2025 Blue Care Network of Michigan

Quality Improvement Program Description

January 29, 2025

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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

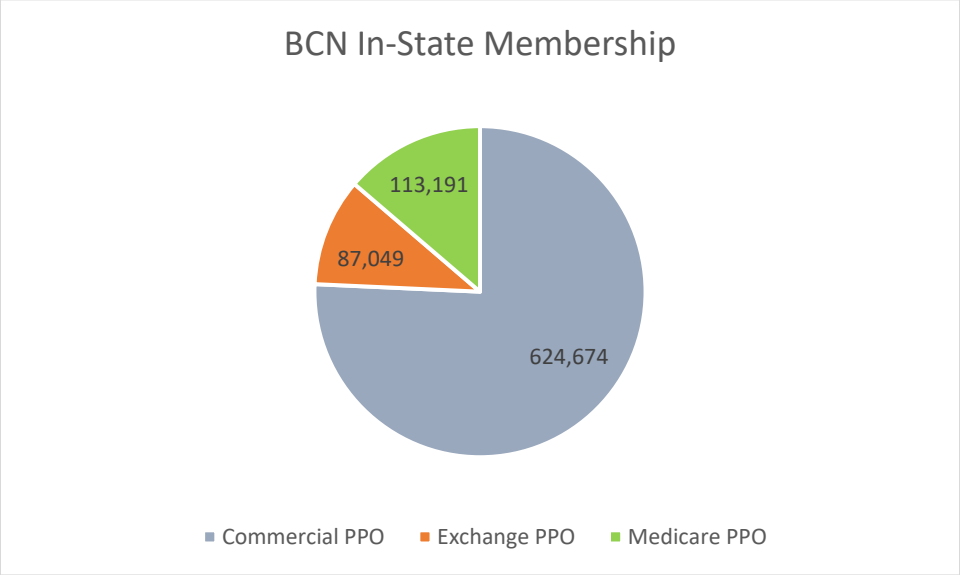
The purpose of the Quality Improvement Program is to establish a planned, systematic and comprehensive approach to measure, assess and improve organization-wide performance. The focus is on the identification of important aspects of care and services, the assessment of the level of care and services 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 Commercial HMO, Exchange HMO and Medicare HMO/POS 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 624,674 (76 percent) Commercial HMO, 113,191 (14 percent) Medicare HMO and 87,049 (11 percent) Exchange members.



**Data reflects BCN members as of 12/31/2024.*

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 2025 Quality Improvement Program Description and Work Plan with all activities based on the 2024 annual QI evaluation findings and recommendations.
- Evaluate 2024 goal and objectives for areas of improvement. Implement findings of the 2024 annual QI Evaluation into the 2025 QI Program and Work Plan.
- Maintain minutes that demonstrate the health plan's QI Committee develops and implements the QI program and oversees the QI functions within the organization.

Quality of Service

- Maintain an adequate network of primary care, behavioral healthcare and specialty care practitioners and monitors how effectively this network meets the needs and preferences (cultural, ethnic, racial, and linguistic) of its membership.
- Provide and maintain appropriate access to primary care services, behavioral health care services and specialty care (high volume and high impact) services.
- Ensures communication with members correctly and thoroughly represents the benefits and operating procedures of the health plan.
- Provide members with the information they need to easily understand and use their health plan and 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 partnership programs.
- Outline the population heath management strategy for meeting the 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.
- Demonstrate performance on continuity and coordination measures.

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

- Promote organizational diversity, equity and inclusion.
- Pursue NCQA Health Equity Accreditation.

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.

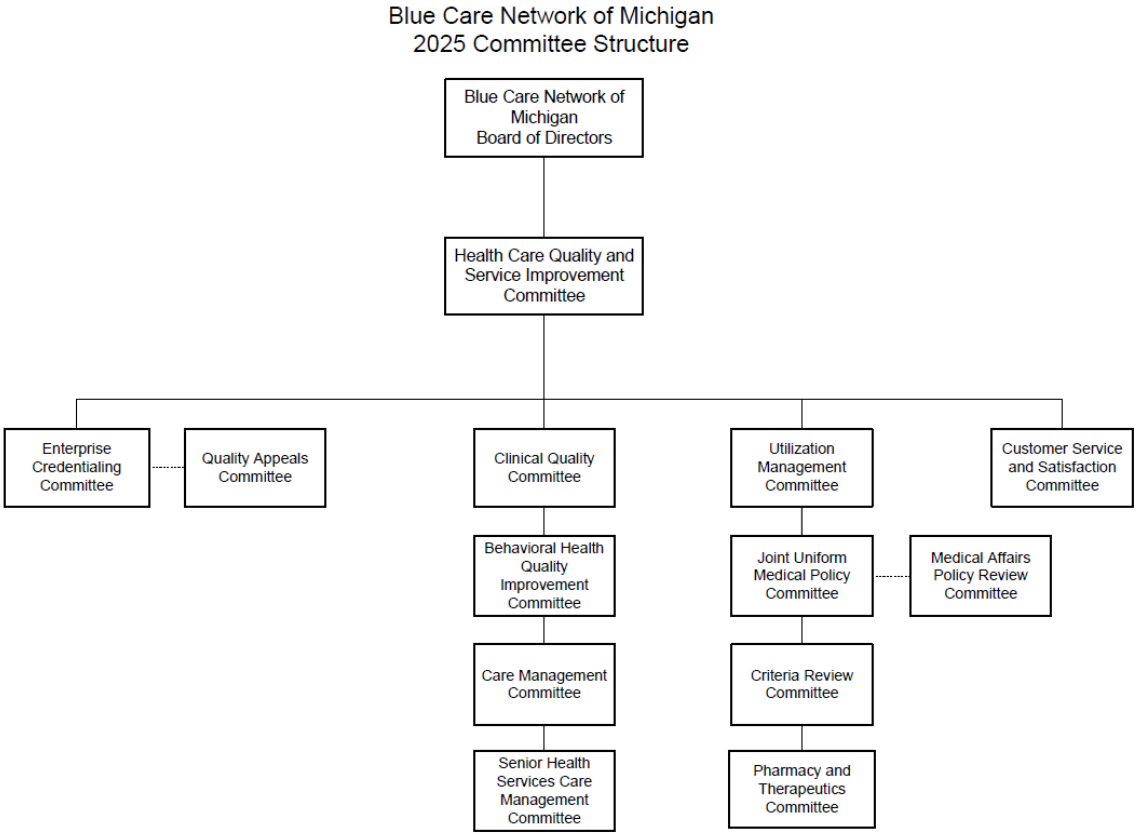
- In collaboration with the compliance officer, ensure compliance with local, state, and federal regulatory requirements.

Communication

- Maintain a 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.
- 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.

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
- Medical Director, 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 Delivery Committee for BCBSM PPO and the Health Care Quality and Service Improvement Committee for BCN HMO. The committee has oversight responsibilities for utilization management activities, including behavioral health.

Responsibilities:

- Review and approve the Utilization Management program description annually which includes the program structure, scope, processes and information sources used to make UM determinations.
- Review and approve the UM program evaluation annually to assess over and under-utilization.
- Review and approve the UM policies and procedures at least annually.
- Provides oversight for delegated utilization management services.
- Designation of a senior physician who is actively involved in implementation, supervision, oversight and evaluation of the UM programs as a member of this committee.
- Designation of a behavioral health practitioner who is actively involved in implementing behavioral healthcare aspects of the UM program as a member of this committee.
- Ensures the utilization management programs are compliant with regulatory and licensing requirements.
- Review and approve subcommittee meeting minutes.
- Review and provide feedback on criteria and medical policies used to make utilization decisions and procedures used to apply the criteria including annually adopting criteria sets and guidelines for program components ensuring unform application.
- Designation of representatives from subcommittees who are actively involved in developing criteria used to make utilization decisions.
- 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, Clinical Decision Support
- 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 physicians 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.
- Coversheet highlighting criteria with significant changes that require review.

7.1.5. Behavioral Health Quality Improvement Committee

The Blue Cross Behavioral Health Quality Improvement Committee reports to the Clinical Quality Committee and is a subcommittee of the Blue Cross Quality Improvement Committee. Its goals is to create and maintain a comprehensive and integrated approach to behavioral and medical management. Blue Cross Behavioral Health is responsible for oversight white labeled vendor program and participates in the BH QIC.

The purpose of the committee is to provide oversight of corporate wide quality improvement initiatives related to behavioral health. The committee recommends improvement strategies for programs, policies, and processes with the objective of continuously improving the behavioral health status of Blue Cross members.

Responsibilities:

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

Composition:

- Chairperson: Blue Cross Manager, Behavioral Health Strategy and Planning
- Senior Analyst, Blue Cross Behavioral Health Strategy and Planning
- Medical Director, External Physician
- Medical Director, Blue Cross Clinical Quality
- Director, Quality Management
- Manager, Quality Management
- Senior Health Care Analyst, Blue Cross Value Partnership Programs

- Manager, FEP Care Coordination/Managed Care
- Senior Account Executive, for Blue Cross Behavioral Health

Term:

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

Meetings:

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

7.1.6. 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/Quality Management
- Co-chairperson: Associate Medical Director
- Senior Medical Director & Associate Chief Medical Officer
- Senior Medical Director, Utilization Management
- Medical Director, 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)
- 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.

7.1.7. Enterprise Credentialing Committee

The Credentialing Committee is an enterprise peer review committee representing Blue Cross Blue Shield of Michigan and Blue Care Network. The committee has oversight responsibility for credentialing and recredentialing activities (including utilization management and quality) for all practitioners. The committee also has oversight responsibility for credentialing and recredentialing organizational providers for BCN only. These include hospitals, home health agencies, skilled nursing facilities, nursing homes, freestanding surgical centers, and behavioral health facilities.

Responsibilities:

- Reviews credentialing, quality and utilization information and makes determinations on initial and recredentialing applications for practitioners.
- For BCN only, reviews and makes determinations on initial and recredentialing applications for health care delivery organizations including hospitals, home health agencies, skilled nursing facilities, nursing homes, freestanding surgical centers and behavioral health facilities.
- Reviews credentialing, quality and utilization information for practitioners and providers. Credentialing decisions are based on the enterprise credentialing criteria, utilization information is based on utilization information from each product and quality information includes quality of care and service issues and is based on information from each product.
- Reviews and approves credentialing and recredentialing policies.
- Reviews and makes recommendations on operational/administrative procedures related to practitioner affiliation and quality performance.
- Provides oversight for delegated credentialing activities.
- Makes decisions on reporting to the National Practitioner Data Bank.
- Maintains confidentiality of proceedings and related documentation to support confidentiality of peer review information.
- For BCN and MA PPO serves as the review board for selected first level administrative practitioner appeals.
- Submits written reports to required committees. BCN submits reports to the Health Care Quality and Service Improvement Committee and PPO TRUST submits reports to PPO Network Management Committee.
- Reviews and evaluates annually the credentialing program plan, work plan, annual activity report and annual nondiscriminatory audit report.

Composition:

Voting Members:

- Chairperson: Appointed by the BCN Senior Vice President and Chief Medical Officer and the PPO TRUST Medical Director
- Co-Chairperson: BCN Regional Medical Director – east and mid regions
- PPO TRUST Medical Director
- MA PPO Medical Director
- Two BCN Regional Medical Directors
- Behavioral Health Medical Director
- Three external primary care practitioners. The practitioners will represent internal medicine or family practice and pediatrics.

- Four external specialists. The practitioners will represent the specialties of general surgery or a surgical subspecialty, internal medicine or internal medicine subspecialty, OB/GYN and PARE practitioner
- Chiropractor
- Podiatrist
- Dentist (for dental case review)

Non-Voting Members:

- Director or Manager, Quality Management
- Credentialing Representative
- BCBSM Network Management Representative
- Corporate Financial Investigation Representative

Term:

- Physician members serve for an initial term of two years.
- Committee membership will be reviewed annually by the BCN Senior Vice-President and Chief Medical Office and the PPO TRUST Medical Director,
- Reappointment is at the discretion of the BCN Senior Vice-President and Chief Medical Office and PPO TRUST Medical Director

Meetings:

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

7.1.8. Pharmacy and Therapeutics Committee

The Blue Cross Blue Shield of Michigan and Blue Care Network Joint 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.

7.1.9. 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.

7.1.10. 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.

7.1.11. 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.

7.1.12. Medical Affairs Policy Review Committee

The Medical Affairs Policy Review Committee coordinates the review and approval of Blue Cross Blue Shield of Michigan 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.

7.1.13. 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.

7.1.14. 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. Executive Vice President, Health Care Value

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

8.4. Executive Vice President, Clinical Affairs and Chief Medical Officer

The Executive Vice President, Clinical Affairs 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 Executive Vice President, Clinical Affairs & CMO. The Medical Director of Utilization Management/Quality Management reports to the Senior Medical Director who reports to the Executive Vice President, Clinical Affairs & 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 BCBSM Behavioral Health Medical Director in collaboration with the board-certified psychiatrist with Optum (NCQA accredited MBHO) are responsible for oversight of the Blue Cross Behavioral Health program and are members of the Behavioral Health Quality Improvement Committee. This committee ultimately reports to the Clinical Quality Committee.

8.8. Senior Director, Health Care Value Operations and Execution Excellence

The Senior Director Health Care Value Operations and Execution Excellence is responsible for QI Program Oversight. The Senior Director reports to the Executive Vice President, Health Care Value.

8.9. 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 Senior Director, Health Care Value Operations and Execution Excellence who reports to the Executive Vice President, Health Care Value. The Director, Quality Management, is responsible for Quality Improvement Program operations including accreditation processes, focused quality studies and quality initiatives.

8.9.1. 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 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, High Volume Specialists, High Impact Specialists, 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

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

9.1.2. Accessibility of Service

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

Program and Standards		
Type	**Program**	**Target Rating**
Member 1st Provider 1st Quality Program	The Member 1st Provider 1st Quality Program is designed to assess the accuracy and completeness of service delivery through telephone and written (email) work in the call center.	85% of CSRs receive a Pass on the evaluations.
Interactive Voice Response (IVR) Survey	Survey responses with member feedback based on experience with the customer service representative based on the following two questions; You understood the information received and the information you received was useful.	85% of CSR receive a pass on the evaluations.

All communications with members and providers are delivered with accuracy regardless of whether it is via telephone, letter, email, or any other form of communication. The Member 1st Provider 1st Quality Program contains 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. Interactive Voice Response (IVR) surveys and email resolution response data are used to evaluate the member's understanding and usefulness of the information received.

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

A randomized methodology sampling of inquiries managed by Customer Service Representatives are reviewed for quality, accuracy, and completeness. Evaluations are scored based on a five-point system of the following attributes: HIPAA verification, accuracy, completeness, proper claim handling and completion of any applicable promised actions. Accuracy and completeness are evaluated based on the member or provider 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 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 on one evaluation and pass quality for the month.
  - The maximum score for the month is 20, if the CSR misses one attribute the score will be 19 out of 20 or 95% 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 four evaluations (on average) per CSR.

Interactive Voice Response (IVR) 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

Quality and Accuracy Target Rating

Target Rating:

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.
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 Customer Service and Satisfaction Committee and approval, feedback, and recommendations are 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
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Hemoglobin A1c Control for Patients with Diabetes
- Kidney Health Evaluation for Patients with Diabetes
- Immunization Measures (Childhood Immunization Status – Combo 10, Immunizations for Adolescents – Combo 2)

Medicare measures for focus are:

- Breast Cancer Screening
- Controlling High Blood Pressure
- Hemoglobin A1c Control 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 MY2024 are focused on increasing lower performing measures to the next percentile while increasing or maintaining measures that are currently performing well. For MY2023, BCN Commercial had 69 percent of the Health Plan Rating measures in the 50th percentile or higher and BCNA had 65 percent of the Health Plan Rating measures in the 50th percentile or higher. Health Plan Ratings results for MY2023 are Commercial 4 Stars and Medicare 4.5 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 50th 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.
		Achieve a 90% or higher Overall satisfaction 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.

Focused Areas	Program	Goal
	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.
		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.
		Achieve a 90% or higher overall satisfaction score on member satisfaction survey.
Managing multiple chronic illnesses	Highly comorbid conditions *(Commercial HMO, Exchange HMO)*	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.
		Members managed will have a higher medication adherence gap closure rates than members not managed in the program.
		Members managed exceed in closing gaps over members not managed in the program. This includes closure of all care gaps that may be open for a member and include gaps related to medication adherence, managing their treatment for their condition, provider visits, and prevention/screening guidelines.
		Achieve 90 percent on Satisfaction Survey
		Members managed will have a primary care physician.
Managing multiple chronic illnesses	Longitudinal Care Management *(Medicare HMO)*	The percentage of Gaps in Care (GIC) closure rate will be higher in the managed population of the LCM program over eligible non-managed population. This will be evidenced by a 1% higher gap closure rate for managed members over non-managed members.
		Achieve a 90% or higher Overall satisfaction score on member satisfaction survey.

Overall outcomes are reviewed, reported, and approved at the Care Management Quality Committees and the Clinical Quality Committee. Refer to the annual Population Health Management Strategy & Program Description 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.

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 a reduction in the number of unplanned inpatient admissions/1000 for the BCNA Transition of Care (TOC) program. This is evidenced by a 1% rate reduction in the number of unplanned inpatient admissions/1000 of managed TOC members from January through October.
- Achieve a reduction in observed readmission rate for BCNA TOC program. This is evidenced by a 0.5% reduction in observed readmission rate of BCNA TOC managed members from January to October.
- 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 Personify Health 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 Personify Health 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. Optum Behavioral Health Program

In 2024, Optum Behavioral Health assumed behavioral health management of Blue Cross Blue Shield of Michigan (BCBSM) members. Optum Behavioral Health is accredited by the National Committee for Quality Assurance (NCQA) and has extensive experience managing Behavioral Health benefits for other insurers across the nation. Services included in the contract with Blue Cross Blue Shield of Michigan include utilization management and case management services for all members who receive behavioral health through BCBSM.

Behavioral Health vendor oversight is provided by the BCBSM Behavioral Health Strategy and Planning department and is approved by the Utilization Management Committee.

The program goals are:

- Manage and engage 5% of membership with Behavioral Health Utilization in case management.
- Improve follow-up care after inpatient psychiatric and substance use admissions related to HEDIS FUH 7 performance with the intent of 70% or higher.
- Improve coordination and continuity of care between behavioral health and primary care providers.
- Maintain a 10% or lower 30-day readmission rate for behavioral health or substance use admissions.
- Develop and execute HEDIS-related interventions to support Antidepressant Medication Management (AMM; discontinued in 2025), Management of Treatment Access and Follow-Up with Members with Diabetes and Schizophrenia (SMD), and Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD).
- Maintain a minimum of 90% member satisfaction with Behavioral Health customer service and case management services.
- Participate in the quarterly Behavioral Health – Quality Improvement Committee to examine opportunities to improve any of the above areas.

9.2.6.2. 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. 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.
2. Improve pharmacy integration using the Comprehensive Medication Management
    - Reduce mediation 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.
3. Expansion of Crisis Services
    - Expand the number of contracted crisis providers to allow improved access to community-based services.
4. 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.

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:

Integrated Health Expansion Efforts

Continued expansion of the Collaborative Care (CoCM) Designation

PGIP has developed a Collaborative Care Designation Program that builds off our strong Patient Centered Medical Home (PCMH) foundation using the CoCM model developed by the AIMS Center at the University of Washington.

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.

Rewards

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

Physician organizations rewards:

- A PO A PO reward for support provided to their practices as they deliver CoCM, for collecting outcomes data from those practices. This amount will be based on the number of CoCM-designated practices.
- Value-based reimbursement, which is paying claims at an amount higher than standard fee schedules for a period of one year.

Goals:

1. To retain current designated practices, recruit additional adult and pediatric practices and expand to include OB/GYN specialty practices.
2. There are currently 519 practitioners across 275 different practices, up from 250 in 2023. These include 218 Advanced Primary Care practices which provide advanced treatment and collaborative care management. To retain current designated practices, recruit additional adult and pediatric practices, expand to include OB/GYN specialty practices and using CoCM with those with substance use disorders.
3. That 100 percent of POs and their designated practices will receive rewards as described above.
4. Further opportunities to care team members to both hone skills and to target specific populations. Additional training will focus on specialty populations – substance use disorders, OB/GYN, pediatric/adolescent care.

Behavioral Health Incentive Program

Blue Cross' Value Partnerships program has established the Behavioral Health Incentive Program to pay behavioral health providers for meeting specific HEDIS-related quality standards. These incentives are available to both prescribers and non-prescribers.

Goals:

1. To reward providers that meet select HEDIS measures and close gaps to improve the quality of care and patient outcomes.
2. Align behavioral health practices with evidence-based therapeutic methods so that our members receive the highest quality treatment possible.
3. Reward behavioral health specialists who are providing exceptional care to our members.

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. In 2024 these numbers rose:

- Growth of more than 33%, making it the second-highest participant rate of all Population Health CQIs.
- Three new physician organizations (total of 11), 27 new clinics, and 245 additional providers (total 737), and 124 total practices.

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.

In 2024 this program has helped to lessen the increase of suicides in Michigan to 2% lower than the national average. Participating providers have helped with this by using effective suicide prevention protocols with their patients. There have been significant increases in participating providers' knowledge of such procedures and protocols, support of staff when suicide does occur, and providing safety planning to patients.

In 2025, the scope of this project will continue to expand across the state and also reinforce the use of mobile crisis services in practices where a patient screens positive on question #9 of the PHQ-9 ("[Have you had] thoughts that you would be better off dead or of hurting yourself in some way").

Continuing to add providers and provider organizations remains an on-going initiative. Currently, there are three provider organizations on the enrollment waitlist for 2025-2026.

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:

Certified Community Behavioral Health Clinics (CCBHCs)

A program will begin in 2025 to collect data on members with certain severe and persistent mental illness (SPMIs) across the state, and with that information help outreach to these members to help them locate participating clinics at which to obtain treatment.

CCBHCs are facilities which will provide targeted treatment services to these members in nine core treatment areas (medical, behavioral, care management, medications, etc.) which will provide integrated care to members rather than receiving separate treatment modalities at separate locations, which may be difficult for members.

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. This program will be discontinued in early 2025 due to the focus on the Management Service Organization (MSO) project described below which will perform this function as well as direct treatment services for members across the state.

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. This program has continued through 2024 and will do so in 2025 as well.

As of September 1, 2024, Blue Cross partnered with two large virtual therapy provider groups, Headway and Grow Therapy, to expand telehealth services to members across the state as part of a Management Service Organization (MSO) initiative. These groups combined have over 700 therapists and prescribers, and the aim of the program is to provide prompt, efficacious treatment to members. Metrics for program success include low-latency of time to first appointments, improvement on measures such as the PHQ-9 for depression and GAD-7 for anxiety, and provider demographics which match those of members (Spanish- and Arabic-speaking providers, BIPOC providers, and those who specialize in the treatment of children and adolescents.)

Goals:

1. The goal of the program is to improve access to evidence-based care to treat the two most common behavioral health conditions, and in 2025, Behavioral Health Strategy

will evaluate the success of the two MSO groups noted above that will help bring virtual therapy services to members in a quick and efficacious manner. These organizations will:

- Maintain a provider group size of at least 300 behavioral health providers representing specific provider demographics (e.g., specialties, languages spoken, etc.).
- Participate in the Michigan Health Information Network Shared Services (MiHIN) for clinical quality data sharing.

2. In 2025, Blue Cross will further expand communications and messaging around informing members of where they can find Behavioral Health treatment options.

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

Further expansion took place in 2024 for the City of Detroit, Northern Michigan (including the U.P.) and more rural areas. 2025 will further expand crisis service providers and service provision in the U.P., especially in more populated counties such as Marquette and Mackinac counties.

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 2024, the focus continued with educating members on where and how to get care, including crisis care, behavioral health navigation, virtual and in-person services. The campaign also continues to help reduce the stigma around behavioral health and getting behavioral health care.

Goals:

In 2025, the campaign will build off of previous work and launch with its first email of the year in January, rather than May. It will also try to bring in member testimonials to showcase the support that members are receiving and the success of behavioral health care options.

1. Increase awareness of available programs.
2. Inform members on where to go to find available BH care options.

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®. 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. Continued in 2025, 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:
   - Episode Spending Condition options:
     - Chronic obstructive pulmonary disease (COPD)
     - Colectomy (non-cancer)
     - Congestive heart failure (CHF)
     - Coronary artery bypass graft (CABG)
     - Joint replacement (hip and knee)
     - Pneumonia
   - Value Metric options:
     - Cardiac rehabilitation within 90 days after CABG
     - Cardiac rehabilitation within 90 days after percutaneous coronary intervention (PCI)
     - Follow-up within 7 days after CHF
     - Follow-up within 14 days after COPD
     - Follow-up within 7 days after pneumonia
     - Preoperative testing before low-risk surgeries
     - 30-day risk-adjusted readmissions after sepsis

6. Engage all P4P-participating acute care providers in more robust Health Information

Exchange.

9.2.8. Continuity and Coordination of Care

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

The health plan 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.

Prior to 2025, the health plan identified four opportunities to improve coordination of medical care. annually acted upon three of the selected opportunities. and measured the effectiveness of actions taken for the identified opportunities. Due to changes in the NCQA standards, only one measure remains to be completed in 2025. The target is listed in the table below:

Topics	Target	Measures
Use of Opioids by Multiple Prescribers	NCQA Benchmark	90th percentile for all lines of business

Prior to 2025, BCN annually collected data on six opportunities for collaboration between medical care and behavioral healthcare; conducted quantitative and qualitative analysis and of those identified, selected two opportunities for improvement and measured the effectiveness of the actions taken for the selected opportunities. Due to changes in the NCQA standards, five measure remains to be completed in 2025. The targets are listed in the table below.

Topics	Target	Measures
Bidirectional Exchange of Information between Behavioral Healthcare Providers to Primary Care Physician	Health Plan Target	100 percent for all lines of business
Appropriate Use of Psychotropic Medication: Use of Opioids at High Dosages	Health Plan Target	90th 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 all lines of business
Outpatient Follow-up with 30 Days of Discharge	Health Plan Target	90 percent for all lines of business
Special Needs of Members with Serious Mental Illness	Health Plan Target	87 percent for all lines of business

New in 2025, BCN will demonstrate continuity and coordination of care through performance

on required Health Plan Ratings HEDIS measures. The health plan will use its most recent Health Plan Ratings scoresheet to demonstrate that it met the scoring threshold. If the health fails to meet the threshold, an improvement plan is implemented. The following Health Plan Ratings measures are included in the calculated average for each product line brought forward for Accreditation.

Commercial Measure List	
Eye Exam for Patients With Diabetes (EED) Prenatal and Postpartum Care (PPC)—Prenatal Rate Prenatal and Postpartum Care (PPC)—Postpartum Rate Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) Follow-Up After Hospitalization for Mental Illness (FUH)—7 days—Total Rate Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7 days—Total Rate	Follow-Up After Emergency Department Visit for Substance Use (FUA)—7 days—Total Rate Initiation and Engagement of Substance Use Disorder Treatment (IET)—Engagement of SUD Treatment—Total Rate Follow-Up After High Intensity Care for Substance Use Disorder (FUI)—7 Days—Total Rate Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
Medicare Measure List	
Eye Exam for Patients With Diabetes (EED) Use of High-Risk Medications in Older Adults (DAE)—Rate 3—Total Rate Transitions of Care (TRC)—Patient Engagement Rate Transitions of Care (TRC)—Medication Reconciliation Rate Potentially Harmful Drug-Disease Interactions in Older Adults (DDE)—Total Rate Initiation and Engagement of Substance Use Disorder Treatment (IET)—Engagement of SUD Treatment—Total Rate Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)—65+ Rate	Fall Risk Management (FRM) Follow-Up After Hospitalization for Mental Illness (FUH)—7 days—Total Rate Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7 days—Total Rate Follow-Up After High Intensity Care for Substance Use Disorder (FUI)—7 Days—Total Rate Follow-Up After Emergency Department Visit for Substance Use (FUA)—7 days—Total Rate

New in 2025, BCN will annually monitor performance and act on one required continuity and coordination of care QRS measure and documents an improvement plan for any of the following measures that are required QRS reporting.

Exchange Measure List	
Prenatal and Postpartum Care (PPC)—Prenatal Rate Prenatal and Postpartum Care (PPC)— Postpartum Rate Initiation and Engagement of Substance Use Disorder Treatment (IET)—Initiation of SUD Treatment Initiation and Engagement of Substance Use Disorder Treatment (IET)—Engagement of SUD Treatment	Coordination of Care Follow-Up After Hospitalization for Mental Illness (FUH)—7 days Follow-Up After Hospitalization for Mental Illness (FUH)—30 days Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)*****

*Per the Final 2023 Call Letter for the QRS and QHP Enrollee Survey, CMS intends to propose the addition of the DSF-E measure beginning with the 2025 ratings year. Organizations are not required to include the DSF-E measure in the improvement plan. This element requires the organization to select at least one measure from the table above for the improvement plan.

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 66.67th 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 surveys 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 and 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:
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 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 such as estimate your cost solution.

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 of 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. This organization also owns and maintains cost transparency solution (Estimate Your Cost Tool).

Provider Directory

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 providers demographic components.

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, and the plans they accept to name a few that are key for decision making.

Cost Transparency

Cost Transparency, via the Estimate Your Cost Tool, is an enterprise solution and a key business function used by our members. It allows members to search for costs related to various medical services and procedures, helping them plan and manage their healthcare expenses efficiently.

Goal:

1. Create and maintain a “best in class” cost transparency tool that empowers members to make informed decisions about healthcare costs. The tool includes detailed pricing information for medical services, which is critical for members as they plan their healthcare journeys and manage out-of-pocket expenses.

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 ≤0.15/1000 members.
2. Appeal rate to be ≤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 for access measures is 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 (most meetings are held in person, typically three times a year).
- 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/or 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 2025, Blue Care Network is providing funding for 14 CQIs addressing one or more of the following clinical conditions:

Hospital CQIs

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

Goals:

1. Continue to develop best practices for CQI programs to demonstrate improved patient outcomes and share lessons learned locally, nationally, and internationally.
2. Evaluate each CQI's program performance to identify opportunities for strengthening, revamping, and consolidating, and evaluate the CQIs overall to assure efficiency within and sustainability of the CQI portfolio.
3. Focus on health disparities and health equity within the CQI portfolio and within individual CQIs.

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
- Cancer care
- Cardiac care
- Cellular immunotherapy- CAR-T
- Fertility care
- Gene therapy- Ocular disorders
- Knee and hip replacement

- Maternity care
- Spine surgery
- Substance Abuse Treatment and Recovery
- Transplants

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 of 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 more than 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 or by using our Find a Doctor feature at 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 providers across the U.S.

Goals:

1. Expand BDC/BDC+ designation across all programs by inviting facilities as appropriate to apply for designation.
2. Complete designation activities, launch and maintain the renewed Knee & Hip Replacement and Spine Surgery programs with effective dates of July 1, 2025.

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

The HIE Initiative was introduced in 2014. As of Fall 2024, all 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, all PG 5 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 (February 2024) 229 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. Vendors extract and submit clinical data to MiHIN using the All-Payer Supplemental specification. This has increased participation in MiHIN's QMI use cases and expanded clinical data

transmission and quality reporting capabilities for participating physician organizations.

The HIE initiative also supports physician organizations to appropriately and consistently incorporate ADT messages and discharge medication information into the processes of care. A new transitions of care medication reconciliation post-discharge outcomes measure was rolled out in 2021 and will be retired after the 2024 program year. Physician organizations have worked to improve overall medication reconciliation rates.

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. Currently, all physician organizations offer telehealth options and will continue to offer these services.

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 use case which allows for data submission for a wide variety of clinical data including social needs screening, test results, procedures completed and much more. 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.

Goals:

1. Continue to increase clinical data volumes submitted via MiHIN's Quality Measure Information Use Case including social needs screening data.
2. Focus on a strategy to increase data quality.
3. Support providers in the capacity to ingest and incorporate data to inform clinical 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 2025 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, 2025.

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, 2025 Ensure at least 80% of COPD exacerbation events have a bronchodilator claim within 30 days among patients with COPD by December 31, 2025.

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 assesses 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 is rate is at least 36% among adolescents turning 13 by December 31, 2025.

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] ≥90) for ≥15 days during the measurement year.

Goal:

1. Ensure that the HDO rate does not increase by more than one percent throughout 2025.

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 related to medication safety, quality, and cost-effectiveness are identified and presented to pharmacy representatives and administrators at provider organizations. Example topics addressed through the forum include, but are not limited to, the following: opioids, medication adherence, antibiotics, and pharmacy costs. 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 2025 the forum will identify further opportunities to work with pharmacists in physician organizations. 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 2025.

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 MAPD national average.

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 MAPD national average.

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 MAPD national average.

9.5.2.4. MTM Therapy Management

Pharmacists in the MTM program reach out to qualifying members and, if the member chooses to participate, will complete a Comprehensive Medication Review (CMR) with the member. The CMR 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. Ensure that the MTM program is in compliance with all CMS rules and regulations.

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 a type of cholesterol medication known as statins. This rating is based on the percent of members who are taking diabetes medications and who also take statins.

Goal:

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

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	Languages common to practice are defined as languages identified as primary by at least 5 percent of the established patient population Language services may consist of 3rd-party interpretation services or multi-lingual staff Asking a friend or family member to interpret does not meet the intent of the capability
5.10	Patient education materials and patient forms are available in languages common to practice's established patients	Languages common to practice are defined as languages identified as primary by at least 5 percent of the established patient population Patient education materials and forms are clear and simple and written at an appropriate reading grade level
10.6	Practice has a systematic approach in place for referring patients to community resources	Patients should have access to national and local resources that are appropriate for their ethnicity, gender orientation, ability status, age, and religious preference, including resources that are available in other languages such as Spanish, Arabic, and American Sign Language For example, if Practice Units within a PO have a great deal of diversity within their patient population, the PO may amass specific information about services for those diverse patient groups. Practice Units may also share information about resources for diverse groups.

	Unconscious (implicit bias education) for physician organization administrators, PCMH physicians and office staff	This education is conducted utilizing a free, one-hour, on-demand learning module – Stanford Unconscious Bias in Medicine. The purpose is to raise or increase the level of awareness about unconscious bias in health care delivery, how it plays out, and ways to address it.

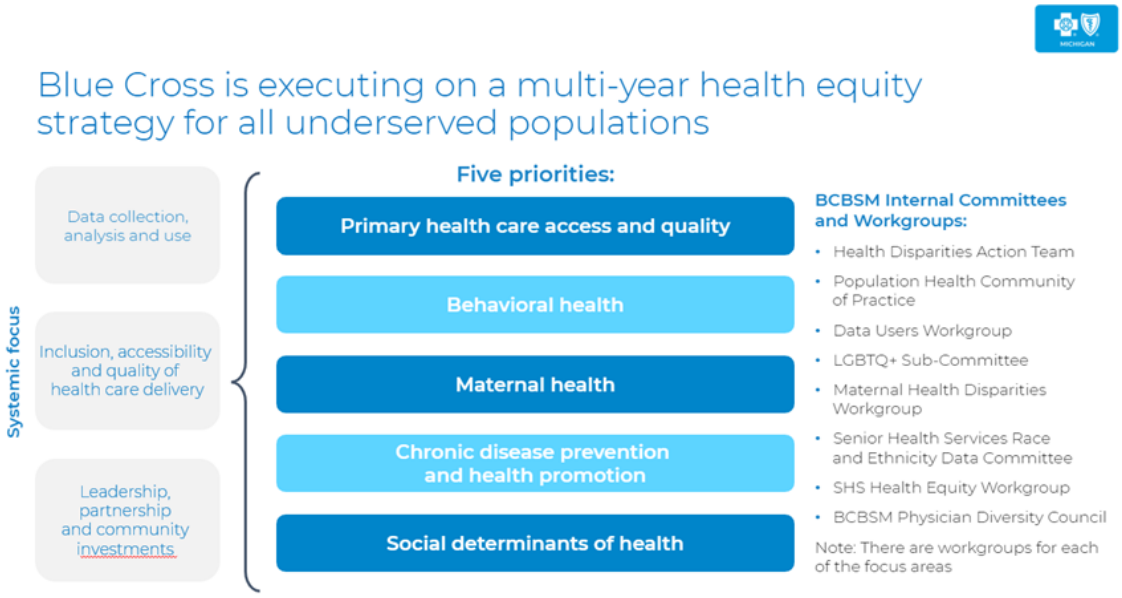
Annually, Blue Cross analyzes populations to assess disparities across race/ethnicity as well as socioeconomic status for various clinical data measures based upon geocoded data utilizing membership zip code as well as other proprietary logic. While activities to address disparities have been occurring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

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

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 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 12 month period) 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 site 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 1st Level written appeals within 30 days of receiving all relevant documentation.
2. Process 2nd 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, and 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, Enterprise Financial Advisory, Enterprise Information Security, Enterprise 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 may be defined as an intentional act to defraud a health care benefit program or to obtain through false representations, money or other property owned by a health care benefit program. Stakeholders are educated on health care fraud and how to report fraud and abuse through member and provider newsletters, handbooks, and manuals. Anyone can choose to report fraud, waste, or abuse anonymously and confidentially, without retaliation.

FWA Identification:

- Facility site and medical record reviews for member complaints and/or provider issues.
- Proactive analytics, early detection monitoring, and artificial intelligence to discover outlier behavior.
- Audits conducted on a random or targeted basis to identify, refer, investigate, resolve FWA and quality of care concerns

When potential fraud, waste or abuse is suspected, the issue should be 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 and 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 CEO BCN and Group Product
- EVP, Chief Medical Officer
- EVP, Health Care Value

- SVP, Provider Partnerships and Network Management
- VP, Advanced Analytics
- VP, Care Delivery Transformation and Affordability
- VP, Clinical Decision Support
- VP, Clinical Partnerships & Associate Chief Medical Officer
- VP, Core Operations
- VP, Corporate Communications
- VP, Corporate Marketing and Customer Experience
- VP, Enrollment, Billing and FEP Operations
- VP, Hospital Contracting & Network Administration
- VP, Inclusion and Diversity
- VP, Market Insight and Care Management
- VP, Pharmacy Services and Chief Pharmacy Officer
- VP, Product Development and Market Solutions
- VP, Provider Contracting
- VP, Quality
- VP, Service Operations
- VP, Stars
- Sr Director Community Responsibility & Social Mission
- Sr Director Corporate Counsel
- Sr Director, HVC Operations and Execution Excellence
- Sr Medical Director and Associate CMO, Clinical Health Equity, Quality and Experience
- Sr Medical Director, Associate CMO, Clinical Innovation and Affordability, Clinical Director
- Sr Medical Director, Associate CMO, Clinical Policy
- Sr Medical Director, Utilization Management
- Medical Director, Behavioral Health
- Medical Director, Utilization Management/Quality Management
- Medical Directors
- Director, Quality Management

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:

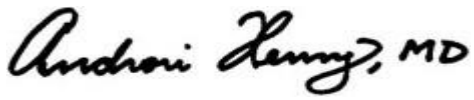
- Map vision and lab claims for inclusion in the data mart to enhance relevant metrics.
- Enhance PGIP Clinical Quality Initiative report to include HEDIS accreditation measures.
- Created process to identify members that need to receive letters informing them that their provider has left the network.

- 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 2025 Quality Improvement Program Plan has been reviewed and approved.

APPROVED BY:

Clinical Quality Committee on 01/29/2025:



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Androni Henry, MD
Senior Medical Director & Associate Chief Medical Officer
Clinical Quality Committee

16. Appendix A