2018 Blue Cross Blue Shield of Michigan
Commercial PPO/Marketplace Quality Improvement Program Description
February 21, 2018
Conflict of Interest

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

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

2.0 Health Plan Overview

Headquartered in Detroit, Blue Cross Blue Shield of Michigan (Blue Cross) is the state’s largest Preferred Provider Organization (PPO) health plan, serving approximately 2.5 million members in the state of Michigan.

This program description document applies to PPO Commercial and Marketplace products. Marketplace indicates the Quality Rating System (QRS) and Exclusive Provider Organization (EPO) population unless specified otherwise. Federal Employee Program (FEP) PPO products are included with Commercial PPO.

Blue Care Network (BCN), the Blue Cross HMO health care product, has been accredited with the National Committee for Quality Assurance (NCQA) for 15 years. In 2012, Blue Cross began expanding its accreditation effort to include the commercial PPO product in the state of Michigan. In 2013, the Blue Cross Commercial PPO received NCQA accreditation with a rating of Commendable. Blue Cross retained the Commendable rating from 2014 to 2016, our most recent survey date.

2.1 Background

The Blue Cross Commercial PPO product is transforming health care through a series of initiatives promoting personal and population health, improving quality and lowering costs. Our goal is to combine innovative plan designs, dedicated health support and enhanced care delivery to provide members with the highest quality health care experience.

2.1.1 Hospitals

Since 1997, Blue Cross has partnered with hospitals across the state of Michigan in a joint effort to improve health care quality and patient safety surrounding many common and costly areas of surgical and medical care. The Blue Cross/BCN-sponsored hospital Collaborative Quality Initiatives (CQIs) enable hospitals and clinicians across the state work together in a trusted, noncompetitive environment collecting patient risk factors and clinical process and outcomes data. Over 80 hospitals across Michigan participate in at least one CQI – 94 percent of eligible hospitals participate in the five most established CQIs.

Collectively, CQIs analyze the care given to over 500,000 surgical and medical patients across Michigan annually. Hospital CQIs collect data on all Michigan patients undergoing surgical procedures or medical treatments – not just Blue Cross members. Hospitals and physicians collect and analyze data to find links between process and outcomes of care. These collaboratives foster the development of best practices that reduce errors, prevent complications and improve outcomes. These outcomes demonstrate that collaborative efforts improve patient safety and clinical quality by preventing complications and reducing morbidity and mortality.
The nationally recognized Blue Cross CQI program has received multiple awards from organizations as diverse as the Blue Cross Blue Shield Association and the National Business Coalition on Health. Findings generated by the CQIs have been profiled in peer-reviewed literature more than 150 times over the last five years. Blue Cross and our hospital CQI partners are routinely asked to present locally and nationally on our statewide success in quality improvement and CQI best practices.

2.1.2 Ambulatory Care
Since 2005, Blue Cross has engaged providers in the ambulatory community through the Physician Group Incentive Program (PGIP). Physicians across the state collaborate on initiatives designed to improve and transform the health care system. Each initiative offers incentives based on clearly defined performance improvement and program participation metrics.

Currently, over 40 physician organizations (POs) participate in PGIP, representing nearly 20,000 primary and specialty care physicians from the Blue Cross network. Physician organizations serve as the effector arm of PGIP by providing the structure and technical expertise to support the development of shared information systems and shared processes of care amongst Michigan physicians.

PGIP provides physician organizations and their physician members with a variety of claims-driven reports including evidence-based care reports that are aligned with Healthcare Effectiveness Data and Information Set (HEDIS®) measures focused on preventive care services and chronic care management. Physicians engaged in PGIP care for approximately 87 percent of the commercial PPO population for Blue Cross in Michigan.

Working with the Michigan provider community, Blue Cross oversees the largest health plan sponsored Patient-Centered Medical Home (PCMH) program in the United States. As of January 2018, Blue Cross PCMH-designated practices included:
- 1,709 designated practices
- 4,692 designated primary care physicians
- 1.35 million attributed Blue Cross members

In PCMH practices, a care team led by a primary care physician focuses on each patient’s health needs and goals to coordinate care across all health settings. Blue Cross designed the PCMH program in partnership with the Michigan physician community as a way to strengthen the primary care system, better manage member care and help patients play an active role in promoting their own good health. Blue Cross continues to expand PCMH designations in Michigan—currently, there are Blue Cross PCMH-designated primary care physicians in 82 of Michigan’s 83 counties—or 99 percent of Michigan counties.

Since 2012, Blue Cross has expanded its provider partnerships by embracing the Patient-Centered Medical Home Neighbor (PCMH-N) concept, which further solidifies the collaborations between PCPs and specialists and rewards specialists for transforming care delivery processes.

Beginning January 1, 2018, select PCMH-designated practices will participate in the Comprehensive Primary Care Plus (CPC+) initiative. CPC+ is a regional, multi-payer, five-year CMS-supported initiative that is intended to strengthen primary care through efforts to transform payment reform and the care delivery system. Some PCMH-designated practices will also participate in the State Innovation Model (SIM), administered by the Michigan Department of Health and Human Services using a grant from the United States Department of Health and Human Services. These efforts build upon our PCMH model and synergize existing efforts to deliver coordinated care to all patients, including those with chronic conditions.
Finally, Blue Cross is taking these efforts to the next level with Organized Systems of Care (OSC). Organized Systems of Care build on the foundation laid by the PCMH program by linking primary care physicians, specialists, hospitals and other health care partners, to fully integrate and coordinate care through the entire health care system. These strategies are integrated into a comprehensive population-based approach to ensure all Blue Cross PPO members receive patient-centered care that provides needed prevention services, chronic care management and integration of behavioral and medical care. Blue Cross launched Physician Choice PPO in the fall of 2016. This product is based on the OSC program.

The PGIP field team supports the statewide collaborative relationships with the over 40 physician organizations and 34 OSCs to ensure program integrity through the following activities:

- Providing educational support to POs, OSCs and their physicians on all PGIP initiatives, administrative requirements and enhancements and associated data distributed
- Developing strategies to improve PO and OSC performance in PGIP initiatives to ensure program value and improved clinical outcomes
- Engaging in frequent, proactive communication with the organizational community regarding program changes, updates and enhancements

In addition to PGIP collaboration and field team support, Blue Cross provides ongoing practitioner education and involvement by addressing gaps in care for clinical measures using PO reports; offering practitioner educational programs; publishing newsletters; distributing and promoting clinical practice guidelines and continuing patient-centered medical home physician designation through the PGIP program.

**Quality improvement philosophy**

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

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

Blue Cross embraces the Institute of Healthcare Improvement’s Triple Aim framework which includes: 1) Improving of the health of the population, 2) Improving the patient experience of care (including quality and satisfaction) and 3) Reducing or at least controlling the per capita cost of care.
3.0 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 covers Blue Cross (Commercial and Marketplace), and BCN members for which Blue Cross is contracted to provide selected medical and quality management programs.

The Quality Improvement Program activities are categorized by the following: Quality of service, clinical quality, satisfaction, continuity and coordination, member safety, cultural and linguistics, qualified providers, delegation, compliance and communications.

3.1 Goals and Objectives

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

- **Quality improvement program structure**
  - Revise, review, approve and implement the 2018 Quality Improvement Program Description and Work Plan with all activities based on the 2017 annual QI evaluation findings and recommendations
  - Evaluate 2017 improvements and areas for improvement. Implement findings of the 2017 annual QI Evaluation into the 2018 QI Program and Work Plan

- **Quality of service**
  - Maintain an adequate network of primary care, behavioral health care and specialty care practitioners and monitors how effectively this network meets the needs and preferences (cultural, ethnic, racial and linguistic) of its membership
  - Provide and maintain appropriate access to primary care services, behavioral health care services and specialty care (high volume and high impact) services
  - Monitor member experience with customer service and identifies areas of potential improvement
  - Monitor provider experience with behavioral health services and identifies areas of potential improvement
  - Collect and evaluate member complaints and appeals

- **Clinical quality**
  - Actively work to improve the health status of members with chronic conditions
  - Coordinate services for members with complex conditions and help them access needed resources
  - Adopt and use clinical practice guidelines relevant to health plan population for the provision of prevention, acute or chronic medical services and behavioral health care services
  - Work collaboratively to ensure compliance with HEDIS® reporting requirements and participate in initiative around improving rates
  - Support utilization management activities for medical and behavioral health care
• Integration of public health goals into the Quality Improvement Program through health education, participation in community public health forums, and collaboration with state and local public health agencies
• Develop strategy for Population Health Management program integrating data to assess member population and needs:
  ▪ Divide population into actionable sections
  ▪ Evaluate effectiveness of strategy
• Promote data, comparative cost and quality, information sharing and value based arrangements with providers

• **Satisfaction**
  o Assess satisfaction with care and services through surveys of members, practitioners and providers

• **Continuity and coordination of care**
  o Facilitate continuity and coordination of medical care across the health plans delivery system
  o Collaborate with behavioral health care practitioners to monitor and improve coordination between medical care and behavioral health care

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

• **Serving culturally and linguistically diverse populations**
  o To meet the cultural and linguistic needs of the population
  o To create a culturally competent workforce

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

• **Delegation**
  o Maintain accountability for delegated functions and conduct annual oversight assessments on all delegates

• **Compliance**
  o In collaboration with the compliance officer, ensure compliance with local, state and federal regulatory requirements and accreditation agency standards

• **Communication**
  o Maintain communication plan to ensure compliance with regulatory requirements
4.0 Organizational Structure

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

Blue Cross Blue Shield of Michigan
2018 Committee Structure

4.1 Program Committees
To promote quality throughout the Blue Cross organization, specific relationships and linkages between Health Care Delivery, program committees, operational departments and key professional staff are described below (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).

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

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

Composition:
• Committee composed of three or more members from the board of directors. Determinations as to whether a particular board member satisfies the requirements for membership on the committee is made by the Nominating and Governance Committee.

Chairperson: Appointed
Vice chairperson: Appointed

Term:
• Committee members serve for terms as appointed by the chairperson and chief executive officer and as the board may determine, or until their earlier resignation, death or removal

Meetings:
• Meetings held at such frequency and at such intervals as it determines necessary to carry out its duties and responsibilities
• Committee meeting minutes are provided to the board for review and approval

4.1.2 Executive Committee of Officers Committee (ECOC)
The ECOC is the governing body of BCBSM. The purpose of this committee is to provide a forum for a comprehensive review of enterprise business performance and to drive fully informed decision-making and issue resolution.

Responsibilities:
• Provide enterprise oversight and governance for key corporate items such as corporate policies, corporate goals, accreditation, enterprise risk management and capital planning and budgeting
• Serve as decision body for enterprise strategy
• Drive resolution of business unit and cross-functional issues impacting the enterprise

Composition:
• President and chief executive officer
• Executive vice president, Chief financial officer
• Executive vice president and president, Health Plan Business
• Executive vice president and president, Emerging Markets
• Executive vice president, chief of staff and corporate secretary
• Executive vice president, Health Care Value
• Executive vice president, Operations and Business Performance
• Executive vice president, Strategy, Government and Public Affairs
• Other executive members:
  o Vice president and chief actuary
  o Senior vice president and chief information officer
  o Vice president, Corporate Strategy
  o Senior vice president and chief risk officer
  o Vice president, Corporate Planning
  o Vice president, Finance Health Plan Business
  o BCBSM executive employees, chief executive officer, compliance officer
  o Vice president, General Counsel

Chairperson: Chief executive officer

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
• Meetings are held monthly (MBR – monthly business review)

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

Responsibilities:
• Reviews and approves clinical quality indicators used for assessment activities
• Reviews, updates and approves Blue Cross clinical practice and preventive health guidelines and standards of care, related to medical care and oral health
• Reviews and makes recommendations to approve, annually, the Quality Improvement Program Plan, work plan and annual evaluation of effectiveness
• Provides oversight for delegated quality improvement, 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 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 and approves quality improvement activities for behavioral health
• Reviews quality indicators and related activities for the Performance Recognition Program
• Reviews and approves collaborative quality improvement activities performed by the organization
• Reviews and recommends activities to make performance data publicly available for members and practitioners
- Integrates clinical pharmacy activities in chronic condition management programs, case management programs, clinical practice guidelines, health promotion and quality improvement activities
- Reviews and recommends approval for BCN only medical policies
- Reviews data and information that addresses member and practitioner satisfaction with the medical management process, determines opportunities and makes recommendations for improvement

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

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

**Chairperson:** Senior medical director, Clinical Affairs  
**Vice chairperson:** Vice president, Health and Medical Affairs

**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

The Clinical Quality committee:
- Recommends policy decisions
- Analyzes and evaluates the results of quality improvement activities
- Ensures practitioner participation in the quality improvement programs through planning, design, implementation or review
- Identifies needed actions
  Ensures follow up, as appropriate
4.1.4 Utilization Management Committee (UM)

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.

**UM Committee responsibilities:**

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

**Composition:**

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

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

**Chairperson:** Senior medical director, Clinical Affairs

**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

4.1.5 Behavioral Health Quality Improvement Committee
The Blue Cross Behavioral Health Quality Improvement Committee reports to the CQC with a goal of creating and maintaining a comprehensive and integrated approach to behavioral and medical management. New Directions is responsible for oversight of the Blue Cross behavioral health program and participates in the BH QIC. The purpose of the committee is to provide oversight of commercial PPO corporate wide quality improvement initiatives related to behavioral health. The committee recommends improvement strategies for programs, policies and processes with the objective of continuously improving the behavioral health status of Blue Cross members.

Responsibilities:
• Provide input/consultation on Behavioral Health development, clinical, vendor and quality program components with particular focus on program review, recommendations and improvements
• Support the alignment of quality goals and activities
• Facilitate objective and systematic program measurement
• Monitor program implementation
• Identify opportunities to increase program efficiency, effectiveness and alignment through measurement(s) based on the program results
• Approve clinical policies and procedures and program components
• Review and approve clinical guidelines
• Monitor behavioral health related HEDIS measures
• Provide oversight and direction for clinical program activities
• Provide oversight and direction for vendor management activities
• Provide oversight and direction for quality improvement activities
• Monitor program performance measures (dashboard)
• Review and monitor annual program evaluations
• Ensure compliance with regulatory and accreditation standards
• Monitor customer/client satisfaction with the program
• Review market expectations/acceptance

Composition:
• Medical director, New Directions
• Senior medical director, BCN Clinical Quality
• Medical director, BCN Behavioral Health
• Senior medical director, BCBSM PPO Care Management
• Director, Quality and Population Health
• Manager, Behavioral Health Services
• Senior health care analyst, BCBSM Value Partnership Programs
• Manager, FEP Care Coordination/Managed Care
• Senior account executive, New Directions
Chairperson: Blue Cross Senior Health Care Analyst

Term:
- Meetings held at least quarterly
- Ad hoc meetings held more frequently, as needed

Meetings:
- Meetings held at least quarterly
- Ad hoc meetings held more frequently, as needed
- Committee members expected to attend all meetings within reason; personal attendance strongly encouraged, however, members may participate by telephone or send alternate if circumstances warrant
- A quorum consisting of 50% of voting members is required

4.1.6 Care Management Quality Committee
The CM Quality Committee has been established to provide oversight and guidance for the development, implementation, maintenance, evaluation and quality improvement of WCM internal and vended programs. This committee sets strategy aligned with corporate goals, review market expectations and seek 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.

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

Composition:
- Vice President, Wellness and Care Management
- Senior Medical Directors, PPO and Care Management
- Director, CM Delivery & Support Services
- Director, CM Program Development
- Directors, CM Program Delivery
- Managers, CM Program Development
- Managers, CM Consulting
- Manager, Quality Accreditation and Training
- Operational Managers ad hoc
- Senior Health Care Analyst, URMBT

Co-chairperson: Health Care Manager, Care Management Programs
Co-chairperson: Manager, Quality Accreditation & Training
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 WCMHP 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.

4.1.7 Joint Uniform Medical Policy (JUMP) – Reports to the UM 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 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 nonestablished 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 Health Care Quality and Service Improvement Committee

Composition:
- Two BCN medical directors
- Two Blue Cross medical directors
- One or two external Blue Cross physicians (must be par with Blue Cross and BCN)

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

Co-chairperson: Medical director, BCN
Co-chairperson: Senior associate medical director, Blue Cross

Term: Not applicable

4.1.8 Criteria Review Committee – Reports to the UM Committee
The CRC reviews clinical criteria used in the utilization management process for the PPO commercial and marketplace lines of business as well as in specialty areas such as substance abuse, foot surgery and psychiatric care.

Criteria Review Committee responsibilities:
- Receives inquiries regarding criteria
- Reviews and monitors clinical criteria
- Advises corporate medical director in areas related to corporate policy for clinical criteria
Composition:
- Senior associate medical director
- Executive medical director, Quality and Medical Policy
- Medical director, physician consultant, Utilization Management
- Medical director, PPO Medicare Advantage
- Medical director, physician consultant, Blue Care Network, Quality
- Medical director/licensed psychiatrist, Utilization Management, Blue Care Network
- Associate medical director, Case Management
- Director, Precertification Services
- Manager, Facility Precertification/Quality
- Manager, Provider Audit

Chairperson: Senior Associate Medical Director

Term: Permanent appointment until position is vacated

Meetings: Ad hoc as needed to review and approve clinical criteria throughout the year

### 4.1.9 Medical Affairs Policy Review Committee – Reports to the UM Committee

The Medical Affairs Policy Review Committee coordinates the review and approval of Blue Cross Blue Shield of Michigan only and interim medical policies on an annual basis. The review of these documents is reported to the Corporate Utilization Management Committee.

Medical Affairs Policy Review Committee responsibilities:
- Presentation of policy statement drafts and supporting rationale
- Preparation for committee meetings
- Attendance at scheduled committee meetings - with active participation
- Minutes shall be taken to record actions and recommendations of the committee
- Participation in evaluation of committee meetings - with an emphasis on continuous quality improvement to meeting processes and functions

Composition:
- Medical Director – Quality Management
- Three Associate Medical Directors – Quality Management
- Three Physician Consultants
- Director – Medical Affairs
- Manager – Medical Policy
- Manager – Medical Review & Appeals
- Two Senior Analysts – Medical Policy
- Analyst – Medical Policy

Chairperson: Medical Director – Quality Management

Meetings:
- Meets a minimum of two times per year
Quorum consists of one-half of the voting members

4.1.10 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 hospitals, home health agencies, skilled nursing facilities, nursing homes, freestanding surgical centers and behavioral health facilities.

Responsibilities:
- Reviews credentialing, quality and utilization information and makes determinations on initial and recredentialing applications for practitioners and providers.
- Reviews and makes determinations on initial and recredentialing applications for health care delivery organizations including hospitals, home health agencies, skilled nursing facilities, nursing homes, freestanding surgical centers and behavioral health facilities.
- 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.
- For Blue Cross and MAPPO, serves as the review board for selected first level administrative practitioner appeals.
- Submits written reports to required committees/workgroups. BCNTh submits reports to the Health Care Quality and Service Improvement Committee and PPO TRUST and submits reports to PPO Network Management Committee.
- 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
- Vice chairperson
- Four Blue Cross/BCN medical directors
- Two external primary care practitioners who represent internal medicine or family practice and pediatrics
- Six external specialists who represent specialties including but not limited to general surgery or a surgical subspecialty, obstetrics and gynecology, behavioral health, oral surgery, pathology, anesthesiology, radiology or emergency medicine specialty
- Chiropractor

Nonvoting members:
- BCN director or manager, Quality and Population Health
- Manager and representative from Corporate Credentialing and Program Support
- BCN network management representative
• Corporate Financial Investigation representative
• BCN corporate Office of General Counsel

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

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

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

4.1.11 Pharmacy and Therapeutics (P&T) Committee
The Pharmacy and Therapeutics Committee evaluates the clinical use of drugs, determines the appropriate formulary placement of drugs, ensures that the formulary is appropriately revised to adapt to both the number and types of drugs on the market, and advises in the development of policies for managing drug use, drug administration, and the formulary system. Decisions are based on available scientific evidence and may 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.

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

Composition:
• BCBSM clinical director, Pharmacy
• Two BCBSM physicians
• Two BCN medical directors
• BCN director, Pharmacy Services
• Six network practitioners representing primary and specialty care
• Two retail or health system pharmacy representatives
• Consumer member

The committee membership may be changed upon recommendation of the co-chairpersons and approval by the BCN senior vice president and chief medical officer, BCBSM chief medical officer and the BCBSM vice president, Pharmacy Services.

Co-chairperson: Director, Pharmacy Services, BCN
Co-chairperson: Director, Clinical Pharmacy Services, Blue Cross

Term:
• Physician members serve for an initial term of two years
• Reappointment is at the discretion of the BCN senior vice president and chief medical officer, Blue Cross chief medical officer and the Blue Cross vice president Pharmacy Services

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

4.1.12 Member Experience Committee
The primary purpose of the member experience committee is to provide oversight for all member and prospective member interactions to include member communications, satisfaction, protected health information, grievances and appeals in order to improve the quality and consistency of services for members across channels, functions, and touch points. The MEC meets quarterly.

Member Experience Committee responsibilities:
• Review a variety of available information related to member experience and make recommendations to improve the experience
• Review results from member surveys, including but not limited to CAHPS and Behavioral Health Services, to see if activities designed to improve the experience are effective or need to be further modified based on survey outcomes
• Promote cultural diversity initiatives
• Oversight and evaluation of materials for all stakeholder communications across channels
• Oversight of website and print materials for member health (pre-enrollment and enrollment)
• Recommend and create content for member and provider communication content
• Monitor external and internal member communication channels across the enterprise
• Review member complaints and appeals and make recommendations
• Review and approve all policies relevant to this committee at least annually
• Provide Clinical Quality Committee updates quarterly and to the Executive Committee of Officers Committee (ECOC) on request
• Analyze data on member complaints and appeals for both medical and behavioral services and identify opportunities for improvement in the following areas: Quality of Care, Access, Attitude and Service, Billing and Financial Issues, Quality of Practitioner Office Site
• Scope includes the commercial PPO, Marketplace, and Federal Employee Program (FEP) product lines

Composition:
• Director, Customer Experience
• Director, Pharmacy Services
• Director, Digital Experience
• Director, Executive Services
• Director, Federal Employee Program
• Director, Direct Care Management
• Director, Provider Outreach
• Director, Quality Management
• Manager, Executive Services

Co-chairperson: Vice president, Service Operations
Co-chairperson: Vice president, Corporate Marketing and Customer Experience

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

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

Composition:
• Senior medical director, Clinical Affairs
• Medical director, Behavioral Health
• BCN medical directors
• Associate medical director, Preferred Provider Organization and Care Management Programs
• Twelve practitioners who represent a cross section of both primary care physicians and specialists
• Nurse practitioner(s)
• Psychologist
• Social worker(s)

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

**Chairperson:** Senior medical director, Clinical Affairs  
**Vice chairperson:** One regional medical director

**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
5.0 Reporting Relationships

5.1 Blue Cross Blue Shield Board of Directors
The Blue Cross board of directors has ultimate authority and responsibility for oversight of the Blue Cross Quality Improvement Program. The president and chief executive officer 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.

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

5.1.2 Senior Vice President and Chief Medical Officer
The senior vice president and chief medical officer is the corporate officer responsible for the quality and safety of clinical improvement activities and reports clinical quality, behavioral health quality and safety of clinical care improvement activities to the president and chief executive officer, the ECOC and the Blue Cross 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

5.1.3 Senior Medical Director, Clinical Affairs
The senior medical director of Clinical Affairs is responsible for providing clinical guidance, input and leadership oversight for health care improvement related activities including utilization management, medical management, credentialing, quality improvement, behavioral health and pharmacy services.

Responsibilities include the following:

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

5.1.4 Medical Directors
The medical director provides 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

5.1.5 Behavioral Health Medical Director
A board-certified psychiatrist with New Directions is responsible for oversight of the Blue Cross Behavioral Health program and is a member of the Behavioral Health Quality Improvement Committee. This committee ultimately reports to the Clinical Quality Committee.

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

Responsibilities include the following:
• Provides direction for Stars and HEDIS Data Management and Operations
• Allocates adequate resources to promote the successful completion of quality improvement activities and programs
• Provides support for clinical performance improvement activities and programs
• Ensure adherence to all regulatory requirements

5.1.6.1 Quality and Population Health Department
The department is responsible for activities related to monitoring and evaluation of the quality of care and service delivered.

This department performs the following functions:
- 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.
6.0 Staffing

The following resources support the Blue Cross Quality Improvement Program:

- Designated associate medical director who chairs the Clinical Quality Committee
- Director and Quality and Population Health staff (see organizational department structure)

An associate medical director is dedicated to the QI Program — responsibilities are as follows:

- Chair the CQC, assist with preparation of Quality Improvement program documents and review of clinical guidelines for QI programs
- Participate in behavioral health QIC and associated activities
- Assist with QI activities related to HEDIS and continuity and coordination of care improvements
- Provide delegation oversight
- Oversee program related to improvement of health care disparities
- Ensure alignment of case management with NCQA standards and assist with internal process improvement

The QI program is further supported by the Health Care Value (HCV) team with IT and HCV data analytics as explained further in the following section.

6.1 Data Sources and Analytical Resources

The HCV Data Analytics department leads data acquisition and analysis for the QI program at Blue Cross PPO. 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. HCV Data Analytics analyzes data to understand what is driving gaps in care and identify areas for provider improvements in order to improve overall quality of care. HCV Data Analytics 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 of the HCV Data Analytics team in support of Blue Cross 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
7.0 Program Activities

7.1 Clinical Quality

7.1.1 Utilization Management
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 Blue Cross 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.

7.1.2 Population health management
In 2018, Blue Cross developed a Population Health Management Strategy 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:
  - Goals and populations targeted for each of the focus areas:
    - Keeping members healthy
    - Managing members with emerging risk
    - Patient safety or outcomes across settings
    - Managing multiple chronic illnesses
  - Programs or services offered to members
  - Activities that aren’t direct member interventions
  - How member programs are coordinated
  - How members are informed about available PHM programs

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

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

7.1.3 Case management (including complex case management)
The case management program is an opt-out, voluntary member centric program that is supported by clinical and nonclinical staff. The case management program is aligned with NCQA, Case Management Society of America (CMSA) and Blue Cross Blue Shield Association (BCBSA) recommendations and standards for best practice for case management.

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

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

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

Case management focuses on assisting members in achieving health and maintaining wellness. Collaboration with the physician, providers, and member increases adherence to a care plan and promotes successful outcomes. The case manager can enhance a member's safety, well-being, and quality of life while reducing health care costs. Case management promotes the following:
• Using available resources to achieve clinical and financial outcomes
• Ensuring appropriate access to care in a timely and cost-effective manner
• Interjecting objectivity, health care choice, and promotion of self-care where it is lacking
• Assisting member to appropriately self-direct care, self-advocate and make informed health care decisions, as appropriate

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

Refer to the specific case management program descriptions for additional information about the health plans program and goals.
**7.1.4 Chronic Condition Management**

The Chronic Condition Management program is an integrated, member-centered program with a comprehensive continuum of care management interventions designed to help members manage their conditions/diseases. This program offers support and assistance to relatively healthy, chronically ill and acutely ill members to maintain, restore or improve health. The program also does “reach and engage” activities for members to ensure interventions are delivered at the most effective point in time, optimizing member health.

Chronic Condition Management is available nationwide to all Blue Cross members who are eligible for Blue Cross Health and Wellness®. Member participation is voluntary and members may opt out of the program at any time. The program is tailored to meet the member’s individual needs based on his or her diagnosis and risk factors. Members and their caregivers receive personalized educational and self-care materials and assistance in the management of their chronic conditions based on current evidence-based practice and standards of care.

The Chronic Condition Management program is based on the principles of self-management. Self-management programs emphasize the patients’ central role in managing their illness. It has been estimated that 95 to 99 percent of chronic illness care is given by the person who has the illness. However, without sustained support, many adults won’t succeed in managing their conditions well, which can result in poor health outcomes, including expensive hospitalizations and avoidable complications. Therefore, it is crucial to support the patient in the role as self-manager.

Chronic Condition Management addresses a broad segment of the Blue Cross member population with targeted chronic conditions. The program identifies members for whom health education and self-care management interventions can have a positive impact on the quality, clinical outcomes and cost effectiveness of care. This is achieved through the proactive identification of our member population with select chronic conditions and the provision of interventions that address demonstrated needs. These interventions are available to members with specific chronic conditions that are generally healthy and may have gaps in the management of their chronic conditions, which require more intensive support in order to achieve compliance with evidence-based clinical practice guidelines for their diseases.

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

**7.1.5 Behavioral Health**

In 2015, New Directions assumed behavioral health management of Blue Cross members nationwide. New Directions is a managed behavioral health organization accredited by the National Committee for Quality Assurance. With more than 20 years’ experience in utilization and case management services, in addition to extensive experience working with Blue plans nationwide, New Directions’ services include preauthorization and case management for members who receive behavioral health through Blue Cross.

Behavioral Health vendor oversight is provided by the Quality and Population Health department and is reviewed and approved by Utilization Management Committee.

**2018 program goals:**

- Continue work with PGIP and the behavioral health workgroup to promote dialogue between physician organizations, their primary care physicians and the behavioral health specialists who provide services to attributed members. This work could include a specific incentive or could enhance the integration of behavioral health into existing programs.
• Work to include behavioral health conditions as part of the required contents of patient registries for PCMH with a proposed measure being the proportion of medical charts with contact from behavioral health specialists
• Improve continuity and coordination between medical and behavioral healthcare in the context of:
  o Communications between Blue Cross medical and/or NDBH behavioral case managers and prescribers to reduce inappropriate prescriptions of opioids
  o Diabetes screenings for members identified as having bipolar disorder or schizophrenia and taking antipsychotic medications
  o Maintain performance on HEDIS FUH7 measure within 75th percentile or better

7.1.6 Continuity and coordination of care
Blue Cross 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.

Blue Cross monitors continuity and coordination by assessing the facilitation of continuity and coordination of medical care services across transitions and setting of care, of members getting the care or services they need, and practitioners or providers getting the information they need to provide the care patients need. The health plan identifies multiple areas, or measures, for improvement based on its analysis. Four opportunities for improvement are selected to improve coordination of medical care by conducting a quantitative and qualitative analysis on medical care coordination data.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulmonologist to primary care practitioner (outpatient to outpatient)-specialist provider records to PCP</td>
<td>100%</td>
</tr>
<tr>
<td>Pulmonologist to primary care practitioner (outpatient to outpatient)-PCP charts with specialist record</td>
<td>100%</td>
</tr>
<tr>
<td>Cardiologist to primary care practitioner (inpatient to outpatient)-specialist provider records to PCP</td>
<td>100%</td>
</tr>
<tr>
<td>Cardiologist to primary care practitioner (inpatient to outpatient)-PCP charts with specialist record</td>
<td>100%</td>
</tr>
<tr>
<td>All Cause Readmissions (PCR – 18-64 yrs)</td>
<td>NCQA 50th percentile</td>
</tr>
<tr>
<td>Ambulatory Care ER visit coordination</td>
<td>Reduce by 10%</td>
</tr>
</tbody>
</table>

The health plan annually collects data about opportunities for collaboration between medical care and behavioral healthcare for the following areas:
• Exchange of information
• Appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care
• Appropriate use of psychotropic medications
• Management of treatment access and follow-up for members with coexisting medical and behavioral disorders
• Prevention programs for behavioral health care
• Severe and persistent mental illness

Blue Cross 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.
Goals:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exchange of information between behavioral health and medical providers</td>
<td>100%</td>
</tr>
<tr>
<td>Management of treatment access and follow-up for members with</td>
<td>80%</td>
</tr>
<tr>
<td>coexisting medical and behavioral disorders</td>
<td></td>
</tr>
<tr>
<td>Prevention programs for behavioral health care</td>
<td>10%</td>
</tr>
<tr>
<td>Severe and persistent mental illness</td>
<td>NCQA 75th percentile</td>
</tr>
<tr>
<td>Appropriate diagnosis, treatment and referral of behavioral disorders</td>
<td></td>
</tr>
<tr>
<td>commonly seen in primary care (ADHD):</td>
<td></td>
</tr>
<tr>
<td>Acute phase</td>
<td>NCQA 75th percentile</td>
</tr>
<tr>
<td>Continuation phase</td>
<td>NCQA 75th percentile</td>
</tr>
<tr>
<td>Appropriate use of psychotropic medications:</td>
<td></td>
</tr>
<tr>
<td>Initiation phase</td>
<td>NCQA 75th percentile</td>
</tr>
<tr>
<td>Continuation/maintenance phase</td>
<td>NCQA 75th percentile</td>
</tr>
</tbody>
</table>

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

7.1.7 Identification and documentation of quality of care concerns

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

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

Goals:

- Cases that don’t require medical director review: 45 days
- Cases that require medical director review: 90 days

7.1.8 Healthcare Effectiveness Data and Information Set (HEDIS)

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

Blue Cross complies with all the HEDIS reporting requirements established by NCQA, the Office of Financial and Insurance Regulations, Centers for Medicare and Medicaid Services and Michigan Department of Community Health. Activities focused on improving rates for select HEDIS measures are integrated with the Chronic Condition Management Program, Complex Case Management Program and Physician Group Incentive Program. Blue Cross implements interventions based on the reporting year results. The impact of the interventions is monitored in the subsequent year. HEDIS activities and results are audited by an NCQA-certified auditor and submitted for public reporting annually.
After scores are reported, a series of HEDIS quality improvement activities are implemented in order to address those areas in which opportunities are identified.

7.1.9 Clinical practice guidelines
Blue Cross adopts and disseminates clinical practice guidelines relevant to its members for the provisions of preventive and nonpreventive acute and chronic medical services and for preventive and nonpreventive behavioral health services. These clinical practice guidelines are reviewed and approved by the CQC every year to ensure the guidelines are evidence-based and are known to be effective at improving health outcomes for members. Blue These guidelines are the evidence-based foundation for the performance reports Blue Cross provides to physician organizations at least quarterly.

Michigan Quality Improvement Consortium
Blue Cross has adopted the clinical practice guidelines developed by the Michigan Quality Improvement Consortium (MQIC). Founded in the fall of 1999, MQIC consists of physicians and other personnel from 13 Michigan-based health plans, along with the Michigan Association of Health Plans, Michigan Department of Health and Human Services, Michigan Osteopathic Association, MPRO, and Michigan State Medical Society, as well as the University of Michigan Health System. The Blue Cross Blue Shield of Michigan’s Chief Medical Officer has been the co-chair of MQIC since its inception.

The purpose of MQIC is to achieve significant, measurable improvements in health care through the development and implementation of common evidence-based clinical practice guidelines. The guideline topics are selected by the MQIC Medical Directors’ Committee and are based on a number of factors including scientific-based evidence, data demonstrating relevancy to the health plans’ population, potential use of subject matter by the primary care practitioner, HEDIS measures and internal and external requests for guideline development. MQIC designs concise guidelines focused on key clinical management components demonstrated to improve outcomes, with the goal of standardizing these processes for Michigan physicians and other health care providers.

When developing new or updating current guidelines, current research is reviewed and feedback is requested from several professional organizations. Recommendations with [A] (randomized controlled trials) and [B] (controlled trials, no randomization) levels of evidence are given priority status. Preventive care guidelines are based on the United States Preventive Services Task Force A and B recommendations.

MQIC clinical practice guidelines are reviewed and updated every two years. In addition, guidelines may be re-evaluated and updated at any time before the established two-year review cycle as new scientific evidence is released. Current versions of all MQIC guidelines are available on the mqic.org website, and the MQIC application for mobile devices. The MQIC website link is also available on the Blue Cross public website and in the site’s provider portal. Any interested party may also ask to receive a copy of the guidelines by U.S. mail.

2018 program goals:
Review and approve guidelines annually.

7.1.10 Physician Group Incentive Program
Founded in 2005, the Physician Group Incentive Program (PGIP) includes nearly 20 initiatives aimed at capability building, improving quality of care delivery and appropriate utilization of services. PGIP includes the Patient-Centered Medical Home (PCMH) program, which helps facilitate the transformation of health care delivery in physician practices and the PCMH designation program, which recognizes those practices that have implemented a significant number of PCMH capabilities and have delivered high quality and cost-effective care.
7.1.10.1 Patient-Centered Medical Home

In partnership with PGIP physicians and physician organizations, Blue Cross developed the Patient-Centered Medical Home (PCMH) program in 2008. This program is based on the Joint Principles of the Patient-Centered Medical Home issued in March 2007 by the American Academy of Family Practice (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP) and the American Osteopathic Association (AOA).

Blue Cross’s PCMH program supports physicians in implementing patient-centered information systems and care processes. Some elements of the PCMH model that specifically address patient safety include:

- Electronic patient registries incorporating evidence-based guidelines and information from other care settings – giving providers a comprehensive view of the care patients have received and ensuring treatment is appropriate and safe
- Written and jointly developed goal planning and patient education and self-management support that uses the teach-back method to ensure patient comprehension
- Provisions for 24/7 telephone availability of clinical decision-makers with access to patient’s medical record or patient registry information
- Tracking system with safeguards in place to ensure patients receive needed tests, timely and accurate results and follow-up care
- Electronic prescription systems that ensure accurate information is transmitted to the pharmacy and alerts providers to any prescribing errors, patient allergies and potential adverse outcomes or drug interactions
- Timely response to urgent patient needs and proper patient guidance about emergency situations and seeking care
- Care coordination and care transition protocols that ensure patient care is efficiently coordinated across all settings and patients receive timely, appropriate care. An example of care coordination is Blue Cross’ Health Information Exchange (HIE) initiative which reports admissions, discharges and transfers notifications to the Michigan Health Information Network (MiHIN), a statewide health information exchange

**NOTE:** Although there are two PCMH capabilities related to HIE, the HIE Initiative is not part of the PCMH program. It is a part of the PGIP and the Hospital P4P program.

- Specialist referral processes that provide the specialist with detailed information regarding the patient’s needs and past medical history to avoid exposing patients to duplicative or unnecessary testing or treatment and include a feedback loop to the primary care provider

PCMH Program: Cost Avoidance

Cost avoidance figures for the first six years of the PCMH program overall, using data from the time period of July 2008 - June 2014, is an estimated $427 million.

**2018 program goal:**

Increase penetration of Patient-Centered Medical Home-designated providers throughout the state of Michigan in 2017. Success in this goal means increasing the number of designated physicians by a minimum of 2-3 percent.

7.1.10.2 Patient-Centered Medical Home—Neighborhood

Patient-Centered Medical Home (PCMH) primary care practices are the foundation of many PGIP programs. PCMH practices must be supported by high-performing specialty practices – known as PCMH-Neighbors (PCMH-N) – that are aligned with the principles and processes of PCMH. The PCMH-N concept was initially defined in a position paper published by the American College of Physicians (ACP) in 2010. Similar to PCMH, the Blue Cross PCMH-N program was developed in partnership with Michigan’s provider community.
While specialists have always been welcome to implement PCMH capabilities, they are now fully integrated into the PCMH model through the Patient Centered Medical Home Neighbor (PCMH-N) concept. All PGIP specialists – more than 14,100 physicians, fully licensed psychologists and chiropractors – can implement PCMH-N capabilities. Specialist practices that serve as high-performing PCMH-Neighbors:

- Provide appropriate and timely consultations and referrals that complement and advance the aims of the PCMH practice
- Assure that appropriate patient information is provided promptly to the PCMH
- Establish shared responsibility for relevant types of clinical interactions
- Support patient-centered high-quality care and enhanced access
- Recognize the PCMH practice as the source of the patient’s primary care
- Understand that the PCMH practice has overall responsibility for coordination and integration of care provided to the patient

The Blue Cross Patient-Centered Medical Home/Patient-Centered Medical Home-Neighbor Interpretive Guidelines describe the various capabilities that practices can implement to become fully functioning, high performing PCMH-Neighbors. The specialist specific guidelines were developed in collaboration with the practitioner community. Specialists who are recognized by their physician organizations as embracing PCMH-N principles and who are associated with high-quality, cost-effective care (primarily at the population level) can be reimbursed in accordance with Blue Cross Value-Based Reimbursement (VBR) Fee Schedule.

2018 program goals:

- Continue to encourage physician organizations to develop plans for working in close partnership with practices to implement PCMH-N capabilities
- Continue to collaborate with the Collaborative Quality Initiatives to develop specialist-specific metrics for value-based reimbursement aligned with the work of the CQIs
- Develop additional specialty-specific value-based reimbursement metrics

7.1.10.3 Organized Systems of Care

Organized Systems of Care (OSC) is a Blue Cross term used to describe a community of caregivers with a shared commitment to quality and cost-effective health care delivery for their primary care-attributed population of patients. By joining primary care physicians, specialists and hospitals into coordinated care delivery systems, OSCs are designed to address problems inherent in the delivery of fragmented and costly health care services that fail to meet the needs of the patient population.

Organized Systems of Care are defined by PCP-attributed member populations and have a shared commitment to proactive population and individual care management across care settings and over time. OSCs are expected to have the ability to conduct ongoing quality and efficiency measurement and to use data from all key providers in their performance measurement efforts.

OSC build upon the success of the PGIP and PCMH-N programs by acting as a catalyst for establishment of systems of care that coordinate delivery of health care services with clinical integration across the continuum and are accountable for the management of a defined patient population. Over time, the OSC becomes the central hub of patient-specific and population information. Care management efforts and population level analyses generated from this information are more robust than information derived solely from claims data from payers and enables the OSC to manage their population of patients.
To support PGIP physician organizations in the transition to OSCs, Blue Cross invites PGIP-participating organized systems of care to collaborate in building competencies to support implementation of OSC-related capabilities. These competencies identify a road map for OSCs to strive to optimally manage their population. Additionally, OSCs are evaluated on their performance in cost and quality.

2018 program goal
Baseline competencies for all organizations and demonstrate improvement. Reduce overall cost and increase quality measures.

7.1.10.4 Clinical quality initiative
At Blue Cross, PGIP administers the Clinical Quality Initiative (CLQI), a reward-based program incorporating HEDIS measures aimed to driving improvement among PGIP participating physician organizations (PO). 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 are able to 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 by analyzing Blue Cross data provided at the PO and practice level
- Encourage or lead rapid quality improvement interventions at partnering practices
- Promote best practices among member physicians
- Support innovation and constructive change in processes for the delivery of care
- 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.

7.1.11 Program Optimization
The objective of Program Optimization is to establish performance recognition incentives and consequences designed to ensure that all PGIP physician organizations and OSCs are fully engaged in PGIP programs and are striving to deliver optimal care to their attributed patient populations.
Program Optimization incentivizes and/or penalizes POs/OSC on performance and leadership in four key areas of measurement:
1. How they are performing with PCMH
2. Quality performance
3. Cost performance
4. Leadership performance

The goal of Program Optimization is to catalyze physician organizations and OSCs to deliver optimal patient-centered care, and in particular, to ensure focus on clinical quality, adoption of the PCMH, PCMH-N and OSC models and leadership and engagement in population management and PGIP programs. All existing physician organizations and OSCs participate in Program Optimization. New physician organizations and OSCs aren’t yet eligible (considered new to PGIP if at least 51 percent of their physician members weren’t participants in PGIP during the most recent twelve-month period).

Each physician organization and OSC receives a scorecard annually, showing their overall performance and improvement scores and ratings, as well as their scores on each of the individual measures. The scorecard includes comparative information on the ratings and financial impact of all other POs or OSCs.

2018 program goals:
Deliver scorecards to 41 physician organizations and 34 organized systems of care by year-end

7.1.12 Hospital Pay-for-Performance Program
The Blue Cross Hospital Pay-for-Performance (P4P) programs provide incentives to acute care providers 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
• 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 (MHA) Keystone Center for Patient Safety (see section 7.4.2.2 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 (MHA) Keystone Center for Patient Safety
• Performance and improvement on selected Centers for Medicare & Medicaid Services (CMS) 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

2018 program goals:
• Continue to require 100 percent of hospitals to fully comply with the program’s patient-safety prequalifying condition, including:
Conducting regular patient safety walk-rounds with hospital leadership

Assess and improve patient safety performance by fully meeting one of the following options:

– Complete and submit the National Quality Forum Safe Practices section of the Leapfrog Hospital Survey at least once every 18 months
– Complete the Joint Commission Periodic Performance Review of National Patient Safety Goals at least once every 18 months
– Review Compliance with the Agency for Healthcare Research Patient Safety Indicators at least once every 18 months
– Participate in a federally-qualified patient safety organization

Ensure results of the patient safety assessment and improvement activities are shared with the hospital’s governing body and incorporated into a board-approved, multidisciplinary patient safety plan that is regularly reviewed and updated

• Increase the number of hospitals demonstrating favorable year-over-year improvements in their own hospital-specific 30-day all-cause readmission rate from 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.

• Observe year-over-year improvements in hospital-selected Michigan Value Collaboration service lines, including:
  o Acute myocardial infarction
  o Colectomy (noncancer)
  o Congestive heart failure
  o Coronary artery bypass graft
  o Joint replacement (hip and knee episodes combined)
  o Pneumonia
  o Spine surgery

• Engage all P4P-participating acute care providers in more robust Health Information Exchange use cases, including:
  o Implementation of the Common Key Service
  o Developing querying abilities via the statewide notification service
  o Submitting lab values into the state’s disease surveillance system for communicable diseases

7.1.13 Hospital Value-Based Contracting

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

Initially, Blue Cross VBK efforts were intended to serve as a glide path for acute care providers to build the necessary infrastructure and partnerships with partnering physician organization partners needed to be successful in this new reimbursement environment. Since the program’s inception, sixty-nine Michigan hospitals, representing nearly 85 percent of the total Blue Cross commercial hospital payout, have signed a Value Based Contract. Although eleven contracts have expired, the remaining fifty-eight contracts represent over half of the total Blue Cross commercial hospital payout.

In the program’s first three years, VBK-participating hospitals have generated over $130 million in savings, over half of which was shared with participating providers. Additionally, VBK participating sites experienced both a lower point-in-time per-member-per-month (PMPM) and year-over-year trend for the patient population they serve with their partnering physician organization partners.
2018 program goals:

- Continue to experience both lower point-in-time and year-over-year PMPM trends for VBK-participating hospitals as compared to their nonparticipating peers. The Blue Cross actuarial department evaluates VBK provider performance annually.
- Develop a second iteration of VBK contracts that potentially address provider feedback from first iteration of contracts including:
  - Outlier methodology
  - Provider attribution
  - Quality metrics
  - Target price benchmarking

7.2 Quality of service

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

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

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

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

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

The Medical Informatics department provides assistance with clinical study design, statistical analysis and evaluation.

The 2018 activities are noted below.
7.2.1 Availability of practitioners
Blue Cross ensures that its networks are sufficient in numbers and types of practitioners to meet the needs of its members. In creating and maintaining the delivery system of practitioners, Blue Cross acknowledges and values the key role of cultural, racial, ethnic, gender, linguistic needs and personal preferences in the effective delivery of health care services.

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

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

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

<table>
<thead>
<tr>
<th>Practitioner/provider type</th>
<th>Large</th>
<th>Metro</th>
<th>Micro</th>
<th>Rural</th>
<th>CEAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCPs</td>
<td>10/5</td>
<td>15/10</td>
<td>30/20</td>
<td>40/30</td>
<td>70/60</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>30/15</td>
<td>45/30</td>
<td>80/60</td>
<td>90/75</td>
<td>125/110</td>
</tr>
<tr>
<td>Dermatology*</td>
<td>20/10</td>
<td>45/30</td>
<td>60/45</td>
<td>75/60</td>
<td>110/100</td>
</tr>
<tr>
<td>Orthopedic Surgery*</td>
<td>20/10</td>
<td>30/20</td>
<td>50/35</td>
<td>75/60</td>
<td>95/85</td>
</tr>
<tr>
<td>Cardiovascular Disease*</td>
<td>20/10</td>
<td>30/20</td>
<td>50/35</td>
<td>75/60</td>
<td>95/85</td>
</tr>
<tr>
<td>Oncology (med/surg)**</td>
<td>20/10</td>
<td>45/30</td>
<td>60/45</td>
<td>75/60</td>
<td>110/100</td>
</tr>
<tr>
<td>Oncology (radiation)**</td>
<td>30/15</td>
<td>60/40</td>
<td>100/75</td>
<td>110/90</td>
<td>145/130</td>
</tr>
<tr>
<td>BH and Substance Abuse</td>
<td>20/10</td>
<td>45/30</td>
<td>60/45</td>
<td>75/60</td>
<td>110/100</td>
</tr>
<tr>
<td>BH Inpatient Facility</td>
<td>30/15</td>
<td>70/45</td>
<td>100/75</td>
<td>90/75</td>
<td>155/140</td>
</tr>
<tr>
<td>Acute Care Hospital</td>
<td>20/10</td>
<td>45/30</td>
<td>80/60</td>
<td>75/60</td>
<td>110/100</td>
</tr>
</tbody>
</table>

*High volume specialty
**High impact specialty

2. The ratio of PCP, SCP (including high volume and high impact), OB/Gyn, and behavioral health practitioners to members should be:
   - General/family practice to members: 1:500 or less
   - Pediatrics to pediatric members: 1:2,000 or less
   - Internal medicine to adult members: 1:500 or less
   - PCP to adult members: 1:500 or less
   - PCP to pediatric members: 1:2,000 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 practitioners who are board certified or board eligible should be
   - PCPs: At least 85 percent
All contracted specialists: at least 90 percent

The outcomes are reported to the Network Management Committee for approval and to the Clinical Quality Committee and Customer Service and Satisfaction Committee for review and input annually.

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

Using valid methodology, Blue Cross accesses standards for the following primary care physicians, high volume specialists and high impact specialists:
- Regular and routine care appointments within 30 calendar days
- Urgent care appointments within 48 hours
- Access to after-hours care (24 hours/7 days a week)

**Goals:**
- Primary care providers: 100 percent
- High volume and high impact: 90 percent

Blue Cross also, accesses standards for its behavioral health providers to include:
- Emergency care (life threatening or requiring rapid intervention to prevent rapid deterioration of the member’s health) within six hours
- Urgent care within 48 hours
- Initial visit for routine care within 10 calendar days
- Follow up routine care within 30 days of the initial visit

**Goals:**
- Initial routing visits: 95 percent
- Urgent and emergent non-life threatening: 100 percent
- Follow up routine care within 30 days of initial visit:
  - Nonprescribers: 45 percent
  - Prescribers: 10 percent

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

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

Data reports are generated quarterly via telephone records. The reports include: The total number of calls offered, handled, and abandons are calculated by pulling data for each of the applications determined to represent commercial business. BCBSM Customer Service calls handled within 40 seconds is calculated by comparing the
queue time on each phone record to a standard 40 seconds. Calls answered in 40 seconds or less percent is calculated by dividing the total number of calls offered to the service center by the number of answered within 40 seconds.

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

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

- Average speed of answer: This metric captures the average length of time a caller waits in a queue before they reach a representative. For this metric, a lower number indicates a better performance.

- Blocked rate: To prevent calls from getting disconnected after long waits, “Advanced Throttling” was established to intelligently look into the queue to determine if there is capacity to service additional calls. If there is no capacity, the customer would hear a message advising politely that we could not accept their call at this time. In essence, purposefully disconnecting the call up front in a courteous manor or “blocking” the call before the customer has to wait in a long queue and possibly get disconnected. For this metric, a lower number indicates a better performance.

**Goals:**
- Average speed of answer: 30 seconds or less
- Call abandonment rate: 5 percent or less
- Blocked rate 3 percent or less

The data is reported quarterly to the Member Experience Committee with a full analysis conducted annually.

### 7.2.4 Monitoring for quality and accuracy of information to members

All communications with members are delivered with accuracy regardless of whether it is via telephone or email. The BluExpert Quality Program is a tool containing methodology for performing oversight and monitoring functions on service delivery via telephone and written communications. This program is designed to supply ongoing assessment information to operational leaders and staff to be used to drive continual improvement in service delivery and outcomes. Data collected from individual evaluations is used to track and trend overall performance to goal.

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

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

- Ongoing coaching and development with individual customer service representatives
- Development and training for operational staff and/or leaders
- Staffing changes
- Systems and knowledgeware modifications and updates
**Goal:** CSR Performance Standard Range minimum of 80 percent.

The outcomes are reported to the Member Experience Committee quarterly for review.

**7.2.5 Monitoring email turnaround**

Blue Cross has a process for responding to email inquiries and evaluating the quality of email response. The BluExpert Quality Program tool is used to perform oversight and monitoring functions on service delivery via telephone and written (email) communications.

A monthly report is run to ensure the turnaround timeframes are being met. All data is pulled and an analysis is completed. The analysis includes but is not limited to a review of:

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

**Goals:**

- 80 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.
- CSR Performance Standard Range minimum of 80 percent

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

**7.3 Satisfaction**

Corporate Marketing and Customer Experience serves as the market and customer insight engine to the organization. These groups provide strategic direction and thought leadership to drive sales, improve the customer experience and build retention and loyalty. We are building a customer centric organization and transforming digital and offline customer touchpoints to ensure increasingly easy, useful and enjoyable experiences. By leveraging the insights gained from CAHPS and other research, as well as the *Voice of the Customer* efforts, this department identifies opportunities and aligns company resources to drive improvements in selected areas. Member experience annual documentation includes analysis of complaints and appeals, CAHPS and other data, and identifies opportunities for improvement of member satisfaction with Blue Cross services, behavioral health care and services and Marketplace network transparency and experience.

The Customer Experience department creates ongoing programs to educate employees on member “pain points” identified through research and analysis. This department also develops opportunities and tools to help employees improve the member experience. Blue Cross believes employees who are knowledgeable about member issues and concerns can make positive improvements in the member experience.

The 2018 annual corporate goals include a customer experience component that applies to all employees. This component focuses employees and resources on key improvement initiatives designed to address significant issues affecting the customer experience.
2018 program goals:
Blue Cross will focus on the following member satisfaction goals in 2018:

- Outperform the industry on member experience as measured by the Weighted Cross Survey Index to assess member satisfaction with Blue Cross care and services
- Drive adoption of Customer Experience practices with employees so they can activate on three behaviors that will create an easy, useful and enjoyable experience
- Outperform the cross-industry average mobile application customer satisfaction rating to ensure Blue Cross continues to have an award winning mobile app for its members
- Implement HITRUST security framework to help protect our members’ protected health information
- Support continuous improvement of services and satisfaction for members and providers
- Systematically evaluate member complaints and appeals as a source of data on member satisfaction, identify root cause, implement process improvements and assess impact of process improvements to ensure member issues are addressed
- Address plan understanding by identifying improvement initiatives through our voice of the customer and survey data and ensure member touchpoints are clear and simple

7.3.1 Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)
Blue Cross 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 BCSRM can improve service to members. CAHPS survey results are reported to NCQA and other governmental and regulatory agencies as required.

7.3.2 ECHO Behavioral Health Survey
Blue Cross surveys members using the ECHO behavioral health survey tool. This survey is designed to support efforts to measure, evaluate and improve the experiences of members with various aspects of mental health and substance abuse treatments, as well as counseling services.

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

The results are reported to Clinical Quality Committee annually.

7.3.3 Voice of the Customer (VOC)
The Blue Cross Voice of the Customer (VOC) 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 on a daily basis 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.

7.3.4 Digital Experience (DX)
The Blue Cross Digital Experience (DX) team supports the organization 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
• Agent Portal – Hub for Blue Cross agents to guide their portfolios from quote to enrollment
• Group Portal – One-stop shop for group customers to access and manage their coverage details
• Provider Portal – Wealth of resources for the Blue Cross 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.

7.3.5 Member Complaints
Blue Cross uses member complaint data to improve services and increase overall member satisfaction. All member complaints regarding medical, contractual or administrative concerns are received, categorized, reviewed and analyzed. Complaint resolution is accomplished through a cooperative effort between Blue Cross and BCN. Blue Cross clinical complaints are forwarded to Quality and Population Health using a mutually agreed-upon process for investigation, resolution, tracking and trending. These service trends are taken into account in the provider recredentialing process.

Blue Cross Executive Services maintains a consistent process in compliance with federal and state regulations for handling member preservice appeals, postservice appeals, coverage appeals and managing the federal external review process.

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

Goal: Improve each overall satisfaction response rate year over year.

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

7.3.7 Network adequacy
Blue Cross conducts an analysis of network adequacy to identify aspects of performance that don’t meet member expectations and initiate actions to improve performance. Blue Cross 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)

The health plan’s goals include:
• Complaint rate: ≤0.5/1000 members
• Appeal rate: ≤0.5/1000 members

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

### 7.3.8 Marketplace network transparency and experience
Blue Cross analyzes of member satisfaction information helps managed care organizations identify aspects of performance that don’t meet member expectations and initiate actions to improve performance. Blue Cross monitors multiple aspects of Marketplace member satisfaction, including:

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

The health plan’s goals include:

- Complaint rate: ≤0.5/1000 members
- Appeals rate: ≤0.5/1000 members

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

### 7.4 Safety
Blue Cross monitors and improves patient safety through activities focused on identifying and reporting safety concern; reducing medical errors; and collaboration with delivery systems, hospitals and physicians/clinicians to develop innovative plans to 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.

#### 7.4.1 Collaborative Quality Initiatives
Collaborative Quality Initiatives (CQIs) support Blue Cross efforts to work collaboratively with physicians, hospital partners and community leaders to develop programs and initiatives that save lives and reduce health care costs. CQIs are developed and administered by Michigan physician and hospital partners, with funding and support from Blue Cross and Blue Cross. 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:
1. Data Collection – Timely feedback of robust, trusted, consortium-owned performance data to hospitals and providers
2. Collaborative Learning – Collaborative, data-driven learning fostered in a noncompetitive environment (meetings are held in person, typically on a quarterly basis)
3. Improvement Implementation – Systematic development, implementation, and testing of hospital-specific and Michigan-wide quality improvement interventions

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

CQI Coordinating Centers
Each CQI is led by a Blue Cross-commissioned, provider-led Coordinating Center, that is independent of Blue Cross. Dedicated Coordinating Centers are responsible for ensuring the validity of the CQI program data and for managing quality improvement activities focused on improving outcomes, increasing efficiencies and reducing patient care costs. Coordinating Centers guide the development of quality improvement plans and generate new knowledge about best practices. The CQIs focus on areas where:
1. Identifiable and clear variations in practices of care exist throughout the health care continuum
2. An opportunity to positively influence outcomes is evident
3. Knowledge about optimal practices aren’t widely implemented or scientific uncertainty exists

The Coordinating Center is staffed by individuals whose primary function is the activities of the consortium—with the exception of the project leader (a practicing physician/surgeon, usually between a 0.25 to 0.40 FTE). Typically staffed by quality improvement, nursing and epidemiological personnel from a hospital (usually an academic center), the Coordinating Center’s role is to engage the provider community in all aspects of the consortium.

In most cases, participants submit disease or procedure-specific data to a centralized data registry. The Coordinating Center conducts risk-adjusted analyses to identify best practices and opportunities for improvement. Reports are then shared with participating hospitals where systematic implementation of the recommendations result in improved outcomes, increased efficiencies and cost avoidance associated with reduction in adverse outcomes.

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

As of 2018, Blue Cross is providing funding and active leadership for 18 CQIs addressing one or more of the following clinical conditions:
## Hospital CQIs
- Anesthesiology (ASPIRE)
- Cardiovascular (BMC2)
- Anticoagulation (MAQI2)
- Bariatric surgery (MBSIC)
- Cardiac surgery (MSTCVS)
- Emergency department care (MEDIC)
- General surgery (MSQC)
- Hospital efficiency (MVC)
- Radiation oncology (MROQC)
- Hospitalist care (HMS)
- Spine surgery (MSSIC)
- Total knee and hip replacement (MARCQI)
- Trauma (MTQIP)

## Ambulatory CQIs
- Urology (MUSIC)
- Lean transformation (Lean) – closing June 2018
- Pharmacy (MPTCQ)
- Oncology (practice and treatment) (MOQC)

## Hybrid CQI
- Integrated Michigan Patient-Centered Alliance on Care Transitions (IMPACT)

### 2018 program goals:
- Continue to develop additional best practices for CQI programs to demonstrate improved patient outcomes and share lessons learned locally, nationally, and internationally
- Evaluate CQI program performance to identify opportunities for strengthening, revamping or retiring

### 7.4.2 Blue Distinction Centers for Specialty Care® (BDC)

The goal of the national Blue Cross Blue Shield Association program, Blue Distinction Centers for Specialty Care, is to offer objective, transparent information about providers with expertise in delivering quality, cost-efficient specialty care, to help support a quicker return to health and productivity for members. Specialty Care recognizes providers as Blue Distinction Centers for demonstrating expertise in delivering specialty care, or as Blue Distinction Centers+ for demonstrating both expertise and cost-efficiency in delivering specialty care. Quality is key: only those providers that first meet Blue Distinction Centers’ objective, nationally consistent quality criteria are considered for designation as a Blue Distinction Center+.

Specialty Care focuses on seven high-impact areas of specialty care, including bariatric surgery, cancer care, cardiac care, knee and hip replacement, maternity care, spine surgery and transplants. These specialty care areas were chosen because they involve procedures and episodes of care in areas of high or increasing demand, yet with variations in quality and cost. Procedures and episodes of care in these areas account for more than 12.7 million inpatient discharges and $272 billion in hospital charges annually across all privately insureds.

Analysis confirms that, overall, patients treated at Blue Distinction Centers and Blue Distinction Centers+ have better outcomes, such as fewer complications and lower readmission rates. Overall, Blue Distinction Centers+ are also more cost-efficient than non-Blue Distinction Centers+, with episode savings near 20 percent on average.

Blue Distinction Centers and Blue Distinction Centers+ offer members and their providers the tools and knowledge that they need to make smart, informed decisions about where to receive quality, cost-efficient specialty care. Specialty Care enables broad national access to providers delivering better quality specialty care, no matter where members work and live in the U.S. Blue Distinction Center and Blue Distinction Center+ designations have been awarded to more than 1,800 providers across the nation, including each of the top 50 Metropolitan Statistical Areas (MSAs).

### 2018 program goals:
1. Provide continued communications support of the new maternity care designation program as well as this year’s redesignation of facilities with cardiac care, knee/hip replacement, and spine surgery BDC designations.

2. Measurement: Meet all Association tactical deadlines. Communications will be done through Blue Cross news releases and articles in our various Blue Cross provider e-newsletters.

7.4.2.1 Blue Distinction Total Care℠ (BDTC)
In 2015, the Blue Cross Blue Shield Association launched a newly created program for all Blues plans with value based programs call Blue Distinction Total Care, expanding the Blue Distinction program into the area of primary care. This new designation identifies high-performing Patient-Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs) that meet nationally consistent criteria for quality, efficiency and patient outcomes. BDTC programs incorporate patient-centered and data-driven practices to better coordinate care and improve quality and safety as well as affordability of care. Providers in BDTC programs are paid with value-based reimbursement rather than traditional fee-for-service, so they must perform against both quality and cost outcome targets in order to receive incentives and rewards for better health outcomes.

To be considered for BDTC designation, a provider must be part of a value-based program with a local Blue Cross and/or Blue Shield Plan that meets all six of the nationally consistent required selection criteria, carefully selected based on their part in driving higher quality and more affordable care:
1. Program focuses on managing care for a population of BCBS members
2. Program attributes BCBS members to the provider responsible for managing care
3. Program provider contracts contain value-based incentives associated with both cost and quality outcomes
4. Providers, in collaboration with BCBS Plans, are responsible for utilizing additional data and analytics to support activities including at least three of the following five practices to improve quality and affordability
   a. Practice Referral Pattern Management – assessing provider referral patterns to enhance quality and affordability
   b. Labs and Imaging Practice Management – assessing lab and imaging patterns to enhance quality and affordability
   c. Readmissions Practice Management – assessing patterns for quality and affordability that reduce avoidable readmissions
   d. Medication Practice Management – assessing patterns for quality and affordability that enhance medication management
   e. Emergency Room Practice Management – assessing patterns for quality and affordability that reduce ambulatory sensitive ER visits
5. Program is available to BCBS members through a PPO-based product.
6. Program is available to BCBS members covered by administrative services only (ASO) and fully insured products

2018 program goals:
• Complete customer reporting and deliver information on total cost of care trend management for book of business.
• Continue to work on BDTC+ designation with the Association.

7.4.2.2 MHA Keystone Center for Patient Safety & Quality
Blue Cross provides considerable funding to the Michigan Health and Hospital Association (MHA) to support the MHA Keystone Center, a collaborative effort among Michigan hospitals – along with state and national patient safety experts – to improve patient safety and reduce health care-acquired infections.
Over the past several years, the MHA Keystone Center has focused on initiatives related to care transitions, catheter-associated urinary tract infections (CAUTI), 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 (IHA) and the Wisconsin Hospital Association (WHA) to form the Great Lakes Partners for Patients Hospital Improvement Innovation Network (HIIN). The focus of the HIIN is to implement person and family engagement practices, enhance antimicrobial stewardship, build cultures of high reliability and address the following types of inpatient harm:

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

**2018 program goals:**
The primary goal of the Blue Cross funding for the MHA Keystone Center is to remove participation barriers for hospitals. In addition, the 2017 Blue Cross Hospital Pay-for-Performance Program rewards hospitals for the following HIIN-related activities:

- Submission of outcome data
  - Goal: At least 90 percent of outcome data submitted across 12-month period
- Improvement on pain management for sepsis and CAUTI measures
  - Goal: Improvement on adverse events related to catheter-induced urinary tract infections, sepsis and inpatients receiving opioids
- Launch of Patient and Family Advisory Councils
  - Goal: Fully include patient advisors
- Assessment of current practices for antimicrobial stewardship (AMS)
  - Goal: Complete AMS gap analysis

**7.4.2.3 Health Information Exchange (HIE)**
The Health Information Exchange (HIE) 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 (MiHIN) 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 (ADT) and Emergency Department (ED) 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 ADT and ED visit data, identify which physician has a care relationship with each patient and transmit a notification to the relevant physician organization.

Expanding on the hospital ADT data available to POs, Blue Cross introduced a skilled nursing facility (SNF) Pay-for-Performance program into the HIE continuum beginning in January 2016. The SNF P4P program provides freestanding and hospital-based SNFs the opportunity to earn an incentive for meeting HIE expectations, including submission and receipt of 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, Blue Cross Chief Medical Officer serves as a member of the MiHIN board.

7.4.2.3.1 Peer Group 1-4 Hospitals Engagement in HIE Initiative
Since the HIE Initiative was introduced in 2014, 83 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 93 percent of all admissions statewide. These efforts will continue to be recognized through 2018, with hospitals earning a portion of their Blue Cross P4P HIE points through continued data quality conformance standards for the ADT and Medication Reconciliation use cases. The remaining points are earned by participating in at least one new HIE use case through the MiHIN statewide service each year. The use case options through 2018 include the common key service and exchange statewide lab results.

7.4.2.3.2 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 (CAH) 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 had the option of participating in the MiHIN statewide service by implementing the Admission-Discharge-Transfer use case. This resulted in 19 of 45 hospitals implementing the ADT use case. Starting in 2018, the remaining hospitals are required to begin participation in the MiHIN statewide ADT use case in order to improve care transitions and reduce readmissions and assist rural providers in joining the existing HIE efforts that PG1-4 acute care hospitals and skilled nursing facility post-acute providers have been participating in as part of their own incentive programs.

7.4.2.3.3 Skilled Nursing Facility Engagement in HIE Initiative
Blue Cross introduced a skilled nursing facility (SNF) Pay-for-Performance program into the HIE continuum beginning in January 2016. In 2018, the SNF P4P program provides freestanding and hospital-based SNFs the opportunity to earn an additional two 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 2017), 188 of 442 SNFs currently meet this requirement.
**7.4.3.4 Physician Organizations (PO) Engagement in HIE Initiative**

Since 2014, thirty-nine physician organizations have started participating in MiHIN’s statewide notification service through implementation of the Active Care Relationship Service (ACRS), Admission-Discharge-Transfer (ADT), and Exchange Medication Reconciliation 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 and ED visit notifications for more than 7 million Michigan patients.

A new component of the HIE Initiative in 2018 is a vendor initiative that leverages PGIP funds to engage IT vendors, on behalf of all participating physician organizations and practices, to implement 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.

In 2018, HIE efforts will also continue to focus on expanding use of the statewide shared infrastructure, improving data quality, and helping recipients appropriately incorporate ADT messages and discharge medication information into processes of care. The HIE Initiative will continue to promote key foundational use cases, such as the Active Care Relationship Service (ACRS) and the statewide Health Directory, designed to increase coordination and collaboration across multiple settings to support population health management and payment reform.

**2018 HIE program goal:**
Engage at least five IT vendors, representing approximately 1,000 practices, in an initiative to promote standard EHR data sharing and quality reporting capabilities across PGIP.

**7.4.2.4 Value Partnerships Pharmacy Workgroup**

Formed in 2013 with a focus on partnering with and providing value to our members and providers, Value Partnerships, HCV Data Analytics and Pharmacy Services formed a workgroup 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 upon those. Pharmacy-related topics are identified and presented to pharmacy representatives at provider organizations related to medication safety, quality and cost-effectiveness. In addition, the workgroup facilitates the use of clinical data by physician organizations to address gaps in clinical care and improve prescribing.

**2018 program goals:**
In 2018, the workgroup will identify further opportunities to work with pharmacists in physician organizations. Topics addressed through the workgroup will include, but not be limited to opioids, medication adherence, antibiotics, medication reconciliation and pharmacy costs. Goals for the Value Partnerships Pharmacy Workgroup include holding at least eight meetings with PGIP physician organization; sustaining physician organization interest and engagement on pharmacy issue; conducting at least one survey and implementing at least one change as a result of the survey.

**7.4.2.5 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:

**Triple Threat Initiative**

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

Members who receive this high-risk combination are identified through prescription claims. Providers who have written at least one prescription in that drug combination for an identified member are notified. Pharmacy Services reaches out to these prescribers via fax letter to provide education about this dangerous drug combination and to encourage use of the state’s Prescription Drug Monitoring Programs (for example, MAPS). Members who are repeatedly identified are referred to a Controlled Substance Workgroup to improve coordination of care.

**Goal:** Decrease the number of members receiving the Triple Threat drug combination by five percent.

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

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

The objective is to increase the percentage of electronically-prescribed controlled substances to 25 percent over three years (by 2018). The focus is to work with primary care providers and specialists who prescribe controlled substances to support adoption of EPCS and help break down existing barriers. Blue Cross provides each physician organization with opportunity reports and physician organizations are eligible for an incentive based on improved EPCS rates.

**Goal:** Increase the percentage of electronically-prescribed controlled substances to 25 percent over three years (by 12/31/2018).
8.0 Cultural and Linguistic Diversity

In 2018, Blue Cross will narrow its focus and address disparities using our Value Partnerships Patient-Centered Medical Home program. The PCMH program supports provider collection of race, ethnicity and language (REL) data in addition to supporting language translation services and bilingual materials. 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.

The Blue Cross PCMH program was featured in the April 2015 JAMA publication. A longitudinal study of 2,218 primary care practices examined breast, cervical and colorectal cancer screening rates on the practices’ plan patients. Results indicated that the implementation of PCMH was associated with higher screening rates and reductions in socioeconomic disparities than were otherwise seen for preventive cancer screenings.

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

<table>
<thead>
<tr>
<th>Guideline number</th>
<th>PCP and Specialist Guideline</th>
<th>Definition</th>
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<tbody>
<tr>
<td>2.20</td>
<td>Registry contains advanced patient information that will allow the practice to identify and address disparities in care</td>
<td>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</td>
</tr>
<tr>
<td>2.21</td>
<td>Registry contains advanced patient demographics</td>
<td>Gender identity, sexual orientation, sexual identity</td>
</tr>
</tbody>
</table>
| 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 3rd-party interpretation services or multi-lingual staff  
Asking a friend or family member to interpret does not meet the intent of the capability |
| 5.10             | Patient education materials and patient forms are available in languages common to practice’s established patients | Languages common to practice are defined as languages identified as primary by at least 5% 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. |

Annually, Blue Cross analyzes marketplace and PPO populations 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, an Enterprise workgroup was formed with the following purpose:

- Create a shared understanding and vision for addressing health disparities
- Collect data
- Define an enterprise health disparities focus

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

In 2017, the workgroup identified disparities within preventive cancer screenings and ED utilization in African Americans and other ethnic groups as primary focus areas. Work is ongoing to identify how current programs address community ethnic needs and the areas of focus as well as determine gaps/opportunities for programs to improve alignment going forward.

**2018 program goals:**

- Maintain PCMH capabilities to encourage provider collection of REL data, support for member language differences and promotion of community linkage to local and national resources that are appropriate for their ethnicity, gender orientation, ability status, age, and religious preference, including resources that are available in other languages;
- Identify and present to key internal stakeholders in the commercial businesses;
- Publish an article about the health disparities efforts in Blues News Direct;
- Form temporary work groups to implement initiatives;
9.0 Qualified Providers

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

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

9.2 Facility site review
Blue Cross sets acceptable standards for provider offices including physical accessibility, physical appearance, adequacy of waiting and examining room space, availability of appointments and adequacy of medical record keeping.

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

Goal: Conduct reviews within 30 days of request

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

Goal: Conduct reviews within 30 days of request.

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

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

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

9.6 Peer review process and implementation of corrective action plan
Blue Cross has a peer review mechanism whereby all potential quality of care and service issues are identified, investigated, analyzed, monitored and resolved timely. Sources of potential quality of care and service issues include, but aren't limited to the following:
- Participating physicians
- Member complaints
- Quality management tracking processes
- Concurrent review
- Content of medical record review
- Referral from Blue Cross internal departments or committees
- Risk management
- Blue Cross medical directors and medical staff members

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

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

A physician may be terminated by Blue Cross for any reason other than a reason prohibited by law (for example, discrimination). Blue Cross may terminate its contractual relationship with an affiliated physician by declining to recredential, failing to renew a time limited contract or by appropriate notification to the physician at any time during the term of the contract.
9.8 Physician appeal process

Blue Cross offers a physician appeal process when the relevant corporate committee, and/or a plan medical director has taken or recommended action based on concerns related to selected administrative issues or quality of patient care provided by the physician. That action includes at least one of the following:

- Denial of a physician’s application for affiliation or continued reaffiliation for reasons related to the quality of care provided by the physician.
- Restriction or regulation of a physician's clinical practice for more than 15 days for reasons related to the quality of care provided by the physician.
- Termination of a physician’s contract for reasons relating to selected administrative concerns or the quality of care provided by the physician.
10.0 Delegation Activities

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

11.0 Compliance

11.1 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 Blue Cross members. Examples of external entities are as follows: Department of Insurance and Financial Service, National Committee for Quality Assurance and Centers for Medicare & Medicaid Services.

11.2 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 Blue Cross 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 Blue Cross 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.
11.3 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.

Blue Cross 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
12.0 Quality Improvement Work Plan

An annual work plan is developed to document the Quality Improvement Program objectives, planned projects, responsible person and targeted time frames for completion. The work plan is initiated by the Quality and Population Health department and is forwarded to the Clinical Quality Committee and the Customer Service and Satisfaction 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
13.0 Quality Improvement Program Evaluation

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

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

The evaluation is initiated by the Quality and Population Health department. The evaluation is submitted to the Clinical Quality Committee and the Customer Service and Satisfaction Committee for review and recommendations. The Health Care Quality and Service Improvement Committee approves and submits the evaluation to the BCN board of directors and the Blue Care of Michigan Inc. board of directors for final approval.
## 14.0 FEDERAL EMPLOYEE PROGRAM

The Federal Employee Program (FEP) Quality improvement Program is consistent with the Commercial PPO/Marketplace program with following exceptions:

<table>
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<tr>
<th>2017 Commercial PPO/Marketplace Quality Improvement Description</th>
<th>FEP Exception</th>
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<tbody>
<tr>
<td>Page 17</td>
<td>The FEP Director’s Office (not the Member Experience Committee) assumes responsibility for providing oversight of the website and print materials for member health (pre-enrollment and enrollment).</td>
</tr>
<tr>
<td>Page 39</td>
<td>The website used by FEP members is <a href="http://fepblue.org">fepblue.org</a>. Web content and member digital experience are managed and monitored by the Director’s Office, not Blue Cross Blue Shield of Michigan.</td>
</tr>
<tr>
<td>Page 39</td>
<td>Administrative member complaints for FEP are handled by FEP. FEP administrative member complaint statistics are provided to Executive Services quarterly for inclusion in the corporate report. FEP Clinical member complaints are handled by Blue Cross and follow the corporate process.</td>
</tr>
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</table>
15.0 Acronyms

AAFP       American Academy of Family Practice
AAP        American Academy of Pediatrics
AB         Abandonment Rates
ABA        Applied Behavioral Analysis
ACA        Affordable Care Act
ACO        Accountable Care Organization
ACP        Advanced Care Planning
ACP        American College of Physicians
ADT        Admission, Discharge, Transfer (and ED visits)
ADHD       Attention Deficit Hyperactivity Disorder
AHRQ       Agency for Healthcare Research and Quality
AIM        American Imaging Management
AOA        American Osteopathic Association
ASA        Average Speed of Answer
ASCO       American Society of Clinical Oncology
ASPIRE     Anesthesiology Performance and Improvement Reporting Exchange
BCBSA      Blue Cross Blue Shield Association
BCBSM      Blue Cross Blue Shield of Michigan
BCN        Blue Care Network
BDC        Blue Distinction Centers for Specialty Care®
BDC+       Blue Distinction Centers Plus
BMC2       Blue Cross Blue Shield of Michigan Cardiovascular Consortium
CA         Care Advance
CAHPS®     Consumer Assessment of Healthcare Providers and Systems
CAP        Corrective Action Plan
CER        Comparative Effectiveness Research
CIT        Clinical Innovator Technology
CIU        Continuous Improvement Unit
CLQI       Clinical Quality Improvement Initiative
CMO        Chief Medical Officer
CMS        Centers for Medicare & Medicaid Services
COPD  Chronic Obstructive Pulmonary Disease
CQI   Collaborative Quality Initiative
CSR   Customer Service Representative
EBC   Evidence-Based Care
EBCT  Evidence-Based Care Tracking
ECOC  Executive Committee of Officers Committee
EMR/DMR  Electronic Medical Record/Disease Management Registry
ESI   Express Scripts, Inc.
FTE   Full-Time Equivalent (employee)
FUH   Follow-up after Hospitalization
GTRQC Genetic Testing Resource and Quality Consortium
HCV   Health Care Value
HEDIS® Healthcare Effectiveness Data and Information Set
HIE   Health Information Exchange
HMO   Health Maintenance Organization
HMS   Hospital Medicine Safety
HOTP  Human Organ Transplant Program
HRM   High Risk Medications
ICP   Intracranial Pressure
IMPACT Integrated Michigan Patient-centered Alliance on Care Transitions
INR   International Normalization Ratio
INS   Infusion Nurses Society
IVR   Interactive Voice Response
JSM   Joint Statistical Meeting
JUMP  Joint Uniform Medical Policy
MAQI2 Michigan Anticoagulation Quality Improvement Initiative
MARCO2 Michigan Arthroplasty Registry Collaborative for Quality Improvement
MBSC  Michigan Bariatric Surgery Consortium
MEC   Member Experience Committee
MEDIC Michigan Emergency Department Improvement Collaborative
MHA   Michigan Health and Hospital Association
MiBOQI Michigan Breast Oncology Quality Initiative
MiHIN  Michigan Health Information Network
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
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<tr>
<td>MiPCT</td>
<td>Michigan Primary Care Transformation Project</td>
</tr>
<tr>
<td>MOQC</td>
<td>Michigan Oncology Quality Consortium</td>
</tr>
<tr>
<td>MQIC</td>
<td>Michigan Quality Improvement Consortium</td>
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<tr>
<td>MSQC</td>
<td>Michigan Surgical Quality Collaborative</td>
</tr>
<tr>
<td>MSTCVS</td>
<td>Michigan Society of Thoracic and Cardiovascular Surgeons Quality Collaborative</td>
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<tr>
<td>MTQIP</td>
<td>Michigan Trauma Quality Improvement Project</td>
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<td>MUSIC</td>
<td>Michigan Oncology Quality Consortium</td>
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<td>NCQA</td>
<td>National Committee for Quality Assurance</td>
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<tr>
<td>NDC</td>
<td>National Drug Code</td>
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<tr>
<td>NRT</td>
<td>Nicotine Replacement Therapy</td>
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<tr>
<td>OOP</td>
<td>Out-of-Pocket Maximum</td>
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<tr>
<td>OSC</td>
<td>Organized System of Care</td>
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<tr>
<td>P4P</td>
<td>Pay for Performance</td>
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<tr>
<td>PCI</td>
<td>Percutaneous Coronary Intervention</td>
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<td>PCMH</td>
<td>Patient-Centered Medical Home</td>
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<tr>
<td>PCMH-N</td>
<td>Patient-Centered Medical Home Neighbor</td>
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<tr>
<td>PDCM</td>
<td>Provider Delivered Care Management</td>
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<td>PCORI</td>
<td>Patient-Centered Outcomes Research Institute</td>
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<td>PCP</td>
<td>Primary Care Physician</td>
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<td>PGIP</td>
<td>Physician Group Incentive Program</td>
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<td>PHI</td>
<td>Protected Health Information</td>
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<td>PMPM</td>
<td>Per Member Per Month</td>
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<td>PO</td>
<td>Physician Organization</td>
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<td>PPO</td>
<td>Preferred Provider Organization</td>
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<td>PSO</td>
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<td>QHP</td>
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<td>QOPI®</td>
<td>Quality Oncology Practice Initiative</td>
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<td>QRS</td>
<td>Quality Rating System</td>
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<td>Society of Thoracic Surgeons</td>
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<td>SVP</td>
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<td>TBI</td>
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<td>TSF</td>
<td>Telephone Servicing Factor</td>
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<td>UM</td>
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<td>VIC</td>
<td>Vascular Interventions Collaborative</td>
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<td>VMCOE</td>
<td>Vendor Management Center of Excellence</td>
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<td>VOC</td>
<td>Voice of the Customer</td>
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<td>VTE</td>
<td>Venous Thromboembolism</td>
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<td>WATCH</td>
<td>Warfarin Alternative Treatment Cohort</td>
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<td>WCM</td>
<td>Wellness and Care Management</td>
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Required Approvals

The 2018 BCBSM Commercial PPO/Marketplace Quality Improvement Program Description has been reviewed and approved.

APPROVED BY:

Health Care Delivery Committee:

Executive Committee of Officers Committee:

Clinical Quality Committee: 02.21.2018
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