2022 Blue Cross Blue Shield of Michigan

Quality Improvement Program Description

January 19, 2022

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Conflict of Interest

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

1. Purpose

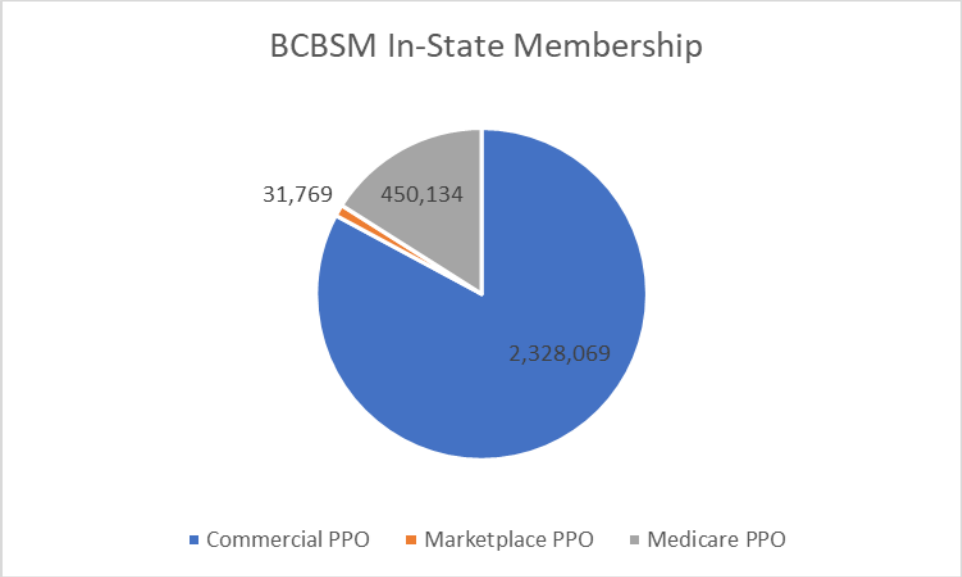
The purpose of the Quality Improvement Program is to establish a planned, systematic and comprehensive approach to measure, assess and improve organization-wide performance. The focus is on the identification of important aspects of care and services; the assessment of the level of care and services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

2. Health Plan Mission

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

3. Health Plan Overview

Headquartered in Detroit, Blue Cross Blue Shield of Michigan (Blue Cross) is the state's largest Preferred Provider Organization health plan, serving approximately 2.8 million members in the state of Michigan. The in-state population consists of 2,328,069 (83 percent) Commercial PPO, 450,134 (16 percent) Medicare PPO and 31,769 (1 percent) Marketplace PPO members.



**Data reflects BCBSM members as of 12/31/2021.*

This program description document applies to PPO Commercial and Marketplace products. The Federal Employee Program is included with the PPO Commercial product line.

Blue Care Network, the Health Maintenance Organization product, has been accredited with the National Committee for Quality Assurance for over 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 has maintained its C*ommendable* rating from 2014 to September of 2020, when NCQA changed it scoring methodology to indicate "*Accredited"* Status as the highest rating achieved for both Commercial PPO and Marketplace PPO lines of business.

In 2021, the health plan maintained its status of “Accredited” and in 2022 the health plan will undergo it’s first time ever Single Site Multiple Entity Survey, along with Blue Care Network of Michigan.

3.1. Background

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

Since 1997, Blue Cross has partnered with hospitals across the state of Michigan in a joint effort to improve health care quality and patient safety surrounding many common and costly areas of surgical and medical care. The Blue Cross and Blue Care Network sponsored hospital Collaborative Quality Initiatives enable hospitals and clinicians across the state to work together in a trusted, noncompetitive environment collecting patient risk factors and clinical process, and outcomes data.

Collectively, CQIs analyze the care given to surgical and medical patients across Michigan. Hospital CQIs collect data on all Michigan patients undergoing surgical procedures or medical treatments – not just Blue Cross members. Hospitals and physicians collect and analyze data to find links between process and outcomes of care. These collaboratives foster the development of best practices that reduce errors, prevent complications and improve outcomes. These outcomes demonstrate that collaborative efforts improve patient safety and clinical quality by preventing complications and reducing morbidity and mortality.

The nationally recognized Blue Cross CQI program has received multiple awards from organizations as diverse as the Blue Cross Blue Shield Association and the National Business Coalition on Health. Blue Cross and our hospital CQI partners are routinely asked to present locally, nationally, and even internationally on our statewide success in quality improvement and CQI best practices. As of 2021, Blue Cross is providing funding and active leadership for 19 CQIs.

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

Currently, over 40 physician organizations participate in PGIP, representing nearly 20,000 primary and specialty care physicians, including behavioral health from the Blue Cross network. Physician Organizations provide the structure and technical expertise to support the development of shared information systems and shared processes of care amongst PGIP participating physicians. PGIP has incorporated an enterprise-wide focus on the Psychiatric Consultant Collaborative Care model.

PGIP provides physician organizations and their physician members with a variety of claims-driven reports including evidence-based care reports that are aligned with Healthcare Effectiveness Data and Information Set (HEDIS®) measures focused on preventive care services, behavioral health and chronic care management. PGIP physicians provide care to more than two million Blue Cross PPO Commercial members. Working with the Michigan provider community, Blue Cross oversees the largest health plan sponsored Patient-Centered Medical Home program in the United States.

In PCMH practices, a care team led by a primary care physician focuses on each patient's health needs and goals to coordinate care across all health settings. Blue Cross designed the PCMH program in partnership with the Michigan physician community to strengthen the primary care system, better manage member care and help patients play an active role in promoting their own health. Blue Cross continues to expand PCMH designations in Michigan.

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

Beginning January 1, 2018, select PCMH-designated practices have participated in the Comprehensive Primary Care Plus initiative. CPC+ is a regional, multi-payer, five-year CMS-supported initiative that is intended to strengthen primary care by payment reform and transforming care delivery. Some PCMH-designated practices will also participate in the State Innovation Model, administered by the Michigan Department of Health and Human Services using a grant from the United States Department of Health and Human Services. These efforts build upon our PCMH model and synergize existing efforts to deliver coordinated care to all patients, including those with chronic conditions.

Blue Cross is taking these efforts to the next level with Organized Systems of Care. Organized Systems of Care build on the foundation laid by the PCMH program by linking primary care physicians, specialists, hospitals and other health care partners, to fully integrate and coordinate care through the entire health care system. These strategies are integrated into a comprehensive population-based approach to ensure all Blue Cross PPO members receive patient-centered care that provides needed prevention services, chronic care management and integration of behavioral and medical care. Blue Cross launched Physician Choice PPO in the fall of 2016. This product is based on the OSC program.

In January 2021, Blue Cross launched the Blueprint to Affordability strategy – a part of the provider value-based reimbursement strategy. The aim is to hold PPO and Medicare Advantage providers accountable for managing their patient population and reducing the cost of care. Providers with cost improvement will see greater levels of reimbursement while those who don't improve their cost performance will receive a lower reimbursement.

4. Quality Improvement Philosophy

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

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

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

- Improving the health of the population

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

5. Scope

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

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

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

6. Goals and Objectives

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

Quality Improvement Program Structure and Operations

- Revise, review, approve and implement the 2022 Quality Improvement Program Description and Work Plan with all activities based on the 2021 annual QI evaluation findings and recommendations.
- Evaluate 2021 improvements for areas of improvement. Implement findings of the 2021 annual QI Evaluation into the 2022 QI Program and Work Plan.
- Maintain minutes that demonstrate the health plan's QI Committee develops and implements the QI program and oversees the QI functions within the organization.

Quality of Service

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

Clinical Quality

- Work collaboratively to ensure compliance with HEDIS® reporting requirements and participate in initiatives that improve rates.
- Work with practitioners and their physician organizations to better manage patients through various value partnership programs.
- Outline the population heath management strategy for meeting the needs of the member population.

- Measure the effectiveness of the population health management strategy.
- Assess the needs of the population and determine actionable categories for appropriate intervention.
- Support the delivery system, patient centered medical homes and use of value-based payment arrangements.
- Help adult members identify and manage health risks through evidence-based tools.
- Coordinate services for members with complex conditions and help them access needed resources.
- Support utilization management activities for medical and behavioral health care.
- Support pharmacy utilization management activities for medical and behavioral health care.
- Facilitate continuity and coordination of medical care across the health plans delivery system.
- Collaborate with behavioral health care practitioners to monitor and improve coordination between medical care and behavioral health care.
- Adopt and use clinical practice guidelines relevant to health plan population for the provision of prevention, acute or chronic medical services and behavioral health care services.

Member Experience and Satisfaction

- Have written policies and procedures for thorough, appropriate and timely resolution of member complaints and appeals.
- Monitor members experience in access to health care services and act to improve network adequacy where indicated.
- Evaluates member experience with nonbehavioral and behavioral health care and services and identifies opportunities for improvement.
- Assess physician directory accuracy.

Member Safety

- Support health plans safety initiatives (e.g., Doctor Shopper, Opioid Use).
- Participate on collaborative workgroups on patient safety programs to maximize safety of clinical practices.

Organizational Diversity, Equity and Inclusion

- Meet the cultural and linguistic needs of the population.
- Create a culturally competent workforce.
- Promote diversity and inclusion in hiring.
- Offers training to employees on cultural competency, bias or inclusion.

Qualified Providers

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

Delegation

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

Compliance

- Prepare for NCQA Resurvey in 2022 as the lookback period began 6/2020.
- Adhere to ACA reporting requirements associated with the annual Quality Improvement Strategy.

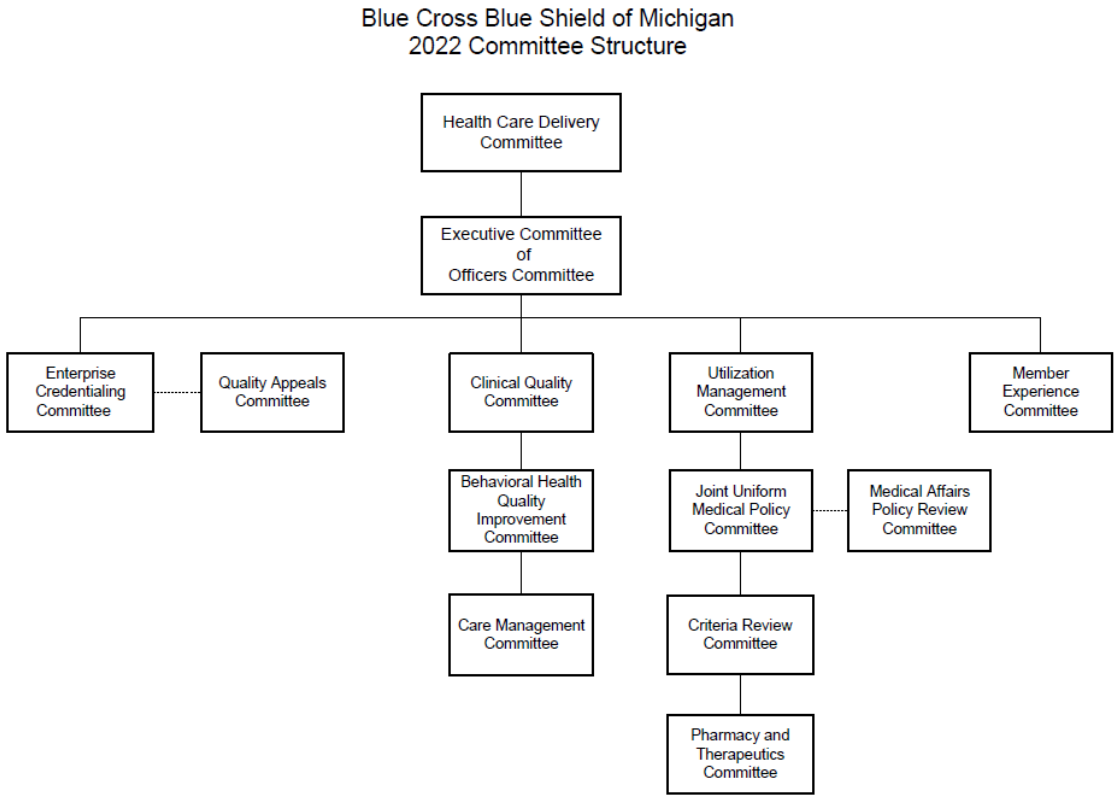
- In collaboration with the compliance officer, ensure compliance with local, state and federal regulatory requirements and accreditation agency standards.

Communication

- Maintain a communication plan to ensure compliance with regulatory requirements.

7. Organizational Structure

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



7.1. Program Committees

To promote quality throughout the Blue Cross organization, specific relationships and linkages between health care delivery, program committees, operational departments and key professional staff are described below. The quality improvement committees are designed and designated to provide oversight for the Quality Improvement Program activities, including access, quality of service, clinical quality, satisfaction, continuity and coordination, qualified providers, compliance and communication.

7.1.1. Health Care Delivery Committee

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

Responsibilities:

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

Composition:

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

Term:

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

Meetings:

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

7.1.2. Executive Committee of Officers Committee

The ECOC is the governing body of BCBSM. The purpose of this committee is to provide a forum for a comprehensive review of enterprise business performance and to drive decision-making and issue resolution.

Responsibilities

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

Composition:

- Chairperson: Chief Executive Officer
- Daniel J. Loepp, President and CEO
- Ken Dallafior, EVP and President, Health Plan Business
- Rebecca Erfurt, VP, Chief of Staff
- James Grant, MD, SVP and Chief Medical Officer
- Tricia Keith, EVP and President, Emerging Markets
- Darrell Middleton, EVP, Chief Operating Officer
- Paul Mozak, EVP, Chief Financial Officer
- Lynda Rossi, EVP, Strategy, Innovation and Public Affairs
- Todd Van Tol, EVP, Health Care Value

Meetings:
The ECOC meets approximately two times a month in Executive Committee of Officers Committee.

- Minutes are taken to record actions and recommendations.
- Minutes are maintained in a confidential matter.

7.1.3. Clinical Quality Committee

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

Responsibilities:

- Reviews and makes recommendations to approve, annually, the Quality Improvement Program Plan, work plan and annual evaluation of effectiveness
- Reviews annually, the UM Descriptions and Evaluation.
- Reviews and approves, annually, the Care Management Program Descriptions and Evaluation.
- Recommends policy decisions.
- Analyzes and evaluates the results of QI activities.
- Ensures practitioner participation in the QI program through planning, design implementation or review.
- Reviews, updates and approves clinical practice and preventive health guidelines and standards of care, related to medical care and oral health.
- Provides oversight for delegated quality improvement, utilization management, chronic condition management including wellness and education, and case management services.
- Reviews quality peer review activities, determines interventions and monitors the interventions, as needed.
- Submits written reports on clinical quality management activities to the Health Care Quality and Service Improvement Committee.

- Ensures the quality improvement programs are compliant with regulatory and licensing requirements.
- Reviews and evaluates the results of quality improvement activities, determines action for improvement and ensures follow-up.
- Evaluates and monitors clinical coordination of care activities and recommends opportunities for improvement.
- Reviews and approves activities to improve patient safety related to medical care
- Reviews quality indicators and related activities for the Performance Recognition Program.
- Reviews and approves collaborative quality improvement activities performed by the organization.
- Reviews and recommends activities to make performance data publicly available for members and practitioner.
- Reviews developed criteria and guidelines annually.

Composition:

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

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

Term:

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

Meetings:

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

7.1.4. Utilization Management Committee

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

Responsibilities:

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

Composition:

- Co-Chairperson: Senior medical director, Utilization Management
- Co-Chairperson: Vice president, Utilization Management
- Medical director, Behavioral Health
- BCN and BCBSM medical directors
- Directors, Utilization Management
- Director, Clinical Review
- Manager, Pharmacy Services
- Seven practitioners who represent a cross section of both primary care physicians and specialists.

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

Term:

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

Meetings:

- A quorum is defined as a majority of voting members including a minimum of two external practitioners. All committee members are voting members. Only physician members are voting members for peer review cases and practitioner appeals.

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

7.1.5. Behavioral Health Quality Improvement Committee

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

Responsibilities:

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

Composition:

- Chairperson: Blue Cross Senior Health Care Analyst
- Medical director, New Directions
- Medical director, Blue Cross Clinical Quality
- Medical director, Blue Cross Behavioral Health
- Director, Quality Management
- Manager, Behavioral Health Services
- Senior health care analyst, Blue Cross Value Partnership Programs
- Manager, FEP Care Coordination/Managed Care
- Senior account executive, New Directions

Term:

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

Meetings:

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

7.1.6. Care Management Quality Committee

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

Responsibilities:

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

Composition:

- Co-Chairperson: Health Care Manager, Care Management Development
- Co-Chairperson: Manager, Quality Accreditation & Training
- Vice President, Care Management
- Senior Medical Directors and Care Management
- Directors, Care Management Leadership
- Director, Care Management Development
- Manager, Care Management Development
- Health Care Manager, Care Management Operations
- Manager, Quality Accreditation and Training
- Operational Managers, ad hoc

Term:

- Not applicable.

Meetings:

- The Committee meets quarterly. A quorum of 2/3 of participating membership is required to vote and conduct business. If a committee member is unable to attend the committee member must send a proxy. The Care Management Quality Committee meeting agenda and handouts are prepared and distributed to attendees in advance of the meeting. Written minutes are taken by a designated scribe and will be sent out for email approval. Once the minutes are approved by the committee,

the meeting facilitator formally signs the meeting minutes. The minutes are retained for a minimum of one year or as otherwise required by external regulatory/accrediting entities.

7.1.7. Joint Uniform Medical Policy

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

Responsibilities:

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

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

Upon review of the information the JUMP Committee will vote to:

- Recommend the technology, device or healthcare service as established (non-investigational) or to deny it as investigational. Additionally, a new technology, device, procedure, or service may be considered “Not Medically Necessary” if a comparable alternative exists which provides equivalent outcomes but is less expensive. The more expensive service with equivalent outcomes would be considered “not medically necessary”.
- Request additional information or data for review, with the potentially

Composition:

- The Joint Uniform Medical Policy Committee is comprised of physician representatives of varying specialties and responsibilities. Physician representatives comprise the voting membership. Physician membership consists of the following:
- Chairperson: Senior Medical Director of Medical Policy
- Co-Chair: Associate Medical Director
- Associate Medical Directors
- Network Physician Representatives
- Team members at both BCN and BCBSM provide ongoing support to the JUMP Committee. While these team members are not voting members, they have responsibility for meeting coordination, presentations, and documentation. Supporting membership consists of:
- Manager, Medical Policy
- Medical Policy Coordinators
- Senior Analysts

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

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

Term:

- Not applicable.

Meetings:

- Decisions shall be by majority vote unless there are two dissenting votes from either Blue Cross or BCN in which case the BCN senior vice president and chief medical officer and the Blue Cross chief medical officer review the policy.
- Physician representatives have voting authority.
- Minutes are taken to record actions and recommendations.
- Minutes are maintained in a confidential manner.
- Meetings are held quarterly at a minimum.

7.1.8. Criteria Review Committee

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

Responsibilities:

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

Composition:

- Chairperson: medical director, Utilization Management
- Medical directors, Utilization Management

Term:

- Permanent appointment until position is vacated.

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

7.1.9. Medical Affairs Policy Review Committee

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

Responsibilities:
- Presentation of policy statement drafts and supporting rationale.
- Interim Medical Policies will represent emerging technologies as Investigational/Experimental or Established to support the handling of inquiries and appeals for services where there is no standing JUMP medical policy.
- Policies under consideration are developed by Associate Medical Directors using evidence-based literature, proprietary technology assessment reports, Medicare Policy documentation, with benchmarking of other national health plan medical policy.
- Policies are signed by the Senior Medical Director for Quality and Medical Policy, the designer of the Chief Medical Directors of BCBSM and BCN.
- Policies are reviewed annually.
- When appropriate, Interim Medical Policies May be referred to the JUMP Committee for full review.
- Interim Medical Policies will be retired upon referral to JUMP when a full review is completed.
- Interim Medical Policies May be retired if and when the technology is determined to be obsolete, no longer available or when requests for the service are no longer being made.

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

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

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

- Medical Policy Coordinators
- Senior Analysts, Medical Policy

Meetings:

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

7.1.10. Enterprise Credentialing Committee

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

Responsibilities:

- Reviews credentialing, quality and utilization information and makes determinations on initial and recredentialing applications for practitioners and organizational providers.
- Reviews credentialing and recredentialing policies as needed.
- Reviews and makes recommendations on operational/administrative procedures related to practitioner affiliation and quality performance.
- Provides oversight for delegated credentialing and recredentialing activities.
- Makes decisions on reporting to the National Practitioner Data Bank.
- Maintains confidentiality of proceedings and related documentation to support confidentiality of peer review information.
- Serves as the review board for first level administrative appeals or reconsiderations, as applicable.
- Submits written reports included in committee minutes to the Health Care Delivery Committee and PPO TRUST.
- Reviews and evaluates annually the Credentialing Program Plan, work plan, annual activity report and annual nondiscriminatory audit report.
- Demonstrates annually that the committee and program objectives are being fulfilled with identification of opportunities for improvement.

Composition:

Voting Members:

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

Non-Voting Members:

- Director or Manager, Quality Management
- Director or Manger, Provider Operations
- Representative from Corporate Credentialing and Program Support
- Blue Care Network Management Representative
- Blue Cross Corporate Financial Investigation Representative
- Blue Cross Corporate Office of General Counsel

Term:

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

Meetings:

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

7.1.11. Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics Committee is a joint committee representing both Blue Cross and BCN. The 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.

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

Responsibilities:

- Provides a thorough, critical review of the pharmaceutical and medical literature in the evaluation of criteria for drug usage and for inclusion on the formularies. The criteria and selection of items to include in the formularies are based on objective evaluation of their relative therapeutic merit and safety. Decisions may also be based on economic considerations that achieve appropriate, safe and cost-effective drug therapy. The Committee approves criteria for drug usage and inclusion or exclusion of the therapeutic classes in the formulary on an annual basis.
- Provides oversight for delegated pharmacy activities.
- Approves policies regarding formulary management activities, such as prior authorizations, step therapies, quantity limitations, generic substitutions and other drug utilization activities that affect access.

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

Composition:

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

Term:

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

Meetings:

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

7.1.12. Member Experience Committee

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

Responsibilities:

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

Composition:

- Co-Chairperson: Vice president, Service Operations
- Co-Chairperson: Vice president, Corporate Marketing and Customer Experience
- Vice President, Care Management
- Director, Customer Experience
- Director, Pharmacy Services
- Director, Digital Experience
- Director, Executive Services
- Director, Federal Employee Program
- Director, Provider Outreach
- Director, Quality Management
- Manger, Quality Management
- Manager, Federal Employee Program
- Manager, Pharmacy Services
- Manager, Executive Services
- Senior Health Care Analyst, Behavioral Health

Term:

- Not applicable.

Meetings:

- In-person meetings conducted at least quarterly.
- A voting quorum is defined as the majority of the voting membership.
- Committee members may request to send a delegate with approval from one committee chair.

- Meeting minutes will be stored on the Blue Cross Blue Cross ENT- Member Exp Committee Microsoft Teams site.

7.1.13. Quality Appeals Committee

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

Responsibilities:

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

Composition:

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

Term:

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

Meetings:

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

8. Reporting Relationships

8.1. Blue Cross Blue Shield Board of Directors

The Blue Cross Board of Directors has ultimate authority and responsibility for oversight of the Blue Cross Quality Improvement Program. The president and chief executive officer and the senior vice president and chief medical officer provide oversight and coordination of the Quality Improvement Program and act subject to and on the board's behalf in the review and approval of policies, procedures and activities of the Quality Improvement Program.

8.2. President and Chief Executive Officer

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

8.3. Vice President, Health Care Value Performance and Execution Excellence

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

8.4. Senior Vice President and Chief Medical Officer

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

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

8.5. Medical Director, Quality Management

The medical director of Quality Management is responsible for providing clinical guidance, input and leadership oversight for health care improvement related activities including utilization management, medical management, credentialing, quality improvement, behavioral health and pharmacy services.

Responsibilities include the following:

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

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

8.6. Medical Directors

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

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

8.7. Behavioral Health Medical Director

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

8.8. Director, Quality Management

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

8.8.1. Quality Management Department

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

- Develops and submits for approval the annual Quality Improvement Program Plan, Quality Improvement Work Plan and the annual Quality Improvement/Utilization Management Program Evaluation.

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

9. Program Activities

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

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

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

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

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

The Medical Informatics department under HCV Business Analytic Services provides assistance with clinical study design, statistical analysis and evaluation. The 2022 activities are described below.

9.1. Quality of Service

9.1.1. Availability of Practitioners

Blue Cross ensures that its networks are sufficient in numbers and types of practitioners to meet the needs of its members. In creating and maintaining the delivery system of practitioners, Blue Cross acknowledges and values the key role of cultural, racial, ethnic, gender, linguistic needs, and personal preferences in the effective delivery of health care services. Blue Cross completed an analysis of provider race and ethnicity data and established that the highest three percentages by race for responding providers aligned with the member race and ethnicity distribution.

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

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

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

1. For at least 90 percent of the population, members should have access to at least one of the following practitioner/provider types, based on time and distance from the member's home for:

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

** High Volume Specialty*
*** High Impact Specialty*

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

- PCP to adult members: 1:1000 or less
- PCP to pediatric members: 1:1000 or less
- OB/GYN to female members: 1:10,000 or less
- SCP to members: 1:10,000 or less
- Behavioral Health to members: 1:10,000 or less

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

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

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

9.1.2. Accessibility of Service

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

Using valid methodology, Blue Cross accesses standards for the following primary care physicians, high volume specialists and high impact specialists:

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

Goals:

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

Blue Cross also assesses standards for its behavioral health providers to include:

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

Goals:

- 95 percent of appointments for routine care are within 10 days.

- 100 percent of appointments for urgent care are within 48 hours.
- 100 percent of appointment for emergency non-life threatening are within 6 hours.
- 10 percent for prescribers and 45 percent for non-prescribers and for follow up visits within 30 days of initial visit.

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

9.1.3. Monitoring for Quality and Accuracy of Information to Members

All communications with members are delivered with accuracy regardless of whether it is via telephone or email. The Member 1st Provider 1st Quality Program containing methodology for performing oversight and monitoring functions on service delivery via telephone and written communications. This program is designed to supply ongoing assessment information to operational leaders and staff to be used to drive continual improvement in service delivery and outcomes. Data collected from individual evaluations is used to track and trend overall performance to goal. The soft skills evaluations and first call resolution surveys are used to evaluate the member's understanding and usefulness of the information received.

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

A random sample of inquiries handled by Customer Service Representatives is reviewed for quality, accuracy and completeness. Evaluations are scored pass/did not pass based on HIPAA verification, accuracy, completeness, proper claim handling and completion of any applicable promised actions. Accuracy and completeness are evaluated based on the member receiving correct and complete information. If the CSR does not provide accurate and complete information, the CSR will not pass the evaluation. Soft Skill evaluations are used to identify opportunities where communication could've enhanced the members understanding and usefulness of information provided.

Each evaluation includes scoring of one (1) point for each attribute for a total of 5 points possible for each evaluation.

1. HIPAA violations
2. Promised action
3. Claim adjustments
4. Accuracy
5. Completeness
    - To reach a passing Quality level, the minimum pass rate is 95 percent (Total points earned must equate to a 95 percent passing rate).
    - CSR can miss one attribute of evaluation and pass quality for the month.
    - This information is compiled and utilized to assess performance at all levels.
        - Quality evaluations are entered and captured in the Verint system.
        - Monthly samples can consist of phone only, written only (includes email) or a combination of phone and written.
        - Targeted sampling goal is five evaluations (on average) per CSR.
    - The servicing strategy evaluation uses a holistic approach including providing coaching and skill building tools to improve the call experience and instill confidence in the CSR, member, and provider.

First Call Resolutions surveys, members are specifically asked to select how much they agree with each statement based on their experience with the customer service representative who handled their call.

As of January 1, 2021, each survey includes scoring of a point for each attribute for a total of 5 points possible for each survey. Scale of 1-5: 1 is strongly disagree, 2 is somewhat disagree, 3 is neither agree nor disagree, 4 is somewhat agree, and 5 is strongly agree.

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

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

Target Rating:

1. Accuracy Target: 85 percent of CSR will meet the target passing rate.
2. Quality Target: 85 percent of surveys will meet the target passing rate.

A quarterly data analysis is performed against the target rating to assess gaps, opportunities, and document improvement activities to address deficiencies. A full analysis including interventions and recommendations are provided to the Member Experience Committee annually. Approval, feedback, and recommendations from the committee are incorporated into the final report.

9.1.4. BCBSM - Monitoring Email Turnaround

Blue Cross has a process for responding to email inquiries and evaluating the quality of email response. The Member 1st Provider 1st Quality Program is used to perform oversight and monitoring functions on service delivery via telephone and written (email) communications.

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

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

Goals:

1. Timeliness Target: 85 percent of email inquiries receive a response within one business day with ongoing review for improvement and enhancement to ultimately achieve the 100 percent turnaround time expectation.
2. Quality Target: CSR Performance Standard Range minimum of 85 percent.

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

9.2. Clinical Quality

9.2.1. Healthcare Effectiveness Data and Information Set

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

HEDIS gap closures rates are monitored though out the measurement year in order to identify opportunities for improvement in quality of care for our members. A series of HEDIS quality improvement activities are implemented to address those areas in which opportunities are identified. The Quality Rewards Workgroup, Population Health Workgroup, and STAR Governance Committee meet on a regular basis to track progress of these quality improvement activities. For MY2020, 71 percent of the PPO accreditation measures performed in the 50th percentile or higher.

Goal: Obtain 50 percent or more of the accredited measures to perform at 50th percentile or higher.

9.2.2. Utilization Management

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

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

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

9.2.3. Population Health Management

Blue Cross Blue Shield of Michigan updates its Population Health Management Strategy to meet the care needs of its membership. It is the plan of action for

addressing member needs across the continuum of care. Components include but are not limited to the following:

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

- Keeping member's healthy
- Managing members with emerging risk
- Patient safety or outcomes across settings
- Managing multiple chronic illnesses

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

The Plan assesses the needs of its population and determines actionable categories for appropriate interventions:

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

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

Focused Areas	Program	Goal
Keeping members healthy	Digital Health Assistant – Quit Tobacco	Achieve 50th NCQA percentile for CAHPS Smoking Cessation
Managing members with emerging risk	Chronic Future Risk	Ensure member has an attributed primary care physician.
		Members managed will have a higher medication adherence gap closure rates than members not managed in the program.
		Members managed exceed in closing gaps overall over members not managed in the program. This includes closure of all care gaps that may be open for a member and include gaps related to medication adherence, managing their treatment for their condition, provider visits, and prevention/screening guidelines.
		Achieve 90 percent on satisfaction survey
Patient safety or outcomes across settings	At Risk for Readmissions	Members managed have a higher rate of physician follow-up visits within 7 days of discharge from a medical admission than members not managed in the program.
		Members managed will have a higher medication adherence gap closure rates than members not managed in the program.
		Achieve 90 percent on Satisfaction Survey
Managing multiple chronic illnesses	Highly comorbid conditions	Members managed have a higher rate of physician follow-up visits within 7 days discharge from a medical admission than members not managed in the program.
		Members managed will have a higher medication adherence gap closure rates than members not managed in the program.
		Members managed exceed in closing gaps over members not managed in the program. This includes closure of all care gaps that may be open for a member and include gaps related to medication adherence, managing their treatment for their condition, provider visits, and prevention/screening guidelines.
		Achieve 90 percent on Satisfaction Survey

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

9.2.4. Care Management (including Complex Case Management)

Blue Cross Coordinated Care is an enhancement to the prior Complex Case Management program. The Blue Cross Coordinated Care program provides an integrated care management approach, designed to help reduce the complexity of the healthcare system by giving members access to a comprehensive care team that will help them better manage their health. The BCCC Program is designed to effectively manage the health care resources for members with a variety of health care needs and in multiple care settings. The program provides coordination of care and services for members who have experienced acritical event or diagnosis that requires the extensive use of resources and need help navigating the

system. BCCC is a collaborative process which assesses, plans, implements and evaluates options and services to meet an individual's health needs. Case management principles are utilized according to the individual needs of the member across the care continuum. Care managers handle the day-to-day clinical management of members in the program.

Program Goals

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

Target Population

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

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

Program or Service

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

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

achieving the goal. The progress of each goal is evaluated during each follow-up call with the member and documented in the care plan. The member centered goals are updated to reflect any new barriers, needed interventions or successful outcomes as appropriate.

Member Identification
Blue Cross Coordinated Care identifies members for case management using reactive triggers to identify members that would most benefit from payer led care management. The identification process uses claims data collected from outpatient encounters, hospital discharges/readmissions, pharmacy and other types utilization including inpatient admissions and emergency room visits. Data is evaluated daily. The target member population is evaluated based on risk factors such as age, gender and diagnoses to predict which members in the population are most likely to experience high cost and disease complications without intervention. Members with multiple chronic conditions are identified based on prospective risk score and two or more chronic conditions. These members are prioritized based on their risk score, script count, and time since their last office visit. Members may also be referred to BCCC through providers, facility discharge planner/care manager, vendors, employer groups, internal BCBSM units (24-hour nurse line, customer service, Utilization Management) or member self-referral.

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

- A checklist that offers education, encouragement and daily tasks to support care plan compliance.
- Ability to set reminder tasks such as taking medications or making an appointment with their PCP.
- Brief survey questions to understand their condition. If the member indicates their condition is worsening, the Care Manager will receive a real-time alert to contact the member and promptly respond to changes in health status.

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

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

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

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

Member Interventions

- Ensure that the member is in the most appropriate level of care, or ensure the member receives the appropriate level of home-health care services required.
- Educate member on any adverse side effects, medication interactions, medication adherence; and to establish to most up-to-date list for to member to present during provider visits. Members may be referred for medication reconciliation if necessary.
- Ensure that the member has access to appropriate health care services and community resources based on their functional status and risk for complications.
- Ensure that the member has adequate social support to maximize their functional status, reduce the potential of future complications and avoid emergency visits and hospital admissions.
- Provide education and support to member self-management skills to increase knowledge and to enhance the member's self-efficacy or confidence in their ability to execute specific self-management tasks.
- Referrals to internal multidisciplinary team or external community resources to address barriers such as food insufficiency, housing expenses, legal aid, mental health services, abuse/neglect, prescription assistance, safety concerns, or transportation barriers.

Non-Member Interventions

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

Coordination of member programs

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

- Medical Directors to assist with the medical management of the case.
- A behavioral health medical social worker is available to provide support to the member and care manager in addressing the member's social determinants of health and behavioral health concerns.
- Registered dietitians can help members identify appropriate foods and nutrition to promote health and manage their disease.

- Behavioral health social workers assist members with behavioral health issues.
- Pharmacists to address member medication questions, medication reconciliation, or issues obtaining medications.
- Non-clinical support enables clinicians to work at the top of their license and at higher productivity levels by taking on non-clinical care coordination/ administrative tasks.
- Condition and disease specific educational materials are available to members to assist in understanding and managing their condition.

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

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

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

9.2.5. Behavioral Health

9.2.5.1. New Directions Behavioral Health Program

In 2015, New Directions assumed behavioral health management of Blue Cross members nationwide. New Directions is a managed behavioral health organization accredited by the National Committee for Quality Assurance. With more than 25 years' experience in utilization and case management services, in addition to extensive experience working with Blue plans nationwide, New Directions' services include preauthorization and case management for members who receive behavioral health through Blue Cross.

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

The 2022 program goals are:

- Improve continuity and coordination between medical and behavioral healthcare in the context of:
  - Communications between Blue Cross medical and/or NDBH behavioral case managers and prescribers to reduce inappropriate prescriptions of opioids.
  - Diabetes screenings for members identified as having bipolar disorder or schizophrenia and taking antipsychotic medications.
  - Coordination between medical and behavioral health case management cases closed with goals met at 90 percent
- Maintain performance on HEDIS FUH7 measure within 75th percentile or better.

9.2.5.2. Value Partnerships Behavioral Health Programs

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

BCBSM continues to demonstrate its commitment to behavioral health through inclusion of behavioral health specific corporate goals. Corporate goals are board approved and demonstrate enterprise commitment to addressing mental health and substance abuse needs for our members.

Value Partnerships is a collection of programs, including the Physician Group Incentive Program, among Blue Cross, physicians and hospitals across Michigan that make health care work better for everyone. The Physician Group Incentive Program includes over 20,000 primary care and specialist physicians throughout Michigan in provider-led clinical quality improvement efforts. The program connects approximately 40 physician organizations (representing these 20,000 physicians) statewide to collect data, share best practices and collaborate on initiatives that improve the health care system in Michigan.

The 2022 program goals are:

Collaborative Care(CoCM) Designation*

- There is an enterprise-wide focus on the Psychiatric Consultant Collaborative Care model (also known as CoCM). In 2022 the health plan will launch a CoCM Designation Program. The strong patient-centered medical home processes are foundational to effectively deliver CoCM. In fact, a practice must be patient-centered medical home designated in order to earn CoCM designation.
- In 2022, the goal is for 10 percent of PCMH-designated practices to be designated. In total this would represent about 100 practices.
- CoCM operates through a patient-centered care team that shares a registry. The team includes:
    - Primary care physician
    - Behavioral health care manager (BHCM)
    - Consulting psychiatrist

  100 percent of CoCM-designated practices will have a care team comprised of these roles.
- In addition to having a care team, a practice has to do one of two things to be eligible for designation:
    - Attend PGIP-sponsored training and engage in the ongoing support program.
    - Be evaluated by our training partners using a fidelity checklist, and are deemed to be practicing with fidelity to the original CoCM model promoted by University of Washington's AIMS Center.

  100 percent of CoCM-designated practices will either have attended PGIP-sponsored training or have been deemed to be practicing with fidelity to the original model.

Rewards
Blue Cross' Value Partnerships PGIP has developed a robust incentive structure for practices and their physician organization to encourage CoCM delivery.
These rewards include both physician organization rewards and practice rewards.

Physician organizations rewards:

- A PO base reward for support provided to their practices as they deliver CoCM and for collecting outcomes data from those practices.
- An amount per new practice implementing CoCM.

Practice rewards:

- A flat dollar amount that includes time spent in training, time staff spends in training and away from the office, a base new practice amount.
- Value-based reimbursement, which is paying claims at an amount higher than our standard fee schedules for a period of one year.

100 percent of POs and eligible practices will receive rewards as described above.

Medication Assisted Therapy
Additionally, we will continue to work on the enterprise-wide Medication Assisted Treatment initiative. The MAT initiative is designed to expand the MAT network of providers among Patient Centered Medical Home practices. The POs will receive PGIP incentives for supporting practices that are offering MAT treatment, building patient panels, developing sustainability, and accepting new patients.

A five percent value-based reimbursement is available to both primary care providers and specialists. PCP practices treating at least 10 patients from July 1, 2021 – June 30, 2022 will now receive the PCP VBR at the practice level effective September 2022. The Specialist VBR will continue to be applied at the provider level treating a threshold of at least 10 patients (not the specialist office level).

Collaborative Quality Improvement Initiative – MI MIND*
BCBSM is partnering with Henry Ford Health System to roll out a state-wide project to implement the Zero Suicide Model in 5-7 provider organizations in 2022. Zero Suicide was developed at Henry Ford and adopted nationally as part of a National Strategy for Suicide Prevention as well as globally in over 20 countries. This is an opportunity for health systems to work together and take a systematic clinical approach to suicide prevention through this well researched model.

The overall aim of MI-MIND is to improve suicide prevention and access to behavioral health across the State of Michigan. The CQI will be begin by collaborating with provider organizations to:
- Determine which Zero Suicide elements will be implemented in each system
- Begin implementation of Zero Suicide protocol
- Initiate QI cycle of evidence-based suicide prevention components across all sites and provide analytic support

Participating practices will be expected to meeting requirements throughout year 1 to maintain VBR eligibility. Year one is prospective focus is participation/engagement in MI MIND.

Expanding Access to Behavioral Health Services

Behavioral Health Navigation Services*
Access to behavioral health care continues to be a member challenge and barrier to receiving care; longer wait times and complexity in finding an appointment contributes to many patients not receiving care at all.
- Seventy-four percent of Michigan residents reported challenges regarding access when seeking behavioral health care.
- Access to behavioral care was the primary challenge reported for our active military and veteran members.

Currently, there is a gap in member connectivity and navigating members to care. Members are lost following referral to care or self-identification of need due to difficulty in finding BH care and long wait times resulting in higher no-show rates.
Beginning in 2022, the health plan will roll out behavioral health navigation services to help members identify and be linked to a provider that meets their needs more quickly. The health plan will partner with Quartet, or a similar entity, to increase access and navigate members into mental health care. Quartet will analyze data to identify and segment Blue Cross Blue Shield of Michigan's high-need / high-opportunity members with diagnosed and/or latent mental health needs and navigate them to behavioral health providers. Quartet will conduct navigation through a Care Connections model.

Value of implementing navigation:
Fills current gaps in member connectivity and identification of rising risk populations. This solution would better identify undiagnosed behavioral health conditions through Quartet's analytics capabilities and navigate members to behavioral health care.

- Increases member access to mental health and quickly connects members to care
- Improves the member experience
- Leverages technology to steer members to mental health that meets their needs
- Enable access to in-network providers and new virtual behavioral health providers (i.e.: NOCD, AbleTo)

Virtual Access for Depression and Anxiety*
The health plan partnered with AbleTo to expand access. AbleTo is a best-in-class, high-quality, technology enabled virtual solution approved by the Blue Cross Blue Shield Association with measurable outcomes that provides a structured eight session Cognitive Behavior Therapy intervention, which is the recommended treatment for anxiety and depression. Anxiety and depression are the two most prevalent mental health conditions members struggle with nationally, and ensuring access to evidence-based treatment will improve well-being and outcomes.

- Will add 900+ therapists to expand access in all states

**Initiatives and programs included in 2022 BCBSM Corporate Goals*

9.2.6. Continuity and Coordination of Care

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

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

The health plan identifies multiple areas, or measures, for improvement based on its analysis. Four opportunities for improvement are identified to improve coordination of medical care by conducting a quantitative and qualitative analysis. The health plan annually acts upon three selected opportunities to improve coordination of

medical care and annually measures the effectiveness of improvement actions taken for three identified opportunities.

The health plan annually collects data about six opportunities for collaboration between medical care and behavioral healthcare; conduct quantitative and qualtitative analysis and of those identified, selects two opportunities for improvement and measures the effectiveness of the actions taken for the selected opportunities.

Blue Cross acts as necessary to improve continuity and coordination of care across the healthcare network and collaborates with practitioners to monitor and improve coordination between medical care and behavioral health care. The goals are listed in the table below.

Topics	Goal or Benchmark	Measures
Movement Across Settings: Cardiology	Health Plan Goal	100 percent for all lines of business
Movement Between Practitioners: Pulmonology	Health Plan Goal	100 percent for all lines of business
Movement Between Practitioners: Coordinating retinal Eye Exams in Diabetics	NCQA Benchmark	90th percentile for all lines of business.
Movement Across Settings: Avoidance of Readmissions within 30 Days of Discharge	NCQA Benchmark Health Plan Goal	90th percentile for all lines of business. 0.5771 Commercial 0.5771 Marketplace
Bidirectional exchange of information between behavioral health and medical providers	Health Plan Goal	100 percent for all lines of business
Appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care: Antidepressant Medication Management		
Acute phase	NCQA Benchmark	90th percentile for all lines of business.
Continuation phase	NCQA Benchmark	90th percentile for all lines of business.
Appropriate use of Psychotropic medication: Use of Opioids at High Dosages	Health Plan Goal	Equal or below 3.0 percent of members receiving prescription opioids for ≥15 days for all lines of business.
Management of treatment access and follow-up for members with coexisting medical and behavioral disorders: Co-Case Management		
Referrals to Case Management	Health Plan Goal	90 percent for Commercial and Marketplace
Goals Met	Health Plan Goal	10 percent for Commercial and Marketplace
Prevention programs for behavioral health care: Appropriate Consultation and Follow-up for medical inpatients with a new behavioral health diagnosis		
Consultation Inpatient	Health Plan Goal	10 percent for Commercial and Marketplace

Topics	Goal or Benchmark	Measures
Outpatient follow-up with 30 days of discharge	Health Plan Goal	90 percent for Commercial and Marketplace
Severe and persistent mental illness: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are using Antipsychotic Medications	Health Plan Goal	87 percent for all lines of business

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

9.2.7. Identification and Documentation of Quality of Care Concerns

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

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

Goals:

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

9.2.8. 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 CQC 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.

9.2.8.1. Michigan Quality Improvement Consortium

Blue Cross adopts the clinical practice guidelines developed by the Michigan Quality Improvement Consortium. MQIC was initially established by BCBSM and U of M and BCBSM has been the principal financial and administrative supporter of MQIC until January 2021, when MPRO assumed that role. Founded in the fall of 1999, MQIC consists of physicians and other personnel from 12 Michigan 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 Michigan system.

The purpose of MQIC is to achieve significant, measurable improvements in health care through the development and implementation of common evidence-based clinical practice guidelines. The guideline topics are selected by the MQIC Medical Directors' Committee and are based on a number of factors including scientific-based evidence,

data demonstrating relevancy to the health plans' population, potential use of subject matter by the primary care practitioner, HEDIS® measure, and internal and external requests for guideline development. MQIC develops and maintains one-side of one-page guidelines which provide concise recommendations 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 previously issued guidelines, current research is reviewed, and feedback is requested from several professional organizations, and physician specialists who manage the specific disease condition the guideline represents. Recommendations with [A] (randomized controlled trials) and [B] (controlled trials, no randomization) levels of evidence are given priority status. Preventive care guidelines are based on the United States Preventive Services Task Force A and B recommendations. These guidelines are the evidence-based foundation for the performance reports Blue Cross provides to physician organizations at least quarterly. In addition to the MQIC guidelines, BCN maintains the clinical practice guideline for Chronic Obstructive Pulmonary Disease.

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

Goal: Clinical Quality Committee review and/or approve MQIC guidelines annually.

9.2.9. Value Partnerships – Quality Programs

Blue Cross works with practitioners, physician organizations and acute-care hospitals in the state to improve the health care for Michigan residents.

This purposeful innovative approach to transforming health care forms partnerships and uses technology to improve health care quality, experience and affordability. These partnerships allow us to:

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

9.2.9.1. Physician Group Incentive Program

Founded in 2005, the Physician Group Incentive Program includes approximately 45 initiatives aimed at capability building, improving quality of care delivery and appropriate utilization of services. PGIP includes the Patient-Centered Medical Home 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.

Goals:

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

9.2.9.2. Patient-Centered Medical Home

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

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

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

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

Goal:

1. Increase overall PCP PCMH capability participation.
2. Strengthen the role of the PCP in the delivery and coordination of health care.

9.2.9.3. Patient-Centered Medical Home - Neighborhood

Patient-Centered Medical Home primary care practices are the foundation of many PGIP programs. PCMH practices must be supported by high-performing specialty practices – known as PCMH-Neighbors – 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 in 2010. Similar to PCMH, the Blue Cross PCMH-N program was developed in partnership with Michigan's provider community.

Specialists are fully integrated into the PCMH model through the Patient Centered Medical Home Neighbor concept. All PGIP specialists – more than 14,600 physicians, fully licensed psychologists and chiropractors – can implement PCMH-N capabilities. Specialist practices that serve as high-performing PCMH-Neighbors:

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

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

Goals:

1. Implements specialist team-based care value-based reimbursement.
2. Increase specialist PCMH capability implementation.

9.2.9.4. Organized Systems of Care

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

Through a defined PCP-attributed member population, OSCs have a shared commitment to proactively coordinate population-based care management across multiple care settings. OSCs are expected to have the ability to conduct ongoing quality and efficiency measurement through utilization of data including all key providers in their performance measurement efforts.

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

There are currently no active OSC incentive programs offered through PGIP. PGIP continues to examine ways to engage OSCs.

9.2.9.5. Clinical Quality Initiative

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

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

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

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

- Identify opportunities for improvement in measures by conducting data analysis and continuous quality improvement processes.
- Induce and deploy best practices among their physician community that result in safe and effective care.
- Support innovation and constructive change in processes for the delivery of care.
- Promote better outcomes and coordination of care across provider settings.
- Develop and implement strategies for population health management.
- Only measures where the Physician Organizations meet the NCQA 75th or 90th percentile will earn an incentive payment.

Blue Cross internal subject matter experts, in collaboration with physician organization leadership, annually review measures of care to determine which measures should continue as part of the initiative and which should be retired. Measures selected for the Clinical Quality Initiative include childhood and adolescent prevention, adult prevention, antibiotic use, heart disease, diabetes, medication management and

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

Goals:

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

9.2.9.6. Value Partnerships Strategic Engagement Program

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

Value Partnerships Strategic Engagement Incentive strives to improve engagement in the following areas:

- Quality of Care (HEDIS/Stars)
- Provider Delivery Care Management
- Patient Centered Medical Home
- Health Information Exchange
- Addressing the opioid epidemic

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

Goal: Deliver scorecards to 40 physician organizations by year-end.

9.2.9.7. Hospital Pay-for-Performance Program

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

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

- Performance and improvement on selected Centers for Medicare & Medicaid Services quality Indicators.
- Population insights evaluation by designated Population Health Champions.
- High-level health information exchange efforts to align with large and medium-sized hospitals programs.
- Readmission reduction effort best practice sharing to ensure a focus is placed on these efforts, to align with large and medium-sized hospital programs.

Goals:

1. Continue to require 100 percent of hospitals to fully comply with the program's patient-safety prequalifying condition, including conducting regular patient safety walk-rounds with hospital leadership and assessing and improving patient safety performance by fully meeting one of the following options:
    - Complete and submit the National Quality Forum Safe Practices section of the Leapfrog Hospital Survey at least once every 18 months.
    - Complete the Joint Commission Periodic Performance Review of National Patient Safety Goals at least once every 18 months.
    - Review Compliance with the Agency for Healthcare Research Patient Safety Indicators at least once every 18 months.
    - Participate in a federally-qualified patient safety organization.
2. Ensure results of the patient safety assessment and improvement activities are shared with the hospital's governing body and incorporated into a board-approved, multidisciplinary patient safety plan that is regularly reviewed and updated.
3. Increase the number of hospitals demonstrating favorable year-over-year improvements in their own hospital-specific 30-day all-cause readmission rate from the previous program year (n= ~40 percent of participants).
4. Hospitals are assessed using the CMS/Yale Hospital Wide 30-day unplanned readmission rate (HWR: NQF 1789) for their Blue Cross commercially insured PPO population.
5. Observe year-over-year improvements in hospital-selected Michigan Value Collaboration service lines, including:
    - Colectomy (non-cancer)
    - Chronic obstructive pulmonary disease (COPD)
    - Congestive heart failure (CHF)
    - Coronary artery bypass graft (CABG)
    - Joint replacement (hip and knee)
    - Pneumonia
    - Spine surgery
6. Engage all P4P-participating acute care providers in more robust Health Information Exchange.
7. Encourage participation in the new OB Initiative to reduce C-sections.

9.2.9.8. Hospital Value-Based Contracting

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

Initially, Blue Cross VBK efforts were intended to serve as a glide path for acute care providers to build the necessary infrastructure and partnerships with partnering physician organization partners needed to be successful in this new reimbursement environment. Presently, sixty-five Michigan hospitals, representing nearly 90 percent of the total Blue Cross commercial hospital payout, have signed a Value Based Contract.

Goals:

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

9.2.9.9. Blueprint for Affordability

Blueprint for Affordability is the next generation of Blue Cross' value-based reimbursement programs for PPO providers. In 2022 we will introduce a full-risk Blueprint MA model on our HMO. In these programs, Blue Cross works with health care providers to manage their patient populations. The focus is specifically to reduce the overall cost of care while maintaining high quality standards.

Blueprint holds providers financially accountable for their cost performance, but it also measures quality of care and patient experience (CAHPS which is included for BCNA). Providers who successfully manage the cost of care, share in the savings and those who do not, share in the costs.

What makes it different is that it expands risk-sharing contracting to physician organizations, physician practices and hospital systems. Participants agree to take on upside and downside risk:

- Upside risk - Providers share in the savings generated for effectively managing the cost of care trend and health care quality for their patients.
- Downside risk - Providers share in the cost if they don't effectively manage their cost trend and quality.

Blueprint for Affordability gives providers the tools and the appropriate recognition for successfully managing the health and cost of care for their patients. Cost performance is measured based on the cost of care trend and the quality component will be determined as follows:

- Commercial PPO providers will be measured against select Healthcare Effectiveness Data and Information Set (HEDIS®) quality metrics.
- Commercial PPO risk-based contracting entities must meet a minimum quality threshold based on historical performance. A minimum of 70 percent of gaps across the sum total of measures must be closed to meet the minimum threshold. Otherwise, the RBCEs share of any savings will be reduced for that performance period.

Blueprint is advancing the risk model on the HMO with BCNA in 2022 and is introducing full risk– where groups agree to take 100 percent financial risk.

For full-risk BCNA Blueprint, contracted entities agree to an MLR performance target. If performance exceeds target, they share in rewards. If the MLR falls below target, they suffer financial loss. Groups must also meet a 4.26 Stars performance on clinical and CAHPS performance measures or suffer penalties in their target.

Goal: To ensure that quality is maintained or improved as providers focus on reducing costs.

9.3. Satisfaction

9.3.1.1. Consumer Assessment of Healthcare Providers and Systems Survey

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

Goals:

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

The results are reported to the Clinical Quality Committee annually.

9.3.1.2. ECHO Behavioral Health Survey

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

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

The results are reported to the Clinical Quality Committee annually.

9.3.1.3. Voice of the Customer

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

9.3.1.4. Digital Experience

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

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

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

9.3.1.5. Consumer Transparency

The Consumer Transparency team, a subset of Digital Experience, focuses strategically and tactically on the Provider Directory, also known as Provider Search or Find a Doctor Tool.

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

9.3.1.6. Member Complaints, Inquiry and Grievance Resolution

The member complaint data is utilized to improve services and increase overall member satisfaction. All member complaints regarding medical, contractual or administrative concerns are received, categorized, reviewed and analyzed.

Clinical complaints involving quality of care are forwarded to Quality Management for investigation, resolution, tracking and trending. These service trends are considered in the provider recredentialing process.

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

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

9.3.1.7. Network Adequacy

Blue Cross Blue Shield of Michigan provides its members with adequate network access for needed healthcare services. Analysis of network adequacy enables health plan

organizations to identify aspects of performance that do not meet member expectations and initiate actions to improve performance. Blue Cross monitors multiple aspects of network adequacy presented in the following sequence within this report.

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

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

Goals:

1. Complaint rate: ≤0.15/1000 members
2. Appeal rate: ≤0.15/1000 members
3. Annually completes an analysis of utilization of OON services and identifies opportunities for improvement if applicable.
4. OON Cost share appeals: ≤0.15/1000 members
5. For CAHPS:
    - The NCQA Quality Compass 50th percentile benchmark is used to determine the Commercial PPO performance outcomes.
    - Marketplace PPO is to perform either the same as or above the national average of all Qualified Health Plans.
6. For ECHO: The goal is for each measure related to access to increase two percentage points year over year up to 90 percent. The goal is met for measures scoring greater than or equal to 90 percent.

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

9.4. Member Safety

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

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

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

9.4.1. Collaborative Quality Initiatives

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

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

The CQI Program supports:

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

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

As of 2021, Blue Cross is providing funding and active leadership for 19 CQIs addressing one or more of the following clinical conditions:

- Anesthesiology (ASPIRE)
- Cardiovascular(BMC2)
- Care Transitions (IMPACT)
- Anticoagulation (MAQI2)
- Bariatric surgery (MBSC)
- Cardiac surgery (MSTCVS)
- Emergency department care (MEDIC)
- General surgery (MSQC)
- Hospital value (MVC)
- Hospitalist care (HMS)
- Obstetrics (OBI)
- Oncology (MOQC)
- Radiation oncology (MROQC)
- Spine surgery (MSSIC)
- Total knee and hip replacement (MARCQI)
- Trauma (MTQIP)
- Urology (MUSIC)
- Diabetes (MCT2D)
- Low Back Pain (MiBAC)

9.4.2 CQI Coordinating Centers

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

- Identifiable and clear variations in practices of care exist throughout the health care continuum.
- An opportunity to positively influence outcomes is evident.
- Knowledge about optimal practices aren't widely implemented or scientific uncertainty exists.

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

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

Quality improvement interventions include:

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

As of 2021, Blue Cross is providing funding and active leadership for 19 CQIs addressing one or more of the following clinical conditions:

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

Professional CQIs
- Urology (MUSIC)
- Oncology (practice and treatment) (MOQC)

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

Chronic Care/Population Health CQIs
- Diabetes (MCT2D)
- Low back pain (MiBAC)

Goals:

1. Continue to develop additional best practices for CQI programs to demonstrate improved patient outcomes and share lessons learned locally, nationally, and internationally.
2. Evaluate CQI program performance to identify opportunities for strengthening and revamping.

9.4.3 Blue Distinction Centers for Specialty Care®

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

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

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

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

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

The Blue Distinction Specialty Care program provides broad national access to facilities and providers by delivering better quality specialty care, making them easy to find wherever you work and live across the U.S. You can easily locate a Blue Distinction Center at bcbs.com/blue-distinction-center-finder or by using our Find a Doctor feature at bcbsm.com. Today, more than 4,900 Blue Distinction Center and Blue Distinction Center+ designations have been awarded to more than 2,000 health care facilities in 48 states.

Goals:

1. Expand BDC/BDC+ designation across all programs by inviting facilities as appropriate to either apply for designation, or to open an appeal if their prior application was denied and they now meet all of the qualifications for designation.

2. Continue specifically focusing on strategies to recruit new Substance Use Treatment and Recovery facilities into the program and to implement Local Plan Criteria to align with internal Blue Cross behavioral health initiatives.

9.4.4 Total Care℠

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

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

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

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

2022 Goals:

1. Ensure BCBSM value-based programs that qualify for Total Care designation are aligned with Blue Cross Blue Shield Association's national value-based program policies 2.11 and 2.12. Recommend changes to local teams when required.
2. Timely and accurate data submission of Total Care program evaluation files to the Blue Cross Blue Shield Association.
    - Identify and complete analysis of member attribution issues and present solutions that may support more accurate evaluation results.
3. Timely publication of TC program evaluation results to Blue Cross internal and external stakeholders.
4. Implement technical changes required that will allow our members living out of state to be attributed to multiple Total Care programs in compliance with BCBSA policies. This change will allow our members to participate in out-of-state value-based programs that include specialist doctors.

9.4.5 MHA Keystone Center for Patient Safety & Quality

Blue Cross provides considerable funding to the Michigan Health & Hospital Association to support the MHA Keystone Center, a collaborative effort among Michigan hospitals – along with state and national patient safety experts – to improve quality, safety and reduce health disparities and inequities.

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

In 2021, Blue Cross continued their commitment to the MHA Keystone Center by directly supporting new programs and hospital-led innovations related to women and children's health, maternal care parameters, and the safety of both patients and healthcare workers. The funding will also support Blue Cross and the MHA Keystone Center's work encouraging Michigan hospitals to offer medication assisted treatment for substance use disorders to help combat the opioid epidemic.

Goals:

1. Increase implementation of pre- and post-partum Obstetric Hemorrhagic Risk Assessment.
2. Increase implementation of Quantitative Blood Loss Assessment for maternal patients.
3. Increase the percentage maternal patients who receive timely treatment of severe hypertension.
4. Decrease workers' injuries and associated costs.
5. Increase the utilization of medically assisted treatment services.

9.4.6 Health Information Exchange

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

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

In January 2016, Blue Cross introduced a skilled nursing facility Pay-for-Performance program into the HIE continuum to build upon the previously established hospital-based data exchange. The SNF P4P program provides freestanding and hospital-based SNFs the

opportunity to earn an incentive for submitting all-payer admission, discharge, transfer notifications through the MiHIN statewide service.

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

9.4.6.1 Peer Group 1-4 Hospitals Engagement in HIE Initiative

Since the HIE Initiative was introduced in 2014, 112 PG 1-4 hospitals participate in MiHIN' s statewide notification service. Hospitals have significantly improved the availability and quality of admission, discharge, transfer and medication data available to caregivers across the state. Participating hospitals are currently sending notifications for approximately 99 percent of all admissions statewide. These efforts will continue to be recognized through 2022, with hospitals earning a portion of their Blue Cross P4P HIE points through continued data quality conformance standards for the ADTs with the commen key, Exchange C-CDA (formerly Medication Reconciliation), Ambulatory CCDA, and Statewide Labs use cases. The Conformance Task Force, co-chaired by Blue Cross, was created to help set standards and quality guidelines for data flowing through the statewide network. Remaining points may be earned by participating with physician organizations in pilots and projects or transmitting pre-adjudicated claims to the statewide data hub.

9.4.6.2 Peer Group 5 Hospitals Engagement in HIE Initiative

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

Beginning with the 2016-2017 program year, hospitals began participating in the MiHIN statewide service by implementing the Admission-Discharge-Transfer use case. Currently, 43 of 44 hospitals have implemented the ADT use case. Starting in 2020, hospitals also earned a portion of their Blue Cross P4P HIE points by meeting data quality conformance standards for ADTs and for transmitting Exchange C-CDA data to MiHIN to support rural providers in improving care transitions and reducing readmissions. In 2021, hospitals were also incentivized to start sending their lab data.

9.4.6.3 Skilled Nursing Facility Engagement in HIE Initiative

Blue Cross introduced a skilled nursing facility Pay-for-Performance program into the HIE continuum beginning in January 2016. In 2021, the SNF P4P program provides freestanding and hospital based SNFs the opportunity to earn an additional four percent of their commercial Blue Cross payment for transmitting all-payer all patient admission, discharge, transfer notifications through the MiHIN statewide service. As of the last measurement date (August 2021), 220 of 420 SNFs currently meet this requirement.

9.4.6.4 Physician Organizations Engagement in HIE Initiative

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

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

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

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

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

9.5. Pharmacy

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

Pharmacy Services' quality goals are as follows:

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

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

9.5.1. Doctor Shopper Program

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

Through this ongoing program, in 2022 we will continue to monitor claims data to identify members who meet specific criteria for filling controlled substance prescriptions from multiple prescribers or multiple pharmacies. Pharmacy Services will fax a letter to each prescriber identified in the analysis. The letter encourages the prescriber to use their state's prescription drug monitoring program to determine whether patients are receiving controlled substances from other providers. This information gives the physician a better picture of the patient's-controlled substances profile.

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

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

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

Goal: Reduce the number of gaps in care related to statin therapy among patients with diabetes or cardiovascular disease by 1 percent each by December 31, 2022.

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

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

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

Goal: Reduce the number of gaps in care related to controller therapy among patients with asthma or COPD by 1 percent each by December 31, 2022.

9.5.4. High Dose Opioid 90 Morphine Milligram Equivalent Edit

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

Goal: Ensure that the HDO rate does not increase by more than one throughout 2022.

9.5.5. Value Partnerships Pharmacy Forum

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

Goal: In 2022, the forum will identify further opportunities to work with pharmacists in physician organizations. Topics addressed through the forum will include, but not be limited to opioids, medication adherence, antibiotics, medication reconciliation and pharmacy costs. Goals for the Value Partnerships Pharmacy Forum include holding at least four meetings with PGIP physician organization and sustaining physician organization interest and engagement on pharmacy issues.

9.6. Inclusion and Diversity

The Blue Cross Blue Shield of Michigan Patient-Centered Medical Home program supports provider collection of race, ethnicity and language data in addition to supporting language translation services and bilingual materials.

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

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

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

Guideline number	PCP and Specialist Guideline	Definition
2.20	Registry contains advanced patient information that will allow the practice to identify and address disparities in care	Primary/preferred language, race, ethnicity, measures of social support (e.g., disability, family network), disability

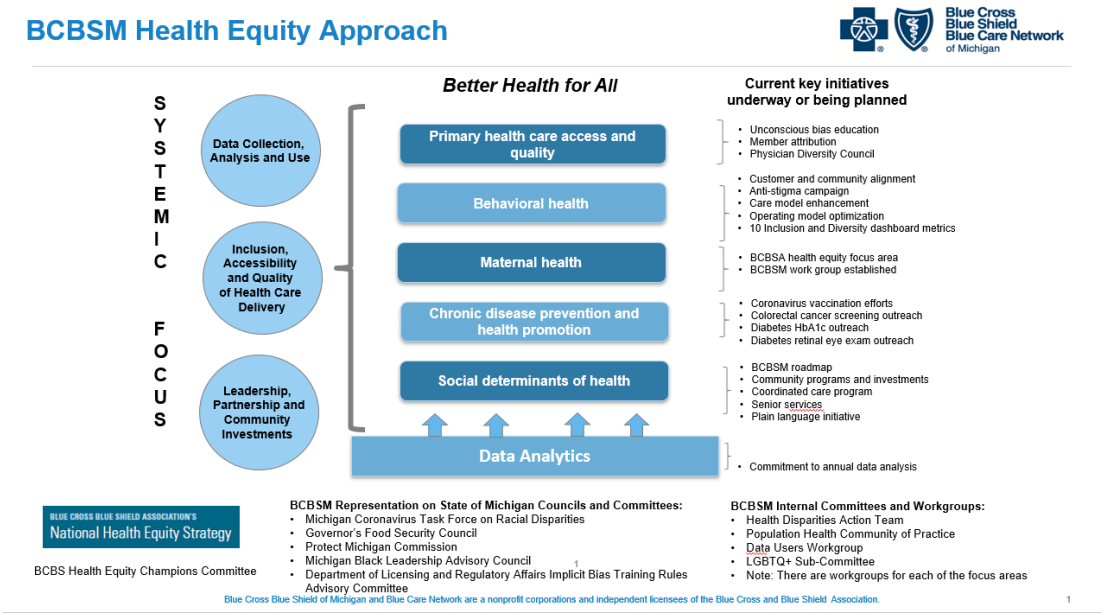
Guideline number	PCP and Specialist Guideline	Definition
		status, health literacy limitations, type of payer (e.g., uninsured, Medicaid), relevant behavioral health information
2.21	Registry contains advanced patient demographics	Gender identity, sexual orientation, sexual identity
2.25	Registry used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

Annually, Blue Cross analyzes populations to assess disparities across race/ethnicity as well as socioeconomic status for various clinical data measures based upon geocoded data utilizing

membership zip code as well as other proprietary logic. While activities to address disparities have been occurring across the company, in 2016, the Health Disparities Action Team was formed with the following purpose:

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

Building upon the foundational work of the Health Disparities Action Team, in December 2020, the Office of Health and Health Care Disparities was established. A health equity strategy has been developed with a vision of better health for all and a current focus on five focus areas: primary care access and quality of care, behavioral health, maternal health, chronic disease prevention (and Management) and health promotion, and social determinants of health. More than 10 initiatives have been completed, are underway or being planned. In addition to the Health Disparities Action Team, there is the Population Health Community of Practice, the Data Users Workgroup and the LGBTQ+ sub-committee.



Promotes diversity and inclusion in hiring.

- Recruits from professional organizations representing and supporting people of color.
- Recruits from organizations supporting veterans and people with disabilities.
- Recruits from community colleges.
- Dedicates resources to recruit from underrepresented groups, including LGBTQ+ community.
- Maintains a silver standing with the Michigan Veterans Affairs Agency.
- Maintains a veterans careers page on the web site.
- Is recognized by the National Organization on Disability as a Leading Disability Employer.
- Provides disability awareness education for HR team and hiring managers.
- Provides unconscious bias education for HR team.
- Analyzes the recruitment funnel to identify gaps and bias in hiring.
- Publishes workforce representation for people of color, women, and by generation to ensure transparency.

- Identifies underrepresentation of people of color, women, individuals with disabilities and veterans (incumbents compared to benchmark) at the job group level and develops targeting sourcing strategies to help close gaps.
- Partners with organizations like Junior Achievement to begin early career discussions with high school students
- Provides an annual update to the board of directors on hiring, promotions within the company and representation.
- Tracks representation of interns.
- Promotes the company's employee resource networks as part of the recruitment process.

Offers training to employees on cultural competency, bias or inclusion.

- Requires all employees to complete a three hour cultural competency session. Cultural competency is a cornerstone of the inclusion and diversity strategy.
- Requires unconscious bias education, a two hour session, for all leaders in the company.
- Provides educational sessions on unconscious bias for all employees.
- Holds more than 100 learning sessions annually to promote inclusion, cultural competency and awareness of differences and similarities in different cultures, communities, generations as well as in terms of different workstyles and perspectives.
- Encourages the participation of employees in experiential volunteer opportunities to increase exposure to different cultures and communities and increase cultural competency.

10. Qualified Providers

10.1. Credentialing and Recredentialing

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

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

10.2. Facility Site Review

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

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

Goals:

1. Conduct site reviews within 30 calendar days of request related to complaints or reassessments.
2. Conduct reviews within 14 business days of request that are not complaint related.
3.

10.3. Physician Participation

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

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

10.4. Peer Review Process and Implementation of Corrective Action Plan

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

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

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

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

10.5. Physician Discipline and Termination

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

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

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

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

10.6. Physician Appeal Process

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

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

11. Delegation Activities

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

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

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

For all credentialing delegates, the Corporate Credentialing and Program Support area conducts pre-delegation and annual delegation oversight evaluations and presents to the Enterprise Credentialing Committee.

12. Compliance

12.1. Review by External Entities

Reviews by external entities are conducted in collaboration with the Corporate Compliance office. The reviews validate compliance with regulatory agency standards and determine the effectiveness of the Quality Improvement Program to continually improve the care and services provided to members. Examples of external entities are as follows:

- Department of Insurance and Financial Service: Requires an annual evaluation of operations and selected aspects of the Quality Improvement Program.
- National Committee for Quality Assurance: Voluntary review of the Quality Improvement Program is conducted by the National Committee for Quality Assurance, which is the leading external review organization for the managed care industry.
- Centers for Medicare & Medicaid Services: Require an annual evaluation of the Medicare Advantage program.
- Annually ensures the Quality Improvement Strategy is updated, reviewed and submitted.

12.2. Confidentiality

All documented peer review activities are maintained in a confidential manner and in compliance with legal requirements and state regulatory standards. The records, data and information collected for or by individuals or committees assigned a professional review function are confidential and shall be used only for the purposes of professional review, aren't public records and aren't subject to court subpoena. Disclosure of quality assessment information is protected under the Federal Health Care Quality Improvement Act of 1986.

Names of members, health care practitioners and providers are removed from documents and coded so as not to identify the individual. Dissemination of practitioner or provider specific information is limited to the involved practitioner or provider, or to those individuals requiring the data to perform recommended corrective action.

Quality improvement documents not protected under the auspices of peer review are maintained in accordance with internal policies and procedures.

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

Staff confidentiality requirements include an annual review and signing of a confidentiality statement and annual conflict of interest disclosure. The signed statements are maintained by Human Resources. All participants in the Quality Improvement Program are expected to respect the confidential information as such. External committee members are required to sign a confidentiality statement annually.

12.3.Fraud, Waste, and Abuse

Health care fraud, waste and abuse is the intentional misrepresentation of health care services by a provider, employer group or member with the intention of personal or financial gain. Employees, members and providers are educated on health care fraud and how to report fraud and abuse through member and provider newsletters, handbooks and manuals. An employee, member or provider can choose to report fraud, waste or abuse anonymously.

Staff identifies potential abuse by providers or members through facility site and medical record reviews for member complaints and/or provider issues. Audits may be conducted on a random or

targeted basis to identify, refer, investigate, resolve and trend quality of care/service concerns as well as any FWA.

When potential fraud, waste or abuse is identified, the issue is promptly reported to one of the following:

- Employee's supervisor
- Compliance officer
- Director of corporate ethics and compliance
- Blue Cross Corporate and Financial Investigations Unit
- Blue Cross Government Programs Investigation Unit
- Health and Human Services Office of the Inspector General for suspected cases of Medicare fraud

13. Annual Work Plan

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

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

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

14. Evaluation of the Quality Improvement Program

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

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

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

15. Resources and Analytical Support

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

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

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

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

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

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

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

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

- Create customer-specific performance reports on HEDIS metrics to help employer groups make data–driven decisions regarding health promotion focused programs for employees.

16. Federal Employee Program

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

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

ME 8A-D	Delegation of ME	The FEP Director's Office contracts with Alliance Walgreens Prime (Prime Therapeutics) and CVS Caremark to provide pharmacy services, Accordant for complex condition management, WebMD for Health appraisals, Livongo for chronic care management, and Teladoc for medical and behavioral health services for FEP members. The FEP Director's Office maintains this contract at a national level and is responsible for the oversight of the delegated activities.
Utilization Management (UM)		
UM 2B	Availability of Criteria	FEP Medical Policies are accessed from fepblue.org. Web content and member digital experience are managed and monitored by the Director's Office, not Blue Cross Blue Shield (this element is N/A for renewal surveys).
UM 2C	Consistency Applying Criteria	The FEP Director's Office contracts with CVS Caremark, an NCQA-Accredited UM organization; therefore, this element receives automatic credit for services provided by CVS Caremark to the FEP population.
UM 3A	Communication Services-Access to Staff	The FEP Director's Office maintains responsibility for the distribution of written communication with information related to how members can access staff to discuss UM issues. Written content, web content and member digital experience are managed and monitored by the FEP Director's Office, not Blue Cross Blue Shield.
UM 4F	Use of Board-Certified Consultants	The FEP Director's Office contracts with CVS Caremark, an NCQA-Accredited UM organization; therefore, this element receives automatic credit for services provided by CVS Caremark to the FEP population.
UM 8A	Policies for Appeals-internal appeals	Blue Cross FEP maintains a separate policy that provides direction for the receipt, review, and resolution of reconsiderations submitted by FEP members (this element is N/A for renewal surveys.
UM 10A	Evaluation of New Technology- Written Process	The FEP Director's Office has a defined process for the evaluation of new technology and new applications of existing technology for inclusion in the benefits plan. This policy is maintained by the FEP Director's Office.
UM 10B	Description of the Evaluation Process	The FEP Director's Office has a defined process for the evaluation of new technology and new applications of existing technology for inclusion in the benefits plan. This policy is maintained and governed by the FEP Director's Office Pharmacy and Medical Policy Committee at an association level.
UM 11A-E	Procedures for Pharmaceutical Management	The FEP Director's Office contracts with Alliance Walgreens Prime (Prime Therapeutics) and CVS Caremark to provide pharmacy services to FEP members.
UM13A-D	Delegation of UM	The FEP Director's Office contracts with Alliance Walgreens Prime (Prime Therapeutics) and CVS Caremark to provide pharmacy services to FEP members.
Credentialing and Recredentialing (CR)		
CR 2A	Credentialing Committee	The FEP Director's Office contracts with Teladoc to provide Telehealth services to FEP members. The FEP Director's Office maintains this contract at a national level and is responsible for the oversight of the delegated activities.
CR 5A	Ongoing Monitoring and Interventions	The FEP Director's Office contracts with Teladoc to provide Telehealth services to FEP members. The FEP Director's Office maintains this contract at a national level and is responsible for the oversight of the delegated activities.
CR 8A-D	Delegation of CR	The FEP Director's Office contracts with Teladoc Physicians, P.A. to provide Telehealth services to FEP members. The FEP Director's Office maintains this contract at a national level and is responsible for the oversight of the delegated activities.
Network Management (NET)		
NET 5A, E, F, H, I, J factor 1	Physician and Hospital Directories	The FEP Director's Office contracts with HealthSparq to provide vendor directories for fepblue.org. The FEP Director's Office maintains this contract at a national level and is responsible for the oversight of the

		delegated activities (NET 5A-B, 5F and 5G are N/A for renewal surveys).
NET 6A-D	Delegation of NET	The FEP Director's Office contracts with HealthSparq to provide vendor directories for fepblue.org. The FEP Director's Office maintains this contract at a national level and is responsible for the oversight of the delegated activities.

The 2022 Quality Improvement Program Plan has been reviewed and approved.

APPROVED BY:

Clinical Quality Committee on 01/19/2022:

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

17. Appendix A