2019 Quality Improvement Program Description

2019 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.

Mission, values and ethics are the foundation of our vision and strategy at CareFirst. Our newly developed CareFirst Compass provides a visual representation of key components being engaged to deliver the highest level of care to our members in the most cost-effective manner possible. In 2019, our intent is to continue doing the things we do well, while innovating to provide the best possible care to our members, in the most appropriate setting. We value our organization, team, leadership, members, and being excellent at what we do. The CareFirst team will focus on making a difference in the communities we serve, striving to expand, innovate, and positively impact services delivered to members in our three geographic areas. Ongoing assessment of member and provider experience, and continuous process improvement, are core to ensuring success in our mission.


OUR MISSION
Affordability
Access
OUR VALUES & ETHICS
One Company, One Team
Accountability for Excellence
TRANSFORM
INNOVATE
THE PEOPLE WE SERVE
EXPAND
Customer First
Integrity
Leadership
CareFirst

Specific QI Program goals and objectives are:

1. Address needs of all patients along the entire health care continuum, including those with complex health needs (advanced developmental, chronic physical and/or behavioral illness, or complicated clinical situations);
2. Support and promote population health initiatives through all aspects of the CareFirst Patient Centered Medical Home (PCMH) and the Clinical Programs to improve quality of care, safety, access, efficiency, coordination, and service;
3. Maintain overall Medical Trend, including pharmacy, at or below 5.0 percent;
4. Implement methods, tracking, monitoring, and oversight processes for all Clinical Programs to measure their value and impact for appropriate patients with complex healthcare needs;
5. Establish collaborative partnerships to proactively engage clinicians, providers, hospitals and other community organizations to address the identified (medical and behavioral) health and service needs of our membership throughout the entire continuum of care which are likely to result in improved health outcomes;
6. Promote the provision of quality and cost data and support to clinicians to promote evidence-based clinical practices and informed referral choices; and members' full utilization of their benefits;
7. 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 services;
8. 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;
9. Monitor and oversee the performance of delegated functions especially for high priority partners (CVS, Sharecare and AIM);
10. 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;
11. 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;
12. Provide insight based on Searchlight data, a data repository in iCentric where data is categorized by Panel, PCP, and/or Practice, to increase the knowledge base of the Medical Panels in the evaluation of their outcome measures;
13. Support quality improvement principles throughout the organization; acting as a resource in process improvement activities;
14. Heighten enterprise-wide awareness and understanding of quality through an ongoing communication strategy directed toward all levels of the organization;
15. Develop and maintain the highest quality of health care; ensure positive health outcomes for our specific populations; keep cost at a minimum, and enable member access to the full spectrum of needed healthcare services; and
16. Create an awareness for social determinants of health; including, what they are and how they affect our members' ability to fulfill their health goals.

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 the effectiveness of those interventions, as necessary, to promote accessible, efficient, quality healthcare for every member.

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

- Clinical Programs
- Case Management
    - Federal Employee Program (FEP)
    - Commercial Care Coordination
- Care Coordination
    - Regional Care Coordinators (RCDs) oversee medical and behavioral health coordinators for patients with chronic and/ or complex health conditions;
    - Local Care Coordinators (LCCs) for patients with multiple chronic or complex conditions; and
    - Behavioral Health and Substance Use Disorder Care Coordinators (BHCCs) for those with Behavioral Health and Substance Use Disorder illness.
- Care Management
    - Out of Area (OOA) for CareFirst BlueCross BlueShield members who live outside our service areas;
    - Hospital Transition of Care (HTC) and Behavioral Health Transition of Care (BHTC) for those who would benefit from care coordination efforts by utilizing our Clinical Programs.
- Continuity and Coordination of Care (including care transitions)
    - FirstCare offers trained Behavioral Health Clinical Triage Specialists who assist members with behavioral and substance use conditions most in need of focused care.
- 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; and
    - Efficiency of services.
- Effectiveness of Care
    - Chronic Care Maintenance;
    - Preventive Health Maintenance;
    - Population Health Maintenance; and
    - Health Outcomes.
- Member Access/Availability

- Safety Initiatives
- Experience of Care (Satisfaction)
    - Member;
    - Provider; and
    - 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

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/Clinical Programs 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.

Day to day management and direction of the QI Program is delegated to the QI department who facilitates the QI Council (QIC) and associated subcommittees. The QIC approves 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 and appoints a designated Medical Director as the Chairman of the Quality Improvement

Council (QIC);

2. The designated Medical Director (physician) oversees and advises the QI Committees and subcommittees and is responsible for the following:
   - 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 ensuring adequate resources;
   - Provides direction for QI study design, quantitative and qualitative data analyses;
   - Oversees QI-related committees, work teams, and Medical Directors, as appropriate; and
   - Reviews and approves the annual QI Program Description, QI Work Plan, and QI Evaluation, and reviews progress in meeting the QI Program objectives.

3. The Behavioral Health Medical Director (Having training as a Medical Director or has a clinical PhD or PsyD) is responsible for the development of a medical integration plan, prevention and care activities, and network relationships. Their responsibilities include the following:
   - Contributes 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 Clinical 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); and
   - Serves on the Delegation Oversight Committee (DOC).

4. 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 QI Program, QI Evaluation and Work Plan;
   - Develops and monitors the QI Work Plan;
   - Supports QI Committees, provides clinical oversight, and maintains documentation for data collection, analysis, and evaluation of products and services. This includes review of the QI Evaluation, supporting collection of company-wide regulatory plans and 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; and
   - 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 including quantitative and qualitative assessments, guide implementation of interventions to improve performance, and report regularly to the QIC.

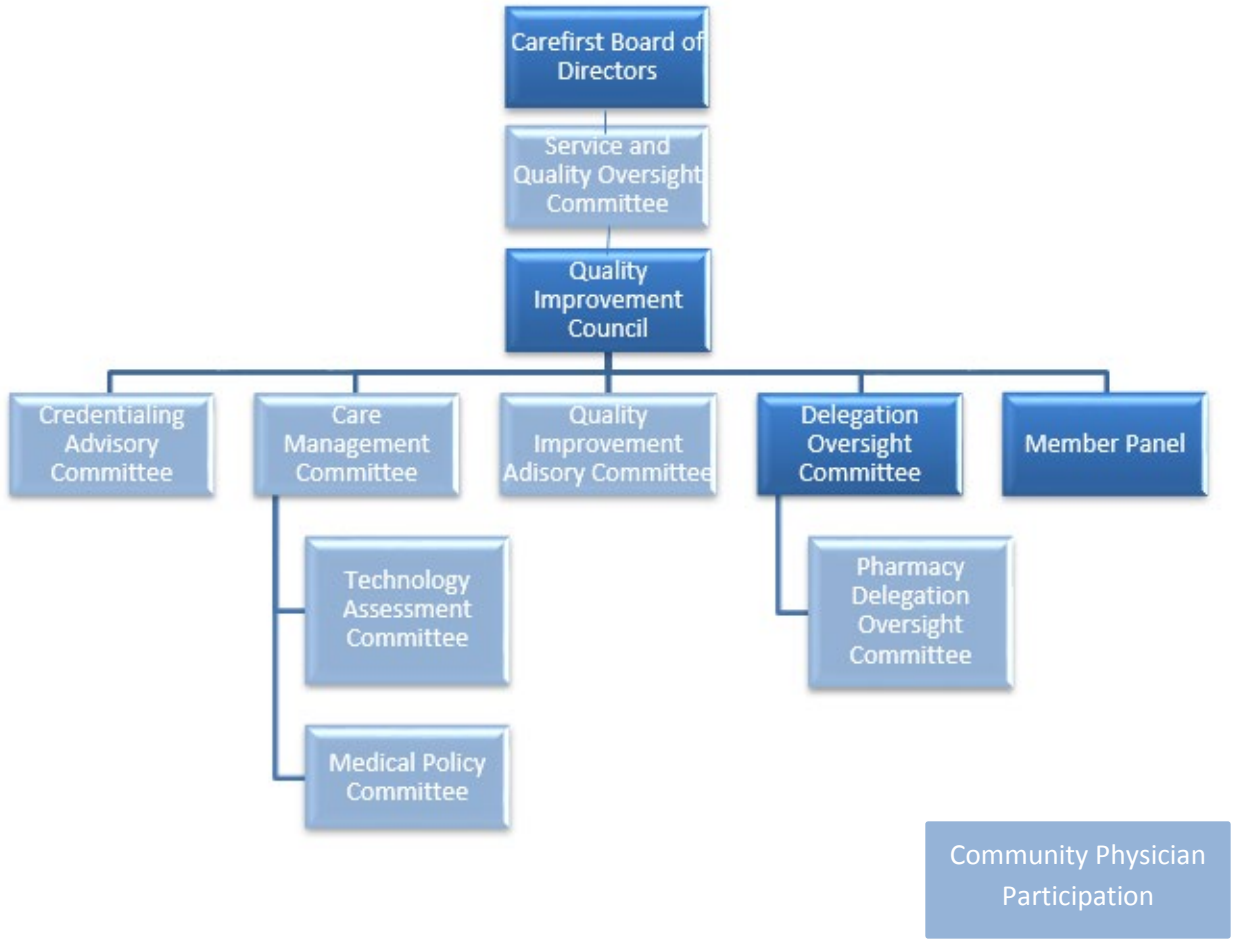
The organizational flow chart describes the reporting relationships for key QI-related committees. Table 1.1 in the appendix provides information about the role, structure, and function of QI-related committees.

Structure

Community Physicians participate in committees offering feedback and guidance on the quality improvement process and areas that need to be addressed. They offer valuable insight and feedback that help us better serve our members and continuously drive improved performance and health outcomes.

CareFirst members also participate in the member panel where feedback is solicited related to their experience in accessing and utilizing our services. This gives CareFirst better insight into their experiences and an opportunity to address any concerns brought to our attention by our members.

CareFirst QI Structure



VI. QI FOCUS

A. Patient Center Medical Home (PCMH)

CareFirst designed Clinical Programs to support providers in achieving the tenets of our Patient Centered Medical Home. These clinical programs seek to address many of the missing key elements in the current health care system to include fostering improved care coordination and promoting the efficient use of health care resources, with an emphasis on enhanced patient care.

B. Integration of Behavioral Health and Substance Use Disorders

Since 2018, The Behavioral Health and Substance Use Disorder program has been closely integrated with medical functions and encompasses all key aspects listed above. This integration includes:

- The capability to submit behavioral health prior authorizations;
- FirstCare assesses members and directs them to the appropriate and preferred place of service, including finding behavioral health appointments;
- The behavioral health crisis line is available to members 24/7;
- Mental Health Parity is continuously evaluated and maintained;
- Behavioral Health is supported by regional teams;

- Behavioral Health and Substance Use Disorder Program offers care coordination to Members; and,
- Behavioral Health Hospital Transition of Care Coordinators appropriately facilitate and transition all behavioral health cases, as needed

The Behavioral Health Program was brought in-house to CareFirst in 2018 and successfully meets all Behavioral Health related CareFirst and regulatory standards.

The Behavioral Health Medical Director, a psychiatrist, advises on matters related to Behavioral Health, is involved in all aspects of the Behavioral Health Continuum, and participates in the Quality Improvement Council (QIC), Quality Improvement Advisory Committee (QIAC), Pharmacy Delegation Oversight Committee (PDOC), Care Management Committee (CMC), and Delegation Oversight Committee (DOC).

C. Clinical Programs Support Population Health Management

Our clinical programs employ a carefully selected team of specialized Nurses and Behavioral Health Care Coordinators working "real time" to connect patients and providers to the most appropriate care support services. Care coordinators 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.

This iCentric platform is vital to all clinical programs, offering 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 an MHR which displays care delivered in all settings, including medical and behavioral health interventions, laboratory data, and prescription fills when the member has the CareFirst pharmacy benefit.

The iCentric system is used to document member assessments and plans for reaching their health goals when they are involved in a care plan. These assessments are useful in providing a plan for our members that facilitates reaching optimal levels of health, with the goal of graduating members from the program in which they participate.

The PCMH program is the core of our clinical programs. These programs are composed of fifteen different elements (shown below) each of which is designed to improve member care and safety, reduce overall costs, and support primary care physician in the PCMH program. Many of these programs are designed to manage patients with complex health needs.

Fifteen Elements of the Clinical Programs that Support Population Health Management

- 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
- Pharmacy Coordination Program (RxP)
- Comprehensive Medication Review (CMR 1 and CMR 2) & Specialty Pharmacy Coordination
- Expert Consult Program (ECP)
- Urgent Care & Convenience Access Program (UCA)
- Telemedicine – Video Visit – Program (TMP)
- High Cost Claimant Unit (HCCU)
- Genetic Testing Utilization Program (GTUP)

Health Promotion, Wellness and Disease Management Program (WDM) is lifestyle and Disease Management coaching by licensed professional expert in motivating people toward healthier lifestyles and reducing risk if they are headed towards, or have already had, 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 changes over time. This program is specifically for an employer group and used for at risk patients. A broad array of supporting program elements on fitness, smoking cessation and other health promotion activities are 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) offers trained professionals who monitor admissions of CareFirst members to hospitals anywhere in the country. Locally, the program relies on specially trained nurses and behavioral healthcare specialists 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 a Complex Case Management or Chronic Care Coordination program. 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") creates and manages 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") creates and manages Care Plans for targeted Members 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 carried out.

Behavioral Health and Substance Use Disorder Program (BSD) includes a range of services, including care plans designed to address the behavioral health needs of Members (such as depression, anxiety, substance use, and various forms of mental health conditions) that often accompany physical illnesses or may stand alone. Included in this Clinical Program Category are substance use disorder services as well as psycho-social services.

Home Based Services Program (HBS) serves CareFirst Members in CCM, CCC, or BSD program who often need considerable support at home, sometimes on a prolonged basis. Services can include home health aides, 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 plan of care maintained by the LCC, BHCC, or Case Manager responsible for the Member. Home based services 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, CCC, and/or BSD 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 and made available to Members with identified needs who 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 linked to other Clinical Program elements to facilitate enhanced care coordination and reporting. Examples include, programs to better manage diabetes, congestive heart failure, coronary artery disease, and chronic kidney disease; as well as improved processes for supporting Members in need of skilled nursing facility care or palliative care/hospice care.

Pharmacy Coordination Program (RxP) is 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) requiring 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.

Comprehensive Medication Review (CMR 1 and CMR 2) & Specialty Pharmacy Coordination supports specialty pharmacists assisting members identified for Specialty Pharmacy Coordination, continuing through their course of treatment. Program deliverables are based on the unique characteristics of each disease state and their specific clinical objectives. This coordination helps to ensure the most positive health outcomes for patients taking specialty medications. Features of the programs include member identification, benefit verification, adherence to clinical guidelines, and appropriate utilization continuing through patient assessments, which will drive the level and frequency of outreach, and is continuously re-assessed based on the patient's needs, outcomes, and care plan goals.

Expert Consult Program (ECP) allows network physicians and CareFirst to seek outside expert opinion from leading, recognized, medical experts when 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 are referred to this program from CCM, CCC, and/or BSD after CareFirst Medical Director review, and are complex and expensive in nature with 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 and are almost always followed by treating providers, resulting in lower overall cost due to fewer Member breakdowns or treatment changes.

Urgent Care & Convenience Access Program (UCA) offers organized back up for Primary Care Physicians to support Members with urgent care needs who might otherwise go to a hospital-based emergency department or outpatient facility. Generally, the cost in offering care in these settings are one-third of the cost of services typically provided in a hospital emergency room. These UCA facilities are found locally in communities and take walk-ins and/or appointments for our members, allowing ready access to an appropriate facility at the appropriate time for all their healthcare needs.

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 Primary Care Physician in certain cases where this is more appropriate than an in-person visit. Telemedicine Video Visit Program also applies in cases where an off-hour visit to a Member's Primary Care Physician and/or Behavioral Health Care Provider is not readily available due to their hours of operations.

High Cost Claimant Unit (HCCU) is an enterprise-wide, multi-disciplinary team that reviews all high-cost Members to identify and execute cost saving interventions across all lines of

business. Composed of RN Specialists and Behavioral Health Specialists, the teams work to identify both clinical and non-clinical interventions that could improve quality outcomes to avoid unnecessary hospitalizations and emergency department visits. They review a daily data feed that identifies all Members whose costs exceed $60K within a three-month period. The HCCU specialist executes interventions and documents impact for each intervention. An Interdisciplinary Care Team meets weekly to review the most challenging cases.

Genetic Testing Utilization Program (GTUP) program connects members to treatment and prevention recognizing the individual genetic variability in each person. The program helps guide providers in more accurately determining which treatment and disease prevention strategies will work for a specific member.

Our suite of Clinical Programs brings a variety of interventions to our members at different levels of illness or wellness, with the goal of preventing disease progression and managing care in the least costly setting.

VII. QUALITY MEASUREMENT

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. CareFirst also uses the data to target population-based interventions.

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.

Core 10

The Core 10 are ten health measures identified by CareFirst to drive improved health outcomes and assist providers in identifying those clinical areas most in need of improvement. These measures comprise a targeted, concise list of metrics that will help drive high-quality care and ideally better health for our members. These metrics are derived from various sources including the Healthcare Effectiveness Data and Information Set (HEDIS) and Agency for Healthcare Research and Quality (AHRQ), among others. CareFirst’s journey to quality starts with these 10

Core Measures, called to the attention of our provider partners in care, and used to assist members in achieving and maintaining their highest level of health. The PCMH training team is working closely with PCMH providers to educate and train them on the Core 10 measures. Providers will receive monthly reports through Searchlight informing them of their current status on each measure. The intent of tying those measures to an incentive plan is that it gives each practice an opportunity to develop the workflows and processes (a program) that are most effective for their individual practice. The Core 10 is focused on provider engagement, rather than member engagement.

Core 10 measures are now being used as our clinical quality score card, having been chosen because they are the ones with the greatest opportunity to positively impact member health. These measures are ones that with improvement, would be expected to have the greatest impact on the health of our member populations.

The following are the Core 10 measures for adults:

- Optimal Diabetes Care
- Controlling Blood Pressure
- Colorectal Cancer Screening
- Use of Imaging for Low Back Pain
- Follow-up After Emergency Department Visits
- Follow-up After Hospitalization for Mental Illness within 7 Days
- Member Experience Composite
- Emergency Department Utilization
- All Cause Readmission
- Hospital Admission for Ambulatory Care Sensitive Conditions

The goals are as follows:
Optimal Diabetes Care ensures the most recent HbA1c level is <8.0% for members with diabetes as identified by automated laboratory data or medical record review, most recent blood pressure is controlled, <140/<90 mm Hg within measurement year, CKD Screening-ACR and eGFR within measurement year, retinal eye exam within measurement year, and 80% statin therapy adherence within measurement year

Controlling Blood Pressure utilizing a composite measure that includes as its components controlling High Blood Pressure [CBP] (<140/90)

Colorectal Cancer Screening screens eligible members appropriately for colorectal cancer.

Use of Imaging for Lower Back Pain entails practicing careful consideration when conducting imaging studies (plain x-ray, MRI, CT scan) within 28 days of diagnosis of uncomplicated low back pain

Follow-up After Emergency Department Visit ensures follow-up visits by any practitioner for mental illness within 7 days of ED visits

Follow-up After Hospitalization for Mental Illness within 7 Days ensures follow-up visit with a mental health practitioner within 7 days of discharge

Member Experience Composite to increase favorable responses to the survey

- Getting Care Quickly
- Getting Needed Care
- Coordination of Care
- Person Doctor

Emergency Department Utilization to observe fewer emergency departments (ED) visits than expected based on risk-adjustment model

All Cause Readmission to observe fewer readmissions within 30 days following an acute inpatient stay than expected based on risk adjustment model

Hospitalization for Potentially Preventable Complications to reduce member admissions and lower rates of discharge for ambulatory care sensitive conditions (ACSC) per 1,000 members, and the risk-adjusted ratio of observed to expected discharges for ACSC by chronic and acute conditions.

The following are the Core 10 measures for Pediatrics:

- Well-Child Visits
- Immunizations
- Preventative Care
- Access
- Acute and Chronic Condition Management
- Care of Asthma
- Specialist Referrals
- Use of Adolescent Depression Screening Tool
- Follow-Up Care for Children Prescribed ADHD Medication Composite
- Follow-Up for Behavioral Health Care Composite

Well-Child Visits to improve visit adherence within the first 15 months for life, visits in the third, fourth, fifth, and sixth years of life, and adolescent well visits

Immunizations to improve childhood immunization status and immunization of adolescents

Preventative Care through use of these tools: Autism Spectrum Disorder Screening Tool, Developmental Screening Tool, Social Determinant of Health Screening Tool, Weight assessment and counseling for Nutrition, Physical activity for children/adolescents, and body mass index assessment for children/adolescents

Access to improve child and adolescent access to Primary Care Physicians

Acute and Chronic Condition Management to appropriately treat children with upper respiratory infections and children with pharyngitis

Care of Asthma to improve medication management for people with asthma

Specialist Referrals through use of Clinical Compacts

Use of Adolescent Depression Screening Tool of children and adolescents for depression

Follow-Up Care for Children Prescribed ADHD Medication Composite and tracking how many children follow-up with the doctor who prescribed their ADHD medication

Follow-Up for Behavioral health Care Composites are comprised of after emergency room visits for alcohol and other drug abuse or dependence, mental illness, or hospitalization for mental illness

VIII. QUALITY AND PATIENT SAFETY

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

- Patient Centered Medical Home (PCMH)
  This program is designed to improve primary care by focusing on the patient-doctor relationship strengthened through a more comprehensive approach to care with more active patient involvement. Care Coordination is tracked across complex health care systems by utilizing tools and resources provided through PCMH and our clinical programs as well as:
    - MHR available to care teams;
    - iCentric web-based platform;
    - Local Care Coordination for medical and behavioral health;
    - Hospital Transition of Care;
    - Behavioral Health Transition of Care;
    - Registries;
    - Roster of patients by practice/ panel to support population management;
    - Outcome Incentive Awards with credit given to PCMH practices (tied to panel scorecard results) that achieve savings, meet specified patient engagement requirements, and improve quality for their entire attributed patient population.
- Quality data collection 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; and,
    - Pharmacy Coordination Program.

IX. QI SOURCES and RESOURCES

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

- Authorization data;
- Claims data (including Rx);
- Supplemental data including clinical data from practices, immunization registries, and lab results;
- Pertinent medical records and/or care plans;
- Utilization Data;
- Patient/Provider/Account Experience Data;
- Complaints/Appeals data;
- PCMH Outcomes (quality, cost and experience);
- iCentric data/ reports;
- Searchlight reports;
- Health assessments;
- Healthcare outcomes trended, measured and analyzed;
- 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; and
- Clinical 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 address opportunities for improvement. Dedicated QI staff collaborate with functional areas and provides QI expertise. CareFirst has an IT 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 are available including auditors; management, marketing research, and operations staff; networks management teams; and behavioral health and other clinical specialists, as necessary.

Population Assessment & Social Determinants of Health

CareFirst serves three primary geographic regions: Maryland, DC, and Virginia. Within those three regions are smaller sub-regions. Within these regions, our areas of focus should be directed

toward Infant Mortality and Violent Crime since these two negatively affect two out of the three regions we serve. Focusing on these two areas will help better our members health, leading to less hospital admissions which will drive healthcare cost down. In these three regions, we have identified different strengths and weaknesses that are a focus in our everyday work. This assessment helps us to determine the projects and interventions most appropriate for our members.

The 2018 data is as follows:

2018 Data	Maryland		District of Columbia		Virginia	
	Value	Rank	Value	Rank	Value	Rank
Air pollution	8.3	36	10.4	Not ranked	7.2	20
Cancer Deaths	181.1	21	203.2	Not ranked	190.7	24
Cardiovascular Deaths	257.7	30	304.8	Not ranked	239.6	24
Children in poverty	12	6	25.6	Not ranked	14.0	15
Chlamydia	510.4	34	1083.4	Not ranked	473.2	27
dentists	70.4	10	103.9	Not ranked	65,2	15
diabetes	10.4	19	7.8	Not ranked	10.5	23
Disparity in health status	28.4	28	24.5	Not ranked	33.3	45
Drug deaths	23.9	41	27.2	Not ranked	13.4	15
Excessive drinking	16.6	10	29.0	Not ranked	17.4	18
Frequent mental distress	11.5	14	9.7	Not ranked	11.6	17
Frequent physical distress	10.8	9	7.4	Not ranked	11.3	16
High school graduation	87.6	12	69.2	Not ranked	86.7	20
Immunization hpv females	57.5	18	79.4	Not ranked	68.0	3
Immunization hpv males	48.4	20	76.6	Not ranked	50.4	15
immunization Tdap	88.3	33	86.1	Not ranked	89.3	29
Immunization-adolescents	0.380	18		Not ranked	0.210	20
Immunization- children	75.2	11	74.0	Not ranked	77.1	6
Infant mortality	6.6	35	7.8	Not ranked	5.9	21
Low birthweight	8.5	30	10.1	Not ranked	8.1	24
Mental health providers	235.5	24	486.9	Not ranked	162.4	40
obesity	31.3	25	23.0	Not ranked	30.0	22
Occupational fatalities	4.4	21	4.9	Not ranked	4.5	24
pertussis	2.2	11	1.6	Not ranked	2.7	13
Physical inactivity	25.6	24	23.0	Not ranked	25.9	27
Premature death	7.655	28	9.092	Not ranked	6.877	18
Preventable hospitalization	46.7	20	38.3	Not ranked	42.8	15
Primary care physicians	188.2	8	455.9	Not ranked	144.6	25
Public health funding	$96	24	$511	Not ranked	$73	35
Salmonella	14.9	24	10.5	Not ranked	14.2	22
Smoking	13.8	8	14.5	Not ranked	16.4	23
2018 Data	**Maryland**		**District of Columbia**		**Virginia**	
	Value	Rank	Value	Rank	Value	Rank

Uninsured	6.1	17	3.9	Not ranked	8.8	31
Violent crime	500	40	1005	Not ranked	208	4
Binge drinking	16.6	10	25.9	Not ranked	16	20
Cholesterol check	91	3	90.5	Not ranked	87	16
Chronic drinking	5.2	6	8.5	Not ranked	5.8	15
Colorectal cancer screening	69.6	20	70.4	Not ranked	70.3	16
Dedicated health care provider	83.2	9	74	Not ranked	76.7	29
Annual dental visit	68.6	16	76	Not ranked	70.5	12
Disconnected youth	11.1	22	14.8	Not ranked	9.8	12
fruits	1.5	12	1.8	Not ranked	1.5	12
Heart attack	3.7	9	2.8	Not ranked	4.5	30
Heart disease	3.3	8	2.2	Not ranked	3.8	20
High blood pressure	32.4	26	26.7	Not ranked	32.4	26
High cholesterol	32.5	20	27.5	Not ranked	34.7	27
High health status	53.7	11	65.2	Not ranked	52.5	14
Income inequity	0.453	13	0.528	Not ranked	0.467	26
Injury deaths	68.6	15	75.2	Not ranked	61.2	9
Insufficient sleep	35.6	31	35.7	Not ranked	36.3	35
Median household income	81084	1	83382	Not ranked	71293	12
Neighborhood amenities	40.3	13	73.5	Not ranked	34.3	29
Poor mental health days	3.7	13	3.5	Not ranked	3.7	13
Poor physical health days	3.5	4	2.6	Not ranked	3.6	11
Seat belt use	91.8	7	86.8	Not ranked	88.5	21
Six + teeth abstractions	13.8	8	15	Not ranked	17.8	26
stroke	3	24	3.2	Not ranked	3	24
Suicide	9.7	4	5.5	Not ranked	13.8	17
Underemployment rate	8	23	9.8	Not ranked	7.9	21
Unemployment rate	4.2	24	6.2	Not ranked	3.7	16
vegetables	2.1	11	3	Not ranked	2	17
Water fluoridation	96.4	5	100	Not ranked	95.9	7

Strength Weakness

Sourced from America's Health Rankings 2018 Report:
https://www.americashealthrankings.org/explore/annual
(a lower number represents a better performance)

As noted, this data is used to determine our focus for upcoming QI projects and interventions. Each year our population is assessed based on the prior years' data so that as a health plan we can determine needs and prioritize services based on identified areas of weakness. In the past we have successfully used this data to help identify and implemented various projects. This data also helps us determine in what regions to focus healthcare resources and/or services to help improve our members health.

Social determinants of health cause many challenges for our members in the different areas that they live. This contributes to variation in health by region and in each of the areas we serve, because different areas come with different challenges. For example, poverty and other complications of inner cities, lack of medical facilities in areas, contribute to these health outcomes. As the health plan for these members we are compelled to create programs and services designed to create the maximum positive impact and health outcomes, regardless of challenging social determinants. As an example, some areas experience a lack of Behavioral Health Providers. CareFirst is actively addressing this need by partnering with behavioral health providers, embedding them in primary care and pediatric offices, encouraging them to join our network, and seeking all creative ways to ensure our members have access to these providers.

Serving Culturally and Linguistically Diverse Membership

CareFirst recognizes that significant racial and ethnic healthcare disparities exist, and populations are becoming more diverse. Racial and ethnic 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 designed to reduce health care disparities and improve member experience. As an example, materials, electronic and written communications are designed to meet a variety of language needs. CareFirst understands that approaches to healthcare requires cultural sensitivity and designs initiatives to target populations with a higher incidence of specific medical conditions as well as outreach to groups with identified gaps in care. 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. We conduct a variety of patient focused surveys, annually and at more frequent intervals, to ensure we are meeting the needs of our members in all ways possible.

To improve communication and support, the CareFirst region is divided into twenty-one distinct sub-regions, providing care to our members in those regions. LCCs, assigned to PCMH practices, live in the regions where their members reside. They are familiar with the health care systems in that area and able to help design care specific to the members and populations they serve. The Regional Care Coordinators, who oversee care for their specific regions, are very familiar with the cultural and linguistic needs of their members and have taken courses on cultural diversity to better serve these members. This improves cultural awareness of the LCCs who are better equipped to coordinate care with a sensitivity to specific cultural and linguistic needs, ideally driving member adherence to healthcare services thus leading to improved health outcomes. This cultural and language awareness helps ensure appropriate referral while driving improved member understanding of their healthcare needs and concerns, communicated in a language they understand.

Through the analysis of population data, CareFirst found that Spanish is the language most frequently requested through the language line (89%). To assist our Spanish-speaking Members in understanding their Plan information, many CareFirst documents are provided in Spanish and other languages. These documents can be found on both the CareFirst website and in print. The next most frequently spoken languages after Spanish are Mandarin (3.74%), Korean (2.75%), Vietnamese (1%) and Russian (1%).

The top five languages spoken by practitioners in CareFirst's networks include Spanish (41%), Hindi (17%), French (13%), Arabic (8) and Chinese (6%). CareFirst offers a language line that can interpret over 40 languages for our members, creating a platform to better serve our members and meet their healthcare needs.

CareFirst strives to maintain 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 is used to update information in the CareFirst provider directory (both printed and at www.carefirst.com).

X. DELEGATION

CareFirst may delegate Quality Improvement, Disease Management, Utilization Management, Pharmaceutical Safety, Pharmacy Benefit Information, Credentialing, Networks, Member Connections, 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, and conducts pre-delegation assessments, initial evaluations, and ongoing monitoring of all delegates. The Delegation Oversight Committee oversees and monitors all delegated functions and makes recommendations to the QIC (and/ or appropriate subcommittee) on issues of overall compliance with CareFirst, regulatory and NCQA requirements.

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

- Responsibilities of CareFirst and delegated entity;
- Specific delegated activities;
- At least semi-annual reporting and review 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;
- Annual evaluation of delegate's program documents and delegate performance to determine compliance with CareFirst requirements, accreditation standards, and state and federal regulatory requirements;
- Process in which member experience and clinical performance data is presented when delegate requests;
- 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; and
- 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.

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

XI. QI PROGRAM GOVERNANCE:

Annually, CareFirst creates the QI Program Description, QI Evaluation, and QI Workplan to 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 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 and member experience;
- 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 The evaluation includes the organizations' determination of overall effectiveness of the QI program, and its effectiveness in meeting safe clinical practice goals based on its assessment of performance in all aspects of the QI program. It includes:

- A description of completed and ongoing QI activities for the year for quality of care, service, safety and experience;
- Adequacy of QI program resources;
- QI committee structure;
- Practitioner participation and leadership involvement in the QI program;
- Need to restructure or change the QI program for the subsequent year;
- Trended data of measures to assess performance in the quality and safety of clinical care and the quality of service (over time and against goals and benchmarks;
- 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 2018 Annual QI Program Evaluation

The 2019 QI Program Description
The 2019 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
Annual Approval Date:	May 21, 2019

Appendix: Table 1.1
QI COMMITIEES ROLES, STRUCTURE AND FUNCTION

Committee	Role	Structure	Function
Service and Quality Oversight Committee (SQOC) Meets quarterly	Board Oversight	Membership: at least 5 Directors of Board (including physicians), CareFirst CMO VPs of Service Units, and IT. Reports to the BoD	• Oversee ongoing performance of Clinical Quality and Service • Act 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 (IT) • Pharmacy Management • QI • Marketing Research • Corporate Communications • Customer Services • PCMH • Operations • Disease Management Reports to SQOC	• Approve QI Program, Evaluation and Workplan • Establishment of practitioner availability and access standards • Selection of quality performance measures or initiatives • Establishment of performance goals, objectives, and thresholds • Establishment of selection criteria for complex case management and disease management • Approvals of policies and procedures covered in QI, PHM, NET, UM, CR, RR, and MEM standards categories • Development and review of clinical practice guidelines • Analysis of member experience results • Selection of QI initiatives to improve access to care and services • 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

Committee	Role	Structure	Function
			• Analyze and evaluate results of QI activities • Oversee QI functions of the organization • Recommend policy decisions • Ensure practitioner participation in the program through planning, design and implementation or review • Identify needed actions • Ensure follow up, as appropriate • 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 programs 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, conduct barrier analysis • 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 Clinical and PCMH programs • Assess effectiveness of interventions
Credentialing Advisory Committee (CAC) Meets monthly (At least 10 times per year) and as needed.	Reviews the credentials of 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

Committee	Role	Structure	Function
			• 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 • Networks • Member Connections • PCMH/Clinical Programs Reports into QIC	• Oversee delegation of functions related to Quality Improvement, Disease Management, Utilization Management, Pharmaceutical Safety, Pharmacy Benefit Information, Credentialing, Networks, Member Connections, and others as needed. • Review, discuss, and revise delegation-related policies and procedures. • Review at least semi-annual reports, note deficiencies, and develop quality improvement 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,	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 • review Pharmacy program description and policy and procedures annually • Collaborates with CVS Health and monitors PCMH Clinical 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

Committee	Role	Structure	Function
	and MEM standards.		• Review at least semi-annual reports and make recommendations based on the information as needed • Tracks performance of Pharmacy care coordination and Clinical programs • Tracks any identified corrective actions as needed
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 (Medical and Behavioral Health) 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
Member Panel Quarterly and as needed, a panel of consumers are surveyed to solicit input into CareFirst programs, policies and	Solicit insight from consumers to increase satisfaction, improve quality of care and service evaluate usability and functionality from	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. • Testing materials for usability • Evaluate adequacy of network availability and accessibility • Host live online focus groups and in-depth interviews (IDIs) or pre-recorded IDIs • Using data to improve our quality here at CareFirst

Committee	Role	Structure	Function
materials. Representation from MD, DC, and Northern VA	communications, products and services.		