2018 Quality Improvement Program Description

2018 QI Program Description

I. PURPOSE:

The Quality Improvement (QI) Program Description provides the framework necessary to improve the quality, safety, and efficiency of clinical care; enhance satisfaction; and improve the health of the entire CareFirst membership and the communities it serves commercial and Marketplace products {BlueChoice Health Maintenance Organization (HMO)/ Point of Service (POS), BluePreferred Preferred Provider Organization (PPO/EPO), Indemnity, Maryland Point of Service (MPOS) plans, and the Federal Employee Program (FEP)}.

The QI Program description defines the authority, scope, structure, and content of the QI program, including the roles and responsibilities of committees and individuals supporting program implementation.

II. GOALS AND OBJECTIVES:

The goal of the QI program is to continuously improve the quality and safety of clinical care, including behavioral health care, and the quality of services provided to Plan members/enrollees within and across healthcare organizations, settings, and levels of care. CareFirst strives to provide access to healthcare that meets The Institute of Medicine's (IOM) aims of being safe, timely, effective, efficient, equitable, and patient centered.

Specific QI Program goals and objectives are:

1. Support and promote all aspects of the CareFirst Patient Centered Medical Home (PCMH) program and the Total Care and Cost Improvement (TCCI) programs as a means to improve quality of care, safety, access, efficiency, coordination, and service.
2. Maintain a high-quality network of providers and practitioners to meet the needs of the population we serve.
3. Maintain overall Medical Trend at or below 5.0 percent.
4. Implement methods, tracking, monitoring, and oversight processes for all TCCI Programs to measure their value and impact for appropriate patients with complex healthcare needs.
5. Ensure all elements of the CareFirst TCCI Program will be operating at targeted levels in 2018 (maintaining at least 4 out of 5 quality score) by actively managing core target list identifying members with complex health needs:
    - Percent Admissions Triaged by HTC = 99%;
    - Comprehensive Medication Review (CMR):
        i. CMR Tier 1 Service Requests: 4,000
        ii. CMR Tier 2 Interventions with Recommendations: 720,000
        iii. CMR Tier 2 Percent of Drug Savings Review Recommendations Implemented: 60%;
    - Medical and Behavioral Health Care Coordination Care Plans = 37,500;
    - Specialty Pharmacy Coordination Cases = 12,000;
    - Home Based Services Cases = 10,000;
    - Community Based Program Cases = 5,000;
    - Enhanced Monitoring Program Cases = 4,000;
    - Expert Consult Cases Tier 1 = 1,500
    - Expert Consult Cases Tier 2 = 400;
    - Telemedicine encounters = 4,000 video visits

6. Establish collaborative partnerships to proactively engage clinicians, providers, and community hospitals and organizations to implement interventions that address the identified (medical and behavioral) health and service needs of our membership throughout the entire continuum of care and those that are likely to improve desired health outcomes;
7. Promote the provision of quality and cost data and support to clinicians to promote evidence-based clinical practice and informed referral choices and members to use their benefits to their fullest;
8. Maintain a systematic process to continuously identify, measure, assess, monitor, and improve the quality, safety, and efficiency of clinical care (medical and behavioral health), and quality of service;
9. Assess the race, ethnicity, language, interpreters, cultural competency, gender identity, and sexual orientation needs of our diverse populations while considering such diversity in the analysis of data and implementation of interventions to reduce health care disparities, improve network adequacy and improve cultural competency in materials and communications;
10. Monitor and oversee the performance of delegated functions especially for high priority partners (CVS, ShareCare, and Medtronic);
11. Develop and maintain a high-quality network of health care practitioners and providers meeting the needs and preferences of its membership by maintaining a systematic monitoring and evaluation process;
12. Operate a QI Program that is compliant with and responsive to federal, state, and local public health goals, and requirements of plan sponsors, regulators and accrediting bodies;
13. Provide insight based on Searchlight data to increase the knowledge base of the Medical Panels in the evaluation of their outcome measures;
14. Address health needs of all patients along the health care continuum, including those with complex health needs (advanced developmental, chronic physical and/or behavioral illness, or complicated clinical situation);
15. Support the migration of behavioral health program from delegation to internal functions; and
16. Support quality improvement principles throughout the organization; acting as a resource in process improvement activities.

III. SCOPE:

The scope of the Quality Improvement Program is broad and includes a wide range of activities. Such activities incorporate assessment and improvement of key aspects of clinical care (medical and behavioral), patient safety, quality of products and services, satisfaction, and efficient use of resources. The program is comprehensive and dynamic and includes processes to identify, monitor, analyze, prioritize, and implement interventions and evaluate as necessary to promote accessible, efficient, quality healthcare for every member.

Key aspects included in the QI Program (medical and behavioral healthcare):

- PCMH and TCCI Programs
- Care Coordination
    - Local Care Coordinators (LCCs) for patients with multiple chronic or complex conditions
    - Behavioral Health and Substance Use Disorder Care Coordinators (BHCCs) for those with Behavioral Health and Substance Use Disorder illness

    - Pharmacy Coordination Programs for patients on complex pharmaceutical regimens
- Continuity and Coordination of Care (including care transitions)
- Lifestyle Management/ Disease Management
- Primary Care Physician (PCP) and specialist engagement
- Appropriate Use of Services
    - Admissions
    - Readmissions
    - Emergency Room (ER) use
    - Ambulatory Services
    - Pharmaceutical Services
    - Establishment of Standards of Care and Services
    - Efficiency of services
- Effectiveness of Care
    - Chronic Care Maintenance
    - Preventive Health Maintenance
    - Population Health Maintenance
    - Health Outcomes
- Member Access/Availability
- Safety Initiatives
- Experience of Care (Satisfaction)
    - Member
    - Provider
    - Account
- Utilization and Resource Use
- High quality network of physicians and providers
- Structural Capabilities
    - Use of iCentric
- Searchlight: Provision of panel level data to inform care
- Oversight of selected delegated partners
- Assessment of race, ethnic and linguistic, interpreter, and cultural competency needs and interventions to address barriers and limitations
- Community Programs to improve access, quality and safety, and elimination of disparities

A. Behavioral Health Aspects

Beginning April 1, 2018, CareFirst will manage behavioral health and substance use disorder functions in-house. The Behavioral Health and Substance Use Disorder program will be closely integrated with medical functions and encompass all key aspects listed above. Significant changes made to support the integration that will be closely monitored include:

- The capability to submit behavioral health prior authorizations will be fully functional.
- The Intake, Assessment, and Appointment unit will be assessing members and directing them to the appropriate and preferred place of service, including finding behavioral health appointments.
- The behavioral health crisis line will be available to members 24/7.
- Mental Health Parity will be continuously evaluated and maintained throughout 2018.
- The in-house program will meet all Behavioral Health related NCQA standards.

Additionally, in order to more closely integrate Behavioral Health within the regional teams and the other TCCI programs, the in-house Behavioral Health and Substance Use Disorder Program will be offering care coordination to Members.

- Behavioral Health Care Coordinators will be fully staffed in the regional teams.
- Behavioral Health Hospital Transition of Care Coordinators will facilitate and transition all case categories.

The Behavioral Health Medical Director will advise on matters related to Behavioral Health and will be involved throughout all aspects of the Behavioral Health Continuum. He or she will sit on the Quality Improvement Council (QIC), Quality Improvement Advisory Committee (QIAC), Pharmacy Delegation Oversight Committee (PDOC), Care Management Committee (CMC), and Delegation Oversight Committee.

IV. QI PROCESS

The Quality Improvement Process:

1. Define: The Plan defines the quality projects in a systematic process by collecting data and information. The defining step includes identifying and prioritizing the opportunities, creating goals and benchmarking.
2. Measure: The data and information are collected using statistically valid techniques using a variety of quality tools in the quality management process.
3. Analyze: The data and information undergo further evaluation by key interdivisional representatives, including qualitative and quantitative analysis
4. Intervene: Initiatives are designed using a targeted robust approach utilizing the PCMH/TCCI framework. The targeted approach incorporates research and evidence-based best practice.
5. Re-measure: Tests for improvements are conducted at periodic intervals. Continuous QI process loop follows allowing for modifications and enhancements as necessary.

V. ORGANIZATION AND STRUCTURE:

A. Authority

The CareFirst, Inc., Board of Directors (BOD) has the ultimate responsibility and authority for the QI program. The Service and Quality Oversight Committee, a subcommittee of the BOD is responsible for fulfilling the oversight functions related to the Quality Improvement Program.

Management and direction of the QI Program is delegated to the QI Council (QIC) and associated subcommittees. The QIC oversees the development of the QI Program Description, QI Work Plan, and annual QI Evaluation. This Council establishes the scope of the QI Program and prioritizes activities based on an organizational view of clinical care, service and operations.

B. Responsibilities:

1. The Vice President and Chief Medical Officer oversees the QI Program:
   - Appoints the Chairman of the Quality Improvement Council (QIC).
   - Provides direction and expertise for the QI initiatives, coordinating initiatives with health promotion and disease management, patient safety, health care disparities and care support programs, and ensures adequate resources.

- Provides direction for QI study design, quantitative and qualitative data analyses.
- Oversees QI-related committees, work teams, and Medical Directors, as appropriate.
- Reviews and approves the annual QI Program Description, QI Work Plan, and QI Evaluation, and reviews progress in meeting the QI Program objectives.

2. The Behavioral Health Medical Director is responsible for the development of a medical integration plan, prevention and care activities, and network relationships.
    - Has significant involvement in the Behavioral Health/Substance Use Disorder Care Management clinical operations.
    - Provides direction and expertise in the implementation of the Behavioral Health and Substance Use Disorder TCCI program
    - Serves on the CareFirst Quality Improvement Council (QIC).
    - Serves on the CareFirst Quality Improvement Advisory Committee (QIAC).
    - Serves on the CareFirst Care Management Committee (CMC).
    - Serves on the CareFirst Pharmacy Delegation Oversight Committee (PDOC).
    - Serves on the Delegation Oversight Committee (DOC)

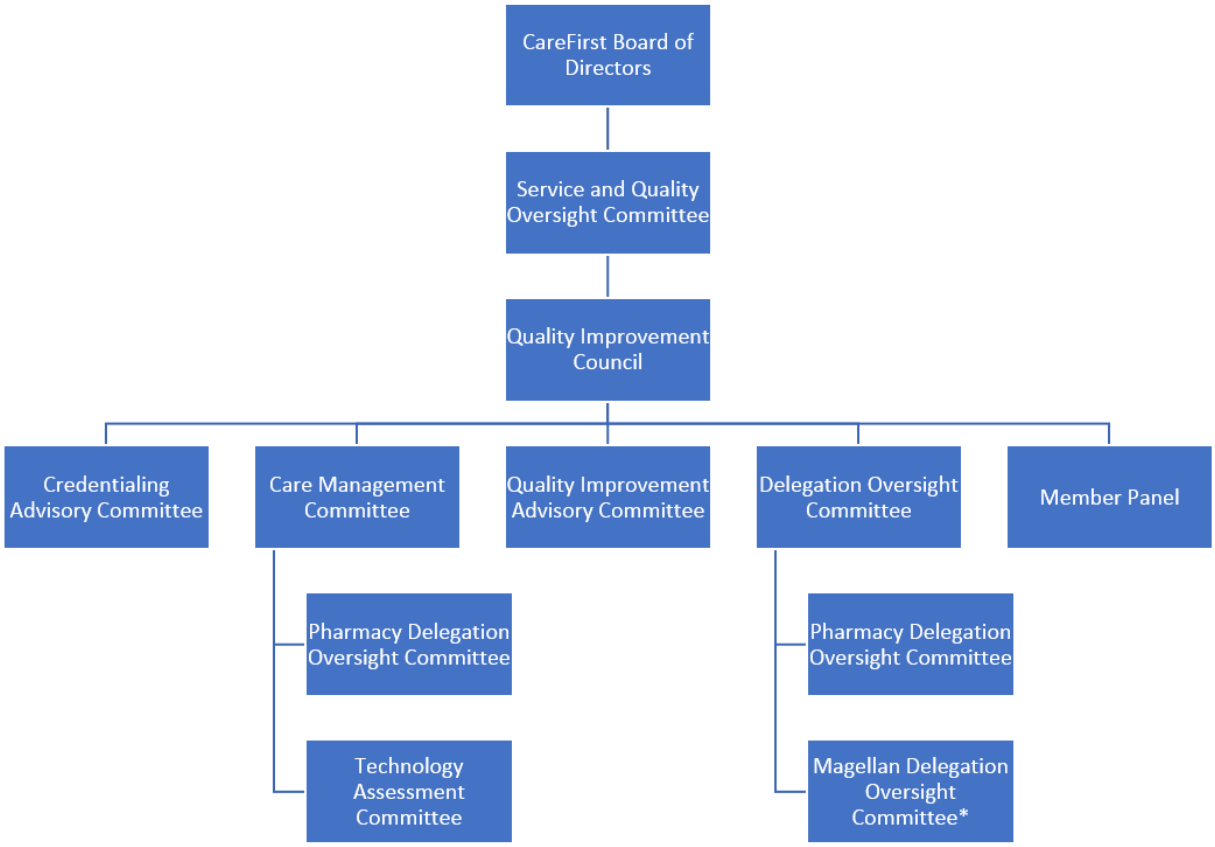
3. The Quality and Accreditation department is responsible for fostering collaboration throughout the organization by providing direction and oversight of the QI program and delegated activities. These activities include but are not limited to:
    - Develops and monitors the QI Work Plan.
    - Continuously supports QI Committees, provides clinical oversight, and maintains documentation for data collection, analysis, and evaluation of products and services to include but not limited to QI Evaluation, Supporting collection of regulatory plan wide Quality Measurement Sets, and delegation oversight for QI initiatives.
    - Utilizes outcome measures to establish baselines and identify trends to aid in identifying opportunities and prioritizing activities in quality improvement projects.
    - Facilitates continuous quality improvement within the QI work teams.
    - Provides compliance support for accreditation, regulatory compliance, and licensure.
    - Works to improve the safety of clinical care and service.

C. QI PROGRAM COMMITTEE STRUCTURE

The QI Staff coordinates and integrates inter-departmental quality improvement activities and QI information throughout the Plan. Multidisciplinary committees and work groups monitor performance indicators analyze data, implement interventions to improve performance, and report regularly to the QIC.

The organizational flow chart describes the reporting relationships for key QI-related committees. Table 1.1 in the appendix provides information about the role, structure, and function of QI-related committees.

QI Committee Structure



**Magellan Delegation Oversight Committee will only be responsible for Q1 2018 reporting. Effective April 1, 2018 the behavioral health program will be handled internally.*

VI. QI FOCUS

A. Patient Centered Medical Home (PCMH)

The PCMH program is an integral CareFirst program aimed at improving quality by utilizing the primary care provider as the central figure throughout a Member's entire continuum of care. The program is built on a set of incentives to primary care providers (PCPs) for providing arranging, coordinating, and managing quality, efficient, and cost-effective health care services for individuals enrolled in health benefit plans through CareFirst. These incentives reinforce that the central role of the PCP, which is to assist Members to understand and manage their health risks as well as guide their care when they experience major illness, especially when managing or more chronic diseases.

The program is rooted in the belief that PCPs are in the best position to make positive contributions toward restraining the rise in health care costs by better focusing on the needs of chronic care patients and those at greatest risk for chronic disease. Thus, the program seeks to reward primary care providers for differentially focusing on the high-risk patients and for achieving improvements in the quality of patient care and cost efficiency of outcomes.

In order to achieve these goals, it is necessary to share available medical information with the member's PCP, as well as other treating clinicians and health care professionals. This will only occur with appropriate consent. CareFirst Members will benefit from the increased engagement and coordinated care by their provider, which will be beneficial to improve their health status.

The program is supported by online, web-based connectivity that facilitates enhanced information sharing among patients, clinicians, care coordination teams and CareFirst. This enables the creation and monitoring of care plans for high risk patients and a member health record (MHR), upon consent. The MHR is available for every participating member so he or she, or their caregivers can be better informed and gaps in care can be identified and closed. CareFirst provides the PCP with support in the use of care plans. These care plans are directed by the PCP with the assistance of local community-based care teams headed by Nurse Coordinators. The Nurse Coordinators arrange for and track the care of those members who are at highest risk or who would benefit most from a care plan.

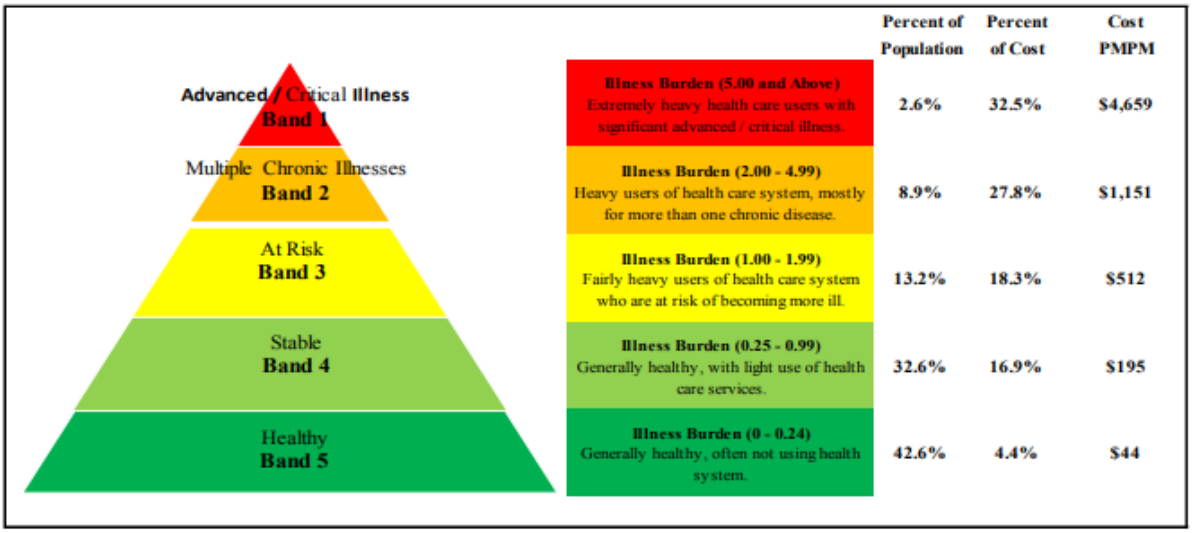
The Patient Centered Medical Home Program seeks to build a sound foundation for initiatives in specialty care, continuous quality improvement and more efficient member use of high cost hospital services. The program is intended to form lasting, stable partnerships among clinicians and CareFirst in the belief that this is essential to sustained improvements in quality and cost restraint.

By its design, PCMH uses claims data to attribute members to PCMH practices based on plurality of visits. An Illness Burden score is calculated to show for each patient the relative illness or wellness of the patient. Cohorts of patients are displayed in the Wellness/ Illness Pyramid shown below. The scoring algorithm recognizes the presence of chronic conditions and clusters of diseases and provides a powerful predictor of current and future health care use. CareFirst has services to address preventive care, wellness, case management, and care coordination services to meet the needs of members along the complete continuum of care.

Annually, CareFirst mines available data to identify population characteristics and needs and programs to address those high volume, high risk bands and aligns them with programs to address identified needs.

Illness/ Wellness Pyramid- Medical, Behavioral Health, and Pharmacy

CareFirst Illness Burden Pyramid



	Percent of Population	Percent of Cost	Cost PMPM
Illness Burden (5.00 and Above) Extremely heavy health care users with significant advanced / critical illness.	2.6%	32.5%	$4,659
Illness Burden (2.00 - 4.99) Heavy users of health care system, mostly for more than one chronic disease.	8.9%	27.8%	$1,151
Illness Burden (1.00 - 1.99) Fairly heavy users of health care system who are at risk of becoming more ill.	13.2%	18.3%	$512
Illness Burden (0.25 - 0.99) Generally healthy, with light use of health care services.	32.6%	16.9%	$195
Illness Burden (0 - 0.24) Generally healthy, often not using health system.	42.6%	4.4%	$44

[19] *Source: CareFirst HealthCare Analytics – Incurred in 2016 and paid through April 2017 – CareFirst Book of Business, excluding Medicare Primary Members.*

The Illness/ Wellness Pyramid for Medical and Pharmacy presents direct and compelling statistical and analytical evidence of the need to offer coordinated care and to perform Care Planning for those in the upper reaches of the pyramid. This is essential to both manage what is already occurring and to minimize additional cost that lies potentially in the future for those at high risk.

The information within the pyramid directly focuses attention to those that require the most care, which is the smallest population. Such data is typically never seen by PCPs and NPs, yet it is central to knowing where to direct their actions. This brings to light what it means to gain a view of an entire population of Members associated with each PCMH Panel and the PCMH Program as a whole.

B. Total Care and Cost Improvement (TCCI)

CareFirst designed twenty programs under the umbrella of the Total Care and Cost Improvement (TCCI) program to support providers in achieving the tenets of our Patient Centered Medical Home program. TCCI seeks to address many of the missing key elements in the current health care system and promotes the efficient use of health care resources, with emphasis on enhanced patient care.

TCCI employs a carefully selected team of specialized Nurses and Care Coordinators working real time to connect patients and providers to the most appropriate care support services. Nurses are aided by a uniform web-based care management system called iCentric that allows patient information to be shared 24/7 with all those involved in care management. This one-of-a-kind

system integrates claims data, including prescription fills, with care management entries to form a consolidated view of all care around a single patient.

ICentric is vital to all of the TCCI programs. This program offers a secure, web-based system that allows records to be shared with all those involved in care management, including PCPs. This one-of-a-kind system integrates claims data with care management entries to form a MHR which displays care delivered in all settings, which include medical and behavioral health interventions, laboratory data as well as prescription fills when the member has the CareFirst pharmacy benefit.

The PCMH program is core of the TCCI program. TCCI is composed of eighteen elements as shown below, each of which is designed to improve care and safety and reduce overall cost while supporting the primary care physician in the PCMH program. Many of these programs are targeted to manage patients with complex health needs.

Twenty Elements of the Total Care and Cost Improvement Program

- Health Promotion, Wellness and Disease Management Services (WDM)
- Hospital Transition of Care Program (HTC)
- Complex Case Management Program (CCM)
- Chronic Care Coordination Program (CCC)
- Behavioral Health and Substance Use Disorder Program (BSD)
- Home-Based Services Program (HBS)
- Enhanced Monitoring Program (EMP)
- Community-Based Programs (CBP)
    - Addiction Program
    - Hospice and Palliative Care Services Program
    - Skilled Nursing Facility Program
    - Chronic Kidney Disease Program
    - Diabetes Management Program
    - Pain Management Program
    - Congestive Heart Failure Program
    - Cardiac Rehabilitation Program
    - Sleep Management Program
- Network Within Network (NWN)
- Pharmacy Coordination Program (RxP)
    - RxP Element #1: Drug Pricing And Ingredient Cost Control
    - RxP Element #2: Formulary Offerings
    - RxP Element #3: Rx Preauthorization For Specialty Drugs and Compounds
    - RxP Element #4: Behavioral Health Pharmacy Coordination
    - RxP Element #5: Comprehensive Medication Review (CMR 1 and CMR 2)
- Expert Consult Program (ECP)
- Urgent Care & Convenience Access Program (UCA)
- Centers of Distinction Program (CDP)
- Medical Preauthorization Program (PRE)
- Telemedicine – Video Visit – Program (TMP)
- Dental-Medical Medical Health (DMH)
- Fraud, Waste and Abuse Program (FWA)
- Administrative Efficiency and Data Accuracy Program (AEA)
- Precision Health Program (PHP)
- Innovations in Care Quality and Outcomes Program (CQO)

Health Promotion, Wellness and Disease Management Program (WDM) consists of lifestyle and Disease Management coaching by licensed professional coaches who are experts in motivating people toward healthier lifestyles and reducing risk if they are headed towards or already have certain common chronic diseases. Also included in this program is a Health Assessment - with and without biometric screening – that reveals one's overall health and wellbeing as well as the changes in this over time. This program is not only for each individual, but for an employer group as a whole. A broad array of supporting program elements on fitness, smoking cessation and other health promotion activities is available as is a rich online set of resources and information to Members that support their wellness and Disease Management efforts.

Hospital Transition of Care Program (HTC) monitors admissions of CareFirst members to hospitals anywhere in the country. Locally, it relies on specially trained nurses who are stationed in hospitals throughout the CareFirst region. The HTC program assesses the member's need upon admission and during a hospital stay, with a focus on post discharge needs. The program begins the care plan process for members who will be placed in the Complex Case Management or Chronic Care Coordination programs. The HTC process also categorizes members based on the level of their severity of need and the nature of their illness or condition so that they can be placed in the best possible "track" for follow-up care coordination services and flags cases that will likely result in high cost to ensure they receive the attention they need.

Complex Case Management Program ("CCM") offers Care Plans for Members with advanced or critical illnesses. These Members are typically being cared for by specialists. CareFirst Specialty Case Managers provide Care Coordination services in concert with the various specialists involved. Case management services most often follow a hospitalization. The HTC is typically the entry point for Members into Case Management prior to discharge. All Specialty Case Managers are registered nurses with substantial experience in their respective specialties.

Chronic Care Coordination Program ("CCC") offers Care Plans to targeted Members that are developed under the direction of the PCP. This Program provides coordination of care for Members with multiple chronic illnesses. While Care Plans often result from a case management episode, they can also result from a review of the trailing 12 months of healthcare use by an attributed Member who is identified as likely to benefit from a Care Plan. Care Coordination for these Members is carried out through the LCC, a registered nurse who is assigned to each provider/practice within a Panel. The LCC assists the PCP in coordinating all Elements of the Member's healthcare and ensures all action steps in the plan are followed up and carried out.

Behavioral Health and Substance Use Disorder Program (BSD) includes a range of services that deal with the behavioral health needs of Members (such as depression and various forms of psychosis and other disorders) that often accompany physical illnesses or that may stand alone. Included in this TCCI Program Category are substance use disorder services as well as psycho-social services.

Home Based Services Program (HBS) serves Members in CCM or CCC who often need considerable support at home, sometimes on a prolonged basis. These services can include home health aide, psycho-social services and other behavioral health services as well as medication management and support in activities of daily living. If such services are needed, they are provided following an assessment of the home situation by an RN Home Care Coordinator (HCC) and become part of the overall plan of care maintained by the LCC or Case Manager responsible for the Member. HBS are often critical to avoiding the cycle of breakdown (admission,

readmission) that commonly occurs with Members who have multiple chronic diseases. Only Members specifically referred to the Home Based Care Coordination Program through the CCM and CCC Programs are eligible for full assessment and integrated home-based services pursuant to a Care Plan. A preferred list of home care agencies is used in the provision of services within the HBS Program.

Enhanced Monitoring Program (EMP) focuses on those members at high risk for disease progression to more advanced or serious illness. The Enhanced Monitoring Program uses prescription drug and other data to identify members in each Panel who have patterns of illness that suggest incipient high risk for progression, or have chronic conditions already that need active monitoring to ensure member stability. EMP services are provided at home or even in the work setting using mobile and digital capabilities that send a stream of data to a central monitoring station staffed by highly qualified nurses. Special alerts are sent to PCPs or NPs as necessary.

Community Based Programs (CBP) is a compendium of local Programs that have been reviewed and selected in advance by CareFirst to be made available to Members with identified needs that could benefit from such Programs. These selected programs are created in collaboration with specifically contracted Providers on an ongoing basis and typically reflect improvements in organization of care within existing benefits that are linked to other TCCI elements to enable care coordination and reporting. Examples include, but are not limited to, programs to better manage diabetes, congestive heart failure, coronary artery disease, chronic kidney disease; as well as, improved processes for supporting Members in need of skilled nursing facility care or palliative care/hospice care.

Network Within Network Program (NWN) is a program that refers Members to preferred, high-value providers in a variety of specialties. While many insurers have embraced the "narrow network" strategy, the NWN Program was created in lieu of narrow networks, which often restrict Members' choice. The NWN Program seeks to direct Members under the direction of their PCPs to a subset of preselected ancillary and specialty providers who are particularly effective without locking in either the Member or the PCP to a compulsory choice of these providers.

Pharmacy Coordination Program (RxP) is a program available for Members with pharmacy benefits as part of their coverage plan. This includes management of retail and wholesale pharmacy benefits, including formulary management as well as specialty pharmacy benefits for certain disease states (such as hepatitis C, rheumatoid arthritis, and multiple sclerosis) that require high-cost pharmaceuticals that must be administered according to rigorous treatment plans. The RxP program consists of five key elements including obtaining the best possible ingredient cost pricing for generic and brand drugs, optimum formulary design and administration, specialty pharmacy preauthorization and case management, analysis of drug therapy problems and identification of Members taking drugs for behavioral health purposes.

Expert Consult Program (ECP) allows network physicians or CareFirst to seek an outside expert opinion from leading, recognized, medical experts when this is needed for highly complex cases. Through this program, CareFirst has access to the top physicians in the nation in every specialty and sub-specialty category, organized by disease state. Cases referred to this program from CCM and CCC after CareFirst Medical Director review are complex, expensive and have the characteristic that diagnosis and treatment have not been complete, accurate or effective up to the point of referral. Recommendations are made in each case by the expert reviewers that are almost always followed by treating providers resulting in lower overall cost due to fewer Member breakdowns or inappropriate treatments.

Urgent Care & Convenience Access Program (UCA) offers organized back up for PCPs to support Members with urgent care needs that might otherwise go to a hospital-based emergency department or outpatient facility. Generally the costs are one-third of what they would otherwise have been had these services been provided in a hospital emergency room

Centers of Distinction Program (CDP) is a TCCI Program focused on highly specialized, high cost categories of hospital care. Hospitals that demonstrate expertise in delivering quality specialty care in these high volume/impact specialty areas are designated by the Blue Cross Blue Shield Association as Blue Distinction Centers ("BDCs").

Medical Preauthorization Programs (PRE) obtains a review of certain proposed services to Members that are usually infrequent but that are high cost and where evidence of medical need must be established before approval for payment is given. Examples include high cost specialty drugs and certain durable medical equipment.

Telemedicine – Video Visit – Program (TMP) offers the integration of voice, data and image to create a virtual visit to a provider for a Member. The program also enables a specialty consult for a Member or PCP in certain cases where this is more responsive than an in-person visit. TMP also applies in cases where an off hours visit to a Member's PCP is not readily available.

Dental-Medical Health Program (DMH) recognizes dental care is an important part of overall health. This Program is designed to enable and encourage appropriate dental care as determined by the Member's treating dentist and to integrate the Member's dental health into their overall health profile.

Fraud, Waste And Abuse Program (FWA) is a TCCI Program that detects – based on claim patterns – areas of abuse or outright fraudulent billing. There is an underlying heavy reliance on data mining and analytics to identify these patterns, which is derived from the same data warehouse that is used for SearchLight Reporting. This data warehouse is extremely comprehensive including all claims for all services ever rendered by any provider to any Member over a multi-year period.

Administrative Efficiency And Data Accuracy Program (AEA) is a TCCI Program that provides both the means and incentives to providers to maintain accurate and timely information for credentialing purposes as well as for inclusion in the CareFirst provider directory.

Precision Health Program (PHP) is a TCCI Program that connects Members to treatment and prevention that takes into account the individual genetic variability in each person. This Program allows providers to predict more accurately which treatment and prevention strategies for a particular disease will work for a specific Member. Some elements of this Program require preauthorization.

Innovations in Care Quality and Outcomes Program ("CQO") is a TCCI Program aimed at developing strategic partnerships with emerging healthcare companies that have products and/or services that can improve the health and well-being of CareFirst Member while reducing the total cost of care but that are not yet in widespread use.

In effect, TCCI brings to bear different interventions for members at different levels of illness or wellness, with the goal of preventing disease progression and managing care in the least costly setting.

The PCMH program takes the point of view that high quality, cost effective results go hand in hand. Quality indicators used to evaluate clinical effectiveness are evidence based, consensus driven and based on national standards. Organizations such as the National Quality Forum (NQF), the National Committee for Quality Assurance (NCQA), the Agency for Healthcare Research, Quality (AHRQ), and Centers for Medicare and Medicaid Services (CMS) have contributed measurements to evaluate the effectiveness of patient management across all settings at both health plan and physician group levels. In addition, standardized customer satisfaction tools are used to evaluate patient experience.

PCMH practices are expected to adhere to a minimum standard for access and availability, chronic care registries, transition of care processes, medical record documentation, medication reconciliation, care coordination and use of electronic capabilities and tools. CareFirst provides resources for practices to assist them in transformation into becoming a Patient-Centered Medical Home. For those practices that participate in the PCMH program, quality improvement efforts are directed through the mechanisms embedded in PCMH. For those patients and PCPs not yet included, CareFirst will use the data to target population-based interventions.

As a means to promote the improvement of quality, safety and efficiency, incentives are aligned for PCPs, patients, and health plan staff. CareFirst offers “Healthy Blue,” a product which provides incentives for members to adopt healthy lifestyle behaviors and follow the PCP’s recommendation for care.

VII. QUALITY AND PATIENT SAFETY

The Quality Improvement Council (QIC) is responsible for the direction and implementation of the patient safety strategies. Program objectives are aimed toward improving safe clinical practices in ambulatory and hospital settings. Patient safety initiatives include the following:

- PCMH: the goal is to improve primary care by focusing on the patient-doctor relationship and strengthening this through a more comprehensive approach to provide care with more active patient involvement. Care Coordination is tracked across complex health care systems by utilizing tools and resources provided through PCMH and the TCCI programs as well as:
    - MHR available to care teams
    - iCentric web-based platform
    - Local Care Coordination (Medical and Behavioral Health)
    - Hospital Transition of Care
    - Registries
    - Roster of patients by practice/ panel to support population management
    - Outcome Incentive Awards: Credit given to PCMH practices, which is tied to panel scorecard results in achieving savings while meeting specified patient engagement requirements and improving quality for their entire attributed patient population.
- Quality data collection publication of performance information of hospitals and practitioners
- Pharmacy patient safety initiatives:
    - Communication and publication of drug recalls and withdrawals
    - Identification of drug-drug interactions and notification at the point of dispensing
    - Comprehensive Medication Review Program
    - Behavioral Health Pharmacy Management Program

    - Pharmacy Coordination Program
- Adverse Events, Serious Reportable Events, and practitioner quality of care monitoring

VIII. QI SOURCES and RESOURCES

The QI Program is data driven and, as such, includes the following sources (medical and behavioral healthcare):

- Authorization data
- Claims data (including Rx)
- Pertinent medical records and/or care plans
- Utilization Data
- Patient/Provider/Account Experience Data
- Complaints/Appeals data
- PCMH Outcomes
- iCentric data/ reports
- Searchlight reports
- Health assessments
- Enrollment and demographic data
- Access and availability mapping to determine Network Adequacy
- Race, ethnicity, language, interpreter, and cultural competency assessment
- Delegate reporting
- Plan-wide Quality Measurements:
    - HEDIS
    - CAHPS
    - Quality Rating System data (QRS)
    - Quality, Customer Service, and Resource Use (QCR)
- Plan Operations Metrics
- Nationally published cost and quality metrics
- Cost and Quality Specialist Outcomes
- TCCI and PCMH Program Evaluations

CareFirst has adequate resources to meet the QI Program objectives, carry out the scope, and complete ongoing and annual evaluations. Each functional unit within CareFirst is responsible for establishing goals, measuring effectiveness and designing interventions to improve when opportunities are realized. Dedicated QI staff collaborates with functional areas and provides QI expertise. CareFirst has a data informatics department to support collection and analysis of measurements of effectiveness as well as cost and quality assessments. Medical Directors (medical and behavioral) provide expertise in all aspects of the QI Process.

Through an organized committee structure, participating practitioners and members have input into the QI program. A variety of other resources within the organization is available, which includes auditors, management, marketing research, operations staff, networks management and behavioral health and other clinical specialties as necessary.

Serving Culturally and Linguistically Diverse Membership

To improve communication and support, the CareFirst region is divided into twenty distinct sub-regions, providing care to our members that is specific to the demographics of their region. LCCs, assigned to PCMH practices, live in their specific region and are familiar with the health care systems in that area; enabling tailored care to the population they serve. The Regional Care

Coordinators, who oversee the care for their specific region, have also taken a Cultural Diversity Course.

The PCMH Program has implemented reporting and analysis of Quality Scorecard results by geographic area/region, to assist in determining if any specific areas require focused interventions to improve the health of, and healthcare provided to, the Members in that area/region.

CareFirst recognizes that significant racial and ethnic healthcare disparities exist and populations are becoming more diverse. Racial and ethnic cultural backgrounds influence the perception of healthcare and influence healthcare outcomes. CareFirst uses member race, ethnicity, language, interpreter, and cultural competency data to assess the existence of disparities and incorporates the information in quality improvement efforts to reduce health care disparities in clinical areas as well as in materials and communications. The Plan understands that approaches to healthcare require cultural sensitivity and is designing initiatives to target conditions of high prevalence with identified health status and gaps in identified population groups. CareFirst analyzes member and practitioner data to determine whether the CareFirst networks meet the cultural, ethnic, language, interpreter and cultural competency needs and preferences of members.

Through the analysis of population data, CareFirst found that, on the state and district level, no single minority population reached the 10% threshold for primary language spoken other than English. CareFirst drilled down to county level and identified several counties/cities in Maryland and Northern Virginia with a Hispanic/Latino or Asian population greater than 10%. However, only one county and one city exceeded the 10% threshold for Spanish-speaking members; no counties/cities exceed the 10% threshold for Asian-speaking members. To assist Spanish-speaking Members in understanding Plan information, many CareFirst documents are transcribed in Spanish and other languages, both on the CareFirst website and in print. CareFirst also provides a language line that can interpret over 40 languages. While Spanish is CareFirst's most requested language, Korean, Mandarin, Vietnamese, and Russian also top the list.

CareFirst strives to maintain, within all networks an adequate network of practitioners to meet the diverse needs of our members. Practitioners can list up to four languages that they speak on their credentialing application form. This information is maintained in the Credentialing files and used to update information in the CareFirst provider directory (both printed and at www.carefirst.com). The QI department will continue work to improve other areas of need that are found appropriate.

IX. DELEGATION

CareFirst may delegate Quality Improvement, Case Management, Disease Management, Care Coordination, Utilization Management, Pharmaceutical Safety, Pharmacy Benefit Information, Credentialing, Networks, Member Connection, Population Health Management, and other activities as appropriate to other entities that meet CareFirst's requirements. CareFirst has written policies and procedures for the determination of functions to delegate, pre-delegation assessments, initial evaluation, and ongoing monitoring of delegates. The QI Team directly oversees and monitors all delegated functions and makes recommendations to the QIC (and/ or appropriate subcommittee) on issues of overall compliance with CareFirst requirements.

When activities are delegated to another entity, the provision and oversight of these activities are completely and specifically documented in a mutually agreed upon document, that outlines the following:

- Responsibilities of CareFirst and delegated entity;
- Specific delegated activities;

- At least semi-annual reporting from each delegate to the appropriate CareFirst committee;
- Process by which CareFirst evaluates the delegate's performance;
- Remedies, including revocation of the delegation if the delegated entity does not fulfill its obligations; and
- Annual evaluation of delegate's activities to determine compliance with CareFirst requirements, accreditation standards, and state and federal regulatory requirements.
- If sub-delegation is agreed upon, it will be the responsibility of the delegate to oversee sub-delegation in accordance with the same requirements and periodicity established by CareFirst and the delegate, at a minimum. The delegate must confirm sub delegate's compliance with CareFirst, state, federal, and NCQA standards and include any sub-delegate activity in all of it's reporting to CareFirst.

If the delegation arrangement includes the use of protected health information by the delegate, the Delegation Agreement and/or Business Associate Addendum (BAA) also includes the following provisions:

- A list of the allowed uses of protected health information;
- A description of delegate safeguards to protect the information from inappropriate use or further disclosure;
- A stipulation that the delegate ensures that sub-delegates have similar safeguards;
- A stipulation that the delegate provides individuals with access to their protected information;
- A stipulation that the delegate informs CareFirst if inappropriate use of the information occurs; and
- A stipulation that the delegate ensures protected health information is returned, destroyed or protected if the delegation agreement ends.

The Delegated Entities listing is maintained by the QI team and tracked in appropriate work plans.

XI. QI PROGRAM GOVERNANCE:

The annual QI Program Description, QI Evaluation, and QI Workplan systematically document structures and processes necessary to administer an effective quality improvement program and integrate QI-related activities throughout the organization. The effectiveness of the QI Program is evaluated annually as follows:

A. QI Program Description:

The QI Program Description and Work Plan govern the program structure and activities for the calendar year. At least annually, the program will be formally evaluated, and findings inform the following year's goals and objectives.

B. QI Work Plan:

The QI team, with input from appropriate Plan staff, develops a detailed QI Work Plan for the year that addresses the following:

- Objectives for the year, including the Plan's approach to patient safety;
- QI program scope;
- QI activities planned for the year, including both the quality and safety of clinical care and quality of service;

- The timeframe within which each activity is to be achieved;
- The person(s) responsible for each activity;
- Planned monitoring of previously identified issues; and
- Formal evaluation of the QI program.

The QIC monitors the progress of activities in the annual QI Work Plan through reports provided by staff throughout the year.

C. Annual QI Program Evaluation:

The QI team, with input from appropriate Plan staff, documents a detailed description of all the completed and ongoing QI activities addressed in the QI Work Plan for the year, including delegated functions. It includes:

- A description of completed and ongoing QI activities for the year;
- Trended data of measures to assess performance in the quality and safety of clinical care and the quality of service;
- Identification of improvements and opportunities for serving a culturally and linguistically diverse population;
- Analysis and critical assessment of limitations and barriers to achieving each goal of the program; and
- Evaluation of the overall effectiveness of the QI program.

SIGNATURE PAGE:

The 2017 Annual QI Program Evaluation
The 2018 QI Program Description
The 2018 Annual QI Work Plan

Documents were reviewed and approved:

_____ _____
Medical Director, Chairman, QIC Date

_____ _____
Vice President/Chief Medical Officer, CareFirst Date

Original Approval Date:	August 7, 1995
Annual Approval Date:	April 27, 2015
Annual Approval Date:	March 22, 2016
Annual Approval Date:	April 25, 2017
Annual Approval Date:	April 24, 2018

Appendix: Table 1.1
QI COMMITIEES ROLES, STRUCTURE AND FUNCTION

Committee	Role	Structure	Function
Service and Quality Oversight Committee (S&QOC) Meets quarterly	Board Oversight	Membership: at least 5 Directors of Board (including physicians), CareFirst CMO, VPs of Service Units, and TOS. Reports to the BoD	• Oversee ongoing performance of Clinical Quality and Service • Take action as necessary
Quality Improvement Council (QIC) Meets at least 5 times per year	Management and Direction of QI Program	Membership: Medical Directors, QI Specialists, Representatives from following functional areas: • Care Management • Networks Management • Clinical Informatics • Pharmacy Management • QI • Marketing Research • Corporate Communications • Customer Services • PCMH • Operations • Disease Management Reports to S&QOC	• Annual development and approval of QI Program, Evaluation and Workplan • Ongoing monitoring of performance toward meeting goals • Review, analyze and approve programs/ evaluations/ reports supporting all subcommittees (Credentialing, Pharmacy, Care Management) • Approve policies, procedures and standards supporting QI Program • Analyze and evaluate results of QI activities • Oversight of QI functions of the organization • Recommend policy decisions • Ensure practitioner participation in the program through planning, design and implementation • Institute needed actions • Ensure follow up • Provides feedback and guidance to subcommittees
Quality Improvement Advisory Committee (QIAC) Meets at least three Times per year. Includes representation from MD, DC, and northern VA	Committee of Practicing Network Physicians providing input into the QI program planning, design and implementation and oversight	Membership: Chief Medical Officer, At least 7 contracted practitioners representing primary care, OB/GYN, Behavioral Health, and other specialties, Plan Medical Directors, QI staff, other plan staff as needed. A community Physician holds Chair role. Reports to QIC	• Provide input into program design and implementation • Review ongoing QI activities and provide perspectives of practicing physicians • Recommend actions • Advise Plan on policies, procedures, standards and guidelines, with special focus on clinical practice, prevention, and office practice standards of care • Serve as peer review panel as necessary in the QI process, CareFirst TCCI and PCMH programs • Assess effectiveness of interventions

Committee	Role	Structure	Function
Credentialing Advisory Committee (CAC) Meets monthly (At least 10 times per year) and as needed.	Reviews the credentials o those practitioners applying for initial or continued participation with the Plan	Membership: At least 7 contracted practitioners representing primary care, OB/GYN, and other specialties, Chief Medical Officer, Plan Medical Directors (Medical and Behavioral Health), Legal, Director, and Staff. Provider Information and Credentialing. A community Physician holds the Chair role. Reports to QIC	• Review, discuss, revise (as necessary), approve credentialing/ recredentialing policies and procedures • Review the supporting information of all practitioners being credentialed/ recredentialed who do not meet the established criteria for participation • Review a list of names of all the practitioners who meet the established criteria • Recommend actions for applicants: to approve participation; to defer for additional information; or to deny participation • Consider appeals of recredentialing/ credentialing decisions, and oversee delegated credentialing
Care Management Committee (CMC) Meets every other month (at least 5 times per year)	Evaluates and improves care management program processes to promote the efficient use of health care resources by members and physicians.	Membership: Medical Directors (Medical and Behavioral Health), VP Care Management, Care management directors and managers, QI Specialist, representatives from following functional areas: • Quality Improvement • Health Care Policy • Pharmacy Management • Clinical Informatics • Central Appeals and Analysis • Ad Hoc: participating practitioners, legal corp. comm., member and provider services Reports into QIC	• Annual review and approval of CM workplan, program description, and evaluation • Assess performance of CM activities • Review and approve policies, standards and programs supporting CM • Conduct annual review of UM criteria • Analyze grievance and appeal trends • Review consistency of application of UM criteria • • Make recommendations regarding medical coverage and medical technology • Implement transition of Care program

Committee	Role	Structure	Function
Delegation Oversight Committee (DOC) Meets quarterly	Evaluates reporting of all delegated services to ensure NCQA and regulatory standards are being measured against goals and benchmarks.	Membership: Medical Director, QI Specialists, Representatives from functional areas responsible for delegation: • Quality Improvement • Credentialing • Utilization Management • Population Health Management • IAA • Networks • Member Connections • PCMH/TCCI Reports into QIC	• Oversee delegation of functions related to pharmacy, credentialing, utilization management, population health management, and others as needed. • Review, discuss, and revise delegation-related policies and procedures. • Review at least semi-annual reports, note deficiencies, and develop quality improvemen strategies as needed. • Assess pre-delegation, as necessary. • Review and approve annual assessment of each delegate. • Develop and monitor corrective actions, as necessary. • Recommend modifications to delegation agreements.
Pharmacy Delegation Oversight Committee (PDOC) Meets at least 4 times per year.	Provides structure for pharmaceutical management oversight which includes: PCMH TCCI related programs, pharmacy operations including policies and procedures, formulary, patient safety, the efficacious use of medications while mitigating the increase of overall health care costs, and MEM standards.	Membership: Chief Medical Officer, Director of Pharmacy Policy (Co-Chairman), CareFirst Pharmacist(s), Lead CVS Pharmacist, Director of Pharmacy Operations, Operations Manager for Pharmacy Management, Community Physicians and Pharmacists, Behavioral Health Medical Director, CareFirst Medical Directors, One or more additional representatives from CVS Health, Director of Pre-Service & HTC, Senior Director of Medical Review and Appeals, Manager Preservice Review and Compliance, Medical Review and Medical Underwriting, QI Specialist. Reports into CMC and DOC	• Review, discuss and revise pharmaceutical related policies and procedures while identifying QI related activities • Oversee delegation of pharmaceutical related functions: UM, Pharmacy Benefits Information, and Member Connections • Assure full compliance with all NCQA and regulatory standards • Annually review Pharmacy program description and policy and procedures • Collaborates with CVS Health and monitors PCMH TCCI Pharmacy related programs, such as Comprehensive Medication Review, Authorization and Case Management of Specialty Drugs (Pharmacy and Medical), Behavioral health pharmaceutical Management and Medication Therapy Management • Review at least semi-annual reports and make recommendations based on the information as needed • Tracks performance of Pharmacy care coordination and TCCI programs • Tracks any identified corrective actions as needed

Committee	Role	Structure	Function
Magellan Delegation Oversight Committee (MDOC) Meets twice a year* **Magellan Delegation Oversight Committee will only be responsible for Q1 2018 reporting. Effective April 1, 2018 all behavioral health processes will be handled internally. Committee will be sunset.*	Oversees the delegation of the Behavioral Health Substance Abuse program including related policies and procedures.	Membership: Chief Medical Officer (Chairman), Director, Clinical Innovations, QI Specialist, Director PCMH Operations, Director, Case Management, Dir., Medical Review and Appeals, Dir. Pre-service, Compliance & HTC, Dir. Service Request Hub, Manager HTC, Marketing and Member Comm. Representative, Credentialing Representative, SBU Representatives, Dir. Network Management, Program Dir. TOS, Senior Director of Medical Review and Appeals, Manager Preservice Review, Director PCMH Quality and Clinical Practices, VP Regional Care Coordination, and Compliance Magellan Medical Director, as requested. Reports into DOC	• Annually review of Behavioral Health Substance Abuse (BSA) program description, evaluation, and work plan and policies and procedures • Assist in identification of QI activities • Review at least semi-annual reports related to patient safety issues (e.g., status report i no occurrences during the previous six months) and make recommendations based on the information as needed • Oversee operational performance of BSA programs and their status in achieving their goals • Oversee delegation of related functions (Quality Improvement, Utilization Management, Networks, Care Management, Member Connections)
Technology Assessment Committee (TAC) Meets bimonthly (At least 6 times per year)	Evaluates new health care technologies and new applications of existing health care technologies using evidence based criteria to determine contractual coverage	Membership: Chief Medical Officer (Chairman), Plan Medical Directors, Reps from Health Care Policy Department, Reps from the Central Appeals Unit, ad hoc members as needed. Reports into CMC	• Identify new and emerging health care technologies • Review and discuss published medical evidence concerning the effect on patient outcomes of new health care technologies • Consider opinions of physician specialty consultants from outside the company concerning the impact of new and emerging health care technologies • Develop a consensus as to the quality of evidence for new and emerging health technologies as set forth in the five criteria established by the Blue Cross Blue Shield Association, and accepted as standard criteria by CareFirst BlueCross BlueShield • Make recommendations for development or revision of corporate medical policies based on the Committee's consensus

Committee	Role	Structure	Function
Member Panel Quarterly and as needed, a panel of consumers are surveyed to solicit input into CareFirst programs, policies and materials. Representation from MD, DC, and Northern VA	Solicit insight from consumers to: increase satisfaction, improve quality of care and service, evaluate usability and functionality from communications, products and services.	Membership: Voluntary, current CareFirst BCBS Plan Members Reports into QIC	• Serves as a consumer feedback group to improve trends, products, plan operations and quality of care.