2022 BCBSIL QUALITY IMPROVEMENT PROGRAM EVALUATION

Health Care Service Corporation

PROPRIETARY & CONFIDENTIAL

Date approved:

BCBSIL Quality Improvement Committee	**3/1/2023**

2022 BCBSIL QI PROGRAM EVALUATION

Evaluation and Overall Effectiveness

Executive Summary

An evaluation of the Blue Cross and Blue Shield of Illinois (BCBSIL) 2022 Quality Improvement (QI) program has been conducted. This evaluation included review of trended results for QI measures over time, comparison against performance objectives, quantitative and qualitative analyses for completed and ongoing QI activities. Overall, improvements were achieved in planned QI initiatives, both clinical and service. In addition, programs that address patient safety were implemented.

The BCBSIL Quality Improvement Committee (QIC) and the Governance and Nominating Committee reviewed and approved the 2022 QI Program Description. The 2022 QI Work Plan was implemented in accordance with the plan. The indicators measured cover a broad spectrum, including quality of clinical care, quality of service and safe clinical practices. The QI initiatives are relevant to the needs of the membership of the BCBSIL Commercial and Retail HMO and PPO products. Corporate structure and resources are adequate and supportive of the QI process.

Challenges and Accomplishments

Despite some of the lingering impacts of COVID-19 pandemic our determination in operations shows evidence of a strong recovery. Key 2022 accomplishments are as follows:

- Year over year improvements in Healthcare Effectiveness Data and Information Set (HEDIS®) rates across product lines for BCBSIL. The subsequent results show Core Measures performance achieving the Quality Compass National Average for Commercial HMO, 79.6%, Marketplace HMO, 83.3%, for PPO Commercial, 57.4% and for PPO Marketplace, 77.8%.
- QI Best Practice provider educational tools addressing evidence-based methods to achieve high performance were authorized and released to Network Providers. These tools align with HCSC's Common Measure Set including Breast, Cervical and Colorectal Cancer Screenings, and Controlling Blood Pressure Indicators.
- The Collaborative Quality Improvement Coaching (CQuIC) program has provided coaching to providers performing below average in terms of quality related performance in measures identified in the HMO Quality Fund. This collaborative effort has produced interventions that were more contractual and punitive in nature. This program continues to recognize the varied needs of different providers in our network, based on their size, resources, and sophistication allowing a more tailored approach to working with low performing providers and their varied circumstances.
- In building on the collaboration with Epic, one of the largest EHR vendors, we continue the ability for providers to share their HER data directly with us. Enhancing our opportunities to provide better quality and care gap reporting that are essential to effective quality improvement efforts.

BCBSIL Quality Core Measures

The BCBSIL Quality Core Measures are utilized to focus enterprise quality efforts across all five state plans.

Reporting Year 2022 (MY 2021) Benchmarking to Quality Compass

			HMO		PPO		
Measurement Year 2021 Reporting Year 2022			IL HMO Commercial (%)	IL HMO Marketplace (%)	IL PPO Commercial (%)	IL PPO Marketplace (%)	2022 Quality Compass National Average (All LOBs)*
Measure		Type of Measure	MY 2021	MY 2021	MY 2021	MY 2021	
BCS	Breast Cancer Screening	Administrative	73.38 ▲	64.87 ▼	70.88 ▲	65.14 ▼	70.54
COL	Colorectal Cancer Screening	Hybrid	67.22 ▲	56.02 ▼	62.79 ▲	60.55 ▼	62.76
CIS	Childhood Immunization Status (Combination 3)	Hybrid	85.18 ▲	NR	NR	NR	74.23
CBP	Controlling High Blood Pressure	Hybrid	68.09 ▲	71.94 ▲	NR	57.18 ▲	56.31
CDC	Comprehensive Diabetes Care (Eye Exam)	Hybrid	56.08 ▲	54.50 ▲	NR	39.42 ▼	49.98
CDC	Comprehensive Diabetes Care (HbA1c <8)	Hybrid	64.52 ▲	67.40 ▲	NR	47.20 ▼	55.3
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FUH	Follow-up After Hospitalization for Mental Illness (30-Day Follow-up)	Administrative	39.47 ▼	33.70 ▼	78.07 ▲	76.59 ▲	70.39
AMM	Anti depressant Medication Management - Acute	Administrative	75.47 ▼	78.66 ▲	75.96 ▲	78.18 ▲	75.64
AMM	Anti depressant Medication Management - Continuation	Administrative	57.90 ▼	62.43 ▲	61.32 ▲	64.13 ▲	59.59
PPC	Timeliness of Prenatal Care	Hybrid	93.48 ▲	92.47 ▲	NR	79.27 ▲	78.95
PPC	Postpartum Care	Hybrid	94.57 ▲	92.47 ▲	NR	79.88 ▲	78.89
W30	Well child visits in the first 15 months	Hybrid	76.00 ▼	75.68 ▼	87.41 ▲	80.54 ▲	79.44

▲ YoY Improvement
▼ YoY No Improvement
↔ No change
NR Not Reported

* 2022 Quality Compass (Measurement Year 2021) All LOBs Benchmark

Summary of 2022 Health Equity Initiatives

Equity of care has been established as a core component of the QI program at HCSC. As such, initiatives designed to address health equity are reported to the Quality Improvement Committee as requested.

BCBSIL has taken the following actions to address health equity for its members:

- Launch of the Health Equity (HE) Repository: Collaboration with Plan Champions to develop an internal clearinghouse
- Integration of Cultural Awareness Resources: Championed the integration of Cultural Awareness resources to Providers and HCSC employees
- Overhaul of Internal Resource Website: Optimized FYI Blue SharePoint site to include relevant up to date content and resources for internal consumption
- Completion of the Health Equity Landscape Assessment: Invested in the development of HCSC Market Scan and developed a localized Health Equity strategic plan
- Embarked on Health Equity Roadshows: Engaged Plan Leadership to localize Health Equity priorities and investments

- Inauguration of the Maternal and Infant Health Domain: Partnered with Domain champions, key contributors, and subject matter experts in the maternal and infant health to initiate planning and execution of priorities for the Domain
    - Centering Healthcare Institute's CenteringPregnancy program launched in Q.1 2020: This program continues to implement a group prenatal care model in 30 HCSC-approved sites throughout the enterprise, with at least 10 sites in IL (including rural facilities).

- Additional achievements:
    - Health Equity CBT Refresh
    - Launch of Blue Table Conversations℠
    - Launched an Enterprise-wide Health Equity awareness campaign
        - "*Health Equity is All of us*"

Optimized Health Equity Steering Committee

Evaluation of 2022 Work Plan

The following is an assessment of progress made in meeting identified QI goals and an evaluation of the overall effectiveness of the QI Program.

HMO Group/Commercial

Of the 72 indicators listed in the 2022 Work Plan with goals assigned:

- 45 indicators met the goal
    - 8 indicators partially met the goal
- 14 indicators did not meet the goal

HMO Marketplace/Exchange

Of the 64 indicators listed in the 2022 Work Plan with goals assigned:

- 40 indicators met the goal
    - 10 indicators partially met the goal
- 7 indicators did not meet the goal

PPO Group/Commercial

Of the 49 indicators listed in the 2022 Work Plan with goals assigned:

- 30 indicators met the goal
    - 12 indicators partially met the goal
- 6 indicators did not meet the goal

PPO Marketplace/Exchange

Of the 45 indicators listed in the 2022 Work Plan with goals assigned:

- 31 indicators met the goal
    - 6 indicators partially met the goal
- 6 indicators did not meet the goal

Adequacy of QI Program Resources

As part of BCBSIL's QI Program development, resource evaluation is ongoing throughout the year. In 2022, staffing resources were adequate for implementation of the BCBSIL QI Program. Staff included BCBSIL Vice President and Chief Medical Officer (CMO), Medical Directors, Senior Director, Analytics Director, Senior Managers and the clinical and analytic staff reporting to them.

Additional HCSC staff performing QI functions include: BCBSIL Network Management, HCSC Behavioral Health, Credentialing, Delegation Oversight, Medical Management, Enterprise Health Care Management and Enterprise Population Health Management. These individuals supported physician credentialing, utilization management, case management, condition management, delegation oversight, implementation of the behavioral health program and health plan accreditation.

QI Committee Structure
Ultimate accountability for the management and improvement of the quality of clinical care and service provided to HCSC members rests with the Board of Directors of HCSC. The Governance and Nominating Committee of the Board of Directors of HCSC is a committee of the HCSC Board responsible for assisting the Board in fulfilling its oversight functions related to the QI Program for HCSC members. The Governance and Nominating Committee delegates certain responsibilities for management and oversight of the QI Program to individual Plan QICs.
The BCBSIL QIC is responsible for providing oversight and direction to the BCBSIL QI Program. The QIC is chaired by a Medical Director or the Executive Director, Clinical Programs Strategy and Oversight. The QIC brings multidivisional staff together with network providers including a behavioral healthcare practitioner.

The BCBSIL QIC and the Enterprise Quality Improvement Oversight Committee ~~of~~ review and approve the annual BCBSIL QI Program Description. The BCBSIL QIC also reviews and approves the annual BCBSIL QI Work Plan and the annual QI Program Evaluation.

Leadership Involvement and Practitioner Participation
BCBSIL physician leadership is responsible for the QI Program. A dedicated BCBSIL Medical Director or the Executive Director, Clinical Programs Strategy and Oversight provides direction and oversight for the BCBSIL Clinical Quality Program and chairs the BCBSIL QIC. The BCBSIL QIC met 12 times virtually in 2022, included consistent medical and behavioral health practitioner representation and involvement at each meeting.

The BCBSIL QIC thoughtfully reviewed and analyzed QI project results, identified needed actions, recommended policy decisions and followed up on open issues. In addition to the QIC, BCBSIL sponsors several provider forums including the Value Based Care Medical Director Round Table, and Administrative Forums. These conferences and meetings offer an opportunity to review quality data, share best practices and collaborate across organizations.

Quality Improvement Resources

HCSC has sufficient resources to meet the QI Program objectives, carry out the scope of activities to be conducted and complete annual and ongoing activities.
Staffing and resources supporting the QI Program include but are not limited to:

- Blue Care Connection® / Wellness
  - Condition Management and Lifestyle Management
  - Enterprise Wellness Programs
- Clinical Pharmacy Programs
- Credentialing (Network Operations & Solution Delivery)
- Communications (Marketing, Positioning and Targeted, and Public Affairs)
- Customer Service
- Delegation Oversight Programs
- Medical Directors
- HEDIS, Quality and Accreditation Program staff (including nurses and analytic staff)
- Reporting (EHCM Care Management Tools and Technology, EHCM Clinical Operations Performance, Systems and Reporting and Analytics and Information Management)
- Claims, Membership, Medical Management and other systems/platforms as needed
- Utilization Management/Case Management/Wellness Condition Management (Medical Management)
- Special Beginnings®
- HCSC Behavioral Health Unit
- Market Research: Continuous Tracking Survey, Consumer Assessment of Healthcare Providers and Systems (CAHPS), and Qualified Health Plan Enrollee Experience Survey (EES)
- Network Management including but not limited to~~,~~ Value Based Care Models, such as Intensive Medical Home (IMH); and Accountable Care Organization (ACO)~~)~~

Quality Improvement Committee

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The BCBSIL QIC is responsible for providing oversight and direction to the QI Program. The QIC is chaired by a dedicated Medical Director or the Executive Director, Clinical Programs Strategy and Oversight. The QI Committee brings multidivisional staff together with employers, providers and members for the purpose of reflecting customer values. An HCSC Medical Director is responsible for ensuring the Governance and Nominating Committee receives the reports from the QI Committee.

Responsibilities of the QI Committee include:

- Review and approval of the annual HCSC QI Program including the Illinois Appendix
- Review and approval of the annual BCBSIL QI Work Plan
- Review and approval of the preventive care and clinical practice guidelines
- Monitoring and analysis of reports on QI activities from subcommittees
- Oversight of delegated activities
- Review and approval of annual BCBSIL QI Program Evaluations
- Review and approval of the Case Management/Utilization Management QI Projects
- Recommendation of policy decisions
- Analysis and evaluation of the results of QI activities
- Review of analysis of significant health care disparities in clinical areas
- Review of analysis of information, training and tools to staff and practitioners to support culturally competent
- communication
- Review of analysis of Quality Review Audit Team audit results
- Review of analysis and evaluation of member complaints
- Review and analysis of member and provider appeals
- Review of analysis and evaluation of populations with complex health needs
- Ensuring practitioner participation in the QI program through project planning, design, implementation and/or review Institution of needed actions
- Ensuring follow-up, as appropriate
- Maintain signed and dated meeting minutes

The BCBSIL QIC meets a minimum of (10) times per year. Its membership includes: Practitioners from BCBSIL Networks (with at least 1 behavioral health specialist), BCBSIL Vice President and CMO IL, Quality Medical Director (Chair) and additional departmental leadership including representatives from Clinical Operations, Network Programs, Quality, Accreditation, Quality Administration, Provider Affairs Operations, Regulatory Compliance, Leadership Oversight, Enterprise Medical Director, Account Management, and additional staff support as needed may include Marketing, Credentialing, Service Delivery Operations, Legal Department, and Illinois Medical Directors (Medical Management, Quality Improvement and Health Equity).

Quality and Safety of Clinical Care

The HCSC QI Program is designed to meet all applicable state and federal requirements (e.g. HIPAA etc.). Plan staff, in cooperation with the HCSC Compliance and Legal Departments, monitor state and federal laws and regulations related to quality improvement and review program activities to assure compliance. In addition, if the Plan achieves external accreditation/certification, maintenance of such accreditation/certification is monitored through the QI program. There were two (2) Accreditation Organizations used at HCSC, the National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC). As of April 6, 2022, the organization withdrew from the URAC HUM program and was replaced with NCQA Utilization Management (UM) certification, now resulting in (1) accreditation organization. The selection of the Accreditation Organization is based upon a combination of state and federal requirements, and plan-specific preference.

Accreditation Matrix

HCSC maintains accreditation for the products identified from the listed accrediting bodies:

		NCQA (HP) Health Plan	NCQA UM	URAC UM	URAC Health Plan
BCBSIL	HMO	Yes	No	No	No
	PPO	No	Yes	No	No
	Exchange HMO	Yes	No	No	No
	Exchange PPO	Yes	No	No	No

Quality Improvement Projects

BCBSIL's HMO plans are unique in that the clinical care is delegated to physician groups (Medical Groups, IPAs, PHOs). In this arrangement, BCBSIL maintains responsibility for quality and provides delegation oversight to assure compliance. Foundational to the delegated model is an alternative payment model (APM) that includes shared risk and a quality improvement fund that is designed to align incentives. This model has resulted in improved quality and lower cost for our members.

The 2021 QI Fund Projects rates were based on a random sample of the population. The project methodology consisted of five prospective and one retrospective project. The prospective projects being Combined Immunizations, Cervical Cancer Screening, Colorectal Cancer Screening, Controlling High Blood Pressure, and Comprehensive Diabetes Management; with the retrospective project being Combined Prenatal and Postpartum Care.

Data was analyzed using the following sources: claims, medical record and appeals submission, final quality improvement project results, 2021 Quality Compass®, QI Projects instructions, 2020 - 2021 HEDIS Technical Specifications, and the 2021 MSA. Each sample population and/or sample size varied amongst projects. For example, Controlling High Blood Pressure consisted of 250 members who were randomly sampled from HMOI/BlueAdvantage and 250 members from Marketplace HMO, whereas, for CCS 300 members were randomly sampled from HMOI/BlueAdvantage and 300 members from Marketplace HMO. In addition to a varying sample population, the inclusion criteria varied as well amongst the six projects based on project requirements.

The two data collection options were manual medical chart submission and electronic supplemental data submission. Manual medical chart submission was determined manually, with a measurement period between 1/01/2021 and 7/31/2021. Electronic supplemental data submission was determined administratively, with a measurement period between 1/01/2021 and 12/31/2021. For scoring, the rates were calculated for each product line by dividing the number of members who meet numerator compliance by the number in the

denominator. If BCBSIL confirmed that a member met the criteria for exclusion, the member was removed from the denominator. The numerator included the number of members for which there was documentation of the project requirements; whereas the denominator included the number of members in the IPA Project Final Population minus the number of exclusions confirmed by BCBSIL.

2021 QI Fund Projects Network Rates (Hybrid Measures)			
Measure	**IL HMO Commercial (%)**	**IL HMO Marketplace (%)**	**2021 Quality Compass National Avg. (All LOBs)**
Controlling High Blood Pressure	69.12 ▲	67.48 ↔	51.79
Cervical Cancer Screening	75.78 ▲	65.91 ▲	73.84
Comprehensive Diabetes Management (Eye Exam)	54.47 ▲	48.83 ▲	49.01
Comprehensive Diabetes Management (HbA1c Control)	63.08 ▼	61.85 ▼	53.22
Comprehensive Diabetes Management (Kidney Evaluation)	57.26	57.56	-
Combined Children and Adolescent Immunizations (Combo 10)	57.41 ▼	53.68 ▼	58.01
Immunizations for Adolesents (Combo 1)	91.87 ▲	89.63 ▲	81.90
Immunizations for Adolesents (HPV)	41.95 ▲	35.59 ▲	33.43
Colorectal Cancer Screening	65.18 ↔	55.69 ▲	62.00
Combined Prenatal and Postpartum Care	93.22 ▲	92.82 ▲	78.49
▲Improvement	▼No Improvement	↔ No Change	

I. Interventions (when applicable)**:**

Completed:

- 2021 QI Projects positively impacted HEDIS 2022 (MY 2021)

Ongoing:

- 2022 QI Projects were aligned with HEDIS hybrid measures and NCQA Health Plan ratings with a focus on prevention and treatment
- IPAs are strongly encouraged to take advantage of utilizing electronic supplemental data submission primarily for the explanation listed in Section V, bullet point 2
- Manual data submission currently remains in place as all IPAs may not be systematically prepared or hesitant to submit via electronic supplemental data submission
- Projects and benchmarks will continue to be aligned with the aim of improving immunizations, prevention and wellness, and condition management
- Collaboration via the Collaborative Quality Improvement Coaching Program
- Project sample will be used to determine the sampling increase and administrative hits will be allowed until the end of the year; both will be added thereby yielding the final imputed rate

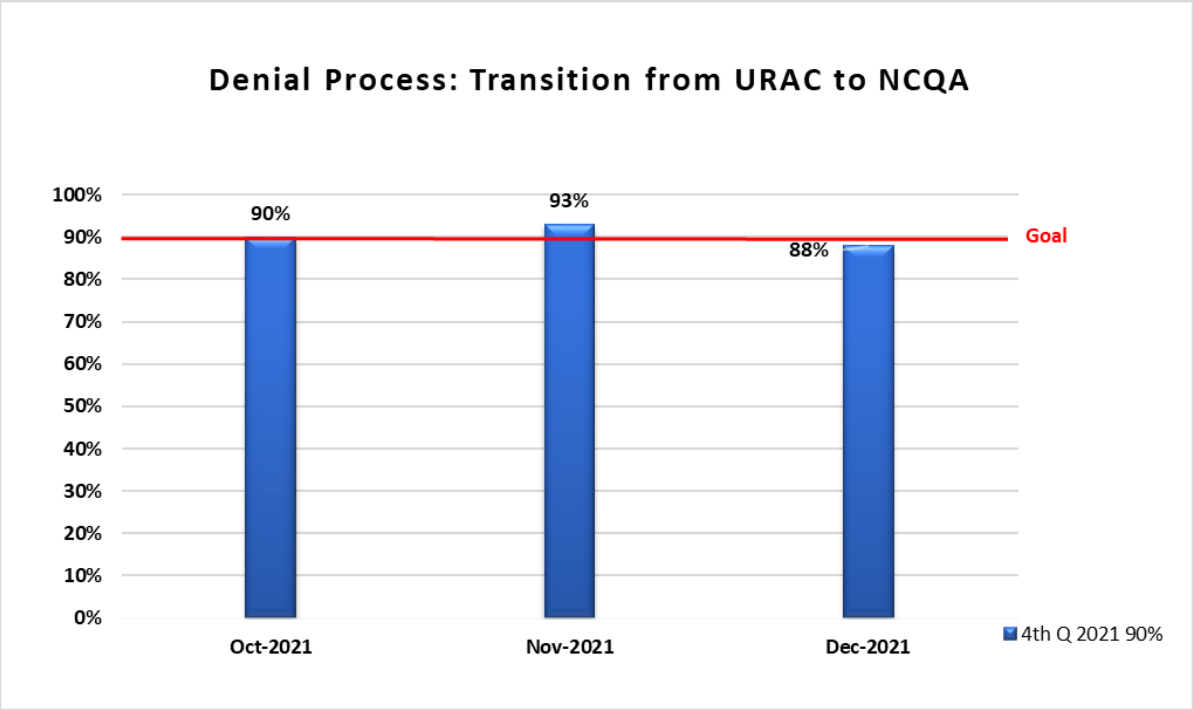
Future:

- It is conjectured that prospective methodology for 2022 QI Projects will positively impact HEDIS 2023 (MY 2022)

Accreditation Monitoring and Compliance (AMC) Denial Review
2022 Illinois Commercial PPO: a random sample of 30 denial files are reviewed monthly. Samples of random denial files are selected by reviewing cases that meets audit/ review parameters.

The turnaround time (TAT)goal is to achieve and maintain a compliance score of ≥ 90%. The Illinois: UM 5A Notification of Nonbehavioral Decisions results are below:

2021 Q 4



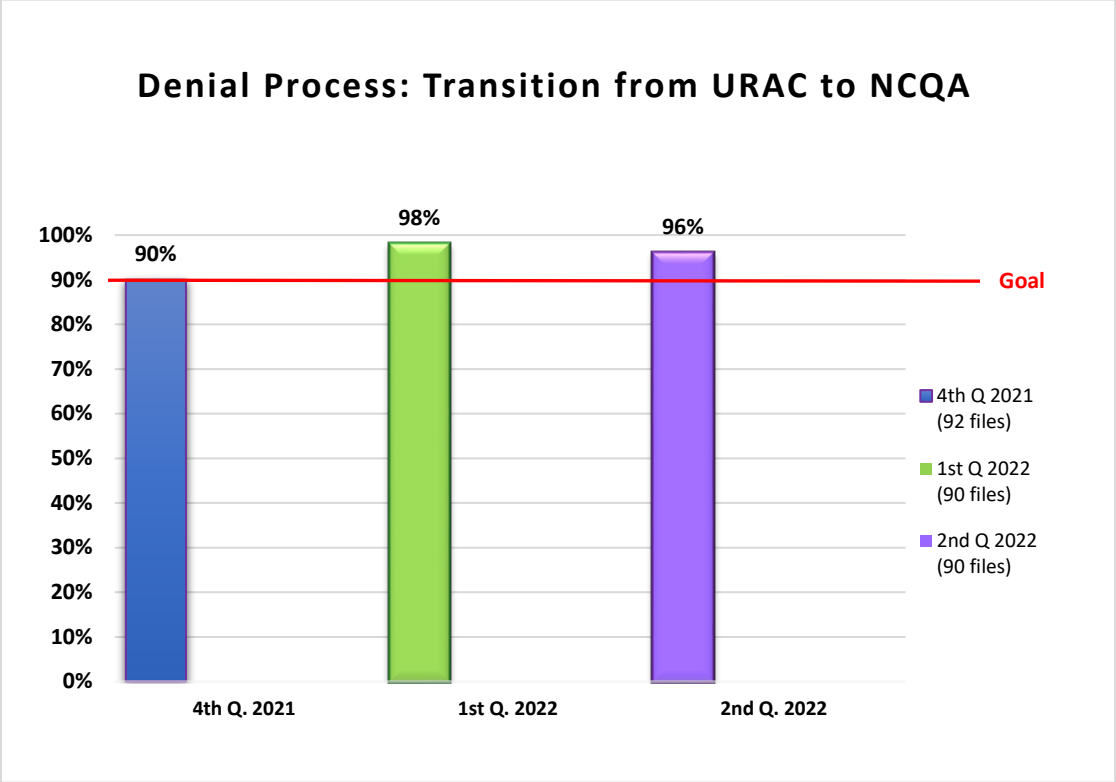
- The data results of 90% for the 4thQuarter 2021 indicated challenges in adjusting from the differences between the URAC to NCQA turn-a-round time requirements. The goal of 90% was met.

2022 Q 1

- **Illinois:** UM 5A Notification of Nonbehavioral Decisions: Results were **98%,** (88/90) files met turn-a-around time).
- The 1st Quarter 2022 Denial review results are 98% (88/90). This is an (8 percentage point or 8.51% increase from the 4th Quarter 2021 review results of 90% (83/92).

2022 Q 2

- **Illinois:** UM 5A Notification of Nonbehavioral Decisions: Results were 96%, (86/90) files met turn-a-around time).
- The 2nd Quarter 2022 Denial review results are 96% (86/90). This is a (2 percentage point or 2.06% decrease) from the 1st Quarter 2022 review results of 98% (88/90).



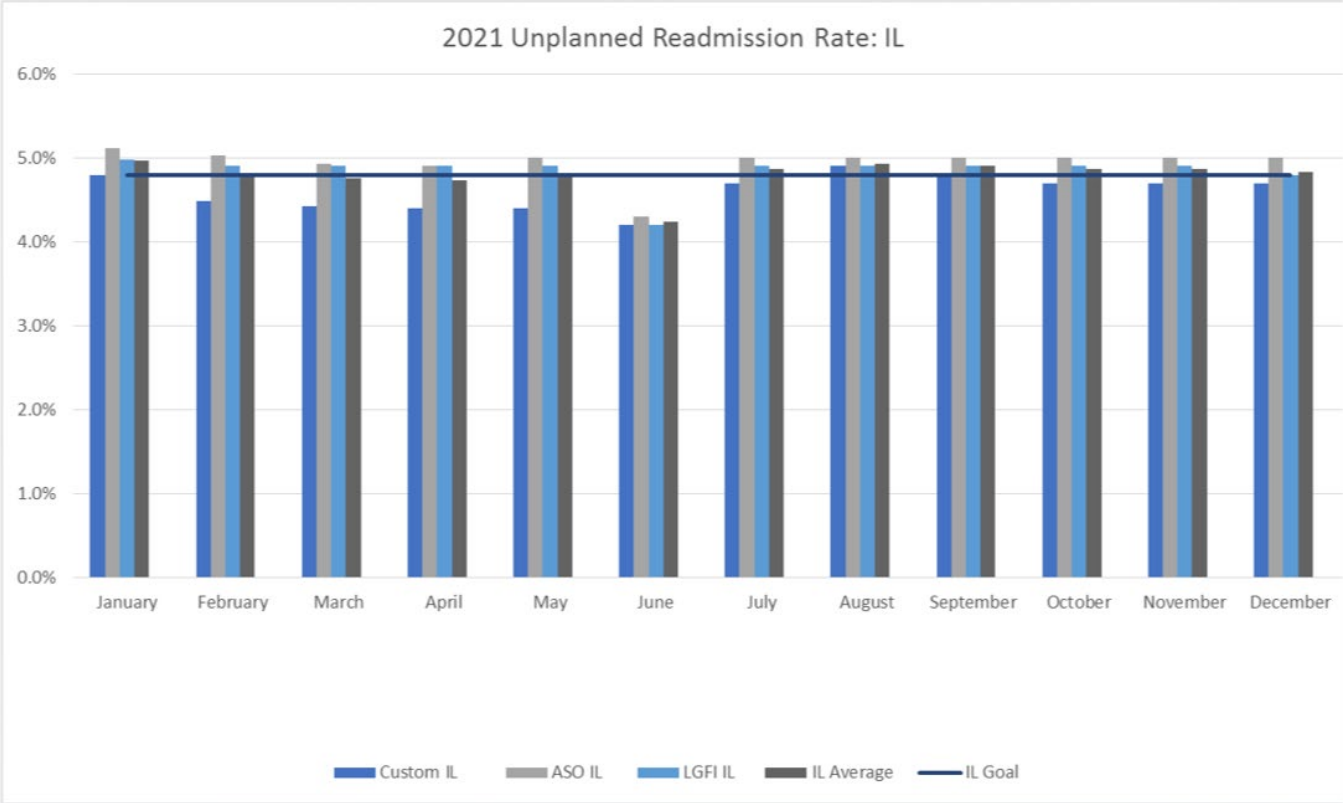
Clinician Outreach to Support Member Safety
The purpose of this report is to address patient safety by reducing the unplanned readmission rate and improve EMMI utilization.

The data collection cycle was conducted January-December 2022, the report derived from the Cost and Utilization Database. Due to the time warranted for processing of claims and data entry and analysis, there was a 6-month lag in readmission rate reporting. EMMI utilization was obtained from the utilization reports from EMMI, Corp. The reports identified all EMMIs issued to members each quarter and was defined by Plan State, clinician name, name of EMMI, and number of EMMIs sent. Readmission Goal: Decrease readmission by 4.8%. EMMI Utilization Goal: Increase the sending of Emmi programs related to Patient Safety to an average of 100-150 per month. The results are below:

Unplanned Readmission Rates:

- IL Plan did meet goal for Unplanned Readmission Rate in Quarter 3 or Quarter 4

IL Unplanned Readmission Rates 2021					
	Q1	Q2	Q3	Q4	Goal
IL Average	4.1%	4.6%	**4.9%**	**4.9%**	4.8



a. Barriers/Issues impacting readmission

Overall preventative care was down in 2021 due to concerns of exposure to COVID, leading to readmission

EMMI Utilization

- IL EMMI Utilization met goal for Quarter 1, Quarter2, Quarter 3 and 4 in 2021.

EMMI Module Utilization 2021 (avg EMMIs sent/month)					
	Q1	Q2	Q3	Q4	Goal
IL	1307	880	1093	994	100-150

b. Barriers/Issues impacting EMMI Utilization

c. Challenging to engage members through a second outreach **Interventions:**

- Trending volume of EMMIs sent and completed
- Sharing above with clinicians monthly
- Utilizing recently implemented digital tools, secure messaging and text, for call and EMMI reminders

- **Future Focus:**
  - This Quality Improvement Project was retired in 2022 due to the transition from URAC to NCQA

Quality of Service

HMO Service Project Initiatives

BlueCross BlueShield of Illinois (BCBSIL) annually monitors member satisfaction within our health plan services and healthcare delivery system and identifies opportunities for improvement. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is used in conjunction with member complaints and appeals data.

CAHPS is a satisfaction survey governed by the Agency for Healthcare Research and Quality that evaluates member experiences with health care. The survey covers topics that are important to members and focuses on aspects of quality that members are best qualified to assess. BCBSIL determines which aspect of quality can be improved upon that will benefit the most to the HMO members health care. Results show that 80% of members feel they can "Always or Usually" get care as soon as needed when care was needed right away, 77% say it is easy to get necessary care, tests, or treatment; this is a significant decrease from the 2021 survey 79% indicate it is "Always or Usually" easy to get an appointment with a specialist.

Members may not be familiar with referral process when requesting to see a specialist and some specialist office hours or geographic location may not be convenient for the members. BCBSIL has contractual requirements with MGs for access to physicians and physicians have contractual agreement with the MG making implementation of interventions challenging.

Wellness and Prevention

Clinical Practice Guidelines

BCBSIL incorporates Clinical Practice Guidelines into the Condition Management Programs. The guidelines are based on evidence-based data developed and published by nationally recognized clinical expert panels and are available to assist providers in clinical practice. Clinical Practice Guidelines are reviewed and revised, as appropriate, at least every two years. Guidelines may be reevaluated and updated more frequently, depending on the availability of additional data and information relating to the guideline topic. A list of commonly used Clinical Practice Guidelines include but is not limited to: Diabetes, Cardiovascular Disease, Depression, Attention Deficit/Hyperactivity Disorder, Metabolic Syndrome, Weight Management, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, HIV, Sleep Apnea and Tobacco Cessation.

In 2022, the following guidelines were updated:

- Diabetes Standards of Care
- COPD
- Asthma

Member Messages

In 2022, a total of 309,683 mailings were sent to BCBSIL members covering topics of preventive screenings and immunizations, cervical cancer screenings, and childhood immunizations. In addition to the mailings, automated calls were made to a sub-set of the female population regarding the importance of getting a mammogram. The breakdown of Group mailings are as follows.

The Preventive Care initiatives for 2022 were:

- ***Women's Birthday Card***: Mailer to females 40 and older in their birthday month to encourage age/gender preventive screenings and immunizations and promote healthy lifestyles.
- ***Cervical Cancer Screening Reminder Card***: Mailer to female members 23 years of age and older who have not had a Pap test within the previous two years to encourage cervical cancer screening. Emails also go out in September.
- ***Childhood Immunization Reminder Cards:*** Reminder cards were mailed to parents of children age of four months and twelve months of age to encourage immunization compliance and well-child visits.

- ***4th Month Childhood Immunization Cards:*** Mailed to parents at their children's 4th month of age to encourage immunization compliance and well-child visits.
  12th Month Childhood Immunization Cards: Mailed to parents at their child's 12th month of age to encourage immunization compliance and well-child visits.

BCBSIL has various initiatives to encourage members to utilize preventive health services. BCBSIL utilizes HEDIS® and the Quality Rating Systems (QRS) effectiveness of care measures, when applicable, to evaluate whether preventive services were received by members and evaluate for opportunities for intervention and improvement over time.

BCBSIL Quality Core Measures
BCBSIL adopted the Quality Core Measures to enable greater focus on high priority quality measures which are common across various external quality measure requirements. This approach was especially important in establishing a new quality measurement foundation for APM programs, such as Accountable Care Organizations, where providers care for BCBSIL members across Lines of Business. The following clinical measures are set to track and trend results for BCBSIL.

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* 2022 Quality Compass (Measurement Year 2021) All LOBs Benchmark

Reporting Year 2022 HEDIS QRS (MY 2021) – Year Over Year Performance

	2020 MY Measures Applicable in MY 2021	Improvement	
		#	%
HMO Commercial	14	9	64%
HMO Marketplace	11	10	91%
PPO Commercial	8	5	63%
PPO Marketplace	11	11	100%

Reporting Year 2022 (MY 2021) Benchmarking to Quality Compass

	Above Quality Compass**		Below Quality Compass**		Total Measures
	#	%	#	%	#
HMO Commercial	9	64%	5	36%	14
HMO Marketplace	10	91%	1	9%	11
PPO Commercial*	5	63%	3	38%	8
PPO Marketplace	11	100%	0	0%	11

*Product not formally accredited. Hybrid measures not reported.
** 2022 Quality Compass (Measurement Year 2021) All LOBs Benchmark

BCBSIL Membership

Commercial HMO	Marketplace HMO	Commercial PPO	Marketplace PPO
627,510	96,917	2,487,138	146,559

* End of Year Membership Counts for 2022 HEDIS® and QRS Reporting for BCBSIL Plan (As of December 31, 2021)

Credentialing and Recredentialing

BCBSIL reviews the performance of the credentialing program to identify opportunities for improvement. Data is pulled from the credentialing and provider systems to identify credentialed and/or network providers. This data will identify volumes and percentages of providers that were processed within the targeted timelines and compliance guidelines according to the goals and regulations.

Credentialing Activity						
	2020		**2021**		**2022**	
	Volume	**TAT**	**Volume**	**TAT**	**Volume**	**TAT**
Initial: Target Avg 45 Days	5,784	16	4,516	32	4,478	33
Recredentialing in 36 months – Facilities	258	99%	254	99%	541	99%

Pharmacy
Specialty Review Unit (SRU) UM Overturns (1st pass MD approvals) for 4Q 2021 & 1-3Q 2022

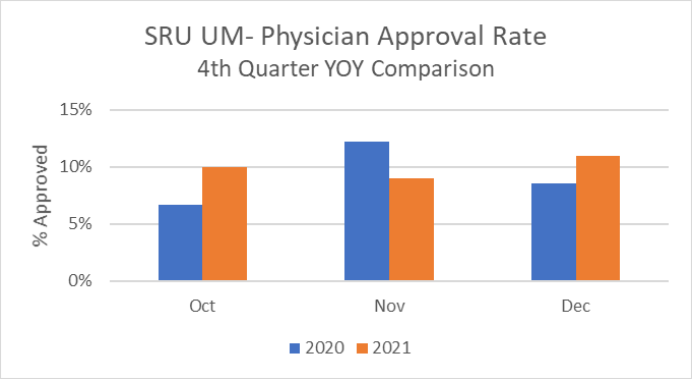
4Q 2021 and 1Q 2022

BCBSIL					
Time Period	**Approved by SRU**	**Not Approved by SRU**	**Denied by Physician**	**Approved by Physician***	**% Approved Final**
Oct-21	2,714	899	811	88	**78%**

Nov-21	2,165	550	502	48	**82%**
Dec-21	1,943	595	531	64	**79%**
Jan-22	2,841	673	605	68	**83%**
Feb-22	2,832	767	672	95	**81%**
Mar-22	2,887	758	659	99	**82%**
Total	**15,382**	**4,242**	**3,780**	**462**	**81%**

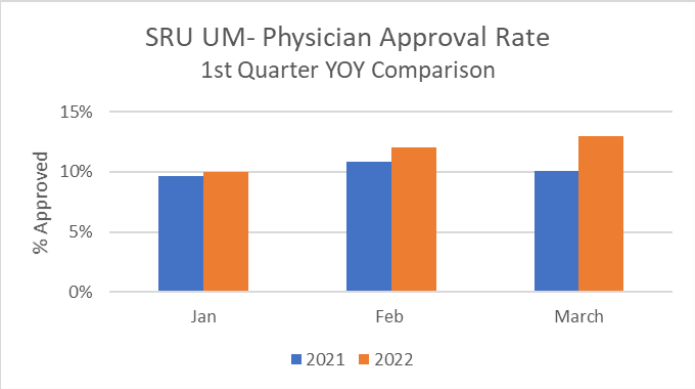
Year-over-year comparison: 4Q 2020 and 4Q 2021

Physician Approval Rate		
BCBSIL		
Month	**2020**	**2021**
Oct	7%	10%
Nov	12%	9%
Dec	9%	11%



Year-over-year comparison: 1Q 2021 and 1Q 2022

Physician Approval Rate		
BCBSIL		
Month	**2021**	**2022**
Jan	10%	10%
Feb	11%	12%
March	10%	13%

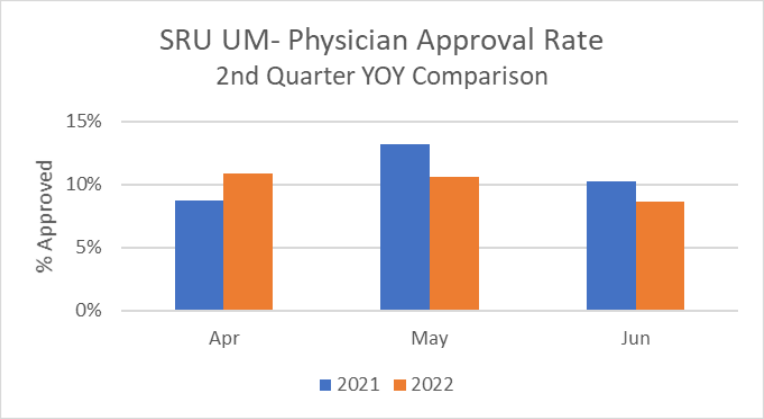


2Q 2022 and 3Q 2022

BCBSIL					
Time Period	**Approved by SRU**	**Not Approved by SRU**	**Denied by Physician**	**Approved by Physician***	**% Approved Final**
Apr-22	2,468	752	670	82	**79%**
May-22	2,465	691	618	73	**80%**
Jun-22	2,396	647	591	56	**81%**
Jul-22	2,540	697	631	66	**81%**
Aug-22	2,587	847	771	76	**78%**
Sep-22	2,579	788	707	81	**79%**
Total	**15,035**	**4,422**	**3,988**	**434**	**80%**

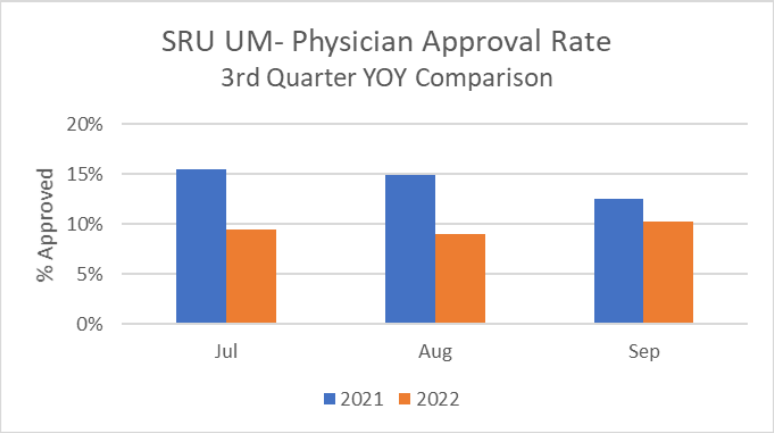
Year-over-year comparison:2Q 2021 and 2Q 2022

Physician Approval Rate		
BCBSIL		
Month	**2021**	**2022**
Apr	9%	11%
May	13%	11%
Jun	10%	9%



Year-over-year comparison: 3Q 2021 and 3Q 2022

Physician Approval Rate		
BCBSIL		
Month	**2021**	**2022**
Jul	16%	9%
Aug	15%	9%
Sep	13%	10%



Analysis

BCBSIL cases reviewed by SRU from 4Q 2021 through 3Q 2022 totaled 39,081. Of those cases, 30,417 (78%) were approved as being medically necessary. 8,664 (23%) were recommended for denial and pended for medical director review. Of the cases pended to the medical director, 7,768 (90%) were denied and 896 (10%) were approved on the first physician review. Year-over-year comparison showed improvement in MD approval rate (SRU UM overturn rate) in 3Q 2022 (9% average vs. 15% average in 3Q 2021). The MD approval rate remained highly constant in 4Q 2020 and 4Q 2021 (about 10%), in 1Q 2021 and 1Q 2022 (about 11%) and in 2Q 2021 and 2Q 2022 (about 10%).

Barriers
Multiple clinical practice guideline revisions, FDA approvals and medical policy updates were published during the reporting period and may have been inconsistently reviewed or interpreted by SRU pharmacists. The overturn rate could also be attributed to receipt of additional clinical information prior to the medical director decision. Rotation of medical directors with various specialties and complicated cases may have also affected the overturn rate.

Actions
SRU has an annual IRR survey that examines reviewer consistency across a variety of different requests. Touchpoint e-mails are sent on a monthly or ad hoc basis to inform staff of updates to guidelines, policy and/or process. Ad hoc surveys were administered via SurveyMonkey to reinforce seasonal product reviews (i.e. Synagis), review process changes, address common audit findings and to reinforce use of resources available on SharePoint. Individual monthly quality audits are conducted for all SRU review pharmacists and technicians. The audits review template consistency, decision reasonability and application of medical policy. Individuals scoring lower than the 90% benchmark are sent a performance expectation email and requires a plan of action for sustained improvement.

Recommendations
SRU works to review all requests in a consistent manner in accordance with medical policy and current medical evidence. Given the volume of reviews conducted and the frequent changes to clinical practice guidelines and FDA approvals, there is some opportunity for an overturn if the reviewing pharmacist misinterprets an updated dose, guideline recommendation, indication or medical policy criteria. There also may be medical director overturns for 'gray' cases, extenuating circumstances or individual considerations. SRU will work to improve quality and consistency in reviews to maintain consistency through the annual IRR, monthly quality audits, ad hoc reasonability training, touchpoint e-mails, targeted surveys administered through SurveyMonkey and meetings with medical directors.

Specialty Review Unit (SRU) Clinical Pharmacist Annual Inter-Rater Reliability (IRR) Report

Purpose
To evaluate the consistency of clinical pharmacists in the Specialty Review Unit (SRU) in the application of medical policy criteria for medical necessity recommendations when completing preservice reviews for members.

Methodology
Utilizing the NCQA "8 and 30 sampling methodology", a SRU pharmacist manager constructed 30 multiple choice questions with 2-4 answer choices per question. The 30 questions were issued to the pharmacists in lieu of the traditional 8 followed by 22, so that a greater sample size could be evaluated. Each question had a reference answer from the choices provided. The reference answer for each question was set by the drafting SRU pharmacist manager and confirmed by the other two SRU pharmacist managers. The IRR was administered via SurveyMonkey® to 29 reviewing pharmacists. Of the 29 pharmacists, 23 were experienced review pharmacists with at least 1 year with the SRU and 6 pharmacists were newly hired with less than 6 months with the SRU. The survey link was sent via email to each available pharmacist on Wednesday, April 13, 2022. The survey link was

open from 7:00am through 7:00pm MT per SRU hours of operation. Each question required an answer prior to submission. The daily production benchmark was adjusted to allow 4 hours to complete the IRR.
Questions were developed based on historic requests reviewed by the SRU (identified in monthly reporting spreadsheets), current medical policies (both HCSC and FEP) and current SRU review lists and processes. The survey included the following subject areas: medical necessity, HCSC and FEP medical policies, current SRU policies and procedures, FDA labeling, Micromedex and nationally recognized compendia or guidelines such as National Comprehensive Cancer Network (NCCN).

Results and Quantitative Analysis
Results of the inter-rater reliability survey were calculated based on the 23 experienced SRU clinical pharmacists. The tables below present the consistency of each question with the reference and the individual pharmacist consistency. The newly hired pharmacists are identified in purple (Four started on 12/6/2021 and had about 3.5 months of experience in performing reviews. Two started on 3/14/2022 and had 1.5 weeks performing reviews, with oversight).

The average time spent on the IRR was 3 hours 14 minutes 1 second.

Eighteen experienced pharmacists met or exceeded the 90% goal for the 2022 IRR.

Three new hire pharmacists met or exceeded the 90% goal for the 2022 IRR.

Ten questions had 100% consistency with the reference answer.

Only 1 question had 70% or less consistency with the reference answer and was excluded from the final results. This question, question 8, was deemed a ‘gray request’ and was excluded from the final results due to variable interpretations of the question.

After review of current guidelines and discussion with the pharmacist team, Question 18 was determined to have 2 possible options. After both possible answers were acknowledged, the consistency for question 18 was 100%, as listed above.

Overall, the experienced SRU pharmacists were 93% consistent in the application of medical policy, nationally recognized guidelines and SRU process.

The five experienced SRU pharmacists that scored below the 90% goal, plus the six new hire pharmacists were administered a follow-up survey. Results of the 10-question follow-up survey are reported below.

The average score on the IRR follow-up survey was 94%. Seven pharmacists, including all six new hire pharmacists scored 100%.

Qualitative Analysis & Casual/Barrier Analysis

The questions were built using requests completed by the SRU and identified on the SRU monthly reporting spreadsheets. Use of these requests allowed for a realistic survey of issues likely to be encountered in the daily review process.

The majority of the SRU review pharmacists were highly consistent with the reference for the 2022 IRR and met or exceeded the 90% goal.

The 2022 SRU IRR had an average score of 93% amongst 23 experienced review pharmacists. Comparatively, the results for the 2022 IRR are consistent with past performance.
2021 SRU IRR had an average score of 95% amongst 26 review pharmacists.
2020 SRU IRR had an average score of 90% amongst 25 review pharmacists.
2019 SRU IRR had an average score of 92% amongst 16 review pharmacists.
2018 SRU IRR had an average score of 90% amongst 17 review pharmacists.

Interventions in the past year included survey administration, clinical meetings, clinical presentations by the pharmacy resident and touchpoint emails. These interventions positively impacted the results for the 2022 IRR. The 2021 version of the IRR was administered to 26 review pharmacists. Since that time, two experienced pharmacists were promoted to management and six pharmacists were hired with four starting 12/6/21 and two starting 3/14/22. Two pharmacists were on leave for IRR administration and will take the survey once available. Frequent guideline and medical policy updates present challenges in upkeep and dissemination of information. Inconsistent review of department emails and use of resources available on the department SharePoint site may also lead to variation between reviewers.

Opportunities for Improvement
Areas for improvement include close attention to differences in criteria between FEP and HCSC medical policies, consistently reviewing available dosing/indication resources for new FDA approvals or guideline recommendations, consistent approval of appropriate dose and frequency increases and close attention to patient specific details in the clinical information presented.
Increased use of the resources available on the SRU SharePoint (including the current SRU Review list, the SRU Best Practices spreadsheet and the SRU Touchpoint document) is necessary/recommended and will be encouraged.

Interventions: Completed
The individual survey results were emailed to the respective owners after all 29 pharmacists had completed the IRR. The findings were discussed with 28 pharmacists at a meeting on April 27, 2022. One pharmacist, who scored 100%, was out of office for the discussion. At the meeting the entire survey was reviewed. Extra time and rationale were provided for each question that scored less than 100% consistency. All questions were addressed, and SRU processes and procedures were reinforced. References and resources were provided for questions with less than 100% consistency.

Following the group discussion, those that scored less than the 90% goal and all new hires (regardless of score) were administered a 10-question follow-up survey on April 28, 2022, to reinforce topics identified with higher inconsistency.

The following topics were clarified:
1. Benlysta for systemic lupus erythematosus,
2. Xiaflex and the REMS program requirement,
3. Dose and frequency escalations for Remicade in rheumatoid arthritis,
4. Botox for bruxism,
5. FEP approval durations for continuations,
6. FEP Tepezza criteria,
7. Zulresso approval statements,
8. Requests lacking current clinical information,
9. Available dosage forms for products available through pharmacy and medical benefit
10. FEP policy for Actemra

Interventions: Ongoing
Between annual IRR surveys, opportunities for improvement will be acted on throughout the year via group and individual meetings, quarterly surveys, SRU Touchpoint e-mails and monthly individual quality audits, in hopes of resolving any inconsistencies in the application of medial policy and/or SRU process.

Interventions: Future
The next IRR survey will be conducted in April 2023.

Delegation Oversight

Group and Retail HMO
BCBSIL delegates Utilization Management (UM) and Care Coordination Program (CCP) to duly constituted Medical Groups, Individual Practice Associations, or Physician Hospital Organizations (hereinafter the IPAs) for HMOI, Blue Advantage, and Blue Precision HMO products. The HMO Utilization Management and Care Coordination Program annual evaluation was completed and presented to the BCBSIL QIC with associated analysis and action plans for 2021. The purpose of the annual evaluation is to document oversight of the Physician Groups or compliance with requirements set forth as outlined in the BCBSIL HMO Utilization Management Plan. The annual evaluation includes describes performance of the IPAs in the following areas:

- Utilization Management
- Adherence Audits
- Complex Case Management
- Hospital Audits
- Denial Files
- Member & Provider Satisfaction
- Potential UM issues

Credentialing Delegation Oversight
Enterprise Delegation Oversight Programs (EDOP) has provisions in place to monitor and audit each subcontractor such as, medical groups, Independent Physician Associations (IPAs), or vendors, for compliance. HCSC has a dedicated staff that performs oversight and monitoring of delegated functions.

Prior to delegation, an extensive review (pre-delegation audit) is conducted; audits are conducted annually thereafter.

The audits include the submission and review of relevant program information, as well as an initial on-site audit of organizational infrastructure, operational staff to perform all requested delegated functions, including a review of files, licensures, board minutes, committee minutes, policies and procedures, insurance requirements and credentialing reporting requirements, as designated.

Ongoing monitoring of delegated functions is accomplished by annual delegation audits and continuous communication, receipt and analysis of monthly, quarterly and annual reporting as well as attendance at operational meetings, email communications, and corrective action plans (if applicable).

The IL Quality Improvement Committee (QIC) and Delegation Oversight Committees (DOC) are multidisciplinary committees which review recommendations regarding pre-delegation, annual audits, corrective action plans, and delegation oversight report monitoring for credentialing functions delegated to medical groups, IPAs, and vendors.

A. AUDITING COMPLIANCE

Analysis

- All credentialing audits were performed within 12 months of their last audit for all 4 quarters.

Interventions

QI interventions conducted auditing requirements included the following:

- Filled open staffing positions to perform all the annual audits
- Reviewed compliance and reporting issues with the delegates during annual audits
- Continued to monitor delegates' compliance with corrective action plans and reporting requirements through follow-up
- Reported recommendation to the delegates from the EDOC and QI committees.
- Involved the contract and business owner to support completing the corrective action plans
- Attended joint operation meeting to discuss delegation oversight and operation issues
- Distributed the annual audit requirements in the Delegation Guidelines to all delegates

Quality Initiatives

QI interventions to improve the delegation strategy included the following:

- Continue to collect service indicators which are reported quarterly to the QI committees
- Continue to attend JOC to discuss delegation activities and operational outcomes.
- Continue Performed Delegated Audits within 12 months
- Continue to work on Network expansion and additional delegation
- Continue to report delegation audit and issue to the appropriate health plan committees
- Collaborated with Core Credentialing areas to improve consistency of delegation outcome reporting
- Continue Conducted Enterprise Delegate Oversight Committee with representation from all five (5) plans.

Complaints and Appeals

A "complaint" is defined as oral or written expression of dissatisfaction made to BCBSIL about a benefit or coverage decision, customer service, or the quality or availability of a health service. The rate of member complaints for HMO Commercial was 0.1 per 1000 members in 2021 compared to 0.2 in 2020 and 0.2 in 2019. BCBSIL received 69 complaints in 2021. Goal of 90% turnaround time (resolving complaint within 30 days) was met in 2021. Majority of the HMO commercial complaints are Billing/Financial related. "Quality of Care" and "Quality of Practitioner Office site" complaints remain low at less than 1% of the total complaints. The rate of member complaints for Retail HMO was 0.6 per 1000 members in 2021 compared to 0.6 per 1000 in 2020 and 1.0 in 2019. Majority of the HMO Retail complaints are Billing/Financial related followed by Access at 3%, Attitude/Service at 4%, and Quality of Care remains low at around 2% of the total complaints.

In 2021, BCBSIL received 188appeals from HMO Commercial members. One hundred seventy-eight appeals out of 188 met the turnaround time resulting in 95% compliance and 5% non-compliance. Majority of the appeals are

related to Billing and Financial and the appeals per member rate remained consistently low at 0.4 appeals/1,000. In 2021, there were 3,392 OON referrals. There were 3,334 services approved for an annual approval rating of 98.3% exceeding the goal of 90%.
Also, in 2021 BCBSIL received 87 appeals from HMO Retail members. Eighty-five appeals out of 87met the turnaround time resulting in 98% compliance and 2% non-compliance. Majority of the appeals are related to Billing and Financial and the appeals per member rate remained consistently low at 0.6 appeals/1,000. In 2021, there were 1,013 OON referrals. There were 981services approved for an annual approval rating of 96.8% exceeding the goal of 90%.

Prioritized opportunities for improvement include 1. CAHPS survey results show that access related to “Getting Care Quickly” may need to be looked at to improve member access to immediate care.

The total rate of Illinois (IL) PPO FEP member complaints were, 0.077 per 1000 members in 2021 which is a decrease in volume, when compared to 2020 at 0.10 per 1000 members. A review of all IL PPO FEP member complaints shows that a broader range of complaint types were identified in 2021 compared to 2020. In 2020 all complaints were related to Billing/Financial. In 2021 there were a total of 13 complaints including 11 for Billing/Financial, 1 for Attitude/Service, and 1 for Access/Availability. There were no complaints related to Quality of Care in 2021. Turnaround time (TAT) for handling PPO commercial complaints was 92.31% in 2021 which was a slight decrease from 94% in 2020. Both goals were met in 2021; with less than 2 complaints per 1000 members (0.077 per 1000 members); and TAT above goal of 90% for 2021, at 92.31%.

In 2021, BCBSIL FEP PPO received 287 appeals, 100% of the total 287 appeals met the goal of less than 2 per 1000 members; compared to 100% compliance in 2020. The Standard Appeals represented 239 of the total appeal volumes, which are required to be resolved in 30 days or less turnaround time. The 2021 results demonstrated 100%, meeting the minimum goal of 99% compliance. In 2020, 286 standard appeals met the minimum TAT goal of 99% compliance by achieving 99.61%. The 2021 standard appeals turnaround time improved from 99.61% to 100% while the average age of closure increased slightly by 1 day from 2020 (18 days) to 2021 (19 days).

In 2021, 44 of 48 expedited appeals were resolved in less than 72 hours with 91.67% compliance. This is a dramatic increase from 2020 where 17 of 31 expedited appeals were resolved (54.83%) and even from 2019 where 6 out of 8 expedited appeals were resolved (75%). TAT rates over the last three years were below the 99% timeliness goal even though strong improvement is noted in 2021. All appeals were related to Billing and Financial issues and the appeals per member rate remained low at 1.691 per 1000; however, slightly up from 1.677 per 1000 in 2020.

FEP does not allow waivers for out-of-network requests. Overall, Commercial PPO (FEP only) complaint rate of 0.077 per 1000 members is well within the plan goal of 2.0 per 1000. The volume of complaints has been relatively the same around 0.1 complaints per 1000 members in the last 3 years. While the overall complaint volume decreased from 17 in 2020 to 13 in 2021, 2021 complaint categories used expanded from only Billing/Financial issues to both Access/Availability and Attitude/Service.

The overall rate of FEP appeals of 1.69 per 1000 members is well within the plan goal of 2.0 per 1000. The standard appeal turnaround time of 100% closed within 30 days met and exceeded the goal of 90%. The expedited appeal TAT of 91.67% compliance rate of timely closure goal within 72 hours; however, did not meet the goal of 99%. An FEP Expedited Appeals Corrective Action Plan (CAP) continued in 2021 which closely monitored performance while tracking multiple interventions to improve timeliness around expedited appeals with a stretch goal of 100% compliance for all expedited appeal closure rate at <72 hours. The 2021 IL FEP expedited appeal volume increased by only 2 from 2020 (285) to 2021 (287).

The overall rate of 0.077 complaints per 1000 and 1.69 appeals per 1000 members are minimal in comparison to the overall membership of 169,740 in Illinois.

Retail Exchange Affected Markets (REAM), On and Off Complaints
Retail Complaints are acknowledged within 5 days and closed within 30 days of complaint reporting date (CRD). Department of Insurance (DOI) compliance is based on the greater of 30 days or the DOI compliance due date. Goal is 90% Compliance. For 1Q & 2Q 2022, the 90% compliance rate was met. Recommendations include continuing to work with the impacted areas for timely receipt of complaints. Continue education/training for compliant staff regarding case review and documentation.
Retail Complaints that met regulatory turnaround times

	1Q 2022			2Q 2022		
	Met	Total	%	Met	Total	%
Illinois PPO						
On and Off REAM Combined	64	64	100.00%	91	91	100.00%
On REAM	43	43	100.00%	51	51	100.00%
Off REAM	21	21	100.00%	40	40	100.00%
Illinois HMO						
On and Off REAM Combined	23	23	100.00%	27	27	100.00%
On REAM	12	12	100.00%	18	18	100.00%
Off REAM	11	11	100.00%	9	9	100.00%

- Complaints that met regulatory TAT with goal of ≥ 90%

Quality of Care Complaints/Adverse Events
Member and QOC complaints are received and triaged by the Customer Assistance Unit (CAU). Complaints classified as QOC are then forwarded to the clinical team for review, evaluation, and determination. In 2022, a total 150 QOC were reported, down from 167 in 2021. The Complaint Main Categories are: Access, Inappropriate/Inadequate Treatment, Quality of Care, Quality of Practitioner Office Site. Of the multiple subcategories, the majority included “level of care” (150) and “perceived lack of caring and concern” (100). BCBSIL takes member safety and satisfaction seriously and will continue to track and trend member complaints across all lines of business by severity and category and implement strategies to ensure member complaints and QOC are resolved timely and according to regulatory requirements.

Plan Access

PCP Specialist and Behavioral Health Practitioner Quality Review Results
In 2022, the QI Audit team conducted Appointment Access/Availability and Medical Chart audits on a random sample of contracted Primary Care Physicians (PCP)s and Behavioral Health Providers. Specialists identified as High Volume/High impact were audited for Appointment Access and Availability only. All audits were conducted utilizing established Quality Site Audit Standards to assess Medical Record compliance and Appointment Availability and Access to care.

Behavioral Health Care Practitioners
The Appointment Access and Availability audit was conducted via mail survey by the Behavioral Health Quality and Accreditation Team. Of the 64 Providers responding to the survey, 42% of Providers were compliant for Non-

Life-Threatening Care, 71% for Initial Visit for Routine Care and 69% for Urgent Care Appointment standard. 100% of responding Providers met the Follow Up Routine Care standard. The survey questions did not ask the specific reasons for the lack of appointment availability; for example, office staffing issues, decreased office hours, COVID 19 restrictions, or if a Behavioral Health Provider's associate was available to see the member.

Behavioral Health Medical Chart Audits were conducted on a total of 60 providers from 15 IL HMO IPAs. All IPAs but 2 passed the overall audit with a score of 90% or higher, of the 60 total Behavioral Health Providers, 51 passed with a score of 90% or higher. It was noted that lack of visits in 2021, possibly due to COVID-19 may have had an impact on the Providers ability to successfully capture patient information.

Primary Care Physician
For the Appointment Access and Availability Audit, all 100 Providers passed the audit with a score of 90% or higher on all standards audited. The PCP Medical Chart Audits were conducted on a total of 169 PCPs from 20 IL HMO IPAs. All IPAs passed the overall audit with a score of 90% or higher.

High Volume/High Impact Specialists
BCBSIL conducted Appointment Access and Availability Audits for 100 Specialists contracted with 20 IL HMO IPAs. A total of 17 IPAs passed the audit with a score of 90% or higher on all standards audited.

FHP/ICP/MLTSS/MMAI
No new standards were added for accessibility and facility as well as for medical records.

Availability of Providers
Availability of Providers is evaluated annually to ensure BCBSIL has an adequate network of practitioners providing care; this includes Primary Care, Specialists including Behavioral Health, and Facilities. Providers geographic accessibility and availability are evaluated by analyzing the distance and number of providers to members. In addition to access and availability, language and cultural background of members is estimated, using U.S. Census data, and the provider network is assessed to determine whether they meet members' language and cultural needs or preferences. Quest Analytics Suite™ software is used for analyzing and communicating access of managed care networks.

Commercial Member Satisfaction/Continuous Tracking Program Results

The Commercial Member Satisfaction Survey (CTP 2.0) is a streamlined and modernized version of the legacy Continuous Tracking Program (CTP). The re-design improves efficiency, reduces cost, and reduces member impact. The program allows HCSC to track commercial (i.e., Group and Retail) member satisfaction and identify areas for improvement. The 10-minute survey is conducted quarterly by live telephone interview through a third-party research partner located in the US and managed by HCSC Market Research.
Stratified random sampling is used to select participants and results are weighted to be representative. A 5-point, fully anchored, excellent to poor scale provides a rational rating of member experience. Results are scored as the percent of positive responses (i.e., excellent, very good, or good, as opposed to fair or poor).

In 2021, a total of 1,900 BCBSIL in-state members, 1,731 group and 191 retail, were surveyed. The key metrics reported below remain consistent and are comparable to prior years. Results are reported for Illinois members living in-state.

<u>BCBSIL Group Results</u>
Overall, BCBSIL Group member ratings remained high in 2021.

BCBSIL Group PPO ratings decreased compared to 2020 on *Overall* and *Likelihood to Recommend*. *Value* is on par with the 2020 rating. Group HMO ratings decreased on Overall but are on par with 2020 ratings on Value and Likelihood to Recommend.

BCBSIL Group Results									
	Overall			Value			Likelihood to Recommend		
	2019	2020	2021	2019	2020	2021	2019	2020	2021
	A	B	C	A	B	C	A	B	C
PPO	93	96	91 B	88	91	89	N/A	81	76 B
HMO	88	94	89 B	91	88	88	N/A	80	78
CDH	88	89	97 A B	87	84	89 B	N/A	74	88 B
Total	**91**	**92**	**91**	**88**	**90**	**89**	**N/A**	**79**	**78**

A, B indicates significant difference from the column listed. Overall and Value ratings indicates the percent of members responding Excellent, Very Good or Good. Recommend rating changed to 0 to 10 scale in 2020 and scores indicate the percent of members rating 7-10.

Number of respondents: PPO –1025; HMO –483; CDH –216

BCBSIL Retail Results

Overall, BCBSIL Retail ratings are steady from last year.

BCBSIL Retail PPO member ratings increased compared to 2020 on *Overall* satisfaction while BCBSIL Retail HMO rating decreased on that measure.

Both Retail PPO and Retail HMO member ratings on *Value* and *Likelihood to Recommend* were on par with 2020 scores.

BCBSIL Retail Results									
	Overall			Value			Likelihood to Recommend		
	2019	2020	2021	2019	2020	2021	2019	2020	2021
	A	B	C	A	B	C	A	B	C
PPO	82	73	83 B	70	69	74	N/A	64	68
HMO	76	85	71 B	69	74	73	N/A	62	64
Total	**79**	**79**	**79**	**70**	**71**	**74**	**N/A**	**63**	**66**

A, B indicates significant difference from the column listed. Overall and Value ratings indicate the percent of members responding Excellent, Very Good or Good. Recommend rating changed to 0 to 10 scale in 2020 and scores indicate the percent of members rating 7-10.

Number of respondents: PPO –124; HMO –67

HMO Asthma and Diabetes Condition Management Population Health Management Surveys

The purpose of the Asthma and Diabetes Condition Management Population Health Management surveys is to obtain the Illinois member perspective of the programs. The surveys aid in assessing the helpfulness of the IPA program staff, the usefulness of educational materials sent to members, and evaluating self-care management. Members who have been with the Condition Management program for at least 60 days and are at least 18 years of age were selected to participate in the Commercial HMO (*HMO Illinois®, Blue Advantage HMO℠*) and the Retail HMO (*Blue Precision HMO℠; Blue Care Direct HMO℠; and Blue Focus Care HMO℠)* surveys.

For 2022 the survey mailings were sent out to members in the first week of October to encompass Q1-Q3 of 2022. This is a change from 2021 where mailings were sent out in the first week of January of 2022 to include survey results for all four quarters. The response rate for the Asthma Condition Management surveys was extremely low (1 response received for the Commercial HMO, and two responses received from the Retail HMO,) and is, therefore, statistically insignificant. As the response numbers are so low, no reasonable conclusion can be drawn to state whether the program was better or worse in comparing 2021 to 2022.

For the 2022 Diabetes Condition Management Survey, the combined results for Commercial and Retail HMO exceeded the 90%-member satisfaction goal for all but one of the survey questions (The program helped me to achieve my health goals - 76.9%Yes.) This is an improvement over the 2021 result of 73% responding 'Yes.'

Ongoing Interventions to improve 2023 survey results:

- HMO Clinical Delegation Coordinators regularly evaluate survey results and provide formal/informal educational opportunities to the IPAs based on the assessment of need.
- IPAs are required to discuss the results of the asthma and diabetes member satisfaction surveys in their UM Committee meetings and implement interventions for results under threshold. IPA intervention plans are submitted to HMO Clinical Delegation Coordinators for approval and oversight.

Future Interventions to improve upon 2022 survey results:

- Initiate a pilot for digital survey process at IPA level to improve response rates.
- IPAs to structure assessments to address health equity and social determinants of health
- Conduct educational webinars on best practices in managing patients with diagnoses of asthma or diabetes.
- Collaborate in discussions with IPAs to consider distributing a communication to members that speak to the importance of surveys in hopes that it will help increase member engagement.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

The 2022 Adult Commercial Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey collected data during the period of March 1 –May 16, 2022. The annual survey is designed to measure member experience and satisfaction with the care that they receive and identify factors that affect that experience level and opportunities for quality improvement.

2022 Adult Commercial CAHPS survey included the following satisfaction and experience measures of Commercial BCBSIL HMO members. Getting Needed Care decreased from the 2021; scores for other items were not significantly different from the prior year:

- Getting care quickly- 80% of surveyed members "Always or Usually" received care, and appointments as soon as needed (Composite measure score)
- Getting Needed Care –77% of surveyed members indicated it is "Always or Usually" easy to get the care they believe is necessary and easy to get an appointment with a specialist (Composite measure score)

- 69% of surveyed members rated their health plan 8-10 (0-10 scale)
- 81% of surveyed members rated their health care 8-10 (0-10 scale)
- 86% of surveyed members rated their personal doctor between 8-10 (0-10 scale)
- 79% of surveyed members rated their specialist between 8-10 (0-10 scale)

2021 QHP Enrollee Experience Survey (PPO and HMO) and Commercial CAHPS (HMO) Member Summary
Annual EES and CAHPS surveys are designed to measure members' experience and satisfaction with their health plan as well as identify factors that affect the experience level while also determining opportunities for quality improvement. This year's QHP PPO and HMO and Commercial HMO surveys were all conducted between February 2021 and May 2022. The samples were members, 18+, who were continuously enrolled in their plan for at least six months as of December 31, 2021 for QHP and at least twelve months for Commercial. Oversamples were used to maximize the number of responses. Surveys were conducted using a multi-mode methodology which included a mail with online option distribution and telephone follow- up for non-respondents. The CAHPS and QHP survey instrument contains four global rating questions, seven composite measures (eight in QHP), and four Healthcare Effective Data and Information Set (HEDIS®2) measures.

Commercial CAHPS key driver analysis recommendations for improving the Overall Health Plan Rating include focus on improving items related to handling claims correctly and quickly, getting urgent and routine care, and Personal Doctor rating including doctor listened carefully. QHP key driver analysis on Overall Health Plan rating recommended attention to several items related to how well doctors communicate for HMO, and some measures related to costs for PPO. Key drivers performing well for PPO were some measures related to getting care quickly and getting needed care.

Measures	**QHP-Illinois HMO**			**QHP-Illinois PPO**			**Commercial Illinois HMO**		
	2020	2021	2022	2020	2021	2022	**2020**	**2021**	**2022**
Sample size	1690	1690	1690	1690	1690	1690	1760	1760	1760
Completed surveys	261	237	182	274	310	234	224	203	166
Response rate	21%	19%	18%	21%	23%	20%	13%	12%	10%
Summary									
The QHP HMO results showed: OvSummary: • Significantly lower scores for plan administration compared to CMS's 2021 benchmark and our vendor's 2022 book of business average. •				The QHP PPO results showed: Summary: • No statistically significant difference in key measures from last year •			There were no statistically significant changes in key overall measures. Getting Needed Care composite measure decreased from 2021 to 2022. Overall Ratings: • Health Plan Rating at 2022 Quality Compass 57th percentile • Overall Rating of Personal Doctor at Quality Compass 57th percentile benchmark • Health Care Rating at Quality Compass 76th percentile • Overall Rating of Specialist at the 5th percentile Composite Measures: • Claims Processing at 7th percentile • Getting Needed Care at 87th percentile		

		• Customer Service at the 49th percentile • How Well Doctors Communicate ranks at 46th percentile benchmark Care Coordination measure at Quality Compass 4th percentile

2022 IL HMO Key Drivers		SMS	2022 IL PPO Key Drivers		SMS
Performing Well			**Performing Well**		
Q14	Paid out of pocket for care unexpectedly	76.8	Q13	Health plan did not pay for needed care	79.4
Q40	Rating of Personal Doctor	87.7	Q27	Rating of Health Care	80.4
Q44	Rating of Specialist	88.2	Q17	Could not get care due to public health emergency	90.4
Room for Improvement			Q22	Getting urgent care	77.1
Q17	Could not get care due to public health emergency	88	Q44	Rating of Specialist	87.4
Q8	Wait time for CS was longer than expected	61.8	Q25	Getting care, tests, or treatment	79.1
Q15	Delayed or did not visit doctor due to cost	74	Q23	Getting routine care	76.1
Q27	Rating of Health Care	76.2	Q41	Getting specialist appointment	70.2
Q16	Delayed or did not fill Rx due to cost	81.2	Q10	Explanation of forms	69
Q31	Showed respect	87.9	**Room for Improvement**		
Q30	Listened carefully	86.3	Q14	Paid out of pocket for care unexpectedly	70.9
Q4	Able to find costs of service or equipment	40.5	Q15	Delayed or did not visit doctor due to cost	73.8
Q5	Able to find costs of prescriptions	38.2	Q8	Wait time for CS was longer than expected	63.3
Q29	Explained things	86	Q9	Ease of filling out forms	67.7
Q32	Spent enough time	85.6	Q16	Delayed or did not fill Rx due to cost	85.9
Q6	CS provided information or help	54.2	Q4	Able to find costs of service or equipment	48.1

2022 Provider Tracking Program (Provider Satisfaction) Results – BCBSIL Retail PPO

HCSC's growth strategy relies heavily on a strong network of providers to serve its members. A major component in building a strong network is an effective relationship between a health plan and their network providers. Such a relationship provides the stability needed to attract and retain quality providers.

The objectives of the Provider Tracking Program are to measure providers' level of satisfaction with their BCBS plan, understand key drivers of that satisfaction and identify areas of strength and opportunities for improving provider relations.

The survey is administered by SPH Analytics, an independent marketing research firm. The surveys are sent annually by mail, phone, and internet. The 2021survey was in the field from June to August 2022.

The following table identifies overall findings from the Provider Tracking Program for BCBSIL Retail PPO. Results are shown as the percent of providers responding positively (Excellent, Very Good, Good as opposed to Fair or Poor).

	2020	2021	2022
Overall Satisfaction^	90*	86	83
Commitment^	59	30	37
Ease of Doing Business	64	58	67

Claims and Member Eligibility	89*	89	88
Provider Relations	72*	69	70
Provider Network	91*	84	83
Utilization and Quality Management	73	72	76
Pharmacy and Drug Benefits	71	61	70
Continuity of Care	69*	74	71

^Overall Satisfaction score measures % Very Satisfied, Somewhat Satisfied; Commitment score is Net Promoter Score
*Rating is significantly higher than competitor

- No statistically significant changes in composite measures compared to 2021, and no significant differences compared to other plans

- Marketplace PPO providers' Overall Satisfaction decreased slightly from 2021. PPO provider ratings of BCBSIL still exceed other PPO plans.

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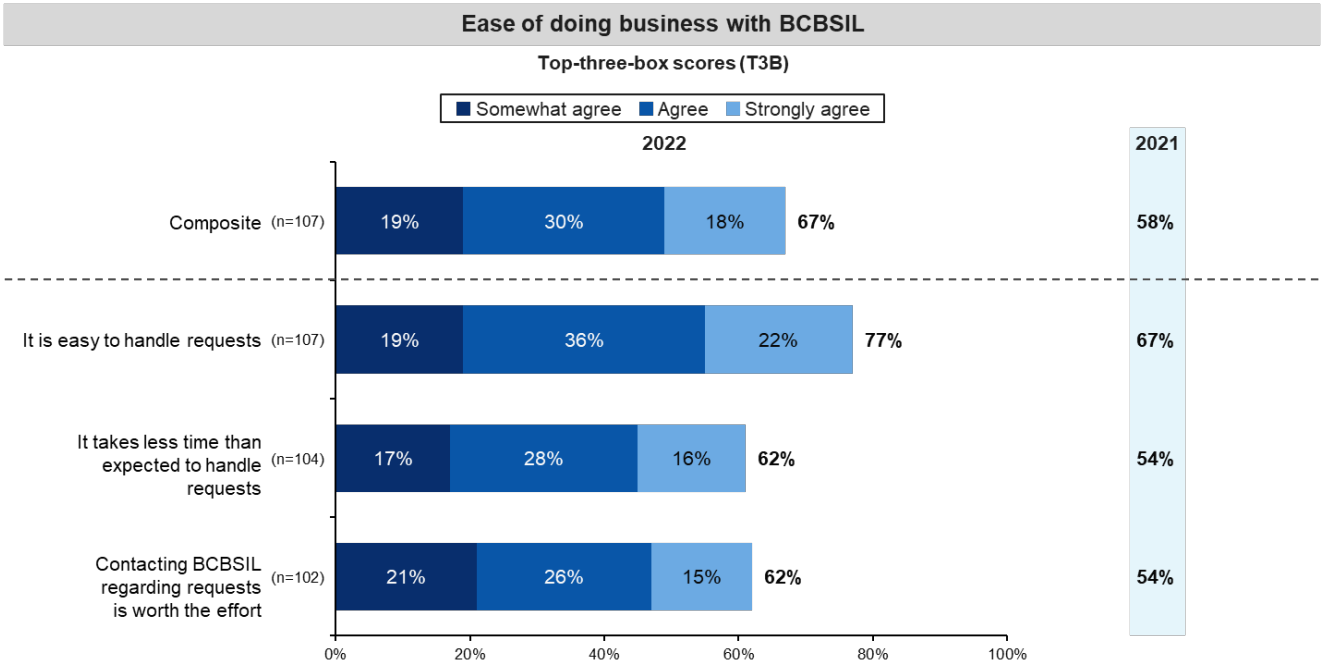
Ease of doing business with BCBSIL continues to be highly important to providers' ratings on Overall Satisfaction, while scores on these measures show room for improvement. Efforts to improve scores on these measures have the potential to increase overall satisfaction.



BCBSIL Marketplace PPO UM Measures

	BCBS Marketplace PPO	Other Health Plans
Phone Availability of UM staff	**73**	**69**
Timeliness of non-emergent authorization	**76**	**73**
Explanation of adverse review decisions	**69**	**73**
Adverse review decisions reflect evidence-based medicine	**65**	**65**
Phone access to Case/Care Managers	**66**	**65**
Community resource options	**83**	**76**
Chronic disease management resources	**79**	**73**
Plan promotes preventative care	**87**	**80**
Understanding of care management program	**76**	**72**
Overall satisfaction with UM	**82**	**74**

Continuity and Coordination of Care

Continuity and Coordination of Medical Care
The purpose of this report is to perform an annual assessment of continuity and coordination of care and acts as necessary, to improve the continuity and coordination of medical care between practitioners or sites of care to avoid miscommunication or delays in care that can lead to poor outcomes. Data was collected from surveys, site audits, QI projects, and Plan all cause readmission measure.

Based on data analysis the following opportunities for improvement were identified:

- To prevent hospital readmissions
- To improve coordination of care between the PCP and other specialists
- To improve coordination of care between the primary care practitioner and eye care provider
- To advance communication and team collaboration between members, providers, and specialist.

PCP's feedback of communication among specialists for both marketplace and commercial HMO showed to have some room for improvements. In 2021, seven of the nine facilities had a decrease of 1-10%, expect for emergency rooms and rehab facilities with an increase of 2-3%. All facilities did not meet the 90%, expect for hospitals, emergency rooms, and rehab facilities.
Our plan all cause readmissions measure has shown an increase in the rates, we did not met our benchmark. In 2021 the results were.63% for HMO-COM,.51% for HMO-Marketplace, and.62% for PPO- Marketplace. Part of the BCBS IL HMO population health strategy, our medical management program description has incorporated a goal to reduce unplanned ER readmissions by .5%

This will be done by:

- Utilization of Predictive Readmission report to identify "high risk" population.
- Staff outreach to top 10 of members identified as high risk for unplanned readmission through the ER, within 30 days of discharge.

PPO providers will continue to be provided the QRS plan all cause readmission data, and results will be continually monitored.

Continuity and Coordination of Care between PCP and Behavioral Health Practitioner
Purpose of this report is to perform an annual assessment of the continuity and coordination of care between medical and behavioral health providers.

There were a few items that were used to assess continuity and coordination of care. Among them the BCBSIL HMO PCP Survey, BCBSIL Behavioral Health Specialists Site Audit Results, BCBSIL PCP Site Audit Results, BCBSIL HMO HEDIS Results, and the BCBSIL Complex Case Management Program.

The first opportunity of improvement was in the communication between the Behavioral Health Specialist and the PCP. When looking at the BCBSIL PCP Survey rating of feedback from Behavioral health specialists, satisfaction was at 87% in 2021 which is an increase from 61% in 2020. The documentation in the BHS medical record of communication between the BHS and the referring practitioner had no effective results due to no onsite medical records audits performance in 2021, extended effects of the COVID-19 pandemic.

For the second opportunity of antidepressant medication management for members with a new episode of major depression for the HMO Marketplace population, the interventions may have had an impact since Antidepressant Medication Management rates HMO Commercial, as both indicators have had a significant increase in the rates. For the HMO Marketplace population there was an increase in both indicators. For the Effective Continuation Phase Treatment indicator was an increase of 1% and increase of 2% for the Effective Acute Phase Treatment. For the HMO Commercial population there was an increase of 1% in Effective Continuation Phase Treatment indicator and an increase of 1% in the Effective Acute Phase Treatment. An article and clinical resources were also provided to the provider website.

To analyze the results of the QI Fund project in 2021 after the 2018 inclusion of ADHD: Follow-up Care for Children Prescribed ADHD Medication-Initiation Phase 30 days. IPAs with rates of >42% where IPAs have the potential to earn incentives. BCBSIL continues to work with the IPAs to improve the quality and completeness of encounter data, which is used in reporting results for the ADHD HEDIS measure. The BCBS provider website also includes clinical resources for best practice standards. The BCBS provider website also includes clinical resources for ADHD.

Continuity and Coordination of Care between PCP and Behavioral Health Practitioner- Group and/or Retail
BH Outpatient Provider Satisfaction/Experience Survey was an email invitation to an online survey followed by two mail surveys sent to 9,000 randomly selected BCBS Behavioral Health providers with outpatient BH claims. Results weighted to reflect Behavioral Health provider population. Providers administering outpatient services are surveyed annually. The types of providers administering outpatient services are surveyed annually which includes, Licensed Clinical Professional Counselor, Licensed Clinical Social Worker, Drug/Alcohol Counselor, Psychologist/Psychological Associate, Marriage/Family Therapist, Psychiatrist, Behavior Health Nurses, Utilization Reviewers, and Behavior Health Clinicians. The response rate increased to 16% in 2019 again to 4.3% in 2020, and then decreased to 4.0% in 2021. The survey had some highlighting points.

Group and/or Retail: Despite the slow lingering effects of the pandemic, the timeliness of provider feedback continued to show efforts in communication of coordination from 87% in 2019 to an increase to 88% in 2020, and another increase of 100% in 2021 meeting above the goal (≥74%). Additionally, helpfulness of the medical practitioner rates increased from 2020 to 2021 by twelve percentage point. Scores for Helpfulness of Feedback were still above the (≥84%) goal at 100%.

The causal analysis of both the provider satisfaction/experience and BH and Medical Management Satisfaction/Experience surveys showed that providers indicate satisfaction with the frequency that coordination of care occurs also indicate a satisfaction with the helpfulness of the communication when it occurs. Coordination of care between BH and medical providers showed a few satisfaction drivers of high ratings in BH telehealth services and helpfulness of provider web pages in coordination of care and a coordination of care tools.. The use of Electronic Medical Record (EMR) systems across large hospital and affiliated provider systems can still present an issue, BH providers are often not part of those systems.

The annual continuity and coordination of Care analysis showed there were some opportunities for improvement.

1. Coordination of care between BH and medical providers can be improved by increased promotion of the efficacy of the coordination of care and a coordination of care tool.
2. Member knowledge related to ADHD and depression treatment can be improved.
3. The Behavioral Health and Medical Management Provider Satisfaction surveys can be more aligned in the same questions related to Coordination of Care, making it more accurate to compare results.
4. Provider knowledge regarding best practices for ADHD treatment and anti-depressant medication management can be improved, especially in the primary care setting.
5. Member accessibility to both PCP and behavioral health diagnosis and treatment information can be improved.
6. The method to obtain consistent BH consult data can be improved.

Based on analysis, there were the following planned interventions:

1. Investigate channels to promote coordination of care and a coordination of care tool between medical and behavioral providers such as a provider newsletter, emails, and/or live meetings via Network Department.
2. Publish a BH Connect Site article related to the topic of ADHD treatment, monthly IL HMO NCQA articles in LifeTime publications, and additional articles related to Depression (and anxiety) to increase member awareness of both topics.
3. Collaborate with Strategic Marketing to align the Behavioral Health and Medical Management Provider Satisfaction surveys to ensure the questions are the same related to Coordination of Care between BH and Medical providers.
4. Improve BHS and PCP communication of patient education of medication and follow-up feedbacks.
5. Improve accessibility to the Behavioral Health landing page on the Connect site to increase traffic to this member facing content.
6. Streamline reporting to accurately capture BH consult and follow-up data.

Plan Acknowledgement and Approval

Conclusion

This report demonstrates that the BCBSIL QI Program was effective in improving the quality of care, quality of service and safe clinical practices in 2022. Overall, the annual evaluation demonstrates the ongoing QI activities performed to address the quality and safety of clinical practices and quality of service with the network.

The BCBSIL QIC approved the 2022 QI Program Evaluation on 3/1/2023.