2010 Quality Management Program Description

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BLUE CROSS & BLUE SHIELD OF RHODE ISLAND
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I. Blue Cross & Blue Shield of Rhode Island (BCBSRI) Mission Statement

To provide our members with peace of mind and improved health by representing them in their pursuit of affordable, high quality healthcare.

II. Statement of Purpose and Philosophy

The Quality Management (QM) Program exists to attain optimal physical and behavioral health outcomes for our members, spanning the continuum of health, establishing a high standard of clinical practice in the community, maximizing member health and safety, and improving member and provider service and satisfaction. By furthering the improvement of healthcare and service to our members, we hope to positively impact our community. The QM Program's ability to achieve optimal health outcomes is facilitated with its organization-wide multidisciplinary approach to identifying opportunities to improve member health, taking actions, and measuring effectiveness of the actions.

III. QM Program Goals and Objectives

A. The overall quality goals of BCBSRI are to:

1. Monitor and improve the quality of clinical care delivered to members.
2. Appreciate and address the cultural and linguistic requirements of our members
3. Promote member safety whenever and wherever possible, including safe medical and behavioral health practices in the provider network delivery system (see annual QM Workplan and Evaluation for details).
4. Monitor and improve the quality and efficiency of service delivered to members and providers.
5. Assist our members to make healthy lifestyle choices and promote self-management of chronic diseases.
6. Support the Corporate Compliance and Ethics Program and its associated employee Code of Conduct to foster ethical business practices and a culture in which all BCBSRI constituencies can trust.

B. The public health goals of BCBSRI

BCBSRI supports the goals established for the nation for *Healthy People 2010,* which are also the goals of *Healthy Rhode Islanders 2010*. BCBSRI strongly believes in the importance of collaboration and advocates cooperative efforts of individuals, family units, community and business organizations, healthcare professionals, media and government in attaining these goals.

BCBSRI uses *Healthy People 2010* strategies as a model for integrating health strategies spanning the health continuum from healthy individuals to individuals living with chronic and/or medically complex conditions. Those strategies include four broad categories:

1. Health promotion strategies, which are related to personal choices made in a social context aimed toward increasing the span of a healthy life for Americans;

2. Health protection strategies, which are related to environmental or regulatory measures, that address issues and apply interventions to protect larger segments of the population;

3. Preventive services, which include specific interventions in clinical and behavioral health settings;

4. Clinical and behavioral health programs, which include interventions to mitigate long term effects of chronic conditions and provide support to members with medically complex conditions while achieving an optimal level of health.

C. The organization-wide quality objectives of BCBSRI:

1. Relating to QM Program infrastructure

- Promote an organization-wide commitment to quality by linking and ensuring consistency between the QM Program goals and the corporate strategic goals.
- Maintain interdisciplinary teams for each approved strategic quality initiative, important function, and/or prioritized improvement project.
- Ensure the adequacy of electronic information management, consistent with the security and confidentiality standards of the organization, to support complete data entry, aggregation, display, and reporting needs for all quality management activities.
- Comply with accrediting and regulatory requirements when developing the QM Program.
- Facilitate the appropriate allocation of resources to support the quality management program.

2. Relating to QM Program Education

- Promote a QM Program structure that facilitates regular communication of the QM Program goals and objectives among all staff levels and interdepartmentally throughout the organization.
- Provide leadership to develop BCBSRI staffs' understanding of quality improvement principles and processes to facilitate the efficient attainment of optimal member health and quality of care.
- Identify opportunities for member, employer, physician, provider, provider office staff and BCBSRI staff education that enhances healthcare delivery choices.

3. Relating to Clinical, Service, and Process Improvements

- Within an interdisciplinary team approach, continuously identify, monitor, evaluate, and design/select quality improvement activities to attain members' optimal clinical and behavioral health
- Continuously monitor and evaluate departmental and system processes that facilitate efficient member and provider service and satisfaction.
- Continuously monitor Health Management and Integration (HMI) clinical and departmental functions to identify opportunities to facilitate the members' optimal medical and behavioral health through care coordination and integration across the health care delivery system.
- Credential and recredential providers considering the clinical quality and performance data available.

4. Relating to Collaborative Initiatives

- Establish and maintain relationships/partnerships with external agencies and organizations to promote and facilitate the pursuit of quality and performance improvement opportunities.
- Foster a supportive environment to help practitioners and providers in practice redesign to facilitate safe patient care and to measure performance and improvement at the practice level.
- Assess and monitor the capability of an organization to conduct delegated functions, as applies.

IV. Scope

Quality Management Program scope encompasses three primary dimensions of healthcare and service delivery:

- the system structure,
- the administrative and clinical processes involved in delivering care or service,
- the results (outcomes) of clinical care and administrative services delivered.

The processes and methodologies described in this document are applied in the assessment of the quality of clinical care delivered to BCBSRI members in settings

by all providers, including behavioral health providers, and to administrative services rendered by BCBSRI staff. Comprehensive organizational goals and objectives set the direction and tone of quality management activities.

V. Delegation

A. Oversight of delegated activities:

Upon the approval of the Quality and Customer Experience Council (QCEC), BCBSRI may choose to delegate various functions that would ordinarily be performed by BCBSRI, e.g., utilization management, claims processing, case and/or disease management, etc. Prior to delegating any function, BCBSRI conducts a comprehensive assessment of the potential delegate's ability to to perform delegated functions compliantly. If it is determined that the entity can successfully manage the delegated functions, a delegation agreement may be executed.

Oversight of the delegated organization's functions is integrated into BCBSRI QM Program by establishing the scope of delegation, assessing policy and procedure requirements, establishing reporting mechanisms, performing oversight reviews of delegate performance as indicated in the delegation agreement**,** and collaborating with the delegates on quality initiatives.

BCBSRI maintains accountability for the delegated functions performed by the external organization, and reserves the right to terminate its contract with any delegate that persistently fails to perform its functions compliantly.

B. Responsibilities in performing delegated activities for another organization:

Upon the approval of the QCEC, BCBSRI may choose to accept certain functions delegated to us by another organization, e.g., provider credentialing, utilization management, or quality management activities. When BCBSRI agrees to perform certain functions for another organization, the following must occur and/or be considered:

- there must be a delegation agreement between BCBSRI and the delegating organization;
- data collected by BCBSRI must be collected in such a way as to identify whether the data applies to BCBSRI's population or to the delegating entity's population;
- if appropriate, BCBSRI may need to modify its organizational structure to meet the needs of the delegating organization, though never at the expense of BCBSRI's QM Program and members;
- the QM goals of the delegating organization must be compatible with BCBSRI's QM goals, unless differences are approved by the QCEC;
- the delegating organization maintains accountability for the delegated

functions.

VI. QM Program Structure

A. Overview

Meeting the QM Program goals and objectives requires participation by the Executive Leadership Team (ELT), QCEC and its subcommittees, BCBSRI department staff, participating providers, delegates and BCBSRI members.

B. Governing Body

The BCBSRI Board of Directors (BOD) has formally delegated the development of the QM Program to the QCEC. The ELT is responsible for providing primary oversight of the QM Program. The ELT reviews and gives final approval to the QM Program Description and Work Plan and reviews and comments on the Annual QM Program Evaluation. The Professional and Provider Affairs (PPAC) Committee, a BOD subcommittee, is apprised of the results of the Annual QM Program Evaluation. The ELT reports significant issues to the BOD, as needed.

The responsibility for implementing the QM Program is shared by the QCEC and it's subcommittees, the Associate Chief Medical Officer (ACMO) of Provider Services PS) and the Director of Quality and Population Health Management (QPHM). While these individuals have primary responsibility to implement the QM Program, all BCBSRI staff has responsibility for ensuring the implementation of certain elements of the QM Program. The Vice President of Health Operations (VPHO) provides resources to support the implementation of the QM Program.

The QM Work Plan is developed annually by the Manager of Quality Management (QM) in conjunction with input from the Associate Chief Medical Officer (ACMO) of Provider Services PS) management staff (as appropriate), and QCEC.

1. QM Program Committee Structure

The QM Program committee structure is established to facilitate the attainment of the QM Program goals and objectives and implementation of the QM Work Plan. These committees launch the BCBSRI QM Program agenda:

- Quality and Customer Experience Council (QCEC), Attachment A
- Physician/Provider Credentials Committee, Attachment B1
- Dental Credentials Committee, Attachment B2
- Behavioral Health Credentials Committee, Attachment B3
- Medical Peer Review Committee (MPRC), Attachment C

- Pharmacy and Therapeutics Committee (P&T) Attachment D1
- Specialty Pharmacy and Therapeutics Committee (SP&T), Attachment D2
- BlueCHiP for Medicare Member Advisory Panel, Attachment E
- BlueCHiP for RIteCare Consumer Focus Groups, Attachment F
- Clinical Quality Oversight Committee (CQOC), Attachment G
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See the attachments as indicated above for descriptions of each of the committees. Unless otherwise noted in a committee description, membership terms for committees are one year. Committee members may be reappointed. No more than 50% of physician and pharmacist members are replaced at one time (as applicable for committee composition) to promote consistency. See sections VIII. Confidentiality and IX. Conflict of Interest for applicable requirements for committee members.

Minutes are taken at all meetings and include the names of attendees, absent/excused members, date and time of meeting, agenda items, discussion, major decisions, recommendations, action items, barriers to improvement, party responsible for follow-up, and follow-up reporting date. Committee members are responsible for reviewing the minutes and reports for comments, recommendations, and to assure their accuracy. Whenever possible, personally identifiable member and provider information are de-identified.

C. BCBSRI Staff Role with the QM Program

BCBSRI dedicates staff from a variety of areas throughout the corporation to ensure the goals and objectives of the QM Program are met. See Attachment J, Allocation of QM Resources, for a listing of staff. The following list represents the key QM Program support staff.

1. BCBSRI President and Chief Executive Officer (CEO)

The President and CEO is responsible for establishing corporate performance goals and priorities, as well as oversight of major policy decisions and their implementation. He also ensures communication, coordination and linkages occur between BCBSRI and the BOD.

2. Vice President of Health Operations (VPHO)

The VPHO provides medical consultation and advice to senior management staff and is responsible for providing resources, oversight and direction of the utilization management, case management, disease management, and preventive health activities which support the QM Program. The VPHO works closely with the Assistant Vice President (AVP) of Health Management Integration (HMI), ensuring alignment of the Utilization (UM) Program activities with the QM Program goals and objectives.

3. Vice President (VP) and Chief Medical Officer (CMO) of Provider Relations (PR)

The VP & CMO of PR is responsible for providing leadership, resources and support to maintain relationships with providers that promote quality improvement and ensure objectives of the QM Program are met. The VP & CMO of PR provides medical consultation and advice to senior management staff. The VP & CMO of PR works closely with the VPHO, the ACMO of PR and Director of QPHM to ensure alignment of goals and objectives among providers and members.

4. Associate Chief Medical Officer (ACMO) of Provider Services PS)

The AMCO of PS is responsible for providing medical leadership within the Plan and with the external provider community. This is done by demonstrating leadership, consistency, research, and excellence in the development, and implementation, of evidence based medicine.

The ACMO of PS serves as the chairperson of the QCEC and ensures QM Program progress reports are submitted to the QCEC. The ACMO of PS serves as a voting member and chairperson of the following QI and QI-related committees: MPRC, and the P&T Committee.

The ACMO of PS works closely with the VPHO, VP & CMO of PR, Director of QPHM, and Manager of QM, and is involved in the day-to-day activities of the QM Program. The ACMO of PS responsibilities include, but are not limited to:

- overseeing and providing direction in the development, implementation, and monitoring of clinical, behavioral, and preventive health guidelines and standards of care,
- providing oversight and direction of the clinical and behavioral QI, health promotion and credentialing activities,
- providing oversight and direction of all quality of care issues/complaints,
- providing oversight of the QM Work Plan,

5. Senior Director HMI

The Director of QPHM monitors the implementation of the operational components of the QM Program and annual evaluation in order to assure that improvement actions are taken when problems or opportunities for improvement are identified.

6. Manager Quality Management (QM)

The Manager of QM is responsible for the day-to-day administrative responsibilities of the QM Work Plan. The Manager of QM provides leadership and management to both clinical and support staff within the QM Department. The Manager of QM reports directly to the Director of HMI. The Manager of QM also works closely with the ACMO of PS in ensuring the operational components of the QM Program are implemented. In addition, the Manager of QM oversees the development, implementation, integration, and evaluation of BCBSRI's QM programs, processes and outcomes. Responsibilities include, but are not limited to:

- reporting administrative, service and clinical quality management activities within the organization, e.g., updating QM Workplan, overseeing medical record and facility site reviews, review of quality of care issues/complaints, and QM/HMI policy & procedure development and updating;
- participating actively in the QCEC and designated QCEC sub-committees, as assigned;
- (under the guidance of the ACMO of PS and Director of QPHM) facilitating the design of, implementation, analysis, and internal/external reporting of focused activities/studies and health management programs, including those for behavioral health;
- developing and implementing interventions to improve outcomes in clinical care, including those for behavioral health and preventive care;
- developing and implementing interventions to improve service to members and providers, when appropriate;
- chairing the CQOC;

  developing the Annual QM Program Description, Annual QM Work Plan (including patient safety initiatives), and Annual QM Program Evaluation

7. Assistant Vice President (AVP) Customer and Provider Service

The AVP of Customer and Provider Service oversees Customer Service, Grievance and Appeals and and the Government Program Strategic Business Unit (SBU) functions of the corporation to ensure quality delivery of service to members and providers.

8. Behavioral Health Clinical Contract Administrator

The Behavioral Health Clinical Contract Administrator supports the behavioral health program in the following ways:

- provides consultation and advice to BCBSRI management on behavioral health issues;
- serves as lead operational liaison between the health plan and its behavioral health vendor;

- participates behavioral health vendors joint perations meeting and attends joint case rounds to monitor and identify any issues related to tBCBSRI network providers
- assists in the review of behavioral health quality of care and service issues and complaints as a member of the MPRC and as requested
- represents BCBSRI behavioral health network providers as a member of the CQOC, reporting the activities of the Joint Behavioral Health Quality Improvement Committee
- assists the Credentialing Committee chairperson in establishing behavioral health credentialing standards;
- represents the company's behavioral health program on the Behavioral Health Specialty Advisory Committee;
- reports behavioral health vendor and network activities to the QCEC as needed.

9. Assistant Vice President (AVP), Health Management and Integration (HMI)

The AVP of HMI provides support to ensure coordination of quality activities supporting the QM Program and QM Workplan, as they pertain to utilization management, population health management, and case management. The AVP of HMI or designee provides UM Program activity and evaluation findings for inclusion in the annual QM Program evaluation.

10. Assistant Vice President (AVP), Corporate Compliance and Ethics (CCE)

As the Corporate Compliance Officer, the AVP of CCE oversees the Corporate Compliance and Ethics Program and the employee Code of Conduct, which are designed to ensure proper business conduct following federal, state, and local laws. The AVP of CCE is also responsible for delegation oversight, accreditation activities, and the corporate policy and procedure process which impact and support the QM Program.

11. Information Security Officer

Reporting to the Executive Vice President and Chief Information Officer, the Information Security Officer supports the QM Program by ensuring procedures meet regulatory, legal, and accrediting requirements pertaining to confidentiality and security of member information. Confidentiality concerning the QM Program is described in Section VIII.

12. Privacy Officer

Reporting to the AVP of Legal Services, the Privacy Officer supports the QM Program by overseeing processes aimed at protecting members' personal health information (PHI) and responding to reports of violations

of HIPAA protection.

D. Additional Resources Supporting the QM Program

1. Participating Physicians/Providers

By contractual agreement, participating physicians/providers shall comply with BCBSRI standards and policies and procedures relating to quality management, including participation in quality management activities. Physicians/providers must allow BCBSRI reasonable access to medical records for the purpose of conducting reviews and for the credentialing/recredentialing process. Selected physicians/providers are asked to serve on various committees and provide consultant services, as needed.

Physicians/participating providers are encouraged to provide input through the formal committee structures, as well as other avenues, such as letters, phone calls, surveys and focus groups. They provide input into technology coverage, medication coverage, utilization review (UR) criteria, quality criteria, credentialing criteria, plan administrative services and medical/healthcare management procedures.

2. Delegated Entities

Delegated entities are encouraged to participate in and to provide input through routine contact/communications and formal committee structures. The delegated entities' participation in the formal committee structure is linked to its specialty and the QM activities that BCBSRI is undertaking.

3. Members

Members are encouraged through the member advisory panels, as well as other avenues, e.g., letters, phone calls, and surveys to provide input into policies, procedures and processes regarding the delivery of healthcare services and plan administrative services.

VII. Insurance

BCBSRI maintains managed care errors and omission liability insurance for BCBSRI employees and consultants under contract to BCBSRI, covering liability arising under utilization review and managed care activities, including, but not limited to, service on the QCEC, MPRC, Credentials Committees, Pharmacy and Therapeutics Committee, and member advisory panels.

VIII. Confidentiality

Documents, created as part of the quality management and peer review processes, are confidential and maintained in compliance with regulatory and

accrediting requirements, including without limitation, National Committee for Quality Assurance (NCQA) Standards, Medicare Managed Care Manual, URAC Standards, State of Rhode Island Confidentiality of Healthcare Communications and Information Act, RI Gen. Laws 5-37.3-1 et seq., State of Rhode Island Rules & Regulations for the Certification of Health Plans, Section 6.5 as amended from time to time, RIteCare Contract, Centers for Medicare and Medicaid Services (CMS) Regulations, Health Insurance Portability and Accountability Act of 1996 (HIPAA), Federal Employees Health Benefits Acquisition Regulation (FEHBAR), as well as BCBSRI's confidentiality policies. These documents include minutes from the QCEC, the subcommittees, and administrative (non-clinical) processes having a direct impact on the provision of healthcare.

BCBSRI is responsible for maintaining the confidentiality of member and provider information obtained or generated in the course of reviewing records. All protected health information (PHI) is maintained in secure, confidential areas or systems, with access limited to staff or committee members on a need-to-know basis. All staff, privileged to access PHI, must have a confidentiality statement on file with Human Resources. Non-staff committee members also sign confidentiality statements.

BCBSRI/ takes appropriate action in the event of a breach of confidentiality including, but not limited to, termination of staff or contracts, as applicable.

Specific confidentiality requirements while serving on committees (as listed in Section IV.B.1) supporting the QM Program include:

- All employee members are required to sign confidentiality and nondisclosure/conflict of interest statements at the beginning of their employment and annually thereafter. Guests, as applicable, also sign a confidentiality statement.

- Committee members will treat copies of all applications, minutes, reports, worksheets, and other data in a manner that will assure confidentiality of PHI and the confidentiality of individual practitioners and members. The deliberations of the committee shall also be kept confidential.

- Access to information listed as Responsibilities/Functions for each committee description (Attachments A – H) is limited only to members of the applicable committee and designated BCBSRI employees.

IX. Conflict of Interest

Procedures for conducting reviews, arriving at authorizations, denial determinations, investigating quality and administrative complaints, conducting general medical record reviews and credentialing/recredentialing determinations have been established to avoid conflicts of interest or the appearance of conflict of interest. For details, please refer to the Corporate Compliance, Credentialing, Health Management and Integration, Grievance and Appeals, and Quality

Management sections of the P&P manual. The policies and procedures (P&Ps) are based on the following essential guidelines:

- an employee, provider or provider consultant may not knowingly perform a review of a case involving a family member or personal friend;

- a physician/provider or consultant may not knowingly perform a review of a case involving one of his/her own patients, or the patients of his/her partner(s);

- an employee, provider, or provider consultant may not perform a review of a case in which the employee or consultant has a proprietary financial interest in the care or location of the care rendered;

- where applicable, an employee, provider, provider consultant, who made an initial adverse determination/decision, is not involved in the final decision during any subsequent reviews of the determinations/decision, unless new information has been made available.

For involvement on committee(s) supporting the QM Program (Section VI.B.1), the following requirement is made:

- Members will not be allowed to vote when there is a conflict of interest (i.e., the member has a business relationship or nonprofessional reason to agree/disagree with a decision to be made by the committee).

X. The Quality Management Program Improvement Methodology

The QM Program methodology is a cyclical quality improvement (QI) process model that involves: identification of strengths and opportunities for improvement, development of metrics to monitor and measure performance, data analysis and barrier analysis, development of interventions that address the barriers identified, and measurement of the effectiveness of the interventions. Methodology follows requirements of the Healthcare Effectiveness Data and Information Set (HEDIS). Policy QI 3.1, Quality Improvement Activities describes the detailed procedures taken by BCBSRI to support the QI process model.

XI. Interdepartmental Coordination

The success of the QM Program depends on a variety of departments within the company. These departments are responsible for working together to conduct various functions to carry out goals identified in the QM Program Description and the activities identified in the QM Work Plan. These include, but are not limited to:

A. Quality Management (QM)

In addition to coordinating quality management activities between various departments, QM is responsible for the initiation and follow through of several quality related activities:

- Logging and investigating potential quality of care issues for corrective actions when appropriate;
- Tracking and trending quality of care complaints in order to identify potential quality of care problems, patient safety issues, access issues, administrative service issues, etc.;
- Providing input into the development, oversight and facilitation of clinical and preventive health initiatives,
- Conducting provider medical record and facility site reviews to assist in the contracting and credentialing process. QM also aggregates the data to identify the potential for Plan-wide interventions;
- Ensuring physician/provider quality related information is shared with the Credentialing Department and included in the credentialing or recredentialing process;
- Providing feedback relating to organizational quality management and performance issues;
- Providing education to corporate staff and network providers on process improvement methodology and quality management.
- Abstracting data from medical records as part of network performance monitoring activities
- Providing HMI division staff education to insure that new and established employees are prepared to effectively meet the requirements of their positions.

B. Customer Service

- Member inquiries are tracked and trended to identify potential problems and opportunities for improvement that may impact member or provider service.
- Through a coordinated effort with the Contracting Department, Customer Service notifies members when their PCPs have left the Plan. A member is assisted in the selection of a new PCP, upon request.
- Telephone calls, into the Customer Service Department, are monitored to assess how quickly staff answers the telephone, rate of first call

resolution, as well as the consistency in their responses to members.

C. Corporate Compliance & Ethics Department

- Facilitates and coordinates the design, development, and implementation of the corporate compliance programs and policies and procedures to ensure compliance with applicable federal, state, municipal, accreditation, and corporate requirements.

- Responsible for the development and implementation of a comprehensive delegation oversight program to ensure compliance of delegated vendors with regulatory and business requirements.

- Maintains the corporate polices and procedures database.

D. Health Management & Integration (HMI)

HMI is comprised of several departments reporting up to the VPHO.
HMI is responsible for the following:

- Conducts utilization review for specific services including inpatient, targeted DME, medical individual consideration cases, behavioral health individual consideration cases, and cosmetic treatments.

- Provides case management for members with catastrophic and complex medical and behavioral health conditions.

- Provides care coordination programs for members with targeted medical and behavioral health events.

- Provides population health management programs for members with chronic conditions, offering education, reminder systems, and health coaching.

- Provides support to participating providers by facilitating transition of members from one level of service to another.

- Processes worker's compensation claims.

- Develops and writes medical and reimbursement policies.

- Provides a fully integrated model of care for specific accounts.

- Plans, and implements preventive health interventions

- Forwards potential quality of care issues identified through UM, DM, and CM activities to QM for investigation and if required, corrective action.

- Utilizes data collected on turn-around times for prospective, concurrent and retrospective reviews to identify areas for improvement within the department.

- Monitors inter-rater reliability of medical necessity decisions to ensure decisions are made in a consistent manner across all reviewers (includes physician and nurse reviewers).

- Coordinates the annual review of utilization review criteria used to make utilization review determinations.

- Maintains a written UM Program, embodied in UM Policies and Procedures, and performs an annual evaluation of the Program, to be incorporated into the written annual QM Program Evaluation report.

- Develops, implements, monitors and evaluates BCBSRI QM Program (see QM Program and department information previous pages)

E. Contracting

- Geographic analysis of the provider network is reported at least annually, to assure contracting efforts meet company goals and regulatory requirements with respect to access and availability of providers of covered services. This includes member-to-physician/provider ratios.

F. Contracting Credentialing/Recredentialing

- Coordination with QM to ensure quality information is included in the credentialing/recredentialing process, including medical record and facility site reviews when appropriate, patient satisfaction with access, quality of care investigations, and utilization information.

- All physicians/providers and health delivery organizations (HDO's) within our service area are initially credentialed and then recredentialed every three years in order to assure they are in compliance with BCBSRI and regulatory standards.

- Individual confidential provider files are maintained to store and organize provider data in a secure, uniform, and consistent manner.

G. Health Analytics (HA)

HA Department is responsible for supporting the QM Program through the analysis and reporting of healthcare and service data, including Healthcare Effectiveness and Data Information Set (HEDIS), and for reports on clinical and service improvement initiatives. HA Department oversees member and participating provider satisfaction surveys and various Plan-wide performance monitoring. This is accomplished by ensuring that appropriate

systems and methods are in place to support the various data collection and reporting requirements of BCBSRI and by providing technical support to various committees and staff in study/activity design and data interpretation. Statistical support and resources are provided by the Director of Medical Informatics. The HA Department works closely with the ACMO of PS and the Manager of QM to ensure the activities outlined in the Annual QM Work Plan are completed as planned.

Other responsibilities include, but are not limited to:

- Data collection and analysis systems are developed and implemented in order to effectively support the QM Program and ensure timeliness, quality, and integrity of reported data across the organization.

- Clinical, administrative and service information is collected, trended, analyzed and interpreted for various activities/departments. Reports are then generated on an ad hoc or routine basis for effective quality management.

- Physician/Provider Satisfaction Surveys are used to measure the physician's/provider's perception and experience with BCBSRI and its contracted providers.

- Member surveys are used to measure the member's perception and experience with BCBSRI and its contracted providers. New member surveys are used to ensure new members understand the products, benefits and services they are purchasing.

- Integrated data from various sources is collected as required for monitoring and evaluation activities, outcome studies, warehousing and reporting for regulatory and other requirements.

H. Provider Relations and Field Services (PRFS)

Orients and educates providers and their staff (both onsite and through an online Provider Manual and newsletter) about BCBSRI policies and procedures, regulatory and contractual requirements, quality of healthcare initiatives and outcomes, availability of the BCBSRI web site and online provider services ("provider finder", formulary, and patient benefit and claims status)

- Uses complaint data (including quality of care issues), HMI reports, and other data analyses to identify potential areas for provider education.
- .Facilitiates a number of internal/external physician/provider committees such as the BCBSRI Healthcare Solutions Partnership Committee, the Healthcare Community Exchange Council, Specialty Advisory Committees, Medical Group and Society Meetings, educational seminars,
- Facilitates provider centric initiatives and campaigns that focus on promoting

quality of care and administrative efficiency.

I. " Marketing/Communications

- Quarterly newsletters are sent to BCBSRI members. Special considerations regarding language barriers, cultural appropriateness and reading levels are considered when developing each newsletter. The newsletters are utilized to assist in updating members regarding clinical and service activities. Member rights and responsibilities, results of improvement initiatives and surveys, preventive health guidelines and health promotional activities are examples of items that are included in the newsletters.

- Member education tools (including brochures, pamphlets, targeted letters, and newsletters) regarding key disease/diagnosis topics are developed and distributed as appropriate to members consistent with BCBSRI privacy practices. Again, special considerations regarding language barriers, cultural appropriateness, and reading levels are considered when developing communications.

- Provider education materials (including, brochures, pamphlets, targeted letters and newsletters) on key diseases/diagnoses are developed and distributed to provider offices.

J. Product Marketing

Coordinates with the Health and Wellness Institute[1] in offering a comprehensive customized workplace wellness and health promotion program, the Good Health Benefit ®, for accounts purchasing the program. These programs are designed to make health education convenient for the working population, and empower members who participate in the program make lifelong, healthy lifestyle changes. Year-end evaluation of program effectiveness is done.

K. Community Relations

Facilitates community wellness programs in conjunction with the Health and Wellness Institute[1] aimed at improving the health of members as well as all Rhode Islanders. Programs focus on the development and delivery of preventive screenings and educational initiatives for both member and community based audiences. Programming includes Wellness Van screening activities, free physical fitness classes and events, and school-based physical activity and walking programs.

L. Operations and Planning

- Produces the Member Touchpoint Measure Reports (MTM).
- Manages non-regulatory external audits and produces reports required by the Blue Shield Association and key customers.

XII. Program Effectiveness and Evaluation

A. Quality Management Program Evaluation Process

The overall effectiveness of the QM Program is determined through a process that is continuous in nature. The major elements of this process are the QM Program Description, QM Work Plan and Annual QM Program Evaluation. UM activities are evaluated through review of the UM Program (comprised of a collection of HMI polices and procedures approved annually by the QCEC), and UM evaluation data included in the QM Program Evaluation report (review described below).

1. Implementation of the Annual QM Work Plan

In the first quarter, the newly developed QM Work Plan is reviewed and approved by the QCEC. The QM Work Plan outlines the QM clinical and service activities planned for the coming year. The Work Plan includes the following:

- planned quality improvement projects that address quality and safety of clinical care, preventive health, and service;
- planned continued monitoring of previously identified issues, including tracking of issues over time;
- the time frame(s) in which initiatives/activities will be achieved;
- who is responsible for the activities.

2. Monitoring of Work Plan Activities

- The workplan is a dynamic document that is amended from time to time in an effort to achieve organizational and QM goals and objectives.

- The Manager of QM, or designee, provides verbal or written updates regarding ongoing activities at regularly scheduled QCEC meetings or appropriate sub-committee meetings in accordance with time frames established in the QM Work Plan. For example, the MPRC receives reports/updates on the status of clinical and preventive health activities and quality of care issues. The ACMO of PS provides annual reports to the ELT.

3. Annual QM Program Evaluation

An annual evaluation of the QM Program is developed to report the effectiveness of the quality improvement activities conducted during the year. The Annual QM Program Evaluation describes the quality improvement projects (completed and on-going) and includes an assessment of performance against the goals and/or benchmarks

established for each metric qualitative and quantitative analysis of the data collected, including a barrier analysis to identify additional opportunities for improvement and focus.

a. Development of the Annual QM Program Evaluation

i. The QM Manager, or designee, compiles the results of all activities outlined in the QM Work Plan. The Annual QM Program Evaluation is based upon information from QM monthly and quarterly reports, minutes of the QCEC and sub-committees, results of studies and monitoring and evaluation activities, member and provider surveys, trending of clinical and service indicators, as well as other performance data, including HEDIS information. The AVP of HMI, or designee, provides UM Program evaluation data to be incorporated into the QM Program written evaluation report. Input is also solicited from MPRC and QCEC committee members.

ii. The above information is evaluated by the Manager of QM, Snior Director HMI, and ACMO of PS. Based upon this review, the Manager of QM, or designee, is responsible for the development of a written report addressing:

- the effectiveness of the QM processes and structures;
- the effectiveness of the UM processes and structures;
- barriers to improvement(s); and
- recommendations for changes in QM and/or UM processes or QM and/or UM structures to improve effectiveness.

iii. The Manager of QM includes in the QM Work Plan, the results of the annual program evaluation. The new QM Work Plan includes new initiatives and continued activities from the previous year's QM Work Plan, as appropriate. The AVP of HMI, or designee, includes relevant findings of the annual program evaluation into a UM Program for new and continuous improvement activities.

4. Review and Approval

a. The Manager of QM presents the Annual QM Program Evaluation, the new QM Work Plan, and the QM Program Description for review, recommendations, and approval to the QCEC within the first quarter of the year.

b. Upon the approval of the QCEC, the ACMO of PS presents the new QM Work Plan and QM Program Description to the ELT for review, recommendations, and approval. The ACMO of PS also presents the Annual QM Program Evaluation for their review.

XIII. External Audit/Review

The QM Program is consistent with the requirements of applicable state and federal regulatory agencies and with the accreditation standards of NCQA and URAC. The Director of QPHM and the QCEC assist with any external surveys and audits requested by BCBSRI clients or regulatory agencies.

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1 Health and Wellness Institute is a wholly owned subsidiary of Blue Cross Blue Shield of Rhode Island contracted to perform selected preventive health activities and community health services.

Quality and Customer Experience Council

The quality management functions for Blue Cross Blue Shield of Rhode Island (BCBSRI) are formally delegated to the Quality and Customer Experience Council (QCEC) by the Board of Directors (BOD). Executive Leadership Team (ELT) gives final approval to the written Quality Management (QM) Program.

Purpose and Objectives

- To assure the quality of healthcare provided to BCBSRI members meets or exceeds community standards.
- To assure administrative services are delivered so as to promote member satisfaction and meet or exceed performance targets.
- To assure healthcare delivery is continuously and measurably improved, and that such activities and improvements are documented.
- To assure compliance with health plan, accreditation, and regulatory agency requirements.
- To assign and monitor the implementation of all quality management activities.
- To assign and monitor implementation of utilization management (UM) activities.
- To assure all delegated activities are monitored and appropriate corrective actions are taken, when necessary.

Committee Composition

The QCEC is a multidisciplinary committee and BCBSRI committee.

- Associate Chief Medical Officer (ACMO) of Provider Services PS)
- Snior Director HMI,
- Manager, Quality Management (QM),
- AVP, Health Management & Integration (HMI), or designee,
- AVP, Contracting Services,
- Corporate CQI Initiative Representative
- VP of Diversity and Community Relations or designee
- Manager, Corporate Compliance & Ethics (NCQA and URAC),
- Special Projects Coordinator, Health Analytics,
- Manager, Grievance and Appeals,
- Director, Strategic Marketing & Product Innovation
- Pharmacy Contract Coordinator, Pharmacy Department
- Regulatory Compliance Coordinator, Provider Database/Credentialing
- Director, Customer and Provider Services

- Manager, Technical & Business Analysis
- External Operations Analyst, External Audits and Quality Assurance
- Other individuals (staff, individuals involved in delegated arrangements, and others) are invited to attend committee meetings on an as needed basis.

Chairperson

The ACMO of PS is designated by the ELT as the chairperson of the committee. There is no term limit for this position.

Voting Rights:

- All members of the committee will be entitled to one vote each with committee decisions based on majority rule.

- Abstention votes are not counted; therefore, the majority vote will result in a decision.

- For purpose of conducting committee business, a quorum will consist of one half or 50% of the voting members, to include the QCEC chairperson.

Meeting Frequency

The QCEC will meet monthly or more often, as required.

Minutes

Minutes are recorded at each QCEC meeting by the QM designated staff member. Minutes and attachments are maintained electronically with a signed hardcopy of the minutes kept in a binder and housed in a locked cabinet in the QM Department.

Relationship to Other Committees:

PPAC: The ELT, provides a report to the PPAC, as needed.
MPRC: MPRC meeting minutes are forwarded to QCEC for approval. The ACMO of PS highlights significant activities conducted by MPRC to QCEC.
Credentials Committees: Physician/Provider, Behavioral Health, and Dental Credentials Committees meeting minutes are forwarded to QCEC for approval.
Pharmacy and Therapeutics Committee: Pharmacy and Therapeutics Committee meeting minutes are forwarded to QCEC for approval.
Clinical Quality Oversight Committee (CQOC): All CQOC meeting minutes are forwarded to QCEC for approval.
BlueCHiP for Medicare Member Advisory Committee: Significant issues are presented by memo from the Government Programs Department to QCEC .
BlueCHiP for RIte Care Consumer Focus Groups Significant issues are presented by memo to QCEC as applicable.
Administrative/Service Improvement Oversight Committee (ASIOC): All ASIOC meeting minutes are forwarded to the QCEC for approval.

Responsibilities/Functions include, but are not limited to:

- Fulfill responsibilities, as delegated by the BOD;
- Review and approve the QM Program Description, QM Work Plan and Annual QM Program Evaluation (which includes the UM Program Evaluation), and related policies and procedures (P&Ps) as approved by Corporate Compliance and Ethics;
- Review and approve the scope of clinical studies, preventive health studies, health management programs and focused audits;
- Review, audit and study findings, and review action plans. This includes member satisfaction data, provider surveys and utilization data;
- Evaluate clinical care. Ensure care provided by physicians is adequate, appropriate, timely, and consistent with BCBSRI guidelines and community standards through ongoing quality management activities such as sentinel events monitoring, medical care evaluation, and member satisfaction data;
- Provide oversight and monitoring of shared delegation and delegation of quality management/utilization management/credentialing/claims, if appropriate;
- Monitor operational performance including, but not limited to, plan benefit interpretation, and contract administration;
- Review data summary reports of departmental specific monitoring and evaluation plans, oversee the effectiveness of activities and assess the strength of action taken to resolve problems identified through the monitoring and evaluation process;
- Oversee confidentiality and member rights;
- Review activities of all sub-committees, including CQOC. Make recommendations and take action, as appropriate;
- Ensure regulatory compliance;
- Review risk management and patient safety issues.

If a delegation arrangement exists for any activity, the QCEC is responsible for the following:

Delegating activities to another organization:

- oversight of all delegation agreements;

- review of Assessment Summary Report, outlining the delegate's ability to perform the specific delegated functions that are outlined in the delegation agreement;

- oversight of the review of delegate's:

    1. QM Program Description (reviewed prior to delegation and annually thereafter),
    2. Annual QM Work Plan (reviewed prior to delegation and annually thereafter),
    3. Last two Annual Program Evaluations (if QM Program has been in place for two years);

        - oversight of ongoing monitoring activities, including reports and results of on-site reviews;

        - oversight of monitoring activities for any corrective action plans and subsequent follow-up, including termination of delegation agreement;

        - oversight of monitoring of activities to ensure that the delegate does not go beyond the scope of the delegation agreement.

Assuming functions for another organization:

- ensuring BCBSRI adheres to requirements in the delegation agreement;

- monitoring any corrective action plans and subsequent follow-up required;

- ensuring data collected by BCBSRI is collected in such a way as to identify whether the data applies to BCBSRI’s population or to the delegating entity;

- providing oversight to ensure that the BCBSRI QM Program does not fail to meet its obligations due to the added responsibilities acquired through the delegation arrangement.

Physician/Provider Credentials Committee

Purpose and Objectives

- To ensure physicians and non-physicians, wishing to participate in the BCBSRI network, meet credentialing requirements as set forth in the Credentialing Policy and Procedures (Exception: Dental providers are credentialed through the Dental Credentials Committee. Behavioral health providers [excluding psychiatrists] are credentialed through the Behavioral Health Credentials Committee).

- To review credentials and practice patterns for contracted physicians during the recredentialing process. When appropriate, recommend to the Medical Peer Review Committee (MPRC) continuing with corrective action, suspending, or terminating a contracted physician/provider in accordance with policies and procedures (P&Ps).

- To ensure health delivery organizations (HDOs), wishing to participate in the BCBSRI network, meet contracting requirements, including a quality assessment, as set forth in BCBSRI's P&Ps. After the initial contracting process, a quality assessment is conducted every three years and the results are reviewed by the Physician/Provider Credentials Committee as part of the recredentialing process.

Committee Composition

The Credentials Committee membership includes:

- BCBSRI Medical Director
- Credentialing Team Leader or designee,
- Physician reviewers,
- Quality Management (QM) representative,
- A minimum of five contracted and board certified physicians, including primary care and specialist providers, as approved by the QCEC,
- Representatives from the Credentialing Department and other individuals (staff, individuals involved in delegated arrangements, and others) are invited to attend committee meetings as determined by the Physician/Provider Credentials Committee.

Chairperson

The Medical Director is designated by the QCEC as the chairperson of the committee. There is no term limit for this position.

Voting Rights

- Each contracted/participating physician member has voting rights on all issues presented to the committee. Non-physicians and physician reviewers do not have voting rights.

- For purpose of conducting committee business, a quorum will consist of one half or 50% of the voting members, to include the Credentials Chairperson.

- Abstention votes are not counted; therefore, the majority vote will result in a decision.

Meeting Frequency

The Physician/Provider Credentials Committee will meet monthly or more often, as required.

Minutes

- Minutes are recorded at each Physician/Provider Credentials Committee meeting by the credentialing specialist, or designee. In addition to the minutes, the committee agenda, which indicates meaningful information discussed during the credentialing and recredentialing with the members of the Physician/Provider Credentials Committee, is kept in a separate binder from the meeting minutes. These binders are housed in a locked cabinet in the Credentialing Department.

- Minutes include physicians recommended for approval and denial by the committee, as well as those discussed by the committee.

- Minutes are maintained in secured files located in the Credentialing Department.

Relationship to Other Committees:

QCEC: Credentialing meeting minutes are forwarded to QCEC for approval.
MPRC: Credentials Committee refers recommendations for termination of a provider or corrective action plan for a provider, during the recredentialing process. MPRC reviews recommendations and decides actions.

Responsibilities/Functions

The Physician/Provider Credentials Committee ensures all physicians, credentialed or recredentialed, meet credentialing requirements as outlined in the Credentialing P&Ps. The committee is responsible for:

- review of completed credentialing or recredentialing applications with questionable findings;

- review of professional liability cases as it relates to current qualifications, review of actions against professional licenses or restrictions to a physician's practice;

- review of information from quality improvement activities, which may include results of medical record and facility site reviews, utilization data, physician profiles for clinical and preventive health and quality of care complaints;

- approval and denial of credentialing applications and approval of recredentialing applications, and recommending to the MPRC whether to continue with corrective action plans, suspension or termination during recredentialing. The Board-designated Fair Hearing Committee retains the right to overturn an adverse decision that has been made by the Physician/Provider Credentials Committee upon initial credentialing or the MPRC, during the recredentialing process. The Fair Hearing Committee's review of an initial decision not to approve contractual status is limited, as defined in the Fair Hearing policy and procedure CN 2.2;

- approval and denial of health delivery organization applications and follow-up reviews (every three years) and recommending to MPRC whether to continue with corrective action plans, or recommending to the Vice President and Chief Contracting Officer to terminate.

Dental Credentials Committee

Purpose and Objectives

- To ensure all dentists, wishing to participate in the Blue Cross Blue Shield of Rhode Island (BCBSRI) network, meet credentialing requirements as set forth in the Credentialing Policy and Procedures.

- To review credentials for contracted dental providers during the recredentialing process. When appropriate, recommend to the Medical Peer Review Committee (MPRC) continuing with corrective action, suspending, or terminating a contracted provider in accordance with policies and procedures (P&Ps).

Committee Composition

The Dental Credentials Committee membership includes:

- Executive Director (ED) of Blue Cross Dental,
- Contracting Team Leader or designee,
- A minimum of four contracted dentists approved by the Quality and Customer Experience Council (QCEC),
- Representatives from the Provider Relations, Contracting, and Credentialing Department and other individuals (staff, individuals involved in delegated arrangements, and others) are invited to attend committee meetings as determined by the Dental Credentialing Committee.

Chairperson

The ED of Blue Cross Dental is designated by the QCEC as the chairperson of the committee. There is no term limit for this position.

Voting Rights

- The ED and each contracted/participating dentist member have voting rights on all issues presented to the committee.
- For purpose of conducting committee business, a quorum will consist of one half or 50% of the voting members, to include the Credentialing Chairperson.
- Abstention votes are not counted; therefore, the majority vote will result in a decision.

Meeting Frequency

The Dental Credentials Committee will meet monthly or more often, as required.

Minutes

- Minutes are recorded at each Dental Credentials Committee meeting by the credentialing specialist or designee. In addition to the minutes, the committee agenda, which indicates meaningful information discussed during the credentialing and recredentialing with the members of the Dental Credentials Committee, is kept in a separate binder from the meeting minutes. These binders are housed in a locked cabinet in the Credentialing Department.

- Minutes include dentists recommended for approval and denial by the committee, as well as those discussed by the committee.

- Minutes are maintained in secured files located in the Credentialing Department.

Relationship to Other Committees:

QCEC: Credentialing meeting minutes are forwarded to QCEC for approval.
MPRC: Credentials Committee refers recommendations for termination of a provider or corrective action plan for a provider. MPRC reviews recommendations and decides actions.

Responsibilities/Functions

The Dental Credentials Committee ensures all dentists, credentialed or recredentialed, meet credentialing requirements as outlined in the Credentialing P&Ps. The committee is responsible for:

- review of completed credentialing or recredentialing applications with questionable findings;

- review of professional liability cases as it relates to current qualifications, actions against professional licenses, or restrictions to a dentist's practice;

- approval and denial of credentialing applications and approval of recredentialing applications, and recommending to the MPRC whether to continue with corrective action plans, suspension or termination during recredentialing. The Board-designated Fair Hearing Committee retains the right to overturn an adverse decision that was made by the Dental Credentials Committee upon initial credentialing and by the MPRC during the recredentialing process. The Fair Hearing Committee's review of an initial decision not to approve contractual status is limited as defined in the Fair Hearing policy and procedure, CN 2.2.

Behavioral Health Credentials Committee

Purpose and Objectives

- To ensure all non-physician behavioral health providers, requesting participation in the Blue Cross Blue Shield of Rhode Island (BCBSRI) network meet credentialing requirements as set forth in the Credentialing policy and procedures (P&Ps).

- To review credentials and practice patterns for contracted non-physician behavioral health providers during the recredentialing process. When appropriate, recommend to the Medical Peer Review Committee (MPRC) continuing with corrective action, suspending, or terminating a contracted provider in accordance with P&Ps.

- To review behavioral health delivery organization applications and follow-up reviews (every three years) and recommend whether to continue with corrective action plans to MPRC, or recommend termination to the Vice President (VP) and Chief Contracting.Officer

Committee Composition

The Behavioral Health Credentials Committee membership includes:

- ,
- Contracting Team Leader or designee
- BCBSRI Medical Director
- A minimum of five behavioral health professionals. Included as part of the five will be at least one of the following:
  - -a Psychiatrist,
  - -a Psychologist,
  - -a Licensed Independent Clinical Social Worker,
- Quality Management (QM) representative,
- Representatives from the Credentialing Department and other individuals (staff, individuals involved in delegated arrangements, and others) are invited to attend committee meetings as determined by the Behavioral Health Credentialing Committee.

Chairperson

The Medical Director is designated by the QCEC as the chairperson of the committee. There is no term limit for this position.

Voting Rights

- Each contracted/participating behavioral health provider member has voting rights on all issues presented to the committee.
- For purpose of conducting Committee business, a quorum will consist of one half or 50% of the voting members.
- Abstention votes are not counted; therefore, the majority vote will result in a decision.

Meeting Frequency

The Behavioral Health Credentials Committee will meet monthly or more often, as required.

Minutes

- Minutes are recorded at each Behavioral Health Credentials Committee meeting by the credentialing specialist or designee. In addition to the minutes, the committee agenda, which indicates meaningful information discussed during the credentialing and recredentialing with the members of the Behavioral Health Credentials Committee, is kept in a separate binder from the meeting minutes. These binders are housed in a locked cabinet in the Credentialing Department.

- Minutes include non-physician behavioral health providers recommended for approval and denial by the committee, as well as those discussed by the committee.

- Minutes are maintained in secured files located in the Credentialing Department.

Relationship to Other Committees:

QCEC: Credentialing meeting minutes are forwarded to QCEC for approval.
MPRC: Credentials Committee refers recommendations for termination of a provider or corrective action plan for a provider. MPRC reviews recommendations and decides actions.

Responsibilities/Functions

The Behavioral Health Credentials Committee ensures all non-physician behavioral health providers, credentialed or recredentialed, meet credentialing requirements as outlined in the Credentialing P&Ps. The committee is responsible for:

- review of completed credentialing or recredentialing applications with questionable findings;

- review of professional liability cases, actions against professional licenses, or restrictions to a non-physician behavioral health provider's practice;

- review of information from quality improvement activities, which may include results of medical record and facility site reviews, utilization data, provider profiles for clinical and preventive health and quality of care complaints;

- approval and denial of credentialing applications, approval of recredentialing applications, and recommending to the MPRC whether to continue with corrective action plans, suspension or termination during recredentialing. The Board-designated Fair Hearing Committee retains the right to overturn an adverse decision that has been made by the Behavioral Health Credentials Committee during the initial credentialing process or by the MPRC during the recredentialing process. The Fair Hearing Committee's review of an initial decision not to approve contractual status is limited, as defined in the Fair Hearing policy and procedure, CN 2.2.

Attachment C

Medical Peer Review Committee

Purpose and Objectives

The Medical Peer Review Committee (MPRC) oversees the design and follow through of clinical and preventive health monitoring and evaluation activities/studies and medical care standards (including preventive healthcare guidelines); reviews care that is of potentially substandard quality or presents patterns of inappropriate utilization; reviews disciplinary or sanction information from licensure authorities and when necessary approves corrective action plans for individual providers. They also initiate provider disciplinary actions up to and including termination.

Committee Composition

- Physician/provider members will include no less than six board certified physicians. Included as part of the six must be at least two primary care physicians and two specialists,
- Group practice manager,
- Associate Chief Medical Officer (ACMO) of Provider Services PS)
- Manager, Quality Management (QM) or designee,
- Contracting Department,
- Behavioral Health Clinical Contract Administrator,
- Health Analytics Department representative (as needed for data/statistical support),
- Grievance and Appeals Unit representative (attends to present quarterly complaints and appeals reports),
- Representatives from QM and other individuals (staff, individuals involved in delegated arrangements, and others) are invited to attend committee meetings as determined by the MPRC Chairperson.

Chairperson

The is designated by the QCEC as the chairperson of the committee. There is no term limit for this position.

Voting Rights

- Each physician/provider member (including the group practice manager) has voting rights on all issues presented to the committee.
- For purpose of conducting committee business, a quorum will consist of one half or 50% of the voting members, to include the MPRC Chairperson.
- Abstention votes are not counted; therefore, the majority vote will result in a decision.

Meeting Frequency

The MPRC will meet at least nine times per year or more frequently, as needed.

Minutes

- Minutes are recorded at each MPRC meeting by the ACMO of PS' administrative assistant or designee.

Relationship to Other Committees:

QCEC: MPRC forwards meeting minutes to QCEC for approval. The ACMO of PS highlights significant activities conducted by MPRC to QCEC.
Credentials Committees: MPRC receives recommendations from all Credentials Committees and from the QM Department for disciplinary actions up to and including termination.
Clinical Quality Oversight Committee (CQOC): MPRC receives minutes and reports on results for clinical activities, preventive health activities, health management programs and significant behavioral health under/overutilization issues from CQOC. MPRC provides input and recommendations concerning these activities to CQOC.

Responsibilities include, but are not limited to:

- review and approve clinical and preventive health practice guidelines or standards of care;
- review, recommend and when appropriate, assist in the design of clinical and preventive health studies;
- recommend to the QCEC the priorities for monitoring and evaluation of clinical activities and of administrative functions that support clinical care;
- act on the decisions of the QCEC on prioritization and the scope of the clinical monitoring and evaluation activities;
- oversee the review of cases that are referred through the QM Department indicative of potential quality of care concerns;
- formulate corrective action plans for individual providers, as necessary;
- make determinations regarding termination, or limitation of clinical privileges of individual providers;
- recommend system/process improvements for the QCEC;
- oversee activities impacting members that are conducted by the Health &

Wellness Institute;

- review reports of disciplinary actions by licensure authorities.

Pharmacy and Therapeutics Committee

Purpose and Objectives

The Pharmacy and Therapeutics (P & T) Committee oversees the creation of medication usage policies and promotes clinically appropriate safe and effective pharmacotherapy for the corporation on plan members. P & T's chief responsibility is the establishment of a preferred drug list (except Medicare Advantage Part D).

Committee Composition

- The physician members will include a minimum of five contracted and board certified physicians. Included as part of the five must be at least one primary care provider (PCP) and three specialists,
- Associate Chief Medical Officer (ACMO) of Provider Services PS) or designated plan physician,
- The pharmacist members shall consist of at least two community pharmacists,
- Pharmacy Benefits Manager Liaison,
- AVP, Contracting Services,
- Plan pharmacist employees,
- Other individuals (staff, individuals involved in delegated arrangements, and others) are invited to attend committee meetings as determined by the P&T Committee.

Chairperson

The ACMO of PS is designated by the Quality and Customer Experience Council (QCEC) as the chairperson of the committee. There is no term limit for this position.

Voting Rights

- Each physician and external community based pharmacist has voting rights on all issues presented to the committee. Individuals, who are neither pharmacists nor physicians, do not have voting rights. Plan pharmacists do not have voting rights. The ACMO of PS or designated plan physician is the only plan employee with voting rights.
- For purpose of conducting committee business, a quorum will consist of one half or 50% of the voting members, to include the P&T Committee Chairperson.
- Abstention votes are not counted; therefore, the majority vote will result in a decision.

Meeting Frequency

The P & T Committee will meet four times each year or more often, if necessary.

Minutes

- Ensuring the minutes are recorded at each P&T Committee is the responsibility of Pharmacy Benefits Manager Liaison.

Relationship to Other Committees

QCEC: The P & T Committee reports minutes at least quarterly to QCEC for approval.

Responsibilities include, but are not limited to:

- to serve in an evaluative, educational and advisory capacity to Blue Cross Blue Shield of Rhode Island (BCBSRI);
- to develop, maintain and promote a formulary system based on appropriate rationale and cost effective care;
- to establish programs and procedures that promote safe, effective and affordable drug therapy for patients, including the review of utilization criteria and quantity limits;
- to review the results of Drug Usage Evaluation (DUE)/Drug Utilization Review (DUR) and make recommendations to promote appropriate drug use;
- to recommend and/or assist in the formulation of educational programs to provide complete and/or current knowledge on matters related to pharmaceuticals and drug use;
- to review and approve practice guidelines, as needed for efficacious pharmacotherapy;
- to monitor appropriateness of usage of pharmacologic agents (under/overutilization and coordination of care);
- oversee the activities of the Speciality Pharmacy and Therapeutics Committee, integrating them into the larger pharmacy management activities.

Specialty Pharmacy and Therapeutics Committee

Purpose and Objectives

The Specialty Pharmacy and Therapeutics (SP & T) Committee oversees the designation of drugs as being consistent with inclusion the specialty drug program, creation of specialty medication usage policies and promotes clinically appropriate safe and effective pharmacotherapy for the corporation on plan members. SP & T's chief responsibility is the establishment of a specialty drug list (except Medicare Advantage Part D). Actions of the SP&T are sent to the Pharmacy and Therapeutics Committee (P&T) for ratification, but may be implemented upon SP&T approval as needed.

Committee Composition

- Physician members will include a minimum of five contracted and board certified physicians. Included shall be at least 3 physicians representing specailties that use drugs designated as specialty. Should include some members of the non-specialty P&T and some who are not.
- Associate Chief Medical Officer (ACMO) of Provider Services PS) or designated plan physician,
- Specialty Pharmacy Liaison,
- Pharmacy Benefits Manager Liaison,
- Plan pharmacist,
- Other individuals (staff, individuals involved in delegated arrangements, and others) are invited to attend committee meetings as determined by the SP&T Committee.

Chairperson

The ACMO of PS is designated by the QCEC as the chairperson of the committee. There is no term limit for this position.

Voting Rights

- Each physician has voting rights on all issues presented to the committee. Individuals, who are neither pharmacists nor physicians, do not have voting rights. Plan pharmacists do not have voting rights. The ACMO of PS or designated plan physician is the only plan employee with voting rights.
- For purpose of conducting committee business, a quorum will consist of one half or 50% of the voting committee members, to include the SP&T Committee Chairperson.
- Abstention votes are not counted; therefore, the majority vote will result in a decision.

Meeting Frequency

The SP & T Committee will meet four times each year or more often, if necessary.

Minutes

Ensuring the minutes are recorded at each SP&T Committee is the responsibility of the plan pharmacist.

Relationship to Other Committees

P&T: The SP & T Committee reports minutes to the P&T Committee. Actions of the P&T Committee accepting the SP&T votes finalize the SP&T action.

Responsibilities include, but are not limited to:

- to serve in an evaluative, educational and advisory capacity to Blue Cross Blue Shield of Rhode Island (BCBSRI);
- to develop, maintain and promote a specialty formulary system based on appropriate rationale and cost effective care;
- to establish programs and procedures that promote safe, effective and affordable specialty drug therapy for patients, including the review of utilization review criteria and quantity limits
- to review the results of Drug Usage Evaluation (DUE)/Drug Utilization Review (DUR) and make recommendations to promote appropriate drug use;
- to recommend and/or assist in the formulation of educational programs to provide complete and/or current knowledge on matters related to specialty pharmaceuticals and drug use;
- to review and approve practice guidelines, as needed for efficacious pharmacotherapy;
- to monitor appropriateness of usage of specialty pharmacologic agents (under/overutilization and coordination of care);
- to work with the specialty pharmacies to promote clinical programs so as to improve efficacy and efficiency.

Attachment E

BlueCHiP for Medicare Member Advisory Panel

Purpose and Objectives

The BlueCHiP for Medicare Member Advisory Panel (MAP) serves as a quasi-focus group to elicit member feedback on current and future product initiatives. Objectives of the panel are:

- to give Government Programs the ability to obtain member feedback on Plan initiatives, benefits, advertising campaigns, and communication materials;
- to give Government Programs insight into members' decision-making and preferences;
- to provide opportunities for Government Programs to obtain member testimonials and/or if applicable, MAP endorsement of marketing submissions to CMS.

Panel Composition

- Minimum of 20 member representatives of BlueCHiP for Medicare plans will be invited to attend each meeting, for a show rate of eight to ten members,
- Marketing Representative,
- Government Programs Representative(s),
- Based on the content of meeting, other individuals may attend.

Project Manager BlueCHiP for Medicare Member Advisory Panel

A research analyst from Marketing Research Department, within the Product Marketing division is designated by the Director of Marketing Research as Project Manager of the panel. There is no term limit for this position.

Term of Membership

- Plan members will be appointed by Project Manager.
- Panel members must be active members in BlueCHiP for Medicare individual plans
- The member is responsible for notifying the Project Manager if he/she is no longer a member with the Plan or is no longer able to participate on the panel for other reasons.
- Panel members serve a maximum term of two years or six meetings, whichever comes first. If a member consecutively misses two meetings, they will be rotated off of the panel.
- Panel members do not receive a stipend or compensation for serving on the Panel.

- Panel members may be asked to provide feedback/input via email regarding Plan initiatives, benefits, advertising campaigns, and communication materials throughout their two year term.

Meeting Frequency

The BlueCHiP for Medicare Member Advisory Panel meets on an ad hoc basis. To ensure members ability to attend, two meeting notices are sent out in advance requiring the members to RSVP.

Minutes

Minutes are recorded at each BlueCHiP for Medicare Member Advisory Panel meeting by the Project Manager, Administrative Assistant, or designee.

Relationship to Other Committees

QCEC: Significant issues are presented by memo to QCEC by the Government Programs department.

Confidentiality/Conflict of Interest

All panel members and guests are required to sign confidentiality and nondisclosure/conflict of interest statements at the beginning of their membership term, and every year thereafter if they continue to serve on the BlueCHiP for Medicare Member Advisory Panel.

Responsibilities include, but are not limited to:

- Serve as quasi-focus group for Government Programs;
- Read and review any materials in advance of the meeting;
- Provide feedback on presented topics including but not limited to benefits, marketing materials, ad campaigns, web content, newsletters and other communication materials/vehicles;
- Generate ideas for improved communications to BlueCHiP for Medicare members, prospects and the community.
- Make recommendations on what is important to Medicare beneficiaries.

Delegation

The Plan does not delegate or accept delegated functions from another entity for the scope of functions overseen by the BlueCHiP for Medicare Member Advisory Panel.

Attachment F

BlueCHiP for RIteCare Consumer Focus Groups

Purpose and Objectives

The BlueCHiP for RIteCare Program places a high value in obtaining consumer feedback with respect to the Plan and it's policies and procedures. Obtaining consumer input for the development of member communications such as the member handbook, benefit summaries and quarterly newsletters is critical to the ongoing process of ensuring that materials are user friendly and comprehensible. Additionally, consumer feedback, with respect to understanding of Plan policies and procedures for areas such as role of the primary care physician, access and availability to routine primary care, and urgent/emergent care, is paramount.

Due to the changes and fluctuation in eligibility for BlueCHiP for RIteCare members, it was determined that holding several consumer focused groups (by geographic location) would be more suitable than establishing a formal committee.

Objectives of the consumer focused groups are:

- To provide a formal mechanism that gives members the opportunity to give Plan representatives input regarding their experience within the managed care product.

- To give Plan representatives the ability to obtain feedback (both prospectively and retrospectively) on Plan initiatives, health and wellness programs and communication materials and understanding.

- To provide information and education to members on particular areas of interest, such as asthma education taught by a nurse certified asthma educator.

Composition of BlueCHiP for RIteCare Consumer Focus Groups

- BlueCHiP for RIteCare member representatives,
- RIteCare Program Manager, as needed,
- RIteCare Outreach Coordinator, SW,
- RIteCare Outreach Coordinator, RN,
- Other individuals are invited to attend committee meetings as determined by the agenda.

Chairperson BlueCHiP for RIteCare Consumer Focus Groups

RIteCare Outreach Coordinator. There is no term limit for this position.

Term of Membership

Not applicable.

A mass mailing invitation is sent to all members living in designated zip codes in conjunction with demographic meeting locations.

Meeting Frequency

BlueCHiP for RIteCare Consumer Focus Group meetings are held ad hoc throughout the state and in locations convenient to members.

Minutes

Minutes are recorded at each BlueCHiP for RIteCare Consumer Focus Group meeting by the RIteCare Program Outreach Coordinator.

Relationship to Other Committees

Quality and Customer Experience Council (QCEC): Significant issues of the BlueCHiP for RIteCare Consumer Focus Groups are presented by memo to QCEC.

Responsibilities include, but are not limited to:

- review and make recommendations regarding access and availability standards;
- review and make recommendations regarding member materials;
- provide input into newsletters and other communications materials/vehicles.

Delegation

The Plan does not delegate or accept delegated functions from another entity for the scope of functions overseen by the BlueCHiP for RIteCare Consumer Focus Groups.

Clinical Quality Oversight Committee

Purpose and Objectives

The Clinical Quality Oversight Committee (CQOC) provides oversight and guidance in the development and implementation of programs and interventions to improve performance as they relate to the clinical quality management program, including preventive health and health promotion activities.

Committee Composition

- Manager, Quality Management (QM)
- Special Projects Coordinator, Health Analytics
- Behavioral Health Clinical Contract Administrator
- Care Coordination (CM, DM & Preventive Health) representative
- Manager, Corporate Compliance and Ethics (NCQA & URAC)
- Clinical Oversight Analyst, Contracting
- RIteCare Program representative
- Accreditation Oversight Analyst, Corporate Compliance and Ethics
- Government Programs representative
- Pharmacist, Ancillary Contract Development
- Medical Director
- Senior Director HMI (Ad Hoc)
- BH Case Management representative

Chairperson

The Manager of Quality Management is designated by the QCEC as the chairperson of the committee. There is no term limit for this position.

Voting Rights

- Each member has voting rights on all issues presented to the committee.
- For purpose of conducting committee business, a quorum will consist of one half or 50% of the voting members, to include the CQOC Chairperson.
- Abstention votes are not counted; therefore, the majority vote will result in a decision.

Meeting Frequency

The CQOC meets monthly or more often if necessary.

Minutes

Minutes are recorded at each CQOC meeting by a QM Dept designated staff member

Relationship to Other Committees

QCEC: CQOC sends meeting minutes to QCEC for approval.
MPRC: CQOC sends meeting minutes for informational purposes.

Responsibilities Include, But Are Not Limited To:

- providing oversight to ensure clinical and preventive health activities meet requirements of the QM Program;
- helping prioritize clinical and preventive health activities by assessing performance monitoring metrics utilized in the QM Program process, including but not limited to under and over utilization, member and provider satisfaction, and access and availability of services;
- assessing feasibility, practicality, and outcomes to determine future continuance of QM Program activities;
- assisting in removing operational barriers to clinical and preventive health improvements, elevating to QCEC as necessary;
- providing oversight of clinical collaborative initiatives, including electronic medical records, statewide skilled nursing facility and homecare initiatives, diabetes collaborative, etc;
- providing oversight of clinical and preventive health aspects and other QM Program components of delegation arrangements in which BCBSRI has delegated such responsibilities to another organization;
- providing oversight of provider medical record and facility site reviews.

Attachment H

Allocation of QM Resources

Personnel Resources (FTEs): *Positions and number of FTEs devoted to QM*
• BCBSRI President & CEO - .2 FTE
• Vice President of Health Operations - .25 FTE
• Vice President & Chief Medical Officer Provider Relations - .2 FTE
• Associate Chief Medical Officer - .5 FTE
• Medical Directors - .25 FTEs
• Director, Quality and Populations Health Management - .2 FTE
• Executive Secretary to Chief Medical Officer and Associate Chief Medical Officer - .5 FTE
• Quality Management (QM) Department Manager - 1 FTE
• QM Quality Consultants - 13 FTEs
• QM Team Leader - 1 FTE
• QM Support Specialists- 2 FTEs
• QM Policy Analyst 1 FTE
• QM. Project Coordinator - 1FTE
• QM Technical Analyst – 1FTE
• Corporate Compliance & Ethics Manager-- 1 FTE
• Corporate Compliance & Ethics Oversight Analysts – 4 FTEs
• Health Analytics, 2 FTE
• Assistant Vice President,-Health Management and Integration - .10 FTE
• Director, Health Management and Integration - .10 FTE
• Divisional Managers, Health Management and Integration – 1 FTE
• Care Coordinators – 2 FTE
• Disease Manager, Project Coordinator, Medical Management Operations - .05 FTE
• Administrative/Support Staff - 2.75 FTE
• Manager, Grievance & Appeals - .50 FTE
• Grievance & Appeals Team Leader – 1 FTE
• Director, Training & Business Process Consulting - .50 FTE
• Quality Analysts – 5 FTE
• Manager, Business Analysis & Support - .25 FTE
• Supervisor, Quality Analyst Team – 1 FTE
• Business Systems Specialist Team - 2 FTEs
• Manager, Training & Performance Management – 1 FTE
• Trainers – 4 FTEs
• Documentation Specialists – 3 FTEs
• Instructional Designers – 2 FTEs
• Business Process Analyst – 1 FTE
• Team Lead, Business Process Analysis – 1 FTE
• Team Lead, Training – 1 FTE
• Manager of RIte Care Program - .25 FTE
Analytical Staff Resources: *Position or advisors used for data analysis and root cause analysis*
• Quality & Customer Experience Council
• Medical Peer Review Committee
• Clinical Quality Oversight Committee
• Administrative/Service Improvement Oversight Committee
• Pharmacy & Therapeutics Committee
• Senior Project Manager, Health Analytics – .75 FTE
• Health Data Analysts, Health Analytics – 2 FTEs

Data Sources:
1. Claims data, 2. Encounter data, 3. Enrollment data, 4. Personal Health Assessment (PHAs), 5. Complaint and Appeal Data, 6. UM Statistics, 7. HEDIS data, 8. Medical Record data, 9. Focused studies, 10. PCP change requests, 11. Member Touchpoint Measures (MTM), 12. Credentialing/Recredentialing data, 13. GeoAccess data, 14. Provider Office Facility Site Reviews, 15. UR Inter-rater reliability,
16. Member Satisfaction Surveys, 17. Internal department performance data, 18. Regulatory and Accreditation Reviews, 19. Provider/Office Manager Satisfaction Surveys, 20. Patient Satisfaction Surveys (Access) 21. Medical Decision Support data

APPROVALS

Date: _____ **By:** _____
Title: Director, Quality and Population Health Management

Date: _____ **By:** _____
Title: Associate Chief Medical Officer Provider Services/ Chair, Quality and Customer Experience Council

Date: _____ **By:** _____
Title: Chief Operating Officer/ Chair, Executive Leadership Team

PRIOR REVIEWS

OED: 1988

Review/Revisions:

1994
03/1996
01/1997
01/1998
03/1999
02/2000
02/2001
01/2002
01/2003
01/2004
01/2005
01/2006
01/2007
01/2008
03/2009
02/2010