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# 2024 Blue Care Network of Michigan Quality Improvement Program Description

January 24, 2024

**Table of Contents**

- 1. Purpose..... 6
- 2. Health Plan Mission..... 6
- 3. Health Plan Membership ..... 6
- 4. Quality Improvement Philosophy ..... 6
- 5. Scope ..... 7
- 6. Goals and Objectives ..... 7
- 7. Organizational Structure..... 9
  - 7.1. Program Committees ..... 9
    - 7.1.1. Blue Care Network Board of Directors.....10
    - 7.1.2. Health Care Quality and Service Improvement Committee.....10
    - 7.1.3. Clinical Quality Committee .....11
    - 7.1.4. Utilization Management Committee.....13
    - 7.1.5. Quality Appeals Committee .....14
    - 7.1.6. Enterprise Credentialing Committee.....14
    - 7.1.7. Pharmacy and Therapeutics Committee.....16
    - 7.1.8. Customer Service and Satisfaction Committee.....17
    - 7.1.9. Joint Uniform Medical Policy Committee .....18
    - 7.1.10. Criteria Review Committee .....20
    - 7.1.11. Medical Affairs Policy Review Committee.....21
    - 7.1.12. Care Management Quality Committee.....22
    - 7.1.13. Senior Health Services Care Management Quality Committee.....22
- 8. Reporting Relationships .....23
  - 8.1. Blue Care Network Board of Directors .....23
  - 8.2. President and Chief Executive Officer.....24
  - 8.3. Vice President, Health Care Value Operations and Provider Enablement.....24
  - 8.4. Senior Vice President and Chief Medical Officer.....24
  - 8.5. Senior Medical Director & Associate Chief Medical Officer and Medical Director,  
Utilization Management/Quality Management.....24
  - 8.6. Medical Directors .....25
  - 8.7. Behavioral Health Medical Director .....25
  - 8.8. Director, Quality Management .....25
    - 8.8.1. Quality Management Department.....25
- 9. Program Activities .....26

9.1.	Quality of Service.....	27
9.1.1.	Availability of Practitioners.....	27
9.1.2.	Accessibility of Service.....	28
9.1.3.	Monitoring for Quality and Accuracy of Information to Members.....	29
9.1.4.	Monitoring Email Turnaround .....	30
9.2.	Clinical Quality .....	30
9.2.1.	Healthcare Effectiveness Data and Information Set.....	30
9.2.2.	Utilization Management.....	31
9.2.3.	Population Health Management .....	32
9.2.4.	Care Management (including Complex Case Management).....	34
9.2.5.	Health Promotion.....	35
9.2.6.	Behavioral Health .....	35
9.2.7.	Quality Incentive Programs .....	41
9.2.8.	Continuity and Coordination of Care.....	42
9.2.9.	Identification and Documentation of Quality of Care Concerns .....	44
9.3.	Member Experience.....	44
9.3.1.	Consumer Assessment of Healthcare Providers and Systems Survey .....	44
9.3.2.	ECHO Behavioral Health Survey.....	44
9.3.3.	Voice of the Customer.....	45
9.3.4.	Digital Experience .....	45
9.3.5.	Consumer Transparency.....	45
9.3.6.	Member Complaint, Inquiry and Grievance Resolution.....	46
9.3.7.	Network Adequacy for BCN and BCN Advantage.....	46
9.4.	Member Safety .....	47
9.4.1.	Collaborative Quality Initiatives.....	47
9.4.2.	Blue Distinction Centers for Specialty Care®.....	48
9.4.3.	MHA Keystone Center for Patient Safety & Quality .....	49
9.4.4.	Health Information Exchange .....	50
9.5.	Pharmacy .....	52
9.5.1.	Commercial and Exchange Pharmacy.....	53
9.5.2.	BCNA Pharmacy.....	55
9.6.	Inclusion and Diversity .....	56
10.	Qualified Providers .....	60
10.1.	Credentialing and Recredentialing .....	60

10.2.	Ongoing Monitoring.....	60
10.3.	Facility Site Review.....	60
10.4.	Physician Participation.....	61
10.5.	Peer Review Process and Implementation of Corrective Action Plan.....	61
10.6.	Physician Discipline and Termination.....	61
10.7.	Physician Appeal Process.....	62
11.	Delegation Activities .....	62
12.	Compliance .....	63
12.1.	Review by External Entities.....	63
12.2.	Confidentiality .....	64
12.3.	Fraud, Waste, and Abuse .....	64
13.	Annual Work Plan.....	65
14.	Evaluation of the Quality Improvement Program.....	65
15.	Resources and Analytical Support.....	65
16.	Appendix A.....	68

## **Conflict of Interest**

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

## 1. Purpose

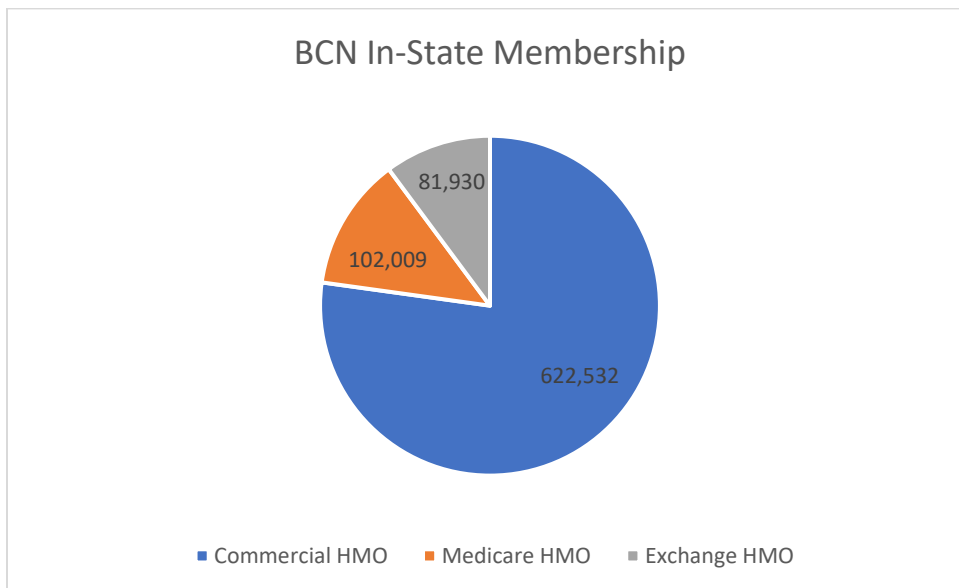
The purpose of the Quality Improvement Program is to establish a planned, systematic and comprehensive approach to measure, assess and improve organization-wide performance. The focus is on the identification of important aspects of care and services, the assessment of the level of care and services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

## 2. Health Plan Mission

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

## 3. Health Plan Membership

Blue Care Network, headquartered in Southfield, Michigan, serves over 800,000 total members. The in-state population consists of 622,532 (77 percent) Commercial HMO, 102,009 (13 percent) Medicare HMO and 81,930 (10 percent) Exchange members.



*\*Data reflects BCN members as of 12/31/2023.*

## 4. Quality Improvement Philosophy

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

Through the efforts of the Quality Improvement Program, BCN strives to improve the quality and safety of clinical care and services that members receive which meet or exceed all stakeholder

expectations for satisfaction and improved health status. BCN strives to conduct its business in a prudent and efficient manner and to maintain a work environment that is exciting, challenging and rewarding. It's Blue Care Network's goal to empower employees to accomplish their work within a friendly atmosphere of teamwork and mutual respect.

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

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

## 5. Scope

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

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

The program indicators relate to structure, process and outcomes of the health care services provided. The Quality Improvement Program activities are categorized by the following: quality of service, clinical quality, member experience, continuity and coordination, member safety, pharmacy, inclusion and diversity, qualified providers, delegation, compliance and communications.

## 6. Goals and Objectives

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

### **Quality Improvement Program Structure and Operations**

- Revise, review, approve and implement the 2024 Quality Improvement Program Description and Work Plan with all activities based on the 2023 annual QI evaluation findings and recommendations.
- Evaluate 2023 goal and objectives and areas for improvement. Implement findings of the 2023 annual QI Evaluation into the 2024 QI Program and Work Plan.
- Maintain minutes that demonstrate the health plan's QI Committee develop, implements the QI program and oversees the QI functions within the organization.

### **Quality of Service**

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

### **Clinical Quality**

- Work collaboratively to ensure compliance with HEDIS® reporting requirements and participate in initiatives that improve rates.

- Support the delivery system, patient centered medical homes and use of value-based payment arrangements.
- Work with practitioners and their physician organizations to better manage patients through various value partnerships programs.
- Outline the population health management strategy for meeting the care needs of the member population.
- Assess the needs of the population and determine actionable categories for appropriate intervention.
- 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.
- Measure the effectiveness of the population health management strategy.
- 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.

#### **Member Experience**

- 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 related to pharmacy.
- Participate on collaborative workgroups on patient safety programs to maximize safety of clinical practices.

#### **Organizational Diversity, Equity and Inclusion**

- To promote organizational diversity, equity and inclusion needs of the BCN population.
- Create a culturally competent workforce.
- Pursue NCQA Health Equity Accreditation as part of the Inclusion and Diversity Strategy.

#### **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 Single Site Multiple Entity Resurvey in 2025.



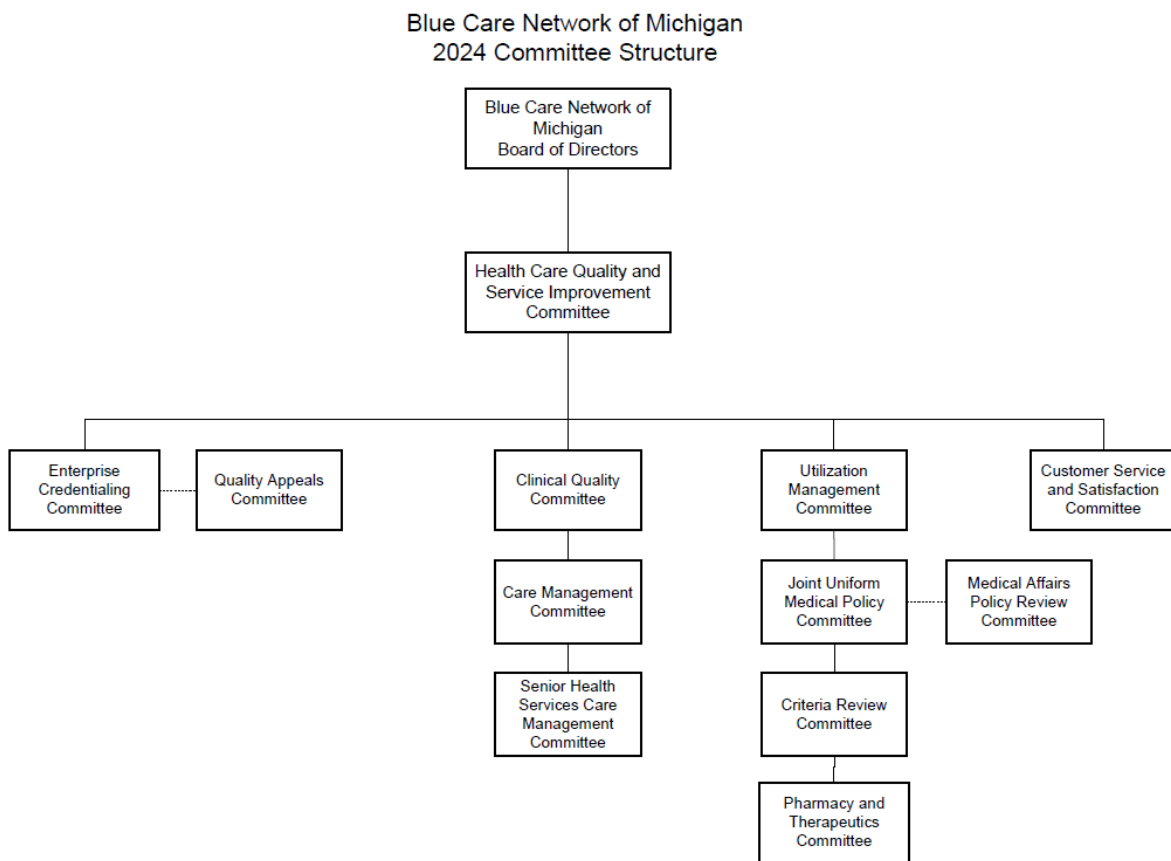
- Adhere to ACA reporting requirements associated with the annual Quality Improvement Strategy.
- In collaboration with the compliance officer, ensure compliance with local, state and federal regulatory requirements and accreditation agency standards.

**Communication**

- Maintain communication plan to ensure compliance with regulatory requirements.

**7. Organizational Structure**

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



**7.1. Program Committees**

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

### 7.1.1. Blue Care Network Board of Directors

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

#### **Responsibilities:**

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

#### **Composition:**

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

#### **Term:**

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

#### **Meetings:**

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

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

The Health Care Quality and Service Improvement Committee is a standing committee of the Board of Directors and provides oversight for activities related to improving the quality and affordability of member health care and to make necessary recommendations to the board based on matters reviewed. The committee has the authority to review decisions made by its subcommittees. The board of directors delegates the responsibility for the design, implementation, and management of the Quality Improvement Program to the Health Care Quality and Service Improvement Committee.

#### **Responsibilities:**

- Provides oversight for quality improvement activities related to health care delivery and service.

- Receives, reviews and makes recommendations to the Board of Directors on quality improvement documents received from the reporting committees.
- Reviews and approves, annually, the Quality Improvement Program Plan, work plan and annual evaluation of effectiveness.
- Submits quality improvement reports to the Board of Directors.
- Reviews and monitors
  - a) Quality and service improvement activities, including CMS Star rating impacts
  - b) Health care value trends,
  - c) Health Care Delivery programs,
  - d) Product strategies, and
  - e) Provider reimbursement strategies.
- Reviews and approves selected policy issues as requested by senior management.

**Composition:**

- Board members, minimum of three (includes chairperson)
- Three licensed clinicians
- Chairperson: Board Member
- Vice Chairperson: Board Member

Committee membership changes require Board approval.

The President and chief executive officer attends but is not a voting member

**Term:**

- Annual appointment.

**Meetings:**

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

**7.1.3. Clinical Quality Committee**

The Clinical Quality Committee reports to the Health Care Quality and Service Improvement Committee. The committee has oversight responsibilities for quality improvement studies, utilization management activities, behavioral health, chronic condition management, patient safety, 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: Senior Medical Director & Associate Chief Medical Officer
- Co-Chairperson: Associate Medical Director
- Senior Medical Director, Utilization Management
- Medical Director, Utilization Management/Quality Management
- Medical Director, Clinical Program Oversight Management SHS
- Senior Medical Director, Health Plan Business
- Medical Director, Behavioral Health
- Medical Director, New Directions Behavioral Health
- Eight external practitioners who represent a cross section of both primary care physicians and specialists
- Director, Quality Management

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

**Term:**

- Physician members serve for an initial term of two years.
- Reappointment is at the discretion of the 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 for BCN/BCNA lines of business; and a subcommittee of the Health Care Delivery Committee for BCBSM lines of business. 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 annually.
- 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 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.
- Annually adopts criteria sets and guidelines for program components and ensures uniform application.
- Reviews developed criteria and guidelines annually.
- Monitors utilization data to detect potential underutilization and overutilization of services and recommends programs to address both, as necessary.

##### **Composition:**

- Chairperson: Senior Medical Director, Utilization Management
- Co-Chairperson: Vice President, Utilization Management
- BCN and BCBSM Medical Directors
- 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 chief medical officer.

##### **Term:**

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

##### **Meetings:**

- A quorum is defined as a majority of voting members with a minimum of two participating external physicians. All committee members do not have voting rights. The chair will only vote if it is to break a tie.
- 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.

- Clinical Criteria Policies are distributed to the external approximately 30 days prior to the UM Committee meeting with information associated to each policy that may include the information listed below. The external physicians are asked to send questions or comments ahead of the UM Committee meeting about 3-5 days before the meeting in order for BCBSM/BCN to have time to review feedback.
  - A summary of changes applicable to the new/updated clinical criteria policy.
  - Redline guidelines reflecting the changes to the clinical criteria policy.

#### 7.1.5. Quality Appeals Committee

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

##### **Responsibilities:**

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

##### **Composition:**

- Chairperson: Medical Director, Utilization Management
- Co-chairperson: Associate Medical Director
- Senior Medical Director & Associate Chief Medical Officer
- Medical Director, Behavioral Health
- Senior Medical Director, Health Plan Business
- Medical Director, New Directions Behavioral Health
- Medical Director, Clinical Program Oversight Management SHS
- 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 chief medical officer.

##### **Meetings:**

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

#### 7.1.6. Enterprise Credentialing Committee

The Enterprise Credentialing Committee is an enterprise-wide peer review committee representing Blue Cross and BCN. The ECC has oversight responsibility for credentialing and recredentialing activities (including utilization management and quality) for all practitioners. The committee also has oversight responsibility for credentialing and

recrediting organizational providers. These include but are not limited to, hospitals, home health agencies, skilled nursing facilities, ambulatory surgical centers and behavioral health facilities.

**Responsibilities:**

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

**Composition:**

Voting Members:

- Chairperson: Appointed by the Senior Vice President, Chief Medical Officer
- Co-Chairperson: Medical Director who has direct responsibility and participation in the credentialing program.
- Four Blue Cross/BCN medical directors
- Two external primary care practitioners who represent internal medicine or family practice and pediatrics
- Six external specialists who represent specialties including but not limited to general surgery or a surgical subspecialty, obstetrics and gynecology, behavioral health, oral surgery, pathology, anesthesiology, radiology or emergency medicine specialty
- Chiropractor

Non-Voting Members:

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

**Term:**

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

**7.1.7. Pharmacy and Therapeutics Committee**

The Pharmacy and Therapeutics Committee is a joint committee representing both Blue Cross and BCN. The P & T Committee evaluates the clinical use of drugs available under the pharmacy and medical benefit, 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 selection of items to include in the formularies shall be based on objective evaluation of their relative therapeutic merit and safety. The Committee will approve inclusion or exclusion of the therapeutic classes in the formulary on an annual basis. Decisions must be based on available scientific evidence and may also be based on economic considerations that achieve appropriate, safe and cost-effective drug therapy. Therapeutic advantages in terms of safety and efficacy must be considered when selecting formulary drugs and when reviewing placement of formulary drugs into formulary tiers.
- 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, BCBSM Chief Medical Officer or their designees and the BCBSM Vice President of Pharmacy Services and Chief Pharmacy Officer. 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.

**7.1.8. Customer Service and Satisfaction Committee**

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

**Responsibilities:**

- Reviews member, practitioner, provider (including facility) and purchaser satisfaction survey results and performance indicators and determines actions for improvement. Appoints workgroups and approves and monitors goals, work plans and performance measures.
- Provides oversight of corporate programs which relate to evaluating and monitoring the quality and appropriateness of service and satisfaction.
- Reviews and determines service quality indicators used for assessment and stakeholder experience improvement activities.
- Evaluates the service quality programs on an annual basis and refocuses direction, as necessary.
- Reviews trends related to stakeholder complaints, appeals and primary care physician change requests; and approves recommendations for improvement.

- Monitors and evaluates effectiveness of improvement plans.
- Reviews trends related to significant stakeholder servicing issues, member access requirements and the quality of information. Appoints workgroups to address issues and approves and monitors remediation plans.
- Reviews and approves member related satisfaction policies and procedures, including complaint and appeal procedures after the approval by the highest-ranking leader of the responsible department.
- Identifies strategies to improve service performance and satisfaction.
- Provides oversight for delegated Customer Service and Claims activities.
- Submits written reports to the Health Care Quality and Service Improvement Committee.

**Composition:**

- Chairperson: Senior Director, Customer Service
- Vice Chairperson: Director, Corporate Performance and Administration and Corporate Secretary
- Senior Director, Corporate Performance and Administration
- Senior Director, BCN Value and Stakeholder Experience
- Director, Quality Management
- Director, Clinical Program Operations, Utilization Management
- Market Research Analyst
- VP, Business Performance & Execution BCN
- Director, Quality and Provider Education
- Senior Director, Customer Service,
- Manager Pharmacy Administration
- Director BCN Business Performance Optimization
- Director, Care Management
- Director, BCN State Accounts and Special Servicing
- Director, Medicare Servicing
- Director Grievance, Appeals and BCN Executive Services
- Managing Director, Member Solutions & Administration, Senior Health Services
- Director, BCN-Claims Automation
- Manager of Provider Engagement
- Manager, Key Accounts, COBX

The committee membership may be changed upon approval of the chief medical officer.

**Term:**

- Not applicable.

**Meetings:**

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

**7.1.9. Joint Uniform Medical Policy Committee**

The Joint Uniform Medical Policy Committee is a joint corporate committee representing Blue Cross and BCN evaluates new technologies, devices and healthcare services, as well as new uses of existing technologies, devices, and healthcare services. Evaluations may result

in the development or revision of medical policy statements that describe the technologies, devices, and healthcare services as investigational or established.

**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). *\* It is noted that most medical policies adopted from BCBSA have been vetted by clinical subject matter experts in national academic medical centers as well as by relevant national provider organizations*
- 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 revised medical policy statement and additional information being presented at a subsequent committee meeting.

**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/Quality Management
  - 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 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 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.

**7.1.10. Criteria Review Committee**

The Criteria Review Committee reviews clinical criteria used in the utilization management process for the Traditional, PPO, MAPPO, POS, and 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: Senior 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.

### **7.1.11. 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 and discussion 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 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 designee 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 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.

### **7.1.12. Care Management Quality Committee**

The Care Management Quality Committee has been established to provide oversight and guidance for the development, implementation, maintenance, evaluation and quality improvement of CM's internal and vended programs. The committee ensures that Care Management 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, focusing on program review, recommendations and improvements.
- Support the alignment of CM's quality goals and activities.
- Ensure integration with clinical guidelines and outcome measures.
- Identification and alignment of opportunities to increase program efficiency and effectiveness and alignment through measurement.

#### **Composition:**

- Chairperson: Health Care Manager, Care Management Quality
- Vice President, Care Management
- Senior Medical Director
- Medical Directors
- Directors, Care Management Leadership
- ECV Consultant, Care Management Quality
- Manager, Care Management Program Enhancements
- Manager, Coordinated Care Analytics
- Manager, System Support
- Manager, Training and Policies and Procedures
- Operational Managers

#### **Term:**

- Not applicable.

#### **Meetings:**

- The Committee meets at least bi-annually. A quorum of 2/3 of participating membership is required to vote and conduct business. If a committee member cannot attend, the committee member must send a proxy. The Care Management Quality Committee meeting agenda and handouts are prepared and distributed to attendees before the meeting. Written minutes are taken by a designated scribe and will be sent out for email approval. Once the committee approves the minutes, the meeting facilitator formally signs the meeting minutes. The minutes are retained for a minimum of one year or as otherwise required by external regulatory/accrediting entities.

### **7.1.13. Senior Health Services Care Management Quality Committee**

The Senior Health Services Care Management Quality Committee has been established to provide oversight and guidance for the development, implementation, maintenance, evaluation and quality improvement of CM internal and vended programs. This committee will set strategy aligned with corporate goals, review market expectations and improve health outcomes.

**Responsibilities:**

- Develop program strategy based on corporate goals, and market expectations.
- 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 implementation of opportunities to increase program efficiency and effectiveness and alignment through measurement.

**Composition:**

- Chairperson: Manager of Quality
- Vice President, Care Management
- Managing Director, Fee For Service
- Director, Care Management Program Delivery
- Director, Care Management Program Support
- Medical Director
- Physician Consultants
- Managers, Care Management Program Delivery
- Manager, Care Management Training & Quality
- Manager, CM Program Development
- Manager, Pharmacy
- Manager, SHS Analytics
- Quality RNs

**Term:**

- Not applicable.

**Meetings:**

- The SHS CM Quality Committee will meet annually at minimum.
- A quorum of 2/3 of participating membership is required to vote and conduct business. If a committee member is unable to attend the committee member must send a proxy.
- The SHS CM Quality Committee agenda and handouts are prepared and distributed to attendees in advance of the meeting. Written minutes are taken by a designated scribe and will be sent out for email approval.
- Once the minutes are approved by the committee, the meeting facilitator formally signs the meeting minutes. The minutes are retained for a minimum of one year or as otherwise required by external regulatory/accrediting entities.

## 8. Reporting Relationships

### 8.1. Blue Care Network Board of Directors

The Blue Care Network board of directors has ultimate authority and responsibility for oversight of the BCN quality improvement program. The president and chief executive officer, the vice president of healthcare values performance and execution and the chief medical officer provide oversight and coordination of the quality improvement program and act subject to and on the board's behalf in the review and approval of policies, procedures and activities of the quality improvement program.

## **8.2. President and Chief Executive Officer**

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

## **8.3. Vice President, Health Care Value Operations and Provider Enablement**

The Vice President, Health Care Value Operations and Provider Enablement 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 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 chief executive officer, the Health Care Quality and Service Improvement Committee, and the BCN board of directors. The responsibility for clinical quality, behavioral health quality and safety of clinical care improvement activities includes, but isn't limited to the following:

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

## **8.5. Senior Medical Director & Associate Chief Medical Officer and Medical Director, Utilization Management/Quality Management**

The Senior Medical Director and Associate Chief Medical Officer reports to the Senior Vice President & CMO. The Medical Director of Utilization Management/Quality Management reports to the Senior Medical Director who reports to the Senior Vice President & CMO. They are responsible for providing clinical guidance, input and leadership oversight for healthcare improvement related activities including utilization management, medical management, credentialing, quality improvement, behavioral health, and pharmacy services. Responsibilities include the following:

- Lead the Clinical Quality Committee.
- Assist in ensuring compliance with legal requirements and regulatory and accrediting agencies' standards and procedures by providing clinical oversight and input into



regulatory and accreditation reviews related to utilization and quality management programs.

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

## **8.6. Medical Directors**

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

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

## **8.7. Behavioral Health Medical Director**

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

## **8.8. Director, Quality Management**

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

### **8.8.1. Quality Management Department**

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

This department performs the following functions:

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

## 9. Program Activities

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

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

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

BCN conducts quality improvement studies to systematically evaluate the quality and safety of clinical care and service delivered to members. BCN relies on its policy and procedure which

provides for the consideration of many factors in the identification, selection and prioritization of study topics, including the following:

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

The Medical Informatics a department under HCV Business Analytic Services provides assistance with clinical study design, statistical analysis and evaluation. The 2023 activities are described below with reference to the MOU if applicable.

## 9.1. Quality of Service

### 9.1.1. Availability of Practitioners

Blue Care Network ensures that its networks are sufficient in numbers and types of practitioners to meet the needs of its members. In creating and maintaining the delivery system of practitioners, BCN acknowledges and values the key role of cultural, racial, ethnic, gender, linguistic needs and personal preferences in the effective delivery of health care services.

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

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

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

#### Goals:

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

1. For at least percent 90% of BCN members in Large Metro and Metro, 85% in Micro, Rural and Counties with Extreme Access Considerations should have access to the following, based on time and distance from the member's home:

Practitioner/Provider	Large	Metro	Micro	Rural	CEAC
Primary Care	10/5	15/10	30/20	40/30	70/60
OB/GYN*	30/15	45/30	80/60	90/75	125/110
^^Dermatology*	20/10	45/30	60/45	75/60	110/100
^^Orthopedic Surgery*	20/10	30/20	50/35	75/60	95/85
Cardiovascular Disease*	20/10	30/20	50/35	75/60	95/85

Oncology (med/surg)**	20/10	45/30	60/45	75/60	110/100
Oncology (radiation)**	30/15	60/40	100/75	110/90	145/130
^Ophthalmology*	20/10	30/20	50/35	75/60	95/85
BH and Substance Abuse	20/10	45/30	60/45	75/60	110/100

\* High Volume Specialty

\*\* High Impact Specialty

^Medicare Advantage only

^^Commercial/Exchange HMO only

Note: The list contained in this grid is not all inclusive

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: 1:1,000 or less
  - Pediatrics to pediatric members: 1:1,000 or less
  - Internal medicine to adult members: 1:1,000 or less
  - PCP to adult members: 1:1,000 or less
  - PCP to pediatric members: 1:1,000 or less
  - OB/GYN to female members: 1:10,000 or less
  - SCP to members: 1:10,000 or less
  - Behavioral Health to members: 1:10,000 or less
3. The percent of PCPs accepting new patients should be at least 80 percent and the percent of PCPs accepting new or current patients (for the purpose of new members transitioning from another health plan) should be at least 97 percent.
4. The percent of practitioners who are board certified or board eligible should be
  - PCPs: at least 85 percent
  - All contracted specialists: at least 90 percent

### 9.1.2. Accessibility of Service

BCN has established mechanisms to provide access to appointments for primary care services, behavioral health services and specialty care services. 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).

The Quality Management department provided multiple options to providers to complete the survey (i.e., phone, online, email and fax). BCN assesses standards for the following primary care physicians, high volume specialists and high impact specialists:

Primary Care Provider:

Appointment Types	Standard	Target
Emergency Care	Immediately	100 percent of the appointments are completed within the standard time frame.
Urgent Medical Care	Immediately	
Not urgent, but requires medical attention	Within seven days	
Regular and Routine Care	Within 30 days	
After-Hours Care	24 hours a day, seven days a week for medically necessary situations	

Specialists:

Appointment Types	Standard	Target
Regular and Routine Care	Within 30 days	90 percent of the appointments are completed within the standard time frame.

Blue Care Network also assesses standards for its Behavioral Health providers to include:

Appointment Types	Standard	Target
Emergency Life Threatening	Immediately	100 percent of the appointments are completed within the standard time frame.
Emergency Care Non-Life Threatening	Immediately	
Urgent Care	Immediately	97 percent of the appointments are completed within the standard time frame.
Not urgent, but requires medical attention	Seven days	
Initial visit for Routine Care	10 days	
Follow-up Routine Care	30 days	

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. First call resolution surveys and email resolution responses data are used to evaluate the member’s understanding and usefulness of the information received.

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

A random sample of inquiries managed by Customer Service Representatives are 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 for each attribute, then the CSR will not pass the evaluation.

Each evaluation includes scoring of one point for each attribute for a total of five 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.

- CSR can miss one attribute of evaluation and pass quality for the month.
  - The maximum score for the month is 25, if the CSR misses one attribute the score will be 24 out of 25 or 96% and the CSR will 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.

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 managed their call.

Each survey includes scoring of 1 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*

**Goals:**

1. Accuracy Target: 85 percent of CSRs will pass monthly evaluations.
2. Quality Target: 85 percent of surveys will pass monthly evaluations.

#### 9.1.4. Monitoring Email Turnaround

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

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

**Goals:**

1. Timeliness Target: 95 percent of email inquiries receive a response within one business day with ongoing review for improvement and enhancement to ultimately achieve 100 percent turnaround time expectation.
2. Quality Target: 85 percent of emails will pass monthly evaluations.

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 shared with the members of the Member Experience Committee. Approval, feedback, and recommendations from the Member Experience Committee members is incorporated into the final report.

## 9.2. Clinical Quality

### 9.2.1. Healthcare Effectiveness Data and Information Set

HEDIS is a tool BCN 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.

BCN complies with all the HEDIS® reporting requirements established by the National Committee for Quality Assurance, Department of Insurance and Financial Services, and Centers for Medicare and Medicaid Services. HEDIS activities and results are audited by a NCQA certified auditor and submitted for public reporting annually.

Commercial measures for focus are:

- Breast Cancer Screening
- Controlling High Blood Pressure
- Glycemic Status Assessment for Patients with Diabetes
- Kidney Health Evaluation for Patients with Diabetes
- Colorectal Cancer Screening
- Immunization Measures (Childhood Immunization Status – Combo 10, Immunizations for Adolescents – Combo 2)

Medicare measures for focus are:

- Breast Cancer Screening
- Controlling High Blood Pressure
- Glycemic Status Assessment for Patients with Diabetes
- Eye Exams for Patients with Diabetes
- Kidney Health Evaluation for Patients with Diabetes
- Colorectal Cancer Screening

HEDIS gap closure rates are monitored throughout the measurement year in order to identify opportunities for improvement in quality of care for our members. A series of quality improvement activities are implemented to address the 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.

Performance goals for HEDIS MY2023 are focused on increasing lower performing measures to the next percentile while increasing or maintaining measures that are currently performing well. For MY2022, BCN Commercial had 70 percent of the Health Plan Rating measures in the 50<sup>th</sup> percentile or higher and BCNA had 69 percent of the Health Plan Rating measures in the 50<sup>th</sup> percentile or higher. Health Plan Ratings results for MY2022 are Commercial 4 Stars and Medicare 4 Stars.

**Goal:**

1. Health Plan Rating of 3.5 Stars or better

### **9.2.2. Utilization Management**

Blue Cross performs designated Utilization Management functions on behalf of Blue Care Network. These are listed in the memorandum of understanding between BCN and Blue Cross. The utilization management program includes medical, behavioral health and pharmacy utilization activities. Pharmacy Services is responsible for review of all pharmaceutical services that require clinical review/benefit interpretation and they follow their own pharmacy program policies.



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 for commercial business (post-acute only) are developed with input from appropriate practitioners to supplement approved criteria.

BCN maintains a consistent process for the development, review and revision of its pharmaceutical utilization management program, including but not limited to prior authorization criteria, step therapy requirements, and quantity limits. Drug criteria are based on current medical information and reviewed and approved annually by the Blue Cross and BCN Pharmacy & Therapeutics Committee.

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

### **9.2.3. Population Health Management**

Blue Cross performs designated PHM functions on behalf of BCN. These are listed in the MOU between BCN and BCBSM. Blue Care Network updates its Population Health Management Strategy annually to meet the care needs of its Commercial HMO, Exchange HMO, and Medicare HMO memberships. It is the plan of action for addressing member needs across the continuum of care. Components include but are not limited to the following:

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

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

The strategy also describes program 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 that includes assessing for racial bias.

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	Tobacco Coaching	Achieve 50 <sup>th</sup> NCQA percentile for CAHPS Smoking Cessation.
Managing members with emerging risk	Chronic Future Risk (Commercial HMO, Exchange HMO)	Members managed will have a 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.
Managing members with emerging risk cont.	Longitudinal Care Management (Medicare HMO)	Achieve a reduction in the number of emergency room visits/1000 for the BCNA LCM program. This is evidenced by a 1% rate reduction in the number of emergency room visits/1000 of managed members from January through December.
		Achieve a 90% or higher score on member satisfaction survey.
Patient safety or outcomes across settings	At Risk for Readmissions (Commercial HMO, Exchange HMO)	Members managed have a higher rate of physician follow-up visits within seven 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
	Members managed will have a primary care physician.	
	Transitions of Care (Medicare HMO)	Achieve a reduction in the number of unplanned inpatient admissions/1000 for the BCNA TOC program. This is evidenced by a 1% rate reduction in the number of unplanned inpatient admission/1000 of managed TOC members from January through December.

Focused Areas	Program	Goal
		<p>Achieve a reduction in observed readmission rate for the BCNA TOC program. This is evidenced by a 0.5% reduction in observed readmission rate of BCNA TOC managed members from January to December.</p> <p>Achieve a 90% or higher score on member satisfaction survey.</p>
Managing multiple chronic illnesses	Highly comorbid conditions ( <i>Commercial HMO, Exchange HMO</i> )	<p>Members managed have a higher rate of physician follow-up visits within seven days discharge from a medical admission than members not managed in the program.</p> <p>Members managed will have a higher medication adherence gap closure rates than members not managed in the program.</p> <p>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.</p> <p>Achieve 90 percent on Satisfaction Survey</p> <p>Members managed will have a primary care physician.</p>
	Longitudinal Care Management ( <i>Medicare HMO</i> )	<p>Achieve a reduction in the number of unplanned inpatient admissions/1000 for the BCNA LCM program. This is evidenced by a 1% rate reduction in the number of unplanned inpatient admissions/1000 of managed LCM members from January through December.</p> <p>Achieve a 90% or higher score on member satisfaction survey.</p>

Overall outcomes are reviewed, reported, and approved at the Care Management Quality Committees and the Clinical Quality Committee. Refer to the annual PHM Strategy document for additional information.

#### 9.2.4. Care Management (including Complex Case Management)

The Blue Cross Coordinated Care program has an integrated care management approach designed to help reduce the complexity of the healthcare system by giving members access to a comprehensive care team that will help them better manage their health. The Blue Cross Coordinated Care Program is designed to effectively manage the healthcare resources for members with various healthcare needs and in multiple care settings. The program provides coordination of care and services for members who have experienced an acute event or diagnosis that requires extensive resources and need help navigating the system. BCCC uses a collaborative process and case management principles that assesses, plans, implements, and evaluates options and services to meet an individual's health needs. Case managers handle the day-to-day clinical management of program members. Case managers are assigned to dedicated geographical regions. The use of regional assignments improves

the care manager/ relationship with local providers and community resources and fosters an understanding of the socioeconomic conditions of that region.

Refer to the Case Management Program description for additional information about the health plans programs and goals

### Program Goals

- Members managed will have a higher rate of physician follow-up visits within seven days of discharge from a medical admission than members not managed in the program.
- Members managed will have 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 the 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.
- Managed members will have a primary care physician.

Refer to the Case Management program descriptions Senior Health Services and Health Plan Business for additional information about the health plans programs and goals.

### 9.2.5. Health Promotion

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

- **Blue Cross Health & Wellness**, powered by WebMD® through **bcbsm.com**. This online service has information on health and wellness and helpful online tools and resources.
- **Tobacco Cessation** BCN's base benefits include the WebMD Tobacco Cessation Coaching program.
- **Health assessment** Our online health assessment is a set of questions that helps members understand how to improve or maintain their health.
- **Weight management** BCN members have access to exercise and nutrition information online at **bcbsm.com**.
- **Preventive care initiatives** Members are sent reminders for preventive services.
- **Virtual Well-being program for members** BCN members have access to weekly Well-being Webinars that are also stored on demand for viewing.

### 9.2.6. Behavioral Health

#### 9.2.6.1. Behavioral Health™ Program

In 2024, Blue Cross consolidated management of behavioral health services for all lines of business to ensure a uniform experience. Services provided to manage the behavioral health members include utilization management of prior authorizations, and case management services through programs accredited by the National Committee for Quality Assurance. The program is titled *Blue Cross Behavioral Health™*. The behavioral health programs are overseen by the Quality Management department and reviewed and approved by the Utilization Management Committee.

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.

Blue Cross Behavioral Health™ continues to demonstrate its commitment to behavioral health through inclusion of mental health and substance use programs in both its long-term strategy and its enterprise goals. Blue Cross Blue Shield Michigan has a dedicated behavioral health strategy team to continuously review its behavioral health programs and procedures and create a robust, long-term strategy to better serve our members.

**Goals:**

1. Manage and engage 5% of membership with Behavioral Health Utilization in case management.
2. Improve Behavioral Health Navigation Services by continuing to promote and expand engagement in the navigation program that was implemented in 2023.
  - Increase member access to behavioral health by connecting members to care more quickly.
  - Improve the member experience.
  - Leverages technology to steer members to the right behavioral health care to meet their needs.
  - Allow members to access both in-person providers and virtual behavioral health providers.
3. Improve follow up care after inpatient admission related to HEDIS FUH 7 performance with intent of 75<sup>th</sup> percentile or better.
4. Improve pharmacy integration using the Comprehensive Medication Management
  - Reduce medication errors and increase medication adherence through pharmacy integration.
  - Provide educational materials and counseling sessions to enhance patients' understanding of the importance of medication and potential side effects.
  - Conduct regular training sessions for healthcare professionals on proper medication handling, storage, and administration protocols to improve patient outcomes.
  - Effective communication and coordination among providers and care team reducing the risk of inpatient when medications or services are difficult to obtain.
5. Expansion of Crisis Services
  - Expand the number of contracted crisis providers to allow improved access to community-based services.
6. Launch integrated behavioral health care initiatives that lead to health and improvement outcomes as related to corporate goals.
  - Develop and pilot an integrated care solution that supports commercial members to better manage medications and access therapy when needed.
  - Integrate medical, behavioral health and pharmacy, and other clinical service pathways for higher risk members.

**9.2.6.2. 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.

Blue Cross continues to demonstrate its commitment to behavioral health through inclusion of mental health and substance use programs in both its long-term strategy and its enterprise goals. In 2020, Blue Cross established a dedicated behavioral health strategy team to continuously review its behavioral health programs and procedures and create a robust, long-term strategy to better serve our members. Over the last three years, Blue Cross has built a robust program and is expanding, and its behavioral health capabilities highlighted below.

**The programs are:**

**Continued expansion of the Collaborative Care (CoCM) Designation**

Collaborative Care adds a behavioral health component to the partnership between a patient and their primary care provider or OB/GYN. It allows patients to connect to appropriate behavioral medicine quickly and right from their doctor's office. A Collaborative Care team consists of the treating physician, who remains the head of the care team, and adds two new team members: a behavioral health care manager and a consulting psychiatrist. The behavioral health care manager meets with the patient often to make sure treatment is going well. The behavioral health care manager also consults with a psychiatrist regularly to discuss treatment progress and make recommendations when needed. The behavioral health care manager connects the dots between the patient, the psychiatrist, and the patient's doctor. The treating physician makes the final decisions about the patient's treatment.

**The Collaborative Care Designation Program:**

- Improves patient care and brings more patients to depression-free days and to remission.
- Creates a strong care team that allows for the provision behavioral health care in a primary care setting.
- Stretches limited psychiatric resources to allow more patients to receive psychiatrist-influenced care, while reserving face-to-face psychiatrist time for high complexity patients.
- Improves self-management for patients with behavioral health and other chronic conditions.
- Reduces member stigma.

To receive the Collaborative Care designation a primary care practice must have all ten of the CoCM capabilities fully in place. The capabilities selected are the basic elements a practice needs to have fully in place to effectively deliver Collaborative Care. Members in BCN plans can receive services at a CoCM practice within the context of their primary care.

**Goals:**

1. To retain current designated practices, recruit additional adult and pediatric practices and expand to include OB/GYN specialty practices.
2. Further opportunities to care team members to both hone skills and to target specific populations. In 2023 we began training and support for practices who wish to deliver CoCM to the perinatal population and to those members who have substance use disorders.

**Behavioral Health Incentive Program**

Blue Cross' Value Partnerships program has established the Behavioral Health

Incentive Program to pay behavioral health providers for meeting specific quality standards. These incentives are available to both prescribers and non-prescribers.

**Goal:**

1. To reward providers that meet select HEDIS measures and close gaps to improve the quality of care and patient outcomes.

**Collaborative Quality Improvement (CQI) Initiative – MI MIND**

Blue Cross partnered with Henry Ford Health System to roll out a state-wide quality improvement initiative to implement the Zero Suicide Model across the provider community starting with four Physician Organizations to pilot in 2022. In 2023, MI MIND had seven physician organizations participating, representing nearly 600 primary care physicians, psychiatrists and psychologists across Michigan. The MI MIND 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 care entities 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 all providers within the State of Michigan.

**Goals:**

The CQI will continue collaborating with Blue Cross associated physician organizations and their affiliated providers to:

1. Refine the Zero Suicide elements that will be implemented in each practice and health system.
2. Implementation of Zero Suicide training protocol across all participating providers.
3. Initiate QI cycle of evidence-based suicide prevention components across all participating providers.
4. Continue to expand the program to include additional physician organizations and their affiliated providers.

**Integrated Behavioral Health and Pharmacy Initiative**

Behavioral health is partnering with pharmacy to develop and implement a new integrated program for members recently prescribed medication to treat anxiety or depression in the primary care setting. Evidence suggests that medication, combined with therapy is more effective than medication alone in treating behavioral health conditions. Finding a therapist can sometimes be challenging and people with depression and anxiety may struggle to find care quickly.

This program will begin as a pilot with select members. It will provide outreach and assistance to members recently prescribed certain behavioral health medications to quickly find a therapist if needed and support them in maintaining adherence to their medications.

**Goals:**

1. Increase adherence to medications prescribed for anxiety depression in primary care.
2. Improve access to psychotherapy, if needed and requested by the member.
3. Link the member to other needed resources to support successful treatment of their behavioral health condition.

## **Expanding Access to Behavioral Health Services:**

### **Behavioral Health Navigation Services**

Access to behavioral health care can be challenging and there is a national shortage of behavioral health providers. Increasing demand, combined with lack of providers, can lead to untreated conditions that worsen over time and negatively affect co-morbid medical conditions.

In 2023, Blue Cross partnered with a behavioral health navigation vendor to increase access by more quickly and easily navigating members to care when they need it. The program is accessible via phone or online and is available at no cost to fully-insured, Michigan-based members 18 or older. The vendor has onboarded 2,255 in-network behavioral health providers onto the platform to serve this need.

When an eligible member engages with the vendor (either via self-referral or by care management referral), the vendor will match the member with an in-network behavioral health provider that best meets their needs and preferences. This includes spoken language, gender and areas of specialty. The provider then coordinates with the member to schedule their appointment.

Anticipated benefits from the program are:

- Reduction in time to first appointment.
- Improved member experience in accessing behavioral health care.
- Improved provider satisfaction around appropriate referrals.

The navigation solution launched 7/1/23 with a direct to member email campaign, which resulted in hundreds of self-referrals for care in the first week.

#### **Goals:**

1. Expand communications directly to members to make them aware of program availability.
2. Add the program to the new digital behavioral health hub within the member portal.
3. Fully integrate the program into the behavioral health utilization and behavioral and medical care management programs.

### **Virtual Access for Depression and Anxiety**

Virtual care remains an important was that Blue Cross is expanding access to behavioral health services. Between 2021 and 2022 there was a 53% increase in virtual care visits and overall, 65% of visits delivered virtually (for any specialty), were behavioral health visits.

Blue Cross partnered with AbleTo to expand national access to evidence-based behavioral health care. AbleTo is a best-in-class, high-quality, technology enabled virtual solution approved by the Blue Cross Blue Shield Association with measurable outcomes that provide 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.

In 2023, Blue Cross expanded messaging to customers and members to increase awareness of the program.



**Goals:**

1. The goal of the program is to improve access to evidence-based care to treat the two most common behavioral health conditions.
2. In 2024, Blue Cross will further expand communications and messaging around the availability of the program.

**Expansion of Crisis Services**

Behavioral health crises are serious events that require trained clinical intervention. Unfortunately, often times the police are called in to manage the situation and the individual in crisis is transferred to the emergency room. Despite work in this area, many emergency rooms do not have full-time behavioral health staff to immediately assess and start treatment. This can lead to longer wait times and delays in treatment initiation.

Per direction of the federal government, in 2022, all 50 states rolled out 988 as the new phone number that anyone can call if they are in a behavioral health crisis situation. 988 will link to the National Suicide Prevention Lifeline, where there trained crisis counselors available 24/7 365. Individuals will be linked to a behavioral health expert who can triage the member and refer to appropriate crisis, community, or hospital (if needed) resources to reduce law enforcement involvement. These tactics also aim to reduce the need for individuals in a psychiatric crisis to sit in an untherapeutic medical emergency room.

Blue Cross is working with the State of Michigan and local community agencies to establish crisis services to support our members. These services have been available for more than 20 years in the public sector (e.g., Medicaid), but have only recently become accessible to the broader commercially insured population. Crisis services are not standard across Michigan or across the country so contracting requires considerable time.

Certain counties have rather robust crisis services and others have very few available. Blue Cross' ideal crisis continuum would contain the following:

- Psychiatric urgent care
- Mobile crisis
- Crisis stabilization
- Crisis residential

In 2023, Blue Cross expanded the number of crisis providers to serve the highest risk members. Further expansion is planned in 2024 for the City of Detroit, Northern Michigan (including the UP) and more rural areas.

**Goals:**

1. Crisis expansion will provide greater access to life-saving behavioral health services, prevent unnecessary hospitalizations and provide an improved member experience.
2. Expand to more geographic regions to expand availability across State.

**Education and Messaging to our Members**

**Educational Campaign**

Beginning in 2021 and continuing through 2023, Blue Cross launched a multi-channel member engagement campaign to provide guidance, education and support members and group customers with behavioral health care resources.



In 2023, the focus continued with educating members on where and how to get care, including crisis care. The campaign also added focus on caregivers with group customer support materials and a new Caregivers Guide on our Resources Page for members.

**Goals:**

In 2024, the campaign will build off of previous work and expand messaging to promote behavioral health navigation, virtual as well as in-person services, and crisis services.

1. Increase awareness of available programs.
2. Improve member perception of behavioral health programs available to them and reduce stigma.

## 9.2.7. Quality Incentive Programs

### 9.2.7.1. Performance Recognition Program

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

**Goals:**

1. To provide each primary care provider with incentive performance credit for services completed through December 31 annually for all eligible members.
2. Encourage primary care physicians and physician organizations annually to assist their patients to get preventive screenings and procedures such as colonoscopies, mammograms and well-child visits as well as to achieve improved patient outcomes such as ensuring that patients with diabetes have their blood sugar controlled.

### 9.2.7.2. 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.
- Plan All-cause Readmission (PCR) performance and readmissions-related initiatives.

The program for small and rural hospitals, including critical access hospitals, has been overhauled to reduce the workload on rural hospitals, so they can deliver the most

value to the unique communities they serve. The program includes the following components:

- High-level health information exchange efforts to align with large and medium-sized hospitals 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 readmission rate from the previous program year.
4. Updated for the 2023 program year and continued in 2024, hospitals are assessed using the hospital Plan All-Cause readmission (PCR) rate 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.

**9.2.8. Continuity and Coordination of Care**

Blue Cross performs designed continuity and coordination of care functions on behalf of BCN. These are listed in the MOU between BCN and BCBSM. BCN is committed to improving quality of care delivered to members. Coordinated care is a critical element in achieving this goal. Coordination involves communication among multiple providers each providing individual expertise, knowledge and skills working toward the goal of reducing inefficiencies and responding to patients' unique care needs.

BCN monitors continuity and coordination by assessing the facilitation 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 are identified to improve coordination of medical care by conducting a quantitative and qualitative analysis. The health plan annually acts upon three of the selected opportunities and measures the effectiveness of actions taken for the identified opportunities.

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

BCN 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 targets are listed in the table below:

Topics	Target	Measures
Follow-Up After Hospitalization for Mental Illness	NCQA Benchmark	90 <sup>th</sup> percentile for all lines of business.
Use of Opioids by Multiple Prescribers	NCQA Benchmark	90 <sup>th</sup> percentile for all lines of business.
Movement Between Practitioners: Coordinating Retinal Eye Exams in Diabetics	NCQA Benchmark	90 <sup>th</sup> percentile for all lines of business.
Movement Across Settings: Avoidance of Readmissions within 30 Days of Discharge	NCQA Benchmark	90 <sup>th</sup> percentile for Commercial and Exchange
Bidirectional Exchange of Information between Behavioral Healthcare Providers to Primary Care Physician	Health Plan Target	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	90 <sup>th</sup> percentile for all lines of business.
Continuation phase	NCQA Benchmark	90 <sup>th</sup> percentile for all lines of business.
Appropriate Use of Psychotropic Medication: Use of Opioids at High Dosages	Health Plan Target	90 <sup>th</sup> percentile for all lines of business
Management of Treatment Access and Follow-up for Members with Coexisting Medical and Behavioral Disorders: Diabetes Monitoring for People with Diabetes and Schizophrenia	Health Plan Target	80 percent for Commercial and Exchange 85 percent for Medicare
Prevention Programs for Behavioral Health Care: Appropriate Consultation and Follow-up for Medical Inpatients with a New Behavioral Health Diagnosis		
Consultation Inpatient	Health Plan Target	10 percent for Commercial and Exchange
Outpatient Follow-up with 30 Days of Discharge	Health Plan Target	90 percent for Commercial and Exchange

Special Needs of Members with Serious Mental Illness	Health Plan Target	87 percent for all lines of business
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The outcomes are reported to the Clinical Quality Committee for review, input and approval annually.

### 9.2.9. Identification and Documentation of Quality of Care Concerns

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

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

**Goals:**

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

## 9.3. Member Experience

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

BCN surveys its members using the CAHPS survey instrument conducted annually by an NCQA-certified vendor. The CQC and MEC evaluate survey results, combining them with other member feedback surveys to determine areas in which BCN 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 66.67<sup>th</sup> NCQA Percentile for Commercial and Medicare.
2. Perform either at or above the national average of all Qualified Health Plans.
3. Attain a 4-star rating for Medicare.

The results are reported to the CQC and MEC annually.

### 9.3.2. ECHO Behavioral Health Survey

Blue Care Network survey members using the ECHO CAHPS behavioral health survey tool, which is conducted annually by Press Ganey, an NCQA-certified vendor. This survey is designed to support efforts to measure, evaluate and improve the experiences of members with various aspects of mental health and substance abuse treatment, as well as counseling services. The ECHO survey is considered a primary measure of customer service and satisfaction with the health plan and is conducted yearly to drive ongoing improvement in the overall member experience.

**Goal:**

1. The goal is for each measure to increase two percentage points year over year up to 90%. The goal is met for measures equal to or greater than 90%.

The results are reported to the Clinical Quality Committee annually.

### 9.3.3. 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.

### 9.3.4. 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.
- Consumer Transparency – Supports enterprise efforts involving member transparency and is the Business Owner for the enterprise Provider Directory and cost transparency solutions.

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.

**Goal:**

1. Delivering an online experience that is “simple, useful and personal” through a combination of educational content and self-service tools for our users that are monitored based on annual satisfaction scores collected from our stakeholders.

### 9.3.5. Consumer Transparency

The Consumer Transparency team, an organization within CMCX (Corporate Marketing and Customer Experience) Digital Experience, focuses strategically and tactically on the

management of the Enterprise Provider Directory which is 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.

**Goal:**

1. Create and maintain a “best in class” directory that our membership can leverage to search for care within their provider network. The Enterprise directory contains key provider demographic and transparency information for our members including office locations, contact information, the plans they accept and cost related data to name a few that is key for decision making.

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

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

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

**Goal:**

1. 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.

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

Blue Care Network 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. BCN monitors multiple aspects of network adequacy including:

- Member experience, complaints, and appeals about network adequacy for non-behavioral healthcare services
- Member experience, complaints, and appeals about network adequacy for behavioral healthcare services
- Requests for and utilization of out-of-network 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 geographic areas or to types of practitioners or providers. The analysis performed relates to the Commercial HMO, Exchange HMO, and Medicare HMO memberships.

**Goals:**

1. Complaint rate to be  $\leq 0.15/1000$  members.
2. Appeal rate to be  $\leq 0.15/1000$  members.
3. Annually completes an analysis of requests and utilization of OON services and identifies opportunities for improvement if applicable.

4. OON Appeals: ≤0.15/1000 members
5. For CAHPS:
  - The NCQA 66.67th percentile benchmark is used to determine the Commercial HMO and Medicare HMO/POS performance outcomes.
  - Exchange HMO is to perform either the same as or above the national average of all Qualified Health Plans
6. For ECHO: The target is for each measure related to access to increase two percentage points year over year up to 90 percent. The target 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 results are reported to Clinical Quality Committee annually.

## 9.4. Member Safety

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

Member 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.

Member 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.

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

As of 2024, Blue Care Network is providing funding for 14\* CQIs addressing one or more of the following clinical conditions:

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

*\*Note that MBSC and MSQC are planning to merge in 2024*

**Goal:**

1. Continue to develop best practices for CQI programs to demonstrate improved patient outcomes and share lessons learned locally, nationally, and internationally evaluate each CQI’s program performance to identify opportunities for strengthening, revamping, consolidating, and evaluate the CQIs overall to assure efficiency within and sustainability of the CQI portfolio.

**9.4.2. Blue Distinction Centers for Specialty Care®**

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

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



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

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

Blue Distinction Center and Blue Distinction Center+ designations are awarded to facilities and providers based on a thorough, objective evaluation of their performance in the areas that matter most, including quality care, treatment expertise and overall patient results.

Selection criteria are developed with the help of expert physicians and medical organizations. Blue Distinction Centers and Blue Distinction Centers+ have a proven history of delivering better quality and results, such as fewer complications and lower readmission rates, than those without these recognitions. Overall, Blue Distinction Centers+ are also more cost-efficient than non-Blue Distinction Centers+, with episode savings of nearly 20 percent on average.

The Blue Distinction Specialty Care program provides broad national access to facilities and providers 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](https://bcbs.com/blue-distinction-center-finder) or by using our Find a Doctor feature at [bcbsm.com](https://bcbsm.com). Today, more than 6,000 Blue Distinction Center and Blue Distinction Center+ designations have been awarded to more than 2,600 health care facilities across the U.S.

**Goals:**

1. Expand BDC/BDC+ designation across all programs by inviting facilities as appropriate to apply for designation.
2. In alignment with market requirements, Network Optimization efforts, and BCBS National Health Equity Strategy, launch and maintain the renewed Maternity Care program with an effective date of Jan. 1, 2024.

### **9.4.3. 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. This initiative is funded for four years and will culminate on July 1, 2025.

**Goals:**

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

**9.4.4. Health Information Exchange**

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

Since the HIE component was introduced in 2014, hospitals have significantly improved the availability and quality of data available to caregivers across the state. In addition, the MiHIN service supports Physician Group Incentive Program 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 Admit Discharge Transfer notifications 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 Skilled Nursing Facility 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 Patient Centered Medical Home model of care and is designed to improve care by ensuring practitioners have the information they need to address patient health care needs more quickly. This is expected to result in a better care transition, an improved health outcome and reduced likelihood of an unplanned readmission. Blue Cross also participates with MiHIN as a health plan qualified organization, which allows it to transmit and receive data for its members. In addition, a Blue Cross representative serves as a member of the MiHIN board.

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

Since the HIE Initiative was introduced in 2014, 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 with hospitals earning a portion of their Blue Cross P4P HIE points through continued data quality conformance standards for the ADTs with common key, Exchange Consolidated Clinical Document Architecture (formerly Medication Reconciliation), Ambulatory C-CDA, 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.

#### **9.4.4.2. Peer Group 5 Hospitals Engagement in HIE Initiative**

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

Beginning with the 2016-2017 program year, hospitals began participating in the MiHIN statewide service by implementing the Admission-Discharge-Transfer use case. Currently, 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.

#### **9.4.4.3. Skilled Nursing Facility Engagement in HIE Initiative**

Blue Cross introduced a skilled nursing facility Pay-for-Performance program into the HIE continuum beginning in January 2016. In 2020, the SNF P4P program provides freestanding and hospital based SNFs the opportunity to earn an additional 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 (September 2023), 152 of 420 SNFs currently meet this requirement.

#### **9.4.4.4. Physician Organizations Engagement in HIE Initiative**

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

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

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.

#### **9.4.4.5. Physician Organizations Engagement in Supplemental Data Initiative**

Data exchange and interoperability are the foundation to continued progress in healthcare delivery. Timely information can provide the building blocks for improved health outcomes. The additional focus on social factors increases the need for effective data exchange to track resources across care sectors. As a result, initiatives have been updated or developed starting in 2022 to support provider organizations in building the infrastructure and creating standardized files.

POs can earn rewards for submitting key data elements via MIHIN use cases. Currently rewards are available for the Quality Measure Information and Social Determinants of Health use cases based on participation and data submission. The QMI use case has a broad incentive as well as more narrow incentives that focus on specific measures such as Transitions of Care Medication Reconciliation and Behavioral Health screenings.

POs have demonstrated a willingness to participate in data exchange. 38 POs participate by submitting data to the QMI use case and 26 POs submit data to the SDOH use case.

#### **Goal:**

1. Continue to increase responsible data exchange by evaluating and evolving supplemental data related initiatives and ADT and CCDA submissions.

## **9.5. Pharmacy**

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

Pharmacy Services' quality goals are as follows:

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

- Provide education to physicians.

### 9.5.1. Commercial and Exchange Pharmacy

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

#### 9.5.1.1. 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 2024 we will continue to monitor claims data to identify members who meet specific criteria for filling opioid prescriptions from multiple prescribers and 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:**

1. Maintain 1% or below for members meeting Doctor Shopper Program criteria.

#### 9.5.1.2. 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:**

1. Ensure at least 60% of patients with diabetes or cardiovascular disease have at least one claim for a statin by December 31, 2024.

#### 9.5.1.3. 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:**

1. Ensure at least 80% of patients with asthma have an asthma medication ratio >50% by December 31, 2024. Ensure at least 80% of COPD exacerbation events have a bronchodilator claim within 30 days among patients with COPD by December 31, 2024.

#### 9.5.1.4. Academic Detailing: HPV Vaccination

Vaccines are a safe and effective way to protect adolescents against potential deadly diseases. The HEDIS IMA measure assess adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap vaccine, and the complete human papillomavirus vaccine series by their 13th birthday. HPV vaccination prevents cancer-causing infections and precancers, however, vaccination against HPV among adolescents remains significantly lower than meningococcal and Tdap. A clinical pharmacist will provide telephonic consultations with provider offices for members ages 9 to 13 identified as needing to complete the HPV vaccination series. Member lists will be provided to providers with gaps in care to be closed.

##### Goal:

1. Ensure the HPV vaccination rate is at least 36% among adolescents turning 13 by December 31, 2024.

#### 9.5.1.5. 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]  $\geq 90$ ) for  $\geq 15$  days during the measurement year.

##### Goal:

1. Ensure that the HDO rate does not increase by more than one percent throughout 2024.

#### 9.5.1.6. Value Partnerships Pharmacy Forum

Value Partnerships, HCV Data Analytics & Insights, and Pharmacy Services developed a forum in 2013 to collaborate internally and externally with providers and other healthcare stakeholders to generate ideas, prioritize efforts, determine and implement success measures and evaluate efforts in providing value to members. The collaboration is designed to further strengthen Blue Cross' efforts to improve quality measure performance. Pharmacy-related topics are identified and presented to pharmacy representatives and administrators 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 to improve prescribing.

##### Goal:

1. In 2024, the forum will identify further opportunities to work with pharmacists in physician organizations. Example topics addressed through the forum include, but are not limited to, the following: opioids, medication adherence, antibiotics, and pharmacy costs. Goals for the Value Partnerships Pharmacy Forum include hosting



at least four meetings with PGIP physician organizations and sustaining physician organization interest and engagement on pharmacy issues.

#### **9.5.1.7. Mending MI Hearts Program**

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

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

##### **Goal:**

1. Ensure the proportion of members adherent to statin therapy is at least 60 percent throughout 2024.

#### **9.5.2. BCNA Pharmacy**

Pharmacy programs work to address member concerns, help in understanding the drug benefit and alleviate barriers leading to improved health care outcomes. The programs are developed in response to the Centers for Medicare and Medicaid Services Stars measures, CMS requirements and internal quality evaluations. The programs and initiatives in general are designed to be an educational outreach to members with a focus on helping members close gaps in care. Pharmacists, pharmacy interns, technicians and others provide member educational outreaches to identify and overcome barriers to care and provide methods to help prevent such barriers in the future.

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

##### **9.5.2.1. Medication Adherence for Diabetes Medications**

Measures the percent of members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

##### **Goal:**

1. One percentage point increase in adherence scores, compared to the previous year.

##### **9.5.2.2. Medication Adherence for Hypertension (RAS antagonists)**

Measures the percent of members with a prescription for blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

##### **Goal:**

1. One percentage point increase in adherence scores, compared to the previous year.

##### **9.5.2.3. Medication Adherence for Cholesterol (statins)**

Measures the percent of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

**Goal:**

1. One percentage point increase in adherence scores, compared to the previous year.

**9.5.2.4. MTM Completion Rate for CMR**

The measure shows how many members in the MTM program had an assessment of their medications from Blue Cross. The assessment includes a discussion between the member and a pharmacist (or other health care professional) about all of the member's medications. The member also receives a written summary of the discussion, including an action plan that recommends what the member can do to better understand and their medications.

**Goal:**

1. One percentage point increase in the number of CMRs completed on enrollees, compared to the previous year.

**9.5.2.5. Statin Use in Persons with Diabetes (SUPD)**

To lower their risk of developing heart disease, most people with diabetes should take cholesterol medication. This rating is based on the percent of members with diabetes who take the most effective cholesterol-lowering drugs.

**Goal:**

1. One percentage point increase in the number of diabetic beneficiaries with statin therapy, compared to the previous year.

**9.5.2.6. Pharmacy Care Management**

Support beneficiaries in understanding the drug benefit and medications they are prescribed.

**Goal:**

1. 80 percent engagement rate.

**9.6. Inclusion and Diversity**

Inclusion and Diversity is embedded throughout the organization in numerous ways with building and practicing cultural competency as the cornerstone of our strategy and key programs and initiatives. 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 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	<p>Languages common to practice are defined as languages identified as primary by at least 5 percent of the established patient population</p> <p>Language services may consist of 3<sup>rd</sup>-party interpretation services or multi-lingual staff</p> <p>Asking a friend or family member to interpret does not meet the intent of the capability</p>
5.10	Patient education materials and patient forms are available in languages common to practice's established patients	<p>Languages common to practice are defined as languages identified as primary by at least 5 percent of the established patient population</p> <p>Patient education materials and forms are clear and simple and written at an appropriate reading grade level</p>
10.6	Practice has a systematic approach in place for referring patients to community resources	<p>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</p> <p>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.</p>

	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.
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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.

### Advancing Health Equity

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, the Physician Diversity Council and workgroups to address the needs of the older adult population.

On annual basis, the goal is to execute on health equity initiatives in at least three out of the five focus areas.



## Blue Cross is executing on a multi-year health equity strategy for all underserved populations



Blue Cross collects and analyzes data on annual basis and for key initiatives.

In partnership with the value-based partnership team, the company is implementing an **unconscious bias education** program to engage primary care providers participating in the PCMH program. Blue Cross also expanded the local plan criteria for the Blue Distinction Program to require facilities and all staff to engage in unconscious bias education to qualify for the designation.

Other initiatives to engage provider organizations and providers include:

- Screening for social determinants of health initiative
- Community health worker initiative
- At risk community needs initiative
- Social risk adjustment initiative

Blue Cross is also executing on a maternal health strategy and has identified disparities for severe maternal morbidities, partnering and making community investments to support the perinatal quality collaboratives in the state of Michigan and other actions to help reduce disparities among members.

#### **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, disabilities 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.

### **Pursue NCQA Health Equity Accreditation as part of the new three-year Inclusion and Diversity Strategy.**

- Perform the gap analysis.
- Make a decision on readiness to move forward.
- Establish an internal framework and structure.
- Begin work on meeting the standards.
- Submit the pre-application form and indicate the desired survey start date.

## **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.

#### **Goals:**

1. To ensure healthcare professionals and organizational providers meet specific health standards and qualifications to provide quality care to patients.
2. To provide written notification within 60 days of the credentialing decision.
3. Recredentialing files be completed every three years.

### **10.2. Ongoing Monitoring**

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

### **10.3. 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.

#### **10.4. Physician Participation**

All practitioners are expected to participate in the Quality Improvement Program. The practitioners agree to this through written consent in their contract with 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.

#### **10.5. 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.

#### **10.6. 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.

**Goals:**

1. To provide written notice to the practitioner at least 60 days before termination of the contract.
2. To complete the National Practitioner Databank Adverse Action Report within 15 days of final decision.
3. Notify the appropriate State Licensing Board within 15 days of the action taken by Blue Cross.

### 10.7. 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.

**Goals:**

1. Process 1<sup>st</sup> Level written appeals within 30 days of receiving all relevant documentation.
2. Process 2<sup>nd</sup> Level written appeals within 30 days of receiving all relevant documentation.

## 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 any changes to NCQA requirements. All delegation agreements state the delegate

must remain compliant, ongoingly, with all changes to 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 writes delegation agreements, conducts pre-delegation and annual delegation oversight evaluations, and presents to the Enterprise Credentialing Committee.

## 12. Compliance

### 12.1. Review by External Entities

Blue Cross is committed to conducting business with integrity and in accordance with all applicable federal, state and local laws, regulations, guidelines, and standards.

The compliance program policies and procedures support and promote the seven elements of an effective compliance program as specified by the Office of Inspector General and U.S Federal Sentencing Guidelines.

Compliance is an integral part of our business. Every workforce member is responsible for understanding and following the rules that help protect customers' health information, enterprise assets, and data.

The enterprise promotes a culture of compliance that builds trust with our stakeholders: customers and clients, providers, regulators, community, and workforce to name a few. It maintains an effective compliance program by leveraging the three lines governance model, which outlines well-defined roles and responsibilities. This model promotes a strong risk management culture and establishes accountability at all levels of the organization.

The model includes the following three tiers of oversight:

1. The business areas are the first line. They help manage the organization's risks by implementing and maintaining effective internal control procedures while providing transparency to their day-to-day operations. Compliance liaisons are first line team members that receive heightened training regarding compliance topics and help to reinforce key compliance topics to their business areas.
2. The Compliance Office resides within the second line and provides second-level oversight for compliance controls, accuracy and completeness of reporting, compliance with laws and regulations, and timely remediation of issues. The Enterprise Compliance Officer reports directly to the CEO with a dotted line to the Audit Committee of the Board. Other areas that reside within this second line include Enterprise Risk Management, Model Audit Rule Oversight, Information Security, Procurement, and the Office of the General Counsel
3. Enterprise Audit comprises the third line and conducts independent risk-based services. These services range from conducting financial, performance, compliance, system security and due diligence audits, to participating on committees to select new systems and teaching training courses in internal controls to new managers.



## 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 workforce members. Strict standards are adhered to concerning patient and fellow workforce member medical information, and all other information that is of a confidential nature.

Workforce confidentiality requirements are part of an acknowledgement form employees sign that includes a commitment to value confidentiality and safeguard corporate and member information. The acknowledgement form is maintained by Human Resources. Annual conflict of interest disclosures are maintained by the Compliance department. 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 and confidentially, without retaliation.

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
- Medicare Compliance Officer
- Corporate Compliance Officer
- Blue Cross Corporate and Financial Investigations Unit (1-844-STOP-FWA)
- Blue Cross Government Programs Investigation Unit (1-888-650-8136)
- Health and Human Services Office of the Inspector General for suspected cases of Medicare/Medicaid fraud



### **13. Annual Work Plan**

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

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

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

### **14. Evaluation of the Quality Improvement Program**

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

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

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

### **15. Resources and Analytical Support**

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

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

- President and Chief Executive Officer
- Executive Vice President of Health Care Value
- Chief Medical Officer

- Senior Medical Director and Associate Chief Medical Officer
- Vice President, Health Care Value Operations and Provider Enablement
- Medical Director, Utilization Management/Quality Management
- Medical Director, Behavioral Health
- Medical Directors
- Director, Quality Management
- Vice President, Provider Network Evaluation and Management and designated SME(s)
- Vice President, Utilization Management and designated SME(s)
- Director, Pharmacy Benefit and Clinical Management and designated SME(s)
- Senior Director, Customer Service and designated SME(s)
- Director, HCV Vendor Management and designated SME
- Director, Provider Operations and designated SME(s)
- Directors, Care Management and designated SME(s)
- Director, Business Analytics and Clinical Data Operations and designated SME(s)
- Director, Value Partnership Programs and designated SME(s)
- Director, Behavioral Health Strategy and Planning and designated SME(s)

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. Clinical Data Operations analyzes data to understand what is driving gaps in care and identify areas for provider improvements in order to improve overall quality of care. Clinical Data Operations also performs the following:

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

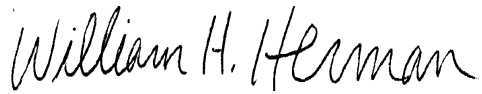
Following are a few more examples of data analytic outcomes in support for quality improvement:

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

**The 2024 Quality Improvement Program Plan has been reviewed and approved.**

**APPROVED BY:**

Clinical Quality Committee on 01/24/2024:

A handwritten signature in black ink that reads "William H. Herman". The signature is written in a cursive style with a large, prominent 'W' and 'H'.

William H. Herman, MD, MPH  
Associate Medical Director  
Clinical Quality Committee

16. Appendix A

