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 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 the conflict of interest policy annually at Blue Cross. A conflict of interest disclosure statement, which is maintained in Human Resources, is signed by all employees annually.
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1.0 INTRODUCTION

Headquartered in Detroit, Blue Cross Blue Shield of Michigan (Blue Cross) is the state’s largest Preferred Provider Organization (PPO) health plan, serving approximately 2.2 million members in the state of Michigan.

This program description document applies to PPO Commercial and Marketplace products. Marketplace indicates the QRS and EPO population unless specified otherwise. FEP PPO products are included under the Commercial PPO.

Blue Care Network (BCN), the Blue Cross HMO healthcare 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 in 2014 and 2015.

1.1 Background

Blue Cross’ Commercial PPO product is transforming healthcare through a series of initiatives that are promoting personal and population health, improving quality and lowering costs. As shown in the Total Health Engagement Model, our goal is to combine innovative plan designs, dedicated health support and enhanced care delivery to provide members with the highest quality healthcare experience.

BLUE CROSS Total Health Engagement Model
1.1.1 Hospitals

Since 1997, Blue Cross has partnered with hospitals across the state of Michigan in a joint effort to improve healthcare quality and patient safety surrounding many common and costly areas of surgical and medical care. In the Blue Cross /BCN-sponsored Hospital Collaborative Quality Initiatives (CQIs), hospitals and clinicians across the state work together in a trusted, non-competitive environment collecting patient risk factors, clinical process data and outcomes data. Seventy-five hospitals across Michigan participate in at least one CQI – 95 percent of eligible hospitals participate in the five most established CQIs.

Collectively, the CQIs analyze the care given to over 475,000 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 Blue Cross CQI program is nationally recognized and has received multiple national 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 nearly 100 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.

1.1.2 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, 45 physician organizations participate in PGIP; they represent nearly 20,000 primary and specialty care physicians from the Blue Cross network. The POs 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.

The Physician Group Incentive Program provides POs 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. Approximately 87 percent of the commercial PPO population for Blue Cross in Michigan is cared for by physicians engaged in PGIP.

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 July 2015, Blue Cross PCMH-designated practices included:

- 1,551 designated practices
- 4,349 designated primary care physicians
- 1.2 million attributed Blue Cross members
In PCMH practices, a care team led by a PCP 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 78 of Michigan’s 83 counties—or 94 percent of Michigan counties.

In 2012, a select group of nearly 400 PCMH-designated practices joined the Michigan Primary Care Transformation Project, a Centers for Medicare and Medicaid (CMS) supported demonstration project to test the PCMH model nationally. Of the eight states participating, Michigan provided over 50 percent of PCMH-designated physicians.

Led in part by Blue Cross, the project includes a program called Provider Delivered Care Management (PDCM). Provider Delivered Care Management embeds care managers employed by POs or medical practices into the primary care setting. This is part of how Blue Cross also works with members to help reduce health risks by providing guidance with smoking cessation, cholesterol management, and blood pressure control. Blue Cross is committed to providing access to high-quality, comprehensive and cost-effective medical care with the ultimate goal of helping members realize positive results in the journey toward better health. This CMS pilot was extended until the end of 2016.

Also in 2012, Blue Cross 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.

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 PCPs, specialists, health care facilities and hospitals, 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.

The PGIP field team supports the state-wide collaborative relationships with the 45 physician organizations and 39 OSCs to ensure program integrity through the following activities:

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

1.2 Quality Improvement Program

Blue Cross created the Commercial PPO/Marketplace Quality Improvement (QI) Program to systematically and comprehensively assess, monitor, measure, evaluate and implement strategies to improve the quality of care delivered to Blue Cross members. 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.

The Quality Improvement Program is overseen by the President’s Operating Committee (OC) and Health Care Delivery Committee (HCDC). The Quality Improvement Committee (QIC), which reports to OC and HCDC, was developed in accordance with accreditation, contractual, federal and state regulatory, local and organizational requirements and guidelines.

Blue Cross collects annual information on member access to care, availability of services, clinical quality and satisfaction, provider performance and compliance and health outcomes through HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and Blue Cross member satisfaction surveys. Assessment of provider and service accessibility, clinical quality, utilization/medical management programs, quality improvement projects, member satisfaction, delegation, continuity and coordination of care and patient safety are also monitored and evaluated within the scope of the Quality Improvement Program. Using a data-driven strategy to direct the Quality Improvement Program, Blue Cross uses this information to understand our population and to identify opportunities to improve member health and satisfaction.

1.2.1 Staffing

The Blue Cross Quality Improvement Program is supported by the following resources:

- Designated Medical Director for Quality
- Designated Associate Medical Director who chairs the Quality Improvement Committee
- Director and four healthcare analysts

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

Involvement of Designated Physician in QI Program

There are two physicians dedicated to the QI Program – a Medical Director who advises the QI Committee and participates in program development as needed and an Associate Medical Director – dedicated to the QI Program full time - whose responsibilities are as follows:

- Chairs the QIC, assisting with preparation of Quality Improvement program documents and review of clinical guidelines for QI programs
- Participates in behavioral health QIC and associated activities
• Assists with QI activities related to HEDIS and continuity and coordination of care improvements
• Provides delegation oversight
• Oversees program related to improvement of health disparities
• Ensures alignment of utilization management and case management with NCQA standards and assists with internal process improvement

**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
• Identified 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
2.0 ORGANIZATIONAL STRUCTURE

The Blue Cross board of directors, program committees, operational departments and Blue Cross 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 (access and availability, clinical quality, member satisfaction, qualified providers and compliance).

2.1 Board of Directors and Health Care Delivery Committee

The Board of Directors, who is responsible for overall governance of Blue Cross, has designated the Health Care Delivery Committee (HCDC), a Board subcommittee, to perform board-level oversight of the Quality Improvement Program. The HCDC, which includes individuals representing the provider and member community, reviews and approves the QI Program Description, Work Plan and Evaluation annually.

* These committees report to the QIC Quarterly.
** This committee reports to the OC and HCDC
2.2 President’s Operating Committee
The President’s Operating Committee (OC) is the Blue Cross executive team that conducts quality oversight for the Quality Improvement Program. The OC facilitates alignment of the Blue Cross strategic plan with the quality mission of the organization. The Blue Cross CEO chairs this committee.

<table>
<thead>
<tr>
<th>PRESIDENT’S OPERATING COMMITTEE</th>
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<tr>
<td>President and Chief Executive Officer (CEO)</td>
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<tr>
<td>Senior VP and Chief Information Officer (CIO)</td>
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<td>Senior VP, Health Care Value, and Chief Medical Officer (CMO)</td>
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<tr>
<td>Senior VP – Corporate Secretary and Services</td>
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<td>Senior VP – General Auditor and Corporate Compliance</td>
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<td>Senior VP – Health Care Value</td>
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<td>Executive VP, Chief Financial Officer (CFO) and President – Emerging Markets</td>
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<td>Executive VP – Group Business and Corporate Marketing</td>
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<td>Executive VP – Health Care Value</td>
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<td>Executive VP – Operations and Business Performance</td>
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<td>Executive VP – Strategy, Government and Public Affairs</td>
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<td>VP – Corporate Strategy</td>
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<td>VP – General Counsel</td>
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2.3 QI Program Committees
The Quality Improvement, Utilization Management, and Member Experience committees report directly to the President’s Operating Committee (OC), which has the authority to assess overall performance, address potential barriers and prioritize company resources to continuously improve the quality of care, clinical outcomes and member experience with Blue Cross. Activities planned for the year are described in the Quality Improvement Work Plan which addresses the quality of clinical care and service, safety of care, yearly objectives, expected timeframe needed to accomplish these activities, monitoring and annual evaluation. The Quality Improvement, Utilization Management, and Member Experience committees meet quarterly, at a minimum.

There are also three enterprise-wide quality improvement subcommittees, performing functions for both Blue Cross and BCN. For the Blue Cross commercial PPO Michigan membership, these sub-committees report to either the QIC or UM Committee.

1. **Credentialing Committee** – reports to the QIC.

   The Credentialing Committee is an enterprise committee representing Blue Cross Blue Shield of Michigan and Blue Care Network, with oversight responsibility for credentialing and re-credentialing activities for practitioners and organizational providers. The Credentialing Committee meets monthly.
2. **Pharmacy and Therapeutics (P&T) Committee** – reports to the UM 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 also be based on economic considerations that achieve appropriate, safe and cost effective drug therapy. Therapeutic advantages in terms of safety and efficacy are considered when selecting formulary drugs and when reviewing placement of formulary drugs into formulary tiers.

The committee is comprised of 15 members, who represent various clinical specialties. Nine of the 15 members are external (not employed by Blue Cross or BCN) and include six practicing physicians, two practicing pharmacists and one consumer advocate. The remaining six members include two Blue Cross and BCN pharmacy directors, two BCN physicians and two Blue Cross physicians. The Committee also relies on invited guests within or outside Blue Cross/BCN, including contracted providers or healthcare professionals who can contribute specialized or unique knowledge or skills. The P&T Committee meets quarterly.


The Joint Uniform Medical Policy Committee, an official corporate committee of Blue Care Network and Blue Cross Blue Shield of Michigan, evaluate new technologies, devices and healthcare services, as well as new uses of existing technologies, devices and healthcare services. Evaluations may result in the development or revision of medical policy statements that describe the technologies, devices and healthcare services as investigational or non-investigational. A behavioral healthcare professional participates in the decision making process on the committee for behavioral medicine topics. The JUMP Committee meets a minimum of four times a year.
2.3.1 Quality Improvement Committee

The Quality Improvement Committee (QIC) provides direction, input and oversight to QI activities that are developed and implemented within the QI program. The QIC meets quarterly.

<table>
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<tr>
<th>QUALITY IMPROVEMENT COMMITTEE</th>
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<tr>
<td><strong>Co-Chairs</strong></td>
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<tr>
<td>Amy McKenzie, MD, FAAFP – Associate Medical Director, PPO and Care Management</td>
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<tr>
<td>Vicki Boyle, RN – Director of Quality Management and Accreditation, PPO and Care Management</td>
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<tr>
<td><strong>Committee Members</strong></td>
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<tr>
<td>Medical Director – PPO and Care Management</td>
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<tr>
<td>Senior Associate Medical Director – Clinical Quality</td>
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<tr>
<td>Senior Associate Medical Director – PPO and Care Management</td>
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<td>Director II – Pharmacy Services</td>
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<tr>
<td>Director – Blue Care Network (BCN) Quality Management</td>
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<td>Director – Market Research</td>
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<td>Director – Medical Affairs</td>
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<tr>
<td>Director – Program and Quality Support</td>
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<td>Manager – Executive Services</td>
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<td>Manager – FEP Care Coordination and Managed Care</td>
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<td>Manager – Healthcare Value IT</td>
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<td>Manager – Medical Informatics</td>
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<tr>
<td>Manager – PPO and Care Management</td>
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<tr>
<td>Manager – PPO Network Administration</td>
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<td>Manager – Value Partnerships</td>
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<td>Business Unit Compliance Liaison – Service Operations</td>
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<td>ECV Business Consultant – Value Partnerships</td>
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**QIC Committee Responsibilities**

- Provide clinical quality oversight including review and annual approval of the QI Program Description, QI Program Evaluation and QI Work Plan
- Facilitate integration of quality initiatives and operations across the enterprise
- Evaluate the Quality Improvement Program and its activities on a regular basis and identify needed actions
- Recommend, review and approve policies relevant to quality improvement at least annually
- Provide annual updates to the Health Care Delivery Committee (HCDC) and President’s Operating Committee (OC)
- Ensure practitioner participation in QI program
- Identify QI program enhancements based on analysis and significance to the organization and provide follow up as appropriate
- Provide oversight of activities shared with BCN
- Approve clinical guidelines annually
2.3.2 Utilization Management Committee (UM)

The Utilization Management Committee provides oversight for the Utilization Management program. The UMC meets quarterly.

### UTILIZATION MANAGEMENT COMMITTEE

| Co-Chairs | Ann Baker, MPH – Vice President, Wellness and Care Management  
Ravi Govila, MD – Vice President, Medical Care Management & PPO |
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<tr>
<td>Committee Members</td>
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Associate Medical Director – PPO & Care Management  
Medical Director – Clinical Management  
Director II – Pharmacy Services, Clinical  
Director II – Medical Affairs  
Director II – Medical Affairs  
Director II – Provider Servicing  
Director – WCM Program Quality and Support  
Director – Chronic Condition Management Program Delivery  
Director – Strategic Informatics & Program Evaluation  
Director – Federal Employee Program  
Director – Utilization Review  
Director – Claims Operations, Data Integrity & Data Analytics  
Manager – Executive Services  
External practicing physicians (2 physicians from New Directions Behavioral Health – titles noted below):  
1. Senior Vice President and Chief Medical Officer  
2. Medical Director |

**UM Committee Responsibilities**

- Approve and review the UM program description at least annually to include program structure, scope, processes and information sources used to make UM determinations
- Review and approve UM Evaluation and UM Work Plan
- Provide a designated a senior physician who is actively involved in implementation, supervision, oversight and evaluation of the UM program as a member of this committee
- Provide a designated behavioral health practitioner who is actively involved in implementing behavioral healthcare aspects of the UM program as a member of this committee
- Designate representatives from the Pharmacy & Therapeutics, Joint Uniform Medical Policy (JUMP), and Criteria Review committees who are actively involved in developing criteria used to make utilization decisions
- Review and provide feedback on criteria used to make utilization decisions and procedures used to apply the criteria
- Collect the following metrics and use to evaluate and make improvements to the UM program annually:  
  - Member and practitioner access to staff seeking information about the UM process and the authorization of care
- Member and provider experience with the UM program
- Type and volume of requests for services, denials and appeals
- Consistency in application of criteria to deny services
- Timeliness of denials and appeals

- Provide oversight of UM delegates

2.3.3 Member Experience Committee
The primary purpose of the Member Experience Committee (MEC) is to provide oversight for all member and prospective member interactions including communications, satisfaction, grievance, and protected health information to improve quality and consistency in services for members across channels, functions and member touch points. The MEC meets quarterly.

**MEMBER EXPERIENCE COMMITTEE**

| Co-Chairs | Amy Frenzel, VP – Service Operations  
|           | Kathryn Levine, VP – Corporate Marketing and Customer Experience |
| Committee Members | Director II – Customer Experience  
|                   | Director II – Pharmacy Services  
|                   | Director – Digital Experience  
|                   | Director – Executive Services  
|                   | Director – Federal Employee Program  
|                   | Director – Wellness & Care Management  
|                   | Director – Provider Outreach  
|                   | Manager – Ancillary Program Management  
|                   | Manager – Executive Services  
|                   | Manager – Federal Employee Program  
|                   | Senior Health Care Analyst – Ancillary Program Management  
|                   | VP – Wellness & Care Management |

**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 determine if activities designed to improve the experience are effective or need to be further modified based on survey outcomes
- Promote cultural diversity initiatives
- Provide oversight and evaluation of materials for all stakeholder communications across channels
- Provide oversight of website and print materials for member health (pre-enrollment and enrollment)
- Recommend and create content for member and provider communication
- Facilitate 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 Quality Improvement Committee (QIC) updates quarterly and to the President’s Operating Committee (OC) on request
• Analyze member complaints and appeals data 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, and quality of practitioner office site
• Scope includes the commercial PPO, Marketplace, and Federal Employee Program product lines

3.0 PROGRAM ACTIVITIES

Quality Improvement Program activities are designed to (1) continuously monitor and evaluate the quality of care and services provided to Blue Cross members and (2) develop strategies to improve member outcomes, safety and overall satisfaction. The QI work plan is the tool utilized to track and monitor the QI Program goals and activities.

The QI Program is designed to achieve the following goals for all members:
1. Ensure quality of care and services that meet the state, federal and accreditation requirements using established, best practice goals and benchmarks to drive continuous performance improvement.
2. Measure, analyze, evaluate and improve the administrative service of the plan.
3. Measure, analyze, evaluate and improve health care services delivered by contracted practitioners.
4. Promote medical, behavioral health and preventive care delivered by contracted practitioners that meet or exceed accepted standards of quality.
5. Achieve outcome goals related to health care access and availability, quality, cost and satisfaction.
6. Empower members to make healthy lifestyle choices through health promotion activities, support for self-management of chronic and/or complex conditions, community outreach activities and coordination with community resources.
7. Promote safe and effective clinical practice through established standards and best practice guidelines
8. Educate members about patient safety through member newsletters/communications, health promotion activities and community outreach efforts.

Current Blue Cross programs include the following areas of quality improvement:
• Value Partnerships including CQI, PCMH, PCMH-N, and OSC programs
• Patient safety management
• Behavioral health and wellness promotion
• Shared Enterprise Services for Credentialing/Re-credentialing, including access and availability of services and continuity and coordination of care
• Member satisfaction
• Cultural and linguistic needs of members
• Medical management programs, including utilization management, disease management and case management
• Quality of clinical care, including clinical practice and preventive health guidelines
• Delegation oversight
• Pharmacy programs for safety and medication adherence
3.1 Value Partnerships Program

Value Partnerships is a collection of clinically-oriented initiatives and Blue Cross-sponsored partnerships that have significantly improved the quality of patient care throughout the state of Michigan. Through these initiatives, Blue Cross partners with physicians, behavioral specialists, physician organizations (POs) and hospitals to create an innovative and quality-based approach to reward the transformation of healthcare. These initiatives focus on:

- Enhancing clinical quality
- Decreasing complications
- Managing costs
- Eliminating errors
- Improving efficiency
- Improving health outcomes
- Enhancing continuity and coordination of care

The goals of the Value Partnerships programs are aligned with the Institute for Healthcare Improvement’s Triple Aim goals, which are:

- Improving the patient experience of care
- Improving the health of the population
- Reducing the per capita cost of health care

Specific information about each initiative can be found at [www.valuepartnerships.com](http://www.valuepartnerships.com).

Value Partnerships initiatives support the organization’s continued move from a fee-for-service to a fee-for-value approach to reimbursement.

3.1.1 Physician Group Incentive Program

Founded in 2005, the Physician Group Incentive Program (PGIP) includes over 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.

3.1.1.1 Patient-Centered Medical Home

In partnership with PGIP physicians and POs, Blue Cross developed the Patient-Centered Medical Home (PCMH) program in 2008 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 (1) patient care is efficiently coordinated across all settings and (2) patients receive timely, appropriate care. An example of care coordination is Blue Cross’ Admission, Discharge and Transfer (ADT) notifications initiative coordinated in conjunction with Michigan Health Information Network (MiHIN), a statewide health information exchange (HIE)

NOTE: Although there are two PCMH capabilities related to ADTs, the ADT 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

2016 program goal

Increase penetration of Patient Centered Medical Home designated providers throughout the state of Michigan in 2016. Success in this goal means increasing the number of designated physicians by at least 5%.

PCMH Program Savings
Cost savings for the first six years of the PCMH program overall, using data from the time period of July 2008 - June 2014, is as follows:

• July 2008 to June 2009: $15 million
• July 2009 to June 2010: $47 million
• July 2010 to June 2011: $93 million
• July 2011 to June 2012: $114 million
• July 2012 to June 2013: $85 million – estimated
• July 2013 to June 2014: $73 million – estimated

Total for six years: an estimated $427 million
3.1.1.2 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 13,500 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 at the population level can be reimbursed in accordance with BCBSM’s Value-Based Reimbursement (VBR) Fee Schedule. In 2016, all physician specialty types as well as fully-licensed psychologists and chiropractors are eligible to be considered for VBR.

2016 program goals

- Encourage POs to develop plans for working in close partnership with practices to implement PCMH-N capabilities
- Explore ways to incorporate PCMH-N Interpretive Guidelines into the VBR methodology
3.1.1.3 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 the primary care-attributed population of patients. By joining together primary care physicians, specialists and hospitals into coordinated care delivery systems, OSCs are designed to address the problems inherent in the delivery of fragmented and costly healthcare services that fail to meet the needs of the patient population.

OSCs 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.

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.

Over time, the OSC will become the central hub of patient-specific and population information. Care management efforts and population level analyses generated from this information will be more robust than information derived solely from claims data from payers and will enable the OSC to manage their population of patients.

To support PGIP POs in the transition to OSCs, Blue Cross invites PGIP-participating organized systems of care to collaborate on the following three Initiatives to support incremental implementation of OSC-related capabilities. All opportunities are optional for PGIP-participating OSCs.

1. **OSC Integrated Patient Registry Initiative** builds on the capabilities in the PCMH Registry Initiatives and enables OSC providers to perform OSC-wide management of the attributed patient population and reduce disparities in the provision of healthcare services.

2. **OSC Integrated Performance Measurement Initiative** builds on the capabilities in the PCMH Performance Reporting Initiative and enables OSCs to generate OSC-wide performance reporting for all patients. Initially, performance reports will be for internal use, but in the longer-term, OSCs will collaborate to define a common set of measures that can be used to provide external entities with information for payment and public reporting.

3. **OSC Processes of Care Initiative** builds on the foundational capabilities in the PCMH Initiatives, catalyzing the OSC to ensure that care partners communicate, coordinate, and collaborate to achieve clinical integration at the OSC level. It is designed to ensure that the relevant PCMH domains of function are in place across all care partners with appropriate linkages at the OSC level.

**2016 program goal**

Increase number of OSC capability phases implemented by at least 5%
3.1.2 Hospital Pay-for-Performance (P4P) Program

The Blue Cross Hospital Pay-for-Performance (P4P) programs provide incentive to acute care providers who are successful in demonstrating achievements in improving 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
- 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 selected quality initiatives sponsored by the Michigan Health and Hospital Association’s (MHA) Keystone Center for Patient Safety
- Performance and improvement on selected Centers for Medicare and Medicaid Services (CMS) quality Indicators
- Community service plans that address the unique health needs of rural communities

2016 program goals

- Continue to require 100% of hospitals to fully comply with the program’s patient-safety prequalifying condition
- 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% of participants)
- Engage all P4P-participating acute care providers in more robust Health Information Exchange (HIE) use cases, including:
  - Implementation of the Common Key Service
  - Developing querying abilities via the statewide notification service
  - Submitting lab values into the state’s disease surveillance system for communicable diseases
### 3.1.3 Hospital Value-Based Contracting

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

Initially, BCBSM’s 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. Sixty-nine Michigan hospitals, representing over 85 percent of the total Blue Cross commercial hospital payout, have signed a Value Based Contract.

In the program’s first two years, VBK-participating hospitals have generated nearly $100 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.

#### 2016 program goals

- Continue to experience both lower point-in-time and year-over-year per-member-per-month (PMPM) trends for VBK-participating hospitals as compared to their non-participating peers. VBK provider performance is evaluated annually by BCBSM’s actuarial department.
- Introduce quality metrics into second iteration of VBK contracts to support provider performance across industry quality programs including Medicare Stars and QHP Quality Rating System (QRS). Providers may be required to minimally meet performance standards for these measures in order to be eligible to receive shared savings generated from cost and utilization management and performance.
3.1.4 Collaborative Quality Initiatives

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

CQIs support continuous quality improvement and development of best practices for areas of care that are highly technical, rapidly-evolving and associated with scientific uncertainty. Given that valid, evidence-based, nationally accepted performance measures are only established for a narrow scope of healthcare, 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 non-competitive environment (meetings are held in person, typically on a quarterly basis).

The goal of the CQI program 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 BCBSM. 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 healthcare continuum
2. An opportunity to positively influence outcomes is evident
3. Knowledge about optimal practices are not widely implemented or scientific uncertainty exists

The Coordinating Center is staffed by individuals whose primary function is the activities of the consortium—with the exception of the project 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 2016, Blue Cross is providing funding and active leadership for more than 20 CQIs addressing one or more of the following clinical conditions:

<table>
<thead>
<tr>
<th>Hospital CQIs</th>
<th>Ambulatory CQIs</th>
<th>Hybrid CQI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiology (ASPIRE)</td>
<td>Urology (MUSIC)</td>
<td>Integrated Michigan Patient-Centered Alliance on Care Transitions (IMPACT)</td>
</tr>
<tr>
<td>Angioplasty (BMC2 PCI)</td>
<td>Lean transformation (Lean)</td>
<td></td>
</tr>
<tr>
<td>Anticoagulation (MAQI2)</td>
<td>Pharmacy (MPTCQ)</td>
<td></td>
</tr>
<tr>
<td>Bariatric surgery (MBSC)</td>
<td>Oncology (practice and treatment) (MOQC &amp; Pathways – [2 separate professional CQIs])</td>
<td></td>
</tr>
<tr>
<td>Breast cancer (MiBOQI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac surgery (MSTCVS)</td>
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<td></td>
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<tr>
<td>Emergency department care (MEDIC)</td>
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<tr>
<td>General surgery (MSQC)</td>
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<td>Hospital efficiency (MVC)</td>
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<tr>
<td>Hospitalist care (HMS)</td>
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<tr>
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<td></td>
</tr>
<tr>
<td>Spine surgery (MSSIC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total knee and hip replacement (MARCIQ)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trauma (MTQIP)</td>
<td></td>
<td></td>
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<tr>
<td>Vascular interventions (BMC2 VIC)</td>
<td></td>
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</tr>
</tbody>
</table>

2016 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
Cost Avoidance for CQI program from 2008-2013

<table>
<thead>
<tr>
<th></th>
<th>Bariatric Surgery</th>
<th>General Surgery</th>
<th>Cardiac Surgery</th>
<th>Angioplasty &amp; Vascular Intervention</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBSM, BCN, MA</td>
<td>15,169,118</td>
<td>180,364,128</td>
<td>11,429,235</td>
<td>64,972,573</td>
<td>271,935,054</td>
</tr>
<tr>
<td>Total Statewide</td>
<td>34,975,936</td>
<td>286,867,065</td>
<td>108,225,587</td>
<td>365,377,363</td>
<td>795,445,951</td>
</tr>
</tbody>
</table>

3.1.5 Patient Safety Management

Blue Cross monitors and improves patient safety through activities focused on identification and reporting of safety concerns, reduction of 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 measureable 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.

Three examples of patient safety management initiatives at Blue Cross are the Blue Distinction Centers for Specialty Care, MHA Keystone Center for Patient Safety and Quality, and Michigan Health Information Network.

3.1.5.1 Blue Distinction Centers for Specialty Care® (BDC)

Established in 2006, Blue Distinction Centers for Specialty Care® (BDC) were developed in partnership with the Blue Cross Blue Shield Association (BCBSA). They are national networks of designated centers that are used by participating Blue Cross plans across the country.

BDC has demonstrated expertise in delivering quality healthcare in specific high-cost, high-variability services. The evaluation processes for these centers are based on a “total value” designation which incorporates quality and patient safety measures, cost, and network access. The designation is based on objective, evidence-based selection criteria established in collaboration with expert physicians and medical organizations. They review best practices, guidelines, and standards that help support the coordination and delivery of services to targeted populations with specific diagnostic and therapeutic needs. Facilities designated as BDCs have collectively demonstrated better outcomes and fewer complications for patients seeking the specialized care the center provides.

BDCs identify facilities that demonstrate proven expertise in delivering safe, effective and cost-efficient care for select specialty care procedures. These areas currently include: bariatric surgery, cardiac care, complex and rare...
cancers, knee and hip replacements, spine surgery, transplants and maternity care. The program was developed in 2006 to eliminate gaps in provider quality and to guide members to higher value facilities.

The Blue Distinction Program has grown. The program now includes a new designation, Blue Distinction Centers+, which evaluates hospitals on cost-efficiency measures in addition to more robust quality measures focused on patient safety and outcomes. This value-based designation is critical because the areas of specialty care covered by the program represent more than 30 percent of inpatient hospital expenditures.

2016 program goals
1. Provide continued communications support of the new maternity care designation program as well as this year’s re-designation 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 BCBSM news releases and articles in our various BCBSM provider e-newsletters.

3.1.5.2 Blue Distinction Total Care SM (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. Participation in the BDTC program is a Blue Cross Blue Shield Association mandate.

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 3 of the following 5 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.

2016 program goals
1. Support BDTCs value proposition through the national evaluation of quality performance and cost savings results of local BDTC participating programs

2. Support the evolution of the BDTC program to support benefit differentials and provider quality and cost measurement evaluation leading to BDTC+ designation by supporting any requirements as put forth by the Blue Cross Blue Shield Association.

3.1.5.3 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 healthcare-acquired infections.

The MHA Keystone Center operates projects focused on care transitions, catheter-associated urinary tract infections (CAUTI), emergency rooms, intensive care units, obstetrics, sepsis, surgery and pain management. The center is 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. Specific information about each initiative can be found http://www.mha.org/MHA-Keystone-Center-Patient-Safety-Organization/Quality-Improvement.

2016 program goals
Blue Cross’ goal in funding the Keystone Center is to ensure all hospitals in Michigan are able to participate in any MHA Keystone collaborative for which they are eligible, without a participation fee. Each year, the MHA Keystone Center reopens all collaboratives to allow new hospitals to join and each year, the number of participating hospitals continues to increase. At present, nearly all community hospitals in Michigan participate in at least one collaborative.

In addition to removing participation barriers, the BCBSM Hospital Pay-for-Performance Program measures hospitals participating in selected Keystone initiatives on various participation, process and outcome reporting measures. The goal of these measures is to maximize hospital engagement in the initiatives and improve performance reporting on the following selected outcome measures:
Catheter Associated Urinary Tract Infection Rates (reporting only)

- Prevalence of patients with urinary catheters per 100 patient days
- Prevalence of symptomatic CAUTIs by urinary catheter days on the unit per 1,000 urinary catheter days
- Prevalence of symptomatic CAUTIs by patient days on the unit per 10,000 patient days

Pain Management (reporting only)

- Percent of emergency department patients having IV opioids administered
- Percent of emergency department patients being discharged with prescription oral opioids
- Percent of patients on IV opioids who received an assessment for opioid naïve/tolerance
- Percent of patients on IV who received a risk assessment
- Percent of patients on IV opioids that received a sedation level assessment
- Percent of patients treated with IV opioids having naloxone administered

Sepsis (reporting only)

- Overall three-hour bundle compliance:
  - Initial lactate within three hours of presentation of severe sepsis
  - Broad spectrum antibiotic within three hours of presentation of severe sepsis
  - Blood cultures drawn prior to administration of antibiotics within three hours of presentation of severe sepsis
- Percent mortality rate
- Resuscitation with 30 ml/kg crystalloid fluids within three hour of presentation of septic shock
- Use of vasopressors (within six hours of presentation of septic shock, if hypotension persists after initial fluid administration of crystalloids 30 ml/kg)(optional measure)

3.1.5.4 Health Information Exchange (HIE)

The Michigan Health Information Network Shared Services (MiHIN) is a nonprofit collaboration dedicated to improving the healthcare experience for Michigan residents by improving quality of care and reducing costs. MiHIN works with the various sub-state Health Information Exchanges (HIE) in Michigan to support the statewide exchange of health information, providing a shared governance and legal framework to safeguard and standardize the transfer of health information across participants.

Blue Cross Blue Shield of Michigan (BCBSM) participates with MiHIN as a health plan qualified organization, which allows it to transmit and receive data for its members. In addition, BCBSM’s Chief Medical Officer serves as a member of the MiHIN board.

In 2013, the BCBSM HIE Initiative (formerly known as the ADT Initiative) was implemented to encourage participation in MiHIN’s statewide notification service by offering incentives to both hospitals and physician organizations (PO). The statewide notification service provides foundational support to the PCMH model of care by improving the state’s data exchange capabilities and ensuring that caregivers have the data they need to
effectively manage the care of their patient population. The HIE initiative is focused on supporting hospitals and POs that participate in MiHIN’s statewide service, improving the quality of data transmitted through the statewide service, expanding the types of data available through the service, and developing capabilities that will help facilitate statewide health information exchange going forward.

### 3.1.5.4.1 Peer Group 1-4 Hospitals Engagement in HIE Initiative

Since the HIE Initiative was introduced in 2014, ninety-five hospitals have started participating 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 95 percent of all admissions statewide. Over the next three years (2016 through 2018) these efforts will continue to be recognized, with hospitals earning a portion of their BCBSM P4P HIE points through continued data quality conformance standards for implemented use cases. The remaining points will be earned by participating in at least one new HIE use case through the MiHIN statewide service each year.

The 2016 use case options include implementing the common key service, submitting lab value or responding to queries for patient information. The use case options proposed for 2017 and 2018 will be finalized based on stakeholder input, BCBSM business needs or alignment with other programs, such as the State Innovation Model (SIM) initiative.

**2016 program goal**

Increase peer group 1-4 hospital participation in new MiHIN use cases by at least 50%

### 3.1.5.4.2 Peer Group 5 Hospitals Engagement in HIE Initiative

BCBSM 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 BCBSM 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.

One component of the BCBSM PG5 P4P is called Health of the Community. Beginning in the 2016-2017 program year, hospitals have the option of participating in the MiHIN statewide service by implementing the Admission-Discharge-Transfer use case. While this is an optional portion of the Health of the Community component in 2016, it is BCBSM’s intention to make it a mandatory component in upcoming program years.
3.1.5.4.3 Skilled Nursing Facility Engagement in HIE Initiative

In December 2015, BCBSM introduced the 2016 Skilled Nursing Facility Pay-for-Performance program, effective January 1, 2016. The SNF P4P program will provide freestanding and hospital-based SNFs the opportunity to earn an additional 1 percent of their commercial BCBSM payment for meeting HIE expectations, including submission and receipt of all-payer admission, discharge, transfer notifications through the MiHIN statewide service.

**2016 program goal**
Increase SNF participation in the statewide ADT notification service by at least 40%.

3.1.5.4.3 Physician Organizations (PO) Engagement in HIE Initiative

Since 2014, twenty-five physician organizations have started participating in MiHIN’s statewide notification service through implementation of the Admission-Discharge-Transfer (ADT) use case. The ADT use case offers providers a single access point to obtain daily admission-discharge-transfer and ER information for all their patients, regardless of hospital affiliation. Participating POs currently receive daily ADT and ER visit notifications for more than 7 million Michigan patients.

In 2016, the focus of the initiative will center on connecting new physician organizations to the statewide service, improving data quality, helping recipients appropriately incorporate ADT messages into processes of care, and implementation of the Exchange Medication Reconciliation Use Case.

**2016 program goal**
Increase PO participation in the statewide ADT notification service by at least 5 physician organizations

3.1.5.5 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 develop measurable objectives with a focus on aligning with current quality metrics, including evidence-based care measures, within the organization and further strengthen Blue Cross’ efforts as we strive to improve upon those. Quarterly 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 through electronic prescribing initiatives.

**2016 program goals**
In 2016, the workgroup will be identifying further opportunities to work with ambulatory-based pharmacists in collaboration with primary care physicians to improve clinical care outcomes related to appropriate medication use, including supporting medication adherence. Goals for this Value Partnerships Pharmacy Workgroup include holding at least 10 meetings (in-person or webinar) with physician group incentive program physician organizations, and conducting an end of year survey.
3.2 Behavioral Health

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

The Blue Cross Behavioral Health Quality Improvement Committee reports to the QIC 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. BH QIC membership includes New Directions BH medical director, medical directors from Blue Cross and BCN and other internal Blue Cross clinical and non-clinical staff, including representation from the following teams: Behavioral Health, Value Partnerships, Epidemiology and Biostatistics and PPO and Care Management. The group meets minimally quarterly to review initiatives, clinical guidelines, and policies and to assess metrics for the behavioral health program.

The Behavioral Health QIC has also been involved in activities to further the integration of medical and behavioral care. The Value Partnerships’ Physician Group Incentive Program launched the Integrating Behavioral Health into General Medical Care Initiative in 3rd quarter 2015 to promote and reward activity related to improving process and communications between behavioral health specialists and PCP’s and other providers. Thirteen POs were selected to work as a PO Cohort Workgroup in this participation-based Initiative. The group held a kick-off meeting in September 2015 and POs submitted their final improvement plans in October 2015. A check-in webinar and second meeting were both held in December 2015.

Groups cover the following topics:

- Depression screening
- Referral to BH specialists
- Communication between BH and PCP
- ADHD medication management
- Follow up after mental health discharge

From 2012 to December 2015, PGIP showed an increase from 444 to 997 combined behavioral health specialists. This represents an increase in total behavioral health practitioner engagement with POs by 124.5 percent over year 2012. Fully licensed psychologist engagement increased by 98.5 percent between 2012 and 2015. Psychiatric engagement increased by 167.3 percent between 2012 and 2015.

2016 program goals

- Continue work with PGIP and the Behavioral Health Interest workgroup to promote dialogue between POs, their PCPs and the behavioral health specialists who provide services to their 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
- Streamline authorizations by implementing online authorization application called WebPass, offered by new vendor, New Directions

Behavioral Health vendor oversight is provided by the Ancillary Program Management team; Accreditation Team, including a quality improvement Associate Medical Director; and the center of excellence at Blue Cross responsible for overseeing vendors (VMCOE).

### 3.3 Shared Enterprise Services

Blue Cross Blue Shield of Michigan maintains an annual agreement with its sister organization Blue Care Network (BCN). Through a Shared Enterprise Agreement, BCN—an NCQA-accredited HMO—performs certain functions for Blue Cross Commercial PPO, including:

- Handling credentialing for the entire organization
- Investigating complaints regarding quality of care issues
- Obtaining and reporting provider access and availability
- Collecting and reporting information on continuity and coordination of care

The components of the Shared Enterprise Agreement are overseen by Blue Cross during meetings attended by representatives from both organizations.

#### 3.3.1 PPO Network Management and Health Services Contracting

Through its quality and legal oversight process, Blue Cross ensures that PPO providers are credentialed before they are contracted and re-credentialed every three years. All credentialing and re-credentialing functions are carried out by BCN on behalf of Blue Cross and provider contracts are compliant with accreditation and regulatory requirements. The oversight groups ensure that contracted Michigan providers adhere to contract requirements and provider manual guideline and policies, which include compliance with quality improvement activities, access to medical records and protection of member information confidentiality. Contracts with PPO practitioners include affirmative statements indicating that practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

### 2016 program goals

In 2016, Blue Cross will focus on the following goals with respect to qualified providers:

- Develop and promote educational opportunities for in-network healthcare providers using Blue Cross-sponsored collaborative initiatives outlined in this document
Oversee process for credentialing and re-credentialing PPO providers including follow up on provider complaints or quality issues brought to the attention of Blue Cross through the clinical complaint process via Executive Services. These are then referred to BCN for further investigation.

- Review physician practices to identify and assist providers with aberrant utilization
- Monitor PPO provider utilization to ensure requirements for utilization management programs are met

3.3.2 Access and Availability

The overall goal of the Quality Improvement Program is to improve the quality of healthcare services Blue Cross members receive and to improve the health status of the Blue Cross entire population.

2016 program goals

In 2016, Blue Cross will focus on the following access/availability goals:

- Identify and resolve issues related to member access to and availability of healthcare services
- Monitor, evaluate and support PPO providers to ensure standards for access and availability are being met for primary, specialty and behavioral health care practitioners
- Ensure a consistently high level of care is delivered to all members regardless of age, gender, care delivery site, healthcare status, ethnicity or religious beliefs through monitoring of member needs and availability of practitioners within the PPO network, adjusting available network practitioners if necessary

Access and availability of practitioners will be measured routinely through processes established by PPO Network Management and the Blue Cross quality improvement team. Member feedback from CAHPS, member complaints and survey results will be analyzed. Areas of focus will include but not be limited to the following:

- Access to services 24 hours a day, 7 days a week
- Appointment availability
- Quality of care
- Urgent care appointments
- Wait times

Blue Cross conducts quarterly meetings with BCN to review reports on access and quality and an annual summary is presented to the QIC for review, analysis and recommendations. The appropriate committee(s) will communicate issues that arise throughout the year to the QIC.
3.3.3 **Continuity and Coordination of Care**

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

**2016 program goals**

In 2016, Blue Cross will focus on the following Coordination of Care goals:

- Collect and analyze data to identify opportunities for improvement in coordination of medical care
- Collect and analyze data to identify opportunities for improvement in coordination between medical and behavioral care
- Select three opportunities for improvement in coordination of medical care to take action upon and measure effectiveness of the interventions implemented.
- Select two opportunities for improvement in coordination between behavioral and medical care to take action upon and measure effectiveness of interventions implemented.
3.4 Member Satisfaction

The Blue Cross Customer Experience department focuses on improving the member experience. 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. This department creates member improvement strategies, aligns resources and monitors member satisfaction results.

Member experience annual documentation includes analysis of complaints and appeals, CAHPS and other data, and identifying opportunities for improvement of member satisfaction with Blue Cross services, behavioral healthcare and services, and Marketplace network transparency and experience.

The Customer Experience Department creates ongoing programs to educate employees on the 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 2016 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 impacting the customer experience.

2016 program goals

Blue Cross will focus on the following member satisfaction goals in 2016:

- Assess member satisfaction with Blue Cross care and services through CAHPS and other member surveys along with other sources of member feedback
- Support continuous improvement of services and satisfaction for members and providers
- Develop and promote opportunities for employees to learn about member “pain points” and what can be done to address them
- Promote activities that will result in better communication between Blue Cross departments to ensure excellent service and satisfaction to members, practitioners, providers and associates with the knowledge that ultimately, better informed providers result in better care for members.
- Provide a complaint mechanism whereby members or providers and practitioners can express concerns to Blue Cross regarding care and service
- 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 member understanding of plan through strategies such as applying the Clear & Simple® methodology and providing employee education
3.4.1 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 QIC and Member Experience Committees evaluate survey results, combining them with other member feedback surveys to determine areas in which BSCSM can improve service to members. CAHPS survey results are reported to NCQA and other governmental and regulatory agencies as required.

3.4.2 Voice of the Customer (VOC)
The Blue Cross/BCN 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.

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

3.4.4 Member Complaints
Member complaints are used as data to improve Blue Cross services and 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 BCN Quality Improvement 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 pre-service appeals, post-service appeals, coverage appeals and managing the federal external review process.

3.4.5 Network Transparency and Experience
Member experience annual documentation includes analysis of complaints and appeals, CAHPS and other data, and identifying opportunities for improvement of member satisfaction with Blue Cross services, behavioral healthcare services, and Marketplace network transparency and experience.
3.5 Cultural and Linguistic Diversity

Blue Cross has a plan in place to identify and address cultural and linguistic diversity in our member population.

In 2016, Blue Cross will continue the pilot program started in 2015 with one PGIP-participating physician organization to identify and address healthcare disparities. Deliverables from the pilot’s first year included: baseline data, quality improvement plan, and physician and office staff training, including language line certification and completion of an online cultural competency overview by staff members.

In addition to the pilot program being conducted, Blue Cross has implemented PCMH capabilities that relate to addressing health/health care disparities which include:

- Effective case management and care coordination provided by PCMH providers
- Data collection related to race/ethnicity as well as language preferences
- Provision for language translation and bilingual materials are part of the PCMH activities in the PCMH Interpretative Guidelines

2016 program goals

The Reducing Disparities pilot program will finish its first year mid-year 2016. At that point, the physician organization will present Blue Cross with a report of findings and plan to proceed for a 2nd year. Year Two of the pilot will focus on the following goals:

- Analyze baseline data to identify:
  - Population composition in terms of race/ethnicity and language
  - Common disease processes within the population
  - Any disparities present related to management of disease processes and/or preventive care

- Complete cultural competency training for office staff, interpreters and physicians. Training began in 2015.

- Develop final project findings report and present to Blue Cross project staff and leadership

- Present pilot program overview and conclusions to larger physician audience at a PGIP Quarterly meeting

Additionally, Blue Cross will strive to increase the number of physician organizations reporting on culturally competent capabilities in 2016.
3.6 Medical Management Programs

Blue Cross medical management programs include Utilization Management, Disease Management and Case Management.

3.6.1 Utilization Management (UM)

The Blue Cross UM program includes medical care and behavioral health utilization activities across the healthcare continuum.

Each area addresses the evaluation of the appropriateness, medical need and/or efficiency of healthcare services, procedures and facilities according to established criteria or guidelines and under Blue Cross provisions. UM 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 healthcare services are annually reviewed and approved by the Criteria Review Committee. 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.

A summary of the Disease Management and Case Management programs is provided on the next pages. For a detailed description of each UM program, goals and measureable objectives, see the 2015 Utilization Management Program Evaluation.

3.6.2 Disease Management

The Blue Cross Disease 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.

Disease 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 will 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 Disease 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 will not 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.
Disease 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.

2016 Disease Management goals include:

- Increase member compliance with closing gaps in care by 5%
- Increase member follow up with PCP 7 days post medical admission discharge by 8%
- Increase member motivation of medication adherence by 5% or stay in high quadrant
- Increase member knowledge of medication adherence by 5% or stay in high quadrant

3.6.3 Case Management

Case Management targets members with high-cost complex chronic and acute conditions, as well as those who are at high risk for incurring high-costs in the future. These members represent 1-3 percent of the member population and almost 45 percent of the annual health care expenditures.

This population represents the greatest opportunity to positively impact member utilization, health status, quality of care, and/or benefit cost. To effectively manage these members, case management provides contract benefit management along with offering the flexibility of occasionally providing cost effective services outside of the member’s benefit plan (extra-contractual or non-contractual services).

Blue Cross Case Management is a member-centric program, available to all members, that provides support and coordination of health care services. The goal of the case management program is to develop cost-effective and efficient ways of coordinating health care services that improve the member’s quality of life. This is achieved through collaboration with the member, family, and the treating physician and members of the healthcare team to arrange appropriate services and care settings, assist in the evaluation of services, encourage communication among health care providers, and provide education for complicated health care needs. This collaborative process includes assessment, planning, implementation, monitoring, and evaluation of options and services to promote quality outcomes.

2016 Case Management goals include:

- Increase member compliance with closing gaps in care by 5%
- Increase member follow up with PCP 7 days post medical admission discharge by 8%
- Increase member motivation of medication adherence by 5% or stay in high quadrant
- Increase member knowledge of medication adherence by 5% or stay in high quadrant
- Increase member perceived physical functional status by 5% or stay in high quadrant
- Increase member perceived emotional functional status by 5% or stay in high quadrant
3.7 Clinical Quality Improvement

All Blue Cross efforts include continuous quality improvement in the interest of improving member and provider services and quality. Our clinical quality improvement efforts focus on improving clinical quality and outcomes as measured by HEDIS. PGIP’s Clinical Quality Initiative (formerly called the Evidence-Based Cared Tracking Initiative) is our provider strategy to provide data and incentives focused on process of care improvements. All of our clinical work is guided by the clinical practice guidelines we use — developed by the Michigan Quality Improvement Consortium (MQIC).

In 2016, Blue Cross will focus on the following clinical quality goals:

- Collect required HEDIS measures and identify additional opportunities to engage member and physicians to close gaps in care
- Engage provider community through PGIP meetings, webinars, and other forums
- Assist in the standardization of the use of evidence-based, preventative service and chronic care guidelines across all health plans in Michigan through the Michigan Quality Improvement Consortium (MQIC), a large, state-wide health plan and physician collaborative

3.7.1 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 Disease 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.

3.7.2 Clinical Quality Initiative

At Blue Cross, PGIP administers the Clinical Quality Initiative, a reward-based program incorporating HEDIS measures aimed to driving improvement among PGIP participating physician organizations (PO). This initiative strives to promote clinical quality improvement by driving best practice behaviors among PGIP physicians. Rewards are provided at the population level for POs who are able to achieve high performance and improve over time.
2016 program goals

In 2016 BCBSM will be working intensely with 20 high impact PGIP physician organizations to improve quality scores through the Clinical Quality Initiative. The 20 high impact POs were identified by reviewing the total BCBSM membership attributed to each PO and their quality score from 2015. The 20 POs with the greatest opportunity to improve quality will participate in face to face discussions with the BCBSM PGIP Clinical Quality team at regular intervals throughout 2016. Regular meetings are designed to discuss quality and process improvement opportunities and to provide analytic support as needed. Activities are expected to start in March 2016 and continue throughout the performance year.

The overall objective of the Clinical Quality Initiative is to improve the performance of the 20 high impact PGIP POs by providing key ad-hoc data analysis, guidance and coaching, and regular feedback about initiative performance. The BCBSM team has developed two goals. The first is to achieve a 2% increase in average composite quality score (includes both performance on Medicare Advantage and Commercial PPO quality measures) for high impact POs, and second to achieve a 5% increase in treatment gaps closed from 2015 to 2016 for commercial PPO quality measures.

To achieve rewards POs 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

Measures of care for the Clinical Quality Initiative are reviewed annually by Blue Cross internal subject matter experts in collaboration with PO leadership 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. Commensurate reporting is provided to PGIP participating POs that includes population performance, practice performance, relative performance to other PGIP POs, and performance against applicable benchmarks.
3.7.3 Clinical Practice Guidelines

Blue Cross adopts and disseminates clinical practice guidelines relevant to its members for the provisions of preventive and non-preventive acute and chronic medical services and for preventive and non-preventive behavioral health services. These clinical practice guidelines are reviewed and approved by the QIC every year to ensure the guidelines are evidence-based and are known to be effective at improving health outcomes for members. 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 healthcare 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.

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. Each year, a postcard mailing is sent to all physicians, nurse practitioners and physician assistants in the state of Michigan, regardless of specialty, to inform them of the guidelines. 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.com 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.

2016 program goals

MQIC will review and update a total of 13 guidelines in 2016.
3.8 Delegation Oversight

Procurement, the Vendor Management Center of Excellence (VMCOE) and Business Area Contract Administrators (BACA) are responsible for monitoring selected delegated activities to ensure that sub-contracted functions are performed in accordance with contract stipulations and accreditation standards. Monitoring includes the periodic review of both the Quality Improvement Program in relation to sub-contracted functions and the subcontractor’s performance.

The delegated activity objectives are:

- Pre-evaluate new delegated entities
- Identify current delegated entities
- Complete an annual assessment of delegated activities
- Monitor oversight of delegated activities
- Annually review and approve the delegate’s Quality Improvement Program
- Identify and follow up on opportunities for improvement
- Ensure delegated entities meet or exceed established performance and operational measures
- Ensure delegated entities meet or exceed accreditation standards
- Establish corrective action plans if performance measures are not met
4.0 QUALITY IMPROVEMENT WORK PLAN

The QI Work Plan specifies quality improvement activities Blue Cross will undertake in the upcoming year. The plan includes goals and objectives based on the strengths and weaknesses identified in the previous year’s evaluation and issues identified in the analysis of HEDIS and CAHPS scores and member complaints. The work plan is a mechanism for tracking quality improvement activities and is updated as needed to assess the progress of initiatives.

The QI Work Plan includes but is not limited to the following information:

- Quality of clinical care
- Quality of service
- Safety of clinical care
- Members’ experience
- Program scope
- Yearly objectives
- Yearly planned activities
- Timeframe within which each activity is to be achieved
- Blue Cross staff member responsible for each activity
- Previously identified issues (monitoring progress of resolution)
- Evaluation of the QI program
- HEDIS submission and performance improvement
5.0 QUALITY IMPROVEMENT PROGRAM EVALUATION

Blue Cross completes an evaluation of the QI Program annually. The written evaluation is an assessment of the effectiveness of the individual components as well as overall effectiveness of the program. The evaluation outlines accomplishments, documents limitations or barriers to meeting objectives and makes assessments and recommendations for the upcoming year. The evaluation addresses the structure and functioning of the overall quality improvement program, the processes in place and the outcomes or results of QI activities.

Quality improvement program evaluation criteria may include but not be limited to the following:

- Evaluation of the effectiveness of activities performed with an emphasis on the identification of improvement in the quality and safety of clinical care and quality of services delivered
- Determination of whether quality improvement information was communicated accurately and to the appropriate person, committees, providers and/or other groups
- Determination of whether identified system-wide issues were adequately addressed and resolved in a timely manner with execution of appropriate follow-up actions
- Assessment, trending and documentation of measurable improvement in the quality of clinical care and quality of service
- Analysis of the results of quality improvement activities including barrier analysis
- Adequacy of resources for the quality improvement program
- Assessment of practitioner participation and leadership in QI program
- Recommendation of changes needed to improve the effectiveness of the quality improvement program
- Analysis of the progress made on influencing safe clinical practices

Measurement (data collection) is the basis for determination of the existing level of performance and the outcomes from those processes. Quantitative measures will be established to evaluate the most critical elements of care and services provided. Selected indicators include:

- Structure measures – 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 either the desired or unintended affect

Data assessment will determine the current performance level and whether or not performance needs improvement. The assessment process includes trending performance over time and comparison to established benchmarks. Action taken is directed at improving outcomes as well as processes. Blue Cross conducts quality improvement projects to systematically evaluate the quality of clinical care and service delivered to members with the goal of achieving demonstrated improvement in care and services.
6.0 FEDERAL EMPLOYEE PROGRAM

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

<table>
<thead>
<tr>
<th>2016 Commercial PPO/Marketplace Quality Improvement Description</th>
<th>FEP Exception</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Page 11</strong></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><strong>Page 32</strong></td>
<td>The website used by FEP members is fepblue.org. Web content and member digital experience are managed and monitored by the Director’s Office, not Blue Cross/BCN.</td>
</tr>
<tr>
<td><strong>Page 32</strong></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 BCN and follow the corporate process</td>
</tr>
</tbody>
</table>
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
BLUE CROSS  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 and Medicaid Services
COPD  Chronic Obstructive Pulmonary Disease
CQI  Collaborative Quality Initiative
CSR  Customer Service Representative
EBC  Evidence-Based Care
EBCT  Evidence-Based Care Tracking
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
HCDC  Health Care Delivery Committee
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  Intra-cranial 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
MARCOM  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>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>MiPCT</td>
<td>Michigan Primary Care Transformation Project</td>
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<td>MOQC</td>
<td>Michigan Oncology Quality Consortium</td>
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<tr>
<td>MQIC</td>
<td>Michigan Quality Improvement Consortium</td>
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<td>MSQC</td>
<td>Michigan Surgical Quality Collaborative</td>
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<td>MSTCVS</td>
<td>Michigan Society of Thoracic and Cardiovascular Surgeons Quality Collaborative</td>
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<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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<td>NDC</td>
<td>National Drug Code</td>
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<td>NRT</td>
<td>Nicotine Replacement Therapy</td>
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<td>OC</td>
<td>President’s Operating Committee</td>
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<td>OOP</td>
<td>Out-of-Pocket Maximum</td>
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<td>OSC</td>
<td>Organized System of Care</td>
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<td>P4P</td>
<td>Pay for Performance</td>
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<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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<td>PCMH-N</td>
<td>Patient-Centered Medical Home Neighbor</td>
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<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>Patient Safety Organizations</td>
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<td>Quality Improvement</td>
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<td>Quality Improvement Committee</td>
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<td>Qualified Health Plan</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>STS</td>
<td>Society of Thoracic Surgeons</td>
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<td>SVP</td>
<td>Senior Vice President</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>TBI</td>
<td>Traumatic Brain Injury</td>
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<td>TSF</td>
<td>Telephone Servicing Factor</td>
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<td>Vascular Interventions Collaborative</td>
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<td>Vendor Management Center of Excellence</td>
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<td>Voice of the Customer</td>
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<td>Warfarin Alternative Treatment CoHort</td>
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<td>Wellness and Care Management</td>
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Required Approvals

Approval Signature(s):

Amy McKenzie, MD, FAAFP

Physician Consultant
Co-Chair, Quality Improvement Committee

Date Signed  March 31, 2016
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<th>Author</th>
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