioid 90 Morphine Milligram Equivalent Edit.....	55
9.5.5.	Value Partnerships Pharmacy Forum.....	56
9.5.6.	Mending MI Hearts Program.....	56
9.6.	Cultural and Linguistic Diversity.....	56
10.	Qualified Providers.....	59

10.1.	Credentialing and Recredentialing	59
10.2.	Facility Site Review	59
10.3.	Physician Participation	59
10.4.	Peer Review Process and Implementation of Corrective Action Plan	59
10.5.	Physician Discipline and Termination	60
10.6.	Physician Appeal Process.....	60
11.	Delegation Activities.....	61
12.	Compliance	61
12.1.	Review by External Entities.....	61
12.2.	Confidentiality.....	62
12.3.	Fraud, Waste, and Abuse	62
13.	Annual Work Plan	63
14.	Evaluation of the Quality Improvement Program	63
15.	Resources and Analytical Support.....	63
16.	Appendix A.....	66

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

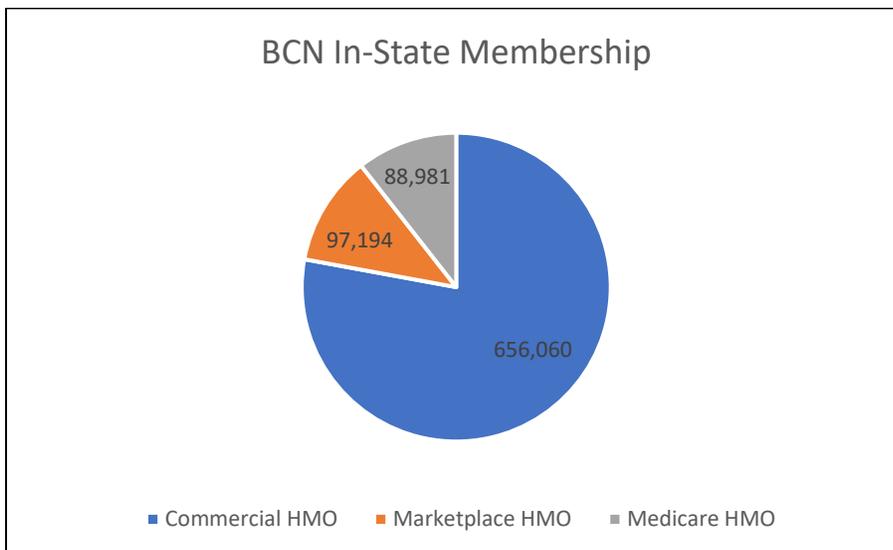
The purpose of the Quality Improvement Program is to establish a planned, systematic and comprehensive approach to measure, assess and improve organization-wide performance. The focus is on the identification of important aspects of care and services, the assessment of the level of care and services 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. This program plan document applies to HMO Commercial, Marketplace and Medicare products.

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

Blue Care Network, headquartered in Southfield Michigan, serves over 842,000 total members. The in-state population consists of 656,060 (78%) Commercial HMO, 88,981 (11%) Medicare HMO and 97,194 (11%) Marketplace members.



**Data reflects BCBSM members as of 11/20/2020.*

BCN has been the largest HMO in Michigan for 25 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 has been accredited since 1998. Every three years the health plan must undergo a renewal survey. In 2020, Blue Care Network had a successful NCQA Renewal Survey, scoring 50 out of 50 points, receiving a

Commendable rating. As of September of 2020, NCQA changed its scoring methodology to indicate an “*Accredited*” status, which is now the highest rating a plan can achieve.

In 2018, the health plan underwent an organizational restructure. As a result of the restructure, the health plan revised its Memorandum of Understanding between BCBSM and BCN. The MOU identifies who performs activities on each other’s behalf with the purview of the NCQA standards and BCN may be eligible to receive automatic credit for specified activities under the NCQA policy for delegation and automatic credit guidelines for Corporate Families.

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. This is no longer a product under BCN.

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 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 2021 Quality Improvement Program Description and Work Plan with all activities based on the 2020 annual QI evaluation findings and recommendations.
- Evaluate 2020 improvements and areas for improvement. Implement findings of the 2020 annual QI Evaluation into the 2021 QI Program and Work Plan.

Program Operations

- Maintain minutes that demonstrate the health plan's QI Committee develop, implements the QI program and oversees the QI functions within the organization.

Quality of Service

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

Clinical Quality

- Work collaboratively to ensure compliance with HEDIS® reporting requirements and participate in initiatives that improve rates.
- work with practitioners and their physician organizations to better manage patients through various value partnerships programs.
- Outline the population health management strategy for meeting the care needs of the member population.
- Measure the effectiveness of the population health management strategy.
- Assess the needs of the population and determine actionable categories for appropriate intervention.
- Support the delivery system, patient centered medical homes and use of value-based payment arrangements.
- Help adult members identify and manage health risks through evidence-based tools
- Coordinate services for members with complex conditions and help them access needed resources.
- Support utilization management activities for medical and behavioral health care.
- Support pharmacy utilization management activities for medical and behavioral health care.
- 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.
- 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.

Satisfaction

- Have written policies and procedures for thorough, appropriate and timely resolution of member complaints and appeals.
- Monitor access to health care services and act to improve where indicated.
- Assess Physician Directory Accuracy.

Member Safety

- Support health plans safety initiatives (for example, Doctor Shopper, Opioid Use).

- 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

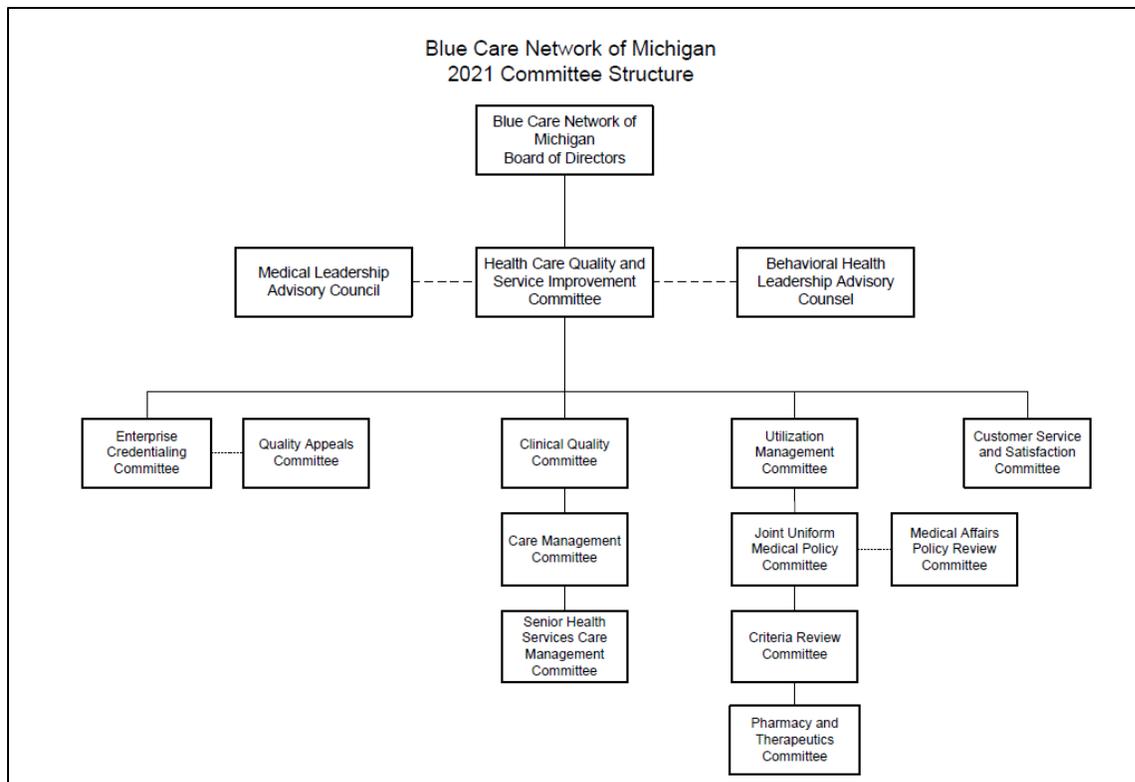
- Prepare for NCQA Resurvey in 2023 as the lookback period began 6/2021.
- Determine if the health plan will proceed with a Single Site Multiple Entity NCQA Survey.
- In collaboration with the compliance officer, ensure compliance with local, state and federal regulatory requirements and accreditation 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 Board of Directors 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

- Chairperson: Senior vice president and chief medical officer
- Vice Chairperson: Senior medical director
- 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.

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. Behavioral Health Leadership Advisory Council

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

- Chairperson: Medical Director, Behavioral Health
- Vice Chairperson: Director, Clinical Review
- 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.

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 reports to two separate entities: the Executive Committee of Officers Committee for Blue Cross and the Health Care Quality and Service Improvement Committee for BCN. The committee has oversight responsibilities for quality improvement studies, utilization management activities, behavioral health, chronic condition management, patient safety, health promotion and wellness activities.

Responsibilities

- Reviews and makes recommendations to approve, annually, the Quality Improvement Program Plan, work plan and annual evaluation of effectiveness
- Reviews annually, the UM Descriptions and Evaluation.
- Reviews and approves, annually, the Care Management Program Descriptions and Evaluation.
- Recommends policy decisions.
- Analyzes and evaluates the results of QI activities.
- Ensures practitioner participation in the QI program through planning, design implementation or review.
- 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 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

- Chairperson: Medical Director, Quality Management
- Co-Chairperson: Associate Medical Director, Utilization Management
- Medical Director, Quality Management
- Interim Senior Medical Director, Clinical Affairs
- Two Medical Director, Utilization Management
- Senior Medical Director, Health Plan Business
- Regional Medical Director, New Directions Behavioral Health
- Medical Director, New Directions Behavioral Health
- Eight external practitioners who represent a cross section of both primary care physicians and specialists
- Director, Quality Management

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

Term

- Physician members serve for an initial term of two years.
- Reappointment is at the discretion of the senior vice president and chief medical officer.

Meetings

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

7.1.6. 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.
- 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

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

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

Term

- Physician members serve for an initial term of two years.
- Reappointment is at the discretion of the senior vice president and chief medical officer.

Meetings

- A quorum is defined as a majority of voting members 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 has responsibility for reviewing practitioner quality of care appeals for the enterprise. Cases are referred from the Enterprise Credentialing Committee. The committee reports its finding back to the Corporate Credentialing and Program Support department for reporting.

Responsibilities

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

Composition

- Chairperson: Medical Director, Utilization Management
- Vice chairperson: Medical Director, Quality Management
- Medical Director, Quality Management
- Associate Medical Director, Utilization Management
- Interim Senior Medical Director, Clinical Affairs
- Medical Director, Utilization Management

- Senior Medical Director, Health Plan Business
- Regional Medical Director, New Directions Behavioral Health
- Medical Director, New Directions Behavioral Health
- Eight external practitioners who represent a cross section of both primary care physicians and specialists
- Director, Quality Management
- Nurse practitioner(s)
- Psychologist
- Social worker(s)

Term

- Practitioners serve for an initial term of two years.
- Reappointment is at the discretion of the senior vice president and chief medical officer.

Meetings

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

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, ambulatory 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 Delivery 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.

Composition

Voting Members:

- Chairperson: Appointed by the vice president of health and clinical affairs and BCN senior vice president and chief medical officer
- Co-Chairperson: Regional medical director (southeast region), who has direct responsibility and participation in the credentialing program
- 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

Non-Voting Members:

- Director or Manager, Quality Management
- Director or Manger, Provider Operations
- Representative from Corporate Credentialing and Program Support
- Blue Care 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 of health and clinical affairs and BCN senior vice president and chief medical officer
- Reappointment is at the discretion of the vice president of 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. BCBSM 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 and biologics.
- Reviews and approves pharmaceutical program policies and procedures.
- Serves in an evaluative, educational and advisory capacity to the affiliated medical community and BCBSM/BCN administration in all matters pertaining to the use of drugs.
- Advises in the establishment of quality clinical programs and procedures that help ensure safe and effective drug therapy.
- Provides a thorough, critical review of the pharmaceutical and medical literature in the evaluation of drugs for inclusion on the formularies. The selection of items to include in the formularies are based on objective evaluation of their relative therapeutic merit and safety. The Committee approves inclusion or exclusion of the therapeutic classes in the formulary on an annual basis. Decisions are based on available scientific evidence and may also be based on economic considerations that achieve appropriate, safe and cost-effective drug therapy. Therapeutic advantages in terms of safety and efficacy are considered when selecting formulary drugs and when reviewing placement of formulary drugs into formulary tiers.
- Provides oversight for delegated pharmacy activities.
- Submits written reports to the Utilization Management Committee.

Composition

- Co-Chairperson: Director, Medical Benefit Drug Management, Blue Cross
- Vice Chairperson: Director, Clinical Pharmacy Services, Blue Cross
- 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.

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

- Chairperson: Senior Director, Customer Service
- Vice Chairperson: Director, BCN Customer Service and Member Engagement
- Senior Director, Corporate Performance and Administration
- Director, BCN Operations Performance, Operational Performance

- Director, Quality Management
- Director ,Utilization Management
- Director, Medical Management
- VP, Business and Program Development and Regional Executive
- Market Research Analyst
- VP, Business Performance & Execution BCN
- Director, Customer Experience
- Director, Provider Outreach
- Director, Provider Consulting Services, Emerging Markets Provider Outreach
- Senior Director, Corporate Performance and Administration
- Director, Customer Service,
- Director, BCN Commercial and Medicare Advantage
- Director, Senior Health Services
- Director, Claims Administration
- Manager Pharmacy Administration

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

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

- The Joint Uniform Medical Policy Committee is comprised of physician representatives of varying specialties and responsibilities. Physician representatives comprise the voting membership. Physician membership consists of the following:
 - Chairperson: Senior Medical Director of Medical Policy
 - BCN Medical Director
 - Two BCBSM Associate Medical Directors or Physician Consultants
 - Network Physician

Team members at both BCN and BCBSM provide ongoing support to the Medical Policy Committee. While these team members are not voting members, they have responsibility for meeting coordination, presentations, and documentation. Supporting membership consists of:

- Manager, Medical Policy
- Medical Policy Coordinators
- Senior Analysts
- Administrative Support
- Representatives from various departments at BCBSM and BCN may also attend the Joint Uniform Medical Policy Committee meeting and provide resource support as needed. These representatives may vary from meeting to meeting, depending on the meeting agenda.
- Behavioral Medicine specialists will be involved in the development of policies addressing mental health related services, devices and procedures.
- Representatives may also include, but are not limited to:
 - Customer Services
 - Business Product Development
 - Marketing
 - Account Representation
 - Claims Payment/Processing
 - Legal
 - Program Planning and Implementation
 - Reimbursement and Payment Policy
 - Pharmacy Administration
 - Other department representation, as appropriate to the policy review.

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 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

- Co-Chairperson: Health Care Manager, Care Management Development
- Co-Chairperson: Manager, Quality Accreditation & Training
- 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

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.

7.1.13. Senior Health Services Care Management Quality Committee

The Senior Health Services Care Management Quality Committee has been established to provide oversight and guidance for the development, implementation, maintenance, evaluation and quality improvement of CM internal and vended programs. This committee will set strategy aligned with corporate goals, review market expectations and seek differentiation from competitors. The SHS CM Quality Committee reports to the CQC Quality Improvement 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

- Chairperson: Manager of Quality
- Vice President, Care Management
- Senior Medical Director
- Director, Care Management Program Delivery
- Managers, Care Management Program Delivery
- Director, Care Management Program Support
- Sr. Health Care Analyst
- Manager, Care Management Training & Quality
- Manager, SHS Analytics
- Manager, Care Management
- Quality RNs

Term

- Not applicable.

Meetings

- The SHS CM Quality Committee will meet at minimum on an annual basis.
- 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 SHS CM Quality Committee agenda and handouts are prepared and distributed to attendees in advance of the meeting. Written minutes are taken by a designated scribe and will be sent out for email approval.
- Once the minutes are approved by the committee, the meeting facilitator formally signs the meeting minutes. The minutes are retained for a minimum of one year or as otherwise required by external regulatory/accrediting entities.

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, the vice president of healthcare values performance and execution 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 work 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. Vice President, Health Care Value Performance and Execution Excellence

The Vice President, Health Care Value Performance and Execution Excellence is the Corporate Executive responsible for broad operational oversight of the corporate Quality Improvement Program. The Vice President reports to the Senior Vice President, Health Care Value.

8.4. Senior Vice President of Health and Chief Medical Officer

The senior vice president and chief medical officer is the physician executive charged with broad quality improvement program clinical oversight, including: the quality and safety of clinical improvement activities and reports clinical quality, behavioral health quality and safety of clinical care improvement activities to the 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 isn't limited to the following:

- Communication of information and the results of quality improvement activities to affiliated practitioners, Michigan Department of Insurance and Financial Services and Centers for Medicare & Medicaid services.
- Review and adjudication of selected peer review cases, as applicable.
- Oversight of the practitioner discipline, suspension and/or termination process.
- Oversight of applicable policies and procedures.

- Review and adjudication of practitioner appeals.
- Oversight of actions implemented to improve the quality of medical care and behavioral health care delivered by the plan.
- Oversight of the patient safety activities.
- Review and approve all benefit changes.
- Review and approve all medical policies.

8.5. Medical Director, Quality Management

The 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:

- Chairs the Clinical Quality Committee.
- Assist in ensuring compliance with legal requirements and regulatory and accrediting agencies' standards and procedures by providing clinical oversight and input into regulatory and accreditation reviews related to utilization and quality management programs.
- Provide leadership, support and direction for development of clinical and cost-effective programs which improve member access, reduce gaps in care, enhance customer satisfaction, lower medical costs and maximize positive health outcomes.
- Provide clinical and operational oversight for pharmaceutical management programs 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.

8.6. Medical Directors

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

- Provides direct clinical guidance, support and oversight for the credentialing and recredentialing daily processes including file review approval and denial designations.
- Participates in providing direction for health promotion and wellness initiatives and chronic condition management programs.

- Participates in the development of internal quality improvement policies and procedures.
- Reviews identified quality of care concerns and determines corrective action required.

8.7. Behavioral Health Medical Director

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

8.8. Director, Quality Management

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

8.8.1. Quality Management Department

The department is responsible for activities related to monitoring and evaluation of the quality of care and service delivered.

This department performs the following functions:

- 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 a department under HCV Business Analytic Services provides assistance with clinical study design, statistical analysis and evaluation.

The 2021 activities are described below with reference to the MOU if applicable.

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. Other specialty care practitioners as identified by regulatory agencies are also reviewed.

Some of the tools used to monitor network availability 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.

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

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

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. The 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 business days
- Urgent care appointments within 48 hours
- Access to after-hours care for PCP only (24 hours/7 days a week)

Goals:

1. PCP:
 - 100 percent of regular and routine care appointments within 30 calendar days.
 - 100 percent of urgent care appointments within 48 hours.
 - 100 percent of access to after-hours care (24 hours/7 days a week).
2. High volume specialists and high impact specialists:
 - 90 percent of regular and routine care appointments within 30 calendar days.
 - 90 percent of urgent care appointments within 48 hours.

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

- Emergency care (non-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 business days.
- Follow up routine care within 30 days of the initial visit.

Goals:

1. 95 percent of appointments for routine care are within 10 days.
2. 100 percent of appointments for urgent care are within 48 hours.

3. 100 percent of appointment for emergency non-life threatening are within 6 hours.
4. 10 percent for prescribers and 45 percent for non-prescribers and for follow up visits within 30 days of initial visit.

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

9.1.3. Monitoring for Quality and Accuracy of Information to Members

All communications with members are delivered with accuracy regardless of whether it is via telephone or email. The Member 1st Provider 1st Quality Program 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.

The Member 1st/Provider 1st quality program for member and provider servicing includes the following program components:

- A Random sample of inquiries handled by Customer Service Representatives. Each random sample is reviewed for quality, accuracy and completeness. Accuracy and completeness are evaluated based on the member receiving correct information. Quality is based on the usefulness and understandability evaluated during the recap questions asked by the CSR at the end of the call. If the CSR does not provide accurate information and ask the recap questions ensuring the member's understanding and the content of the call was useful, the CSR will not pass the evaluation. Servicing evaluations are scored pass/did not pass based on accuracy and completeness; understandability and usefulness 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.
 - Quality evaluations are entered and captured in the Verint system.
 - Monthly samples can consist of phone only, written only (includes email) or a combination of phone and written.
 - Targeted sampling goal is five evaluations (on average) per CSR.
- The servicing strategy evaluation uses a holistic approach including providing coaching and skill building tools to improve the call experience and instills confidence in the CSR, member and provider.

Goals:

1. Accuracy Target: 85% of evaluations will demonstrate a passing response.
2. Quality Target: 85% of evaluations will demonstrate a passing response.

A quarterly data analysis is performed against the target goal and action plans are created to identify improvement activities to address deficiencies. A full analysis including interventions and recommendations are provided to the Customer Service and Satisfaction Committee annually. Approval, feedback and recommendations from the responsible committee are incorporated into final report.

9.1.4. Monitoring Email Turnaround

BCN has a process for responding to email inquiries and evaluating the quality of email response. The Member 1st Provider 1st Quality Program 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. Timeliness Target: 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. Quality Target: CSR Performance Standard Range minimum of 85 percent.

A quarterly data analysis is performed against the target goal and action plans are created to identify improvement activities to address deficiencies. A full analysis including interventions and recommendations are provided to the Customer Service and Satisfaction Committee. Approval, feedback and recommendations from the responsible committee are incorporated into final report.

9.2. Clinical Quality

9.2.1. Healthcare Effectiveness Data and Information Set

BCN complies with all the HEDIS[®] reporting requirements established by 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 - Statin therapy for patients with CVD, Statin therapy for patients with Diabetes
- Comprehensive Diabetes Care
- Breast Cancer Screening
- Colorectal Cancer Screening
- Cervical Cancer Screening
- Immunization Measures

Medicare measures for focus are:

- Pharmacy measures - Statin therapy for patients with CVD, Statin therapy for patients with Diabetes
- Comprehensive diabetes care
- Osteoporosis Management in Women Who Had a Fracture

- Colorectal Cancer Screening

QHP measure for focus are:

- Comprehensive diabetes care
- Breast Cancer Screening
- Colorectal Cancer Screening
- Cervical Cancer Screening

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 HEDIS MY2020 are focused on increasing lower performing measures to the next percentile with a goal of increasing or maintaining measures that are currently performing in the 90th percentile. BCN (Commercial, Medicare, and QHP) achieved 24 accredited measures in the 90th percentile in HEDIS MY2019.

Goals:

1. Maintain the same number of measures performing in the 90th percentile.
2. Obtain 50% or more of the accredited measures in the 50th percentile or higher.

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

Blue Cross performs designated UM functions on behalf of BCN. These are listed in the MOU between BCN and BCBSM. The 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

Blue Cross performs designated PHM functions on behalf of BCN. These are listed in the MOU between BCN and BCBSM. The PHM strategy is designed by

BCN 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

The strategy also describes program or services offered to members, activities that are not direct member interventions, how member programs are coordinated, and how members are informed about available PHM programs.

The Plan assesses the needs of its population and determines 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 the PHM strategy is conducted annually for the following relevant clinical, cost/utilization and experience measures:

Focused Areas	Program	Goal
Keeping members healthy	Digital Health Assistant – Quit Tobacco	Achieve 50 th NCQA percentile for CAHPS Smoking Cessation
Managing members with emerging risk	Chronic Future Risk	Ensure member has an attributed primary care physician.
		Increase member's medication adherence over established baseline.
		Members managed exceed in closing gaps over members not managed in the program.
Patient safety or outcomes across settings	At Risk for Readmissions	Achieve 90 percent on satisfaction survey
		Members managed have a higher rate of physician follow-up visits within 7 days of discharge from a medical admission than members not managed in the program.
		Increase member's medication adherence over established baseline
		Achieve 90 percent on Satisfaction Survey

Managing multiple chronic illnesses	Highly comorbid conditions	Members managed have a higher rate of physician follow-up visits within 7 days discharge from a medical admission than members not managed in the program.
		Increase member's medication adherence over established baseline.
		Members managed exceed in closing gaps over members not managed in the program.
		Achieve 90 percent on Satisfaction Survey

Overall outcomes are reported to the Care Management Quality Committee for Commercial and Marketplace HMO and Senior Health Services Care Management Committee for Medicare HMO/POS. Afterwards the reports are submitted 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)

Blue Cross performs case management functions on behalf of BCN. These are listed in the MOU between BCN and BCBSM. Blue Cross Coordinated Care is an enhancement to the prior Complex Case Management program. Effective 1/1/2020, Blue Cross launched the Blue Cross Coordinated Care program with an integrated care management approach, designed to help reduce the complexity of the healthcare system by giving members access to a comprehensive care team that will help them better manage their health. The Blue Cross Coordinated Care Program (BCCC) is designed to effectively manage the health care resources for members with a variety of health care needs and in multiple care settings. The program provides coordination of care and services for members who have experienced a critical event or diagnosis that requires the extensive use of resources and need help navigating the system. Blue Cross Coordinated Care is a collaborative process which assesses, plans, implements and evaluates options and services to meet an individual's health needs. Case management principles are utilized according to the individual needs of the member across the care continuum. Case managers handle the day-to-day clinical management of members in the program.

Program Goals

- Members managed have a higher rate of physician follow-up visits within seven days discharge from a medical admission than members not managed in the program.
- Increase member's medication adherence over established baseline.
- Members managed exceed in closing gaps over members not managed in the program.
- Achieve 90 percent on satisfaction survey.

Target Population

The target population for the Case Management program includes current Blue Cross Blue Shield of Michigan and Blue Care Network Commercial, Individual Business Unit, Marketplace, and Federal Employee Program members. Members must be eligible to participate. Eligibility is determined by:

- BCBSM/BCN contract for member is found on the BCBSM/BCN system.
- Member's contract is current for the date(s) of service.
- Member is listed on the contract (except for newborns).
- BCBSM/BCN is the primary carrier for the member.

Program or Service

Once a member is engaged, the nurse case manager will complete a telephonic health assessment using motivational interviewing and focused questions. The assessment focuses on the members current health status including specific conditions and recent utilization. Case managers inquire about possible barriers to self-management, including behavioral health issues and/or any cognitive deficits, vision and/or hearing deficits. Social determinates of health are evaluated to determine if specific community resources are needed. Case managers determine if cultural, religious or ethnic beliefs may impact gaps in understanding of his/her health conditions. Member's clinical history, medications, previous and current ADL function, life planning activities as well as caregiver resources and need for community resources are also addressed. Case managers will also evaluate any concerns related to current available health benefits in relation to the member fulfilling their treatment plan.

Case managers are divided into dedicated regions. The use of regional assignments improves the care managers/member relationship due to proximity and fosters an understanding of the socioeconomic situations of that region. Upon completion of the assessment, a care plan inclusive of goals, barriers, interventions and outcomes are developed. The case manager and member and/or authorized representative review and prioritize issues to determine appropriate goals and set timeframes for goal completion. By applying issue-focused questions, the case manager can assist with clarification and prioritization of member-centered goals that direct case management activities. The care plan also identifies self-management goals and activities that the member will be responsible for acting upon. The case manager works with the member to identify any barriers that may impact the member meeting their goals. Access to the multi-disciplinary team as a resource is discussed with the member. All goals are measurable and include a time projection for achieving the goal. The progress of each goal is evaluated during each follow-up call with the member and documented in the care plan. The member centered goals are updated to reflect any new barriers, needed interventions or successful outcomes as appropriate.

Member Identification

Blue Cross Coordinated Care identifies members for case management using reactive triggers to identify members that would most benefit from payer led care management. The identification process uses claims data collected from outpatient encounters, hospital discharges/readmissions, pharmacy and other types utilization including inpatient admissions and emergency room visits. Data is evaluated daily. The target member population is evaluated based on risk factors such as age, sex and diagnoses to predict which members in the population are most likely to experience high cost and disease complications without intervention. Members with multiple chronic conditions are identified based on prospective risk score and two or more chronic conditions. These members are prioritized based on his/her risk score, script count, and time since their last office visit. Members may also be referred to BCCC through providers, facility

discharge planner/case manager, vendors, employer groups, internal BCBSM units (24-hour nurse line, customer service, Utilization Management) or member self-referral.

Member Communications

In addition to traditional telephonic outreach, Blue Cross Coordinated Care includes a mobile app that provides a personalized daily health program and enables secure two-way communication between the member and Care Team. Members who download the app receive content that includes but is not limited to:

- A checklist that offers education, encouragement and daily tasks to support care plan compliance.
- Reminders to set up an appointment with his/her PCP or take their medication.
- Brief survey questions to understand his/her condition. If the member indicates their condition is worsening, the Care Manager will receive a real-time alert to contact the member and promptly respond to changes in health status.

A nurse care manager will reach out to members identified for the program, via phone. Once the member agrees to engage, they can participate according to his/her preferred communication method. If the member has been reached by phone, the nurse will attempt to complete the assessment telephonically.

If a member has not engaged by phone, but has successfully downloaded the mobile app, the care manager can engage the member digitally and incrementally send assessment questions over the app. Although the nurse will begin to evaluate the member's status and needs over the app, the care manager will attempt to schedule a phone call with the member to complete the assessment.

Members may be contacted via mail or email to inform them that his/her care manager is trying to reach them, is closing the member's case, or that the member is eligible for additional services. Letters are often used when the member is not available via phone or would benefit from the additional information provided in written form.

During outreach calls, the case manager will provide the member with education and resources to help the member reach his/her goals. The case manager will then send the member educational materials through mail or email, as agreed upon with the member.

Member Interventions

- Ensure that the member is in the most appropriate level of care, or ensure the member receives the appropriate level of home-health care services required.
- Perform a medication reconciliation to educate member on any adverse side effects; drug-drug and food-drug interactions; evaluate medication adherence; and to establish to most up-to-date list for to member to present during provider visits.
- Ensure that the member has access to appropriate health care services and community resources based on their functional status and risk for complications.
- Ensure that the member has adequate social support to maximize his/her functional status, reduce the potential of future complications and avoid emergency visits and hospital admissions.

- Provide education and support to member self-management skills to increase knowledge and to enhance the member's self-efficacy or confidence in his/her ability to execute specific self-management tasks.
- Referrals to internal or external community resources, housing expenses, legal aid, mental health services, abuse/neglect, prescription assistance, safety issues, and transportation issues.

Non-Member Interventions

- All members have access to WebMD Health Service which provides a multi-touch and multichannel approach to health education, using innovative solutions. Members can easily access electronic resources that provide education and information about his/her specific condition and best practices for care.
- BCBSM 24-hour nurse line is available to members, who have questions about their general health or a specific condition. This 24/7 service connects the member with registered nurses supported by board-certified physicians that can:
 - Share tips for healthy lifestyles.
 - Discuss at-home treatments for minor illnesses and injuries.
 - Answer questions about upcoming surgeries and medical tests.
 - Provide health education materials about rare or chronic conditions.
 - Teach members about preventive care like mammograms, immunizations and prostate screenings.
- Customer Service assistance is available Monday through Friday, 8:30 a.m. to 5 p.m. (holidays excluded).
- Case managers communicate with primary care provider to inform the provider of any recent hospital admissions (if applicable) and the member's participation in care management. This encourages collaboration between the provider and the case manager.
- Case managers will coordinate with hospitals, facility care managers, and other providers outside of treating physicians.

Coordination of member programs

The case manager will evaluate the need for a referral to internal or community resources to assist the member in reaching his/her goals. These referrals and resources include:

- Medical Directors to assist with the medical management of the case.
- A medical social worker is available to provide support to the member and case manager in addressing the member's social determinants of health needs.
- Registered dietitians can help members identify appropriate foods and nutrition to promote health and manage their disease.
- Behavioral health social workers assist members with behavioral health issues.
- Pharmacists to address member medication questions, medication reconciliation, or issues obtaining medications.
- Non-clinical support enables clinicians to work at the top of their license and at higher productivity levels by taking on non-clinical care coordination/ administrative tasks.

- Condition and disease specific educational materials are available to members to assist in understanding and managing their condition.

The case manager is available to collaborate with the member's provider in the care of the member and any specific issues that need to be addressed. This collaborative relationship can include initiating communication with providers on the member's behalf, as well as encouraging the member to address his/her change in health status and/or health issues with their treating provider. The case manager may contact the provider when the member cannot or will not communicate changes in health status that could seriously jeopardize the member's life, health or their ability to regain maximum function. This would include but is not limited to the following examples:

- An increase in a member's symptoms.
- A variation in the member's adherence to the treatment plan.
- High emergency room utilization by the member.
- Referrals for community resources due to issues with social determinants of health.

The case managers also evaluate whether members would benefit from assistance from external vendors for services such as durable medical equipment or home health care.

9.2.5. Health Promotion

Blue Care Network provides our members with innovative, cost-efficient and helpful tools to manage their health, including:

- **Blue Cross Health & Wellness**, powered by WebMD® through **bcbsm.com**. This online service has information on health and wellness and helpful online tools and resources.
- **Tobacco Cessation** BCN's base benefits include the WebMD Tobacco Cessation Coaching program.
- **Health assessment** Our online health assessment is a set of questions that helps members understand how to improve or maintain their health.
- **Weight management** BCN members have access to weight management and nutrition information online at **bcbsm.com**.
- **Preventive care initiatives** Members are mailed reminders for preventive services. In some cases, members receive automated telephone reminder calls.
- **Worksite Wellness Programs** Worksite wellness programs can be held annually upon request to customers with 100 or more Blue Care Network contracts.
- **Virtual Well-being program for members** BCN members have access to weekly Well-being Webinars conducted by a designated Virtual Well-being coordinator.

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. Quality Incentive Programs

9.2.7.1. Performance Recognition Program

The Performance Recognition Program rewards primary care physicians and Physician Organizations who serve Blue Care Network Commercial, BCN Advantage and Medicare Plus Blue PPO members and achieve quality and performance measures as outlined annually by National Committee for Quality Assurance in their Healthcare Effectiveness Data and Information Set® (HEDIS). Each Blue Cross and BCN program has a tailored set of clinical quality measures incenting providers to complete preventative screenings as well as achieving patient outcomes such as ensuring diabetic members have their blood sugar controlled.

Goals:

1. Successfully encourage their patients to get preventive screenings and procedures such as colonoscopies, mammograms and well-child visits.
2. Achieve improved patient outcomes such as ensuring that patients with diabetes have their blood sugar controlled.

9.2.7.2. Behavioral Health Incentive Program

Historically, the quality of behavioral health treatment and clinical improvement has been very difficult to measure. Favorable therapeutic methods and results have been researched but consensus around, or implementation of, these methods is lacking. To resolve this issue of ambiguity, Blue Care Network performed a review of published literature, discussed findings with behavioral health providers, gained consensus through a series of surveys and conducted internal evaluations of possible measures.

BHIP reflects the evidence-based research and rewards multiple dimensions of quality care and outcomes. The program offers broad-based suggestions for implementing practices shown to improve the well-being of patients and to reward those initiatives.

The main objectives of this program include:

- Align behavioral health practices with evidence-based therapeutic methods so our members receive the highest quality treatment possible.
- Reward behavioral health specialists who are providing exceptional care to our members.
- Serve as an avenue for providers to receive feedback regarding performance.

Most of these measures are based in full, or in part, on HEDIS®, Healthcare Effectiveness Data and Information Set.

9.2.7.3. Clinical Quality Initiative

At Blue Cross, PGIP administers the Clinical Quality Initiative, a reward-based program incorporating HEDIS measures aimed to driving improvement among PGIP participating physician organizations. This initiative strives to promote clinical

quality improvement by driving best practice behaviors among PGIP physicians. Value-based reimbursement is provided at the population level for POs who can achieve high performance and improve over time.

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

The overall objective of the Clinical Quality Initiative is to improve the performance of all PGIP physician organizations by providing key ad-hoc data analysis, guidance, coaching and regular feedback about initiative performance.

To achieve rewards physician organizations must be able to complete the following activities:

- Identify opportunities for improvement in measures by conducting data analysis and continuous quality improvement processes.
- Induce and deploy best practices among their physician community that result in safe and effective care.
- Support innovation and constructive change in processes for the delivery of care.
- Promote better outcomes and coordination of care across provider settings.
- Develop and implement strategies for population health management.

Blue Cross internal subject matter experts, in collaboration with physician organization leadership, annually review measures of care to determine which measures should continue as part of the initiative and which should be retired. Measures selected for the Clinical Quality Initiative include childhood and adolescent prevention, adult prevention, antibiotic use, heart disease, diabetes, medication management and appropriate use of services measures. Blue Cross provides commensurate reporting to PGIP participating physician organizations that includes population performance, practice performance, relative performance to other PGIP PO, and performance against applicable benchmarks.

Goals:

1. Better care for members that lead to healthier members and communities.
2. Affordable health care.

9.2.7.4. Hospital Pay-for-Performance Program

The Blue Cross Hospital Pay-for-Performance programs provide incentives to acute care provider who improve health care quality, cost efficiency and population health.

The program for large and medium-sized hospitals encompasses the following program components:

- A mandatory prequalifying condition that ensures hospitals take basic steps to demonstrate a commitment to building a culture of patient safety.
- A mandatory prequalifying condition that requires hospitals to place focus on third-party industry quality ratings such as CMS stars and LeapFrog patient safety ratings.
- Participation in the Blue Cross Hospital Collaborative Quality Initiatives and the Great Lakes Partnership for Patients Hospital Improvement Innovation Network initiatives sponsored by the Michigan Health and Hospital Association's Keystone Center for Patient Safety (see section 11.5 for program details).
- Service-line efficiency within the Michigan Value Collaborative.
- Health Information Exchange requirements to help physicians better manage patient care across the entire continuum.
- All-cause readmissions performance and readmissions-related initiatives.

The program for small and rural hospitals, including critical access hospitals, is structured to positively challenge rural hospitals to deliver the most value to the unique communities they serve. The program includes the following components:

- Participation in quality improvement initiatives under the Hospital Improvement Innovation Network sponsored by the Michigan Health and Hospital Association's Keystone Center for Patient Safety.
- Performance and improvement on selected Centers for Medicare & Medicaid Services quality Indicators.
- Population insights evaluation by designated Population Health Champions.
- High-level health information exchange efforts to align with large and medium-sized hospitals programs.
- Readmission reduction effort best practice sharing to ensure a focus is placed on these efforts, to align with large and medium-sized hospital programs.

Goals:

1. Continue to require 100 percent of hospitals to fully comply with the program's patient-safety prequalifying condition, including conducting regular patient safety walk-rounds with hospital leadership and assessing and improving patient safety performance by fully meeting one of the following options:
 - Complete and submit the National Quality Forum Safe Practices section of the Leapfrog Hospital Survey at least once every 18 months.
 - Complete the Joint Commission Periodic Performance Review of National Patient Safety Goals at least once every 18 months.
 - Review Compliance with the Agency for Healthcare Research Patient Safety Indicators at least once every 18 months.
 - Participate in a federally-qualified patient safety organization.

2. Ensure results of the patient safety assessment and improvement activities are shared with the hospital's governing body and incorporated into a board-approved, multidisciplinary patient safety plan that is regularly reviewed and updated.
3. Increase the number of hospitals demonstrating favorable year-over-year improvements in their own hospital-specific 30-day all-cause readmission rate from
4. the previous program year (n= ~40 percent of participants). Hospitals are assessed using the CMS/Yale Hospital Wide 30-day unplanned readmission rate (HWR: NQF 1789) for their Blue Cross commercially insured PPO population.
5. Observe year-over-year improvements in hospital-selected Michigan Value Collaboration service lines, including:
 - Acute myocardial infarction
 - Colectomy (non-cancer)
 - Congestive heart failure
 - Coronary artery bypass graft
 - Joint replacement (hip and knee episodes combined)
 - Pneumonia
 - Spine surgery
6. Engage all P4P-participating acute care providers in more robust Health Information Exchange.
7. Encourage participation in the new OB Initiative to reduce C-section.

9.2.8. Continuity and Coordination of Care

Blue Cross performs designed continuity and coordination of care functions on behalf of BCN. These are listed in the MOU between BCN and BCBSM. 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.

The BCBSM 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 BCBSM 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 BCBSM 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

BCBSM 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.

Topics	Goal or Benchmark	Measures
Movement Across Settings: Cardiology	Health Plan Goal	100% for all lines of business
Movement Between Practitioners: Pulmonology	Health Plan Goal	100% for all lines of business
Movement Between Practitioners: Diabetic Eye Exams	NCQA Benchmark	90 th percentile for all lines of business.
Movement across settings: Readmissions	NCQA Benchmark Health Plan Goal	90 th percentile for Commercial and Marketplace 0.5771 Commercial 0.5689 for Medicare below 65 0.5788 for Medicare 65+ 0.5771 Marketplace
Exchange of information between behavioral health and medical providers	Health Plan Goal	100% for all lines of business
Appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care: Antidepressant Medication Management		
Acute phase	NCQA Benchmark	90 th percentile for all lines of business.
Continuation phase	NCQA Benchmark	90 th percentile for all lines of business.
Appropriate use of Psychotropic medication: Use of Opioids at High Dosages	Health Plan Goal	Equal to or below 3.0 percent of members receiving prescription opioids for ≥15 days for all lines of business
Management of treatment access and follow-up for members with coexisting medical and behavioral disorders: Diabetes monitoring for People with Diabetes and Schizophrenia	Health Plan Goal	80% for Commercial and Marketplace 85% for Medicare
Prevention programs for behavioral health care: Appropriate Consultation and Follow-up for medical inpatients with a new behavioral health diagnosis		
Consultation Inpatient	Health Plan Goal	10% for Commercial and Marketplace
Outpatient follow-up with 30 days of discharge	Health Plan Goal	90% for Commercial and Marketplace
Severe and persistent mental illness: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are using Antipsychotic Medications	Health Plan Goal	87% for all lines of business

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

9.2.9. 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 concern is identified, the case is referred to the plan medical director for recommendations

Goals:

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

9.2.10. 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.

Goal: The Clinical Quality Committee reviews and approves guidelines annually.

9.3. Satisfaction

9.3.1. Consumer Assessment of Healthcare Providers and Systems Survey

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

Goals:

1. Perform at or above the NCQA Quality Compass 50th Percentile benchmark for Commercial.
2. Perform either the same as or above the national average of all Qualified Health Plans.
3. Attain a 4-star rating for Medicare.

The results are reported to the Clinical Quality Committee annually.

9.3.2. ECHO Behavioral Health Survey

BCN survey their members using the ECHO CAHPS behavioral health survey tool, which is conducted annually by SPH, an NCQA-certified vendor. This survey is designed to support efforts to measure, evaluate and improve the experiences of members with various aspects of counseling services and mental health and substance abuse treatments.

Goal: Perform at or above the SPH Book of Business average score or achieve a 2-percentage point increase from year to year up to 90% when the SPH average is not available for comparison.

The results are reported to the Clinical Quality Committee annually.

9.3.3. Voice of the Customer

The *Voice of the Customer* program is designed to gather and track member feedback from multiple channels and touchpoints across the enterprise. The VOC team uses an analytics dashboard that provides a central repository for employees to access and analyze qualitative and quantitative feedback on the member experience. Data feeding the analytics dashboard refreshes daily allowing the organization to monitor changes in customer satisfaction identify issues when they occur, track progress of overall member experience improvement initiatives and share insights with key leadership and stakeholders company-wide.

9.3.4. Digital Experience

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

- *bcbsm.com* – Destination for prospective members to evaluate plan options and for existing members to learn more about their health care journey.
- Member Portal – Secured and personalized experience that helps members manage their coverage and explore care options.
- Member Mobile Application – Smartphone application that puts members' plan information at their fingertips – available anytime, anywhere.
- Maintenance only of Agent Portal – Hub for agents to guide their portfolios from quote to enrollment.
- Maintenance only of Group Portal – One-stop shop for group customers to access and manage their coverage details.
- Maintenance only of Provider Portal – Wealth of resources for the network of doctors and hospitals, assisting with provision of member quality care.

As part of their human-centered design practice, the DX team actively engages users in the testing of new features and content. They gather feedback from their own initiatives and combine it with those from partnering business units to ensure that every person coming to our site or app has an exceptional health care experience.

9.3.5. Consumer Transparency

The Consumer Transparency team partners with the Digital Experience team to deliver changes in the digital space for the enterprise. The Consumer Transparency focuses on strategically and tactically on how things like cost and data are represented in our digital solutions.

- Provider Directory – As one of the highest utilized business functions by our membership, the Provider Directory (or Provider Search) application allows our membership to search for care.

9.3.6. Member Complaint, Inquiry and Grievance Resolution

The review process is performed through a cooperative effort between the Quality Management 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.

BCN Special Inquiries department maintains a consistent process in compliance with federal and state regulations for handling all lines of business for BCN for all member appeals and grievances, BCN Advantage appeals on behalf of the member, and the external review process for our commercial and Marketplace members.

Goal: The goal for both complaints and appeals is for the total rate per 1,000 members to be equal to, or less, than 0.15%.

9.3.7. 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, ECHO).

Goals:

1. Complaint rate to be $\leq 0.15/1000$ members.
2. Appeal rate to be $\leq 0.15/1000$ members.
3. Annually completes an analysis of requests and utilization of OON services and identifies opportunities for improvement if applicable.
4. OON Appeals: $\leq 0.15/1000$ members
5. For CAHPS:
 - The NCQA Quality Compass 50th percentile benchmark is used to determine the Commercial HMO and Medicare HMO/POS performance outcomes.

- Marketplace HMO is to perform either the same as or above the national average of all Qualified Health Plans
6. For ECHO: The goal is for each measure related to access to increase two percentage points year over year up to 90%. The goal is met for measures scoring greater than or equal to 90%.

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

Safety programs are implemented to improve processes and systems that impact patient safety and are managed under the Blue Cross Health Care Value's Value Partnerships Program department. Activities are focused on identification and reporting of safety concerns, reduction of medical errors, and collaboration with delivery systems, hospitals and physicians/clinicians to develop improvement plans when member safety issues are recognized, develop performance measures on patient safety, maximize safe clinical practices and improve patient safety and clinical outcomes.

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.

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

9.4.1. Collaborative Quality Initiatives

Collaborative Quality Initiatives support efforts to work collaboratively with physicians, 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 BCN. CQIs seek to address some of the most common, complex and costly areas of surgical and medical care.

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

The CQI Program supports:

- Data Collection: Timely feedback of robust, trusted, consortium-owned performance data to hospitals and providers.

- Collaborative Learning: Collaborative, data-driven learning fostered in a non-competitive environment (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.

Goal: Empower providers to self-assess and optimize their processes of care by identifying opportunities to bring care into closer alignment with best practices, which leads to improved quality and lower costs for selected, high cost, high frequency and 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 2020, Blue Cross is providing funding and active leadership for 14 CQIs addressing one or more of the following clinical conditions:

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

9.4.2. Blue Distinction Centers for Specialty Care®

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

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

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 4,900 Blue Distinction Center and Blue Distinction Center+ designations have been awarded to more than 2,000 health care facilities in 48 states.

Goals:

1. Expand BDC/BDC+ designation across all programs by inviting facilities as appropriate to either apply for designation, or to open an appeal if their prior application was denied and they now meet all of the qualifications for designation.
2. Continue specifically focusing on strategies to recruit new Substance Use Treatment and Recovery facilities into the program and to implement Local Plan Criteria to align with internal Blue Cross behavioral health initiatives.

9.4.3. MHA Keystone Center for Patient Safety & Quality

Blue Cross provides considerable funding to the Michigan Health and Hospital Association 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.

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. 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

Goal: The primary goal of the Blue Cross funding for the MHA Keystone Center is to remove participation barriers for hospitals.

9.4.4. Health Information Exchange

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

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

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

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

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

Since the HIE Initiative was introduced in 2014, 92 hospitals participate in MiHIN's statewide notification service. Hospitals have significantly improved the availability and quality of admission, discharge, transfer and medication data available to caregivers across the state. Participating hospitals are currently sending notifications for approximately 98 percent of all admissions statewide. These efforts will continue to be recognized through 2020, with hospitals earning a portion of their Blue Cross P4P HIE points through continued data quality conformance standards for the ADT, Exchange C-CDA (formerly Medication Reconciliation), Ambulatory CCDA, and Common Key Service use cases. A new Conformance Task Force, co-chaired by Blue Cross, was created to help set standards and quality guidelines for data flowing through the statewide network. Remaining points may be earned by participating with physician organizations in pilots and projects.

9.4.4.2. Peer Group 5 Hospitals Engagement in HIE Initiative

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

Beginning with the 2016-2017 program year, hospitals began participating in the MiHIN statewide service by implementing the Admission-Discharge-Transfer use case. Currently, 41 of 44 hospitals have implemented the ADT use case. Starting in 2020, hospitals also earned a portion of their Blue Cross P4P HIE points by meeting data quality conformance standards for ADTs and for transmitting Exchange C-CDA data to MiHIN to support rural providers in improving care transitions and reducing readmissions.

9.4.4.3. Skilled Nursing Facility Engagement in HIE Initiative

Blue Cross introduced a skilled nursing facility Pay-for-Performance program into the HIE continuum beginning in January 2016. In 2020, the SNF P4P program provides freestanding and hospital based SNFs the opportunity to earn an additional three percent of their commercial Blue Cross payment for transmitting all-payer all patient admission, discharge, transfer notifications through the MiHIN statewide service. As of the last measurement date (August 2020), 238 of 419 SNFs currently meet this requirement.

9.4.4.4. Physician Organizations Engagement in HIE Initiative

Since 2014, forty physician organizations have started participating in MiHIN's statewide notification service through implementation of the Active Care Relationship Service, Admission-Discharge-Transfer, and Exchange C-CDA use cases. Participation in the statewide service offers providers a single access point to obtain daily ADT and medication information for all their patients, regardless of hospital affiliation. Participating POs currently receive daily ADT notifications including ED and IP encounters for more than 7 million Michigan patients.

Introduced in 2019, the EHR vendor initiative leverages PGIP funds to engage IT vendors, on behalf of all participating physician organizations and practices, to provide a standard set of EHR capabilities across all PGIP. This is expected to facilitate participation in HIE use cases and expand clinical data transmission and quality reporting capabilities—while reducing provider burden. An Electronic Prescribing of Controlled Substances capability was added to the vendor initiative in 2020 to support providers in meeting the mandate requiring healthcare providers to electronically prescribe all prescriptions with an effective date of October 1, 2021.

HIE efforts will also continue to focus on expanding use of the statewide shared infrastructure with innovation incentives that reward the development of tools and processes that can be leveraged by other organizations to support data sharing and population health management. The HIE initiative also focuses on improving data quality and helping recipients appropriately incorporate ADT messages and discharge medication information into processes of care. In 2020, development began on a new transitions of care medication reconciliation post-discharge outcomes measure that will be rolled out in 2021.

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

Goal: Complete implementation for four IT vendors and engage at least three new IT vendors in an initiative to promote standard EHR data sharing and quality reporting capabilities across PGIP.

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.

Pharmacy Services' quality goals are as follows:

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

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

9.5.1. Doctor Shopper Program

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

Through this ongoing program, in 2021 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.

Goal: Decrease the number of members meeting Doctor Shopper Program criteria by 2 percent.

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

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

Goal: 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, 2021.

9.5.3. Academic Detailing: Controller Inhaler for Patients with Asthma or COPD

Appropriate medication management for patients with asthma or COPD could reduce the need for rescue medication, as well as the costs associated with ER visits, inpatient admissions and missed days of work or school. Treatment guidelines recommend use of a controller inhaler to reduce exacerbation risk. Additionally, patients with asthma or COPD are at increased risk for severe illness from the virus that causes COVID-19.

A clinical pharmacist will provide telephonic consultations with provider offices for members identified as needing controller inhaler initiated. Member lists will be provided to prescribers with gaps in care to be closed, along with prescribing guidelines to assist prescribers.

Goal: Reduce the number of gaps in care related to controller therapy among patients with asthma or COPD by 1 percent each by December 31, 2021.

9.5.4. High Dose Opioid 90 Morphine Milligram Equivalent Edit

Prior authorization will be required the first time a member's opioid dosage exceeds 90 morphine milligram equivalents per day. Higher opioid dosages have not been shown to

reduce long-term pain and are associated with a higher risk of overdose and death. Dosages at or above 100 morphine milligram equivalents per day are associated with a nearly nine-fold increase in overdose risk compared to dosages of 20 morphine milligram equivalents per day or less. This edit addresses the HEDIS measure Use of Opioids at High Dosage which identifies the proportion of members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥ 90) for ≥ 15 days during the measurement year.

Goal: Ensure that the HDO rate does not increase by more than one throughout 2021.

9.5.5. Value Partnerships Pharmacy Forum

Formed in 2013 with a focus on partnering with and providing value to our members and providers, Value Partnerships, HCV Data Analytics & Insights and Pharmacy Services formed a forum to collaborate internally and externally to generate ideas, prioritize efforts, determine and implement success measures and evaluate efforts. The collaboration is designed to further strengthen Blue Cross' quality efforts as we strive to improve quality measure performance. Pharmacy-related topics are identified and presented to pharmacy representatives at provider organizations related to medication safety, quality and cost-effectiveness. In addition, the forum facilitates the use of clinical data by physician organizations to address gaps in clinical care and improve prescribing.

Goal: In 2021, the forum will identify further opportunities to work with pharmacists in physician organizations. Topics addressed through the forum will include, but not be limited to opioids, medication adherence, antibiotics, medication reconciliation and pharmacy costs. Goals for the Value Partnerships Pharmacy Forum include holding at least four meetings with PGIP physician organization and sustaining physician organization interest and engagement on pharmacy issues.

9.5.6. Mending MI Hearts Program

The Mending MI Hearts 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.

Goal: Ensure the proportion of members adherent to statin therapy is at least 60% throughout 2021.

9.6. Cultural and Linguistic Diversity

Conducted on an enterprise level, the Blue Cross Patient-Centered Medical Home program supports provider collection of race, ethnicity and language data in addition to supporting language translation services and bilingual materials.

In addition, language assistance is offered to individuals who have limited English proficiency and/or other communication needs, evaluates network adequacy in order to

better meet the needs of underserved members, and ensures compliance with Meaningful Access and Non-Discrimination requirements.

Core PCMH capabilities that support addressing health disparities within our population include open access same day appointments and extended hours; quality reporting and test tracking; and care coordination and case management.

PCMH capabilities that relate to addressing health/health care disparities include the following:

Guideline number	PCP and Specialist Guideline	Definition
2.20	Registry contains advanced patient information that will allow the practice to identify and address disparities in care	Primary/preferred language, race, ethnicity, measures of social support (e.g., disability, family network), disability status, health literacy limitations, type of payer (e.g., uninsured, Medicaid), relevant behavioral health information
2.21	Registry contains advanced patient demographics	Gender identity, sexual orientation, sexual identity
2.25*	Registry used to identify patients with concerns related to social determinants of health	Transportation limitations, housing instability, interpersonal violence, food insecurity
2.26*	Social determinants of health data shared with Michigan Institute for Care Management and Transformation	Data must be shared routinely and electronically
5.9	Practice unit has telephonic or other access to interpreter(s) for all languages common to practice's established patients	Languages common to practice are defined as languages identified as primary by at least 5% of the established patient population Language services may consist of 3 rd -party interpretation services or multi-lingual staff Asking a friend or family member to interpret does not meet the intent of the capability
5.10	Patient education materials and patient forms are available in languages common to practice's established patients	Languages common to practice are defined as languages identified as primary by at least 5% of the established patient population Patient education materials and forms are clear and simple and written at an appropriate reading grade level
10.6	Practice has a systematic approach in place for referring patients to community resources	Patients should have access to national and local resources that are appropriate for their ethnicity, gender orientation, ability status, age, and religious preference, including resources that are available in other languages such as Spanish, Arabic, and American Sign Language For example, if Practice Units within a PO have a great deal of diversity within their patient population, the PO may amass specific information about services for those diverse patient groups. Practice Units may also share information about resources for diverse groups.
	Unconscious (implicit bias education) for physician	This education is conducted utilizing a free, one hour, on demand learning module – Stanford Unconscious

Guideline number	PCP and Specialist Guideline	Definition
	organization administrators, PCMH physicians and office staff*	Bias in Medicine. The purpose is to raise or increase the level of awareness about unconscious bias in health care delivery, how it plays out, and ways to address it.

**New for 2020*

Annually, the populations are analyzed to assess disparities across race/ethnicity as well as socioeconomic status for various clinical data measures based upon geocoded data utilizing membership zip code as well as other proprietary logic. While activities to address disparities have been occurring across the company, in 2016, the Health Disparities Action Team was formed with the following purpose:

- Create a shared understanding and vision for addressing health and health care disparities.
- Collect and review data on annual basis.
- Define an enterprise health disparity focus.

The Health Disparities Action Team is comprised of employees from Diversity and Inclusion, Health Care Value, Social Mission, Pharmacy Services, Sales and Marketing, and Medicare and includes data analytics experts, to name a few, and meets quarterly.

Work is ongoing and workgroups are in place to evaluate how current programs and policies address diverse community needs, the influence of social determinants of health and determine gaps/opportunities for programs to improve alignment going forward.

Current focus areas of the action team are:

Programs and Processes Inventory	To develop/update a list and increase shared knowledge of the various activities, initiatives and programs across the company that connect to “help address health disparities.”
Data Collection and Analysis	To understand the health and health care disparities most prevalent among members in BCBSM/BCN PPO and HMO populations to influence key focus areas for projects and initiatives.
Unconscious Bias Education	To implement a learning approach to create awareness and understanding of unconscious bias among health professionals. Also communicate the importance of cultural competency.
Physician Attribution	To facilitate an increase in the number of BCBSM members having an attributed primary care physician and knowing who their physician is.
LGBTQ+ and Disabilities Education	Conduct a review and assessment of the training of member-facing staff to determine any gaps and opportunities to provide learning on the unique needs of the LGBTQ+ and people with disabilities communities.

10. Qualified Providers

10.1. Credentialing and Recredentialing

The enterprise wide 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.

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

10.2. Facility Site Review

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

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

Goals:

1. Conduct site reviews within 30 days of request related to complaints or reassessments.
2. Conduct reviews within 14 days of request that are not complaint related.

10.3. Physician Participation

All practitioners are expected to participate in the Quality Improvement Program. The practitioners agree to this through written consent in their contract with the health plan. Participation may include serving on committees, involvement in the development and implementation of quality improvement activities, involvement in actions to improve care and service, review of clinical guidelines and peer review.

Practitioners are provided information regarding their performance in relation to quality indicators through written communication. When deficiencies in quality of care or service are identified, a corrective action plan is requested to monitor ongoing improvement. Physician discipline, suspension or terminations are done in accordance with the 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.

10.4. Peer Review Process and Implementation of Corrective Action Plan

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

- Participating physicians

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

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

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

10.5. Physician Discipline and Termination

There is an established procedural process for initiating disciplinary actions or terminating affiliated physicians. Disciplinary action, non-renewal of a contract or termination of a contract with an affiliated practitioner may be appropriate for a number of reasons. Discipline or termination may be prompted by quality of care concerns, lack of cooperation and behavior inconsistent with 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 is not required.

The appropriate State Licensing Board is notified of cases that involve quality of care issues that will restrict or regulate a practitioner's practice for more than 15 days.

The National Data Bank is notified of quality of care actions that restrict or regulate a practitioner's practice for more than 30 days.

A practitioner may be terminated for any reason other than a reason prohibited by law (e.g., unlawful discrimination). The health plan may terminate its contractual relationship with an affiliated practitioner by declining to recredential, failing to renew a time-limited contract or by appropriate notification to the physician at any time during the term of the contract.

10.6. Physician Appeal Process

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

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

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

- NCQA delegation agreements are written and outline the specific responsibilities being delegated in accordance with NCQA requirements. Annual updates are made, as necessary to reflect any changes to NCQA requirements.
- Prior to implementation, the Quality Management department conducts pre-delegation evaluations and findings are presented to the appropriate oversight committee (e.g., Clinical Quality Committee, Utilization Management Committee, Member Experience Committee, Pharmacy and Therapeutics Committee, Care Management Quality Committee).
- Annual delegation oversight evaluations are completed and presented to the appropriate oversight committee for approval and recommendations for continued delegation.

For all credentialing delegates, the Corporate Credentialing and Program Support area conducts pre-delegation and annual delegation oversight evaluations and presents to the Enterprise 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 members. Examples of external entities are as follows:

- Department of Insurance and Financial Service: Requires an annual evaluation of 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 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 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.

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 Management department and is forwarded to the Clinical Quality Committee for review and recommendations. Annual approval by the Board of Directors and the Health Care 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 Management 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 QI program include but are not limited to:

- President and Chief Executive Officer
- Senior Vice President of Health Care Values
- Vice President, Health Care Values Performance and Execution
- Senior Vice President and Chief Medical Officer
- Medical Director, Quality Management
- Medical Directors
- Director, Quality Management
- Vice President, Provider Network Evaluation and Management and designated SME(s)
- Vice President, Utilization Management and designated SME(s)
- Senior Director, Customer Service and designated SME(s)
- Director, Provider Operations and designated SME(s)
- Directors, Care Management and designated SME(s)
- Director, Clinical Data Operations
- Director, Value Partnership Programs

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

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

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

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

- Map vision and lab claims for inclusion in the data mart to enhance relevant metrics
- Enhance PGIP Clinical Quality Initiative report to include HEDIS accreditation measures
- Created process to identify members that need to receive letters informing them that their provider has left the network.
- Identify the cultural ethnicity/diversity of our population and assist with planning of outreach programs.
- Develop platforms to incorporate supplemental data for HEDIS and physician reports.
- Responsible for informatics functions related to data acquisition from physician practices.
- Create customer-specific performance reports on HEDIS metrics to help employer groups make data-driven decisions regarding health promotion focused programs for employees.

The 2021 Quality Improvement Program Plan has been reviewed and approved.

APPROVED BY:

Clinical Quality Committee:

A handwritten signature in black ink, appearing to read "Jerry A. Johnson, MD". The signature is fluid and cursive, with a horizontal line extending to the right.

01/13/2021

**Jerry A. Johnson, MD
Executive Medical Director, Quality Management**

16. Appendix A

