2017 BCBSIL QUALITY IMPROVEMENT PROGRAM EVALUATION

Date approved:

| BCBSIL QI Committee | 03/07/2018 |

Blue Cross and Blue Shield of Illinois, a Division of health Care Service Corporation, a Mutual Legal Reserves Company, an Independent Licensee of the Blue Cross and Blue Shield Association
PCP and Behavioral Health Practitioner Site Visit Results ................................................................. 16
Behavioral Health Care Practitioners .................................................................................................... 16
Primary Care Physician ........................................................................................................................ 17
FHP/ICP/MLTSS/MMAI .......................................................................................................................... 17
Availability of Providers ........................................................................................................................ 17
Behavioral Health Telephone Access .................................................................................................... 18
HMO Member Survey ............................................................................................................................ 18
Continuous Tracking Program Results .................................................................................................. 18
Continuous Tracking Program Results .................................................................................................. 18
Continuous Tracking Program Results .................................................................................................. 18
Continuous Tracking Program Results .................................................................................................. 18
Consumer Assessment of Healthcare Providers and Systems Survey .................................................... 19
Consumer Assessment of Healthcare Providers and Systems Survey .................................................... 19
Consumer Assessment of Healthcare Providers and Systems Survey .................................................... 19
Consumer Assessment of Healthcare Providers and Systems Survey .................................................... 19
2017 QHP (PPO and HMO) and Commercial CAHPS (HMO) Member Summary ............................... 20
2017 QHP (PPO and HMO) and Commercial CAHPS (HMO) Member Summary ............................... 20
2017 QHP (PPO and HMO) and Commercial CAHPS (HMO) Member Summary ............................... 20
HMO PCP Survey ................................................................................................................................. 21
Provider Satisfaction Survey Marketplace PPO ....................................................................................... 21
Provider Satisfaction Survey Marketplace PPO ....................................................................................... 21
Provider Satisfaction Survey Marketplace PPO ....................................................................................... 21
HMO Contract Entity Survey ................................................................................................................ 22
Continuity and Coordination of Care ..................................................................................... 22
Continuity and Coordination of Care .................................................................................................. 22
Continuity and Coordination of Care .................................................................................................. 22
Continuity and Coordination of Care .................................................................................................. 22
Continuity and Coordination of Care .................................................................................................. 22
Continuity and Coordination of Care .................................................................................................. 22
Plan Acknowledgement and Approval ......................................................................................... 23
Plan Acknowledgement and Approval ......................................................................................... 23
Plan Acknowledgement and Approval ......................................................................................... 23
Conclusion ........................................................................................................................................... 23
Evaluation and Overall Effectiveness

Executive Summary
An evaluation of the Blue Cross and Blue Shield of Illinois (BCBSIL) 2017 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 2017 QI Program Description. The 2017 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.

Accomplishments Include
- Year over year improvements in Healthcare Effectiveness Data and Information Set (HEDIS®) rates across product lines for BCBSIL. Notable improvements were seen in 7 out of 12 of the Health Care Service Corporation (HCSC) Common Measures for Commercial HMO and 6 out of 12 for the Retail PPO lines of business.
- QI Project performance also improved in 3 project indicators that align with the HCSC Common Measure Set.
- QI Best Practice educational and tool kit resources were authored and released to Network Providers. These tools align with HCSC’s Common Measure Set.
- Augmented Approach to Provider Corrective Action Plans:

Twenty-five provider groups in the IL HMO are now under intensified Corrective Action Plans for groups that have not demonstrated meaningful clinical improvement over time. This more robust practice-support approach involves direct meetings with medical leadership of each IPA to review deficiencies and develop a customized plan for improvement with quarterly follow-up.

HCSC Common Measures
The HCSC Common Measures Set is a set of 12 HEDIS quality measures utilized to focus enterprise quality efforts across all five state plans. The specific measures are as outlined below:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Comprehensive Diabetes Care: HbA1c Poor Control (&gt;9%)</td>
</tr>
<tr>
<td>2.</td>
<td>Comprehensive Diabetes Care: HbA1c Control (&lt;8%)</td>
</tr>
<tr>
<td>3.</td>
<td>Controlling High Blood Pressure *‡</td>
</tr>
<tr>
<td>4.</td>
<td>Medication Management for People with Asthma *†</td>
</tr>
<tr>
<td>5.</td>
<td>Well-Child Visits in the First 15 Months of Life</td>
</tr>
<tr>
<td>6.</td>
<td>Childhood Immunization Status - Combo 3*‡</td>
</tr>
<tr>
<td>7.</td>
<td>Appropriate Treatment of Children with Upper Respiratory Infection †</td>
</tr>
<tr>
<td>8.</td>
<td>Avoidance of Antibiotics Treatment in Adults with Acute Bronchitis *†</td>
</tr>
<tr>
<td>9.</td>
<td>Breast Cancer Screening†</td>
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<tr>
<td>10.</td>
<td>Colorectal Cancer Screening *‡</td>
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<tr>
<td>11.</td>
<td>Cervical Cancer Screening *†</td>
</tr>
<tr>
<td>12.</td>
<td>Persistent Beta Blocker Treatment After a Heart Attack</td>
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</table>

*HEDIS® Commercial HMO Measures with improvements  †HEDIS® Retail PPO Measures with improvements  ‡HMO QI Project Performance Measures with improvements

NOTE: Medication Management for People with Asthma noted improvement for both reported rates.
Summary of 2017 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 Governance and Nominating Committee on a regular basis.

BCBSIL has taken the following actions to address health equity for its members:
- Provider Education: simple one-page provider educational tools addressing evidence-based methods to achieve high performance are currently in use with our HMO providers for four of the twelve HCSC Common Measure Set indicators, including Breast Cancer Screening, Comprehensive Diabetes Care, Colorectal Cancer Screening, and Controlling High Blood Pressure. These tools are being updated to address directly relevant health equity concerns, with plans to expand to additional measures.
- LYFT Transportation Pilot expected launch Q1, 2018: HCSC, in coordination with the Blue Cross Association and LYFT, the mobile ride-sharing service, is partnering to pilot the use of ride sharing for members requiring transportation to clinical visits at the discretion of their primary doctor.
- Depression Pilot expected launch Q2, 2018: This pilot attempts to augment current depression QI efforts by obtaining race/ethnicity data for our HMO members with depression to assess if racial disparities are present that might warrant an intervention targeted towards minority groups.

Evaluation of 2017 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.

Group/Commercial
Of the 144 indicators listed in the 2017 Work Plan with goals assigned:
- 129 indicators met the goal
- 15 indicators did not meet the goal

Retail (Marketplace/Exchange)
Of the 150 indicators listed in the 2017 Work Plan with goals assigned:
- 129 indicators met the goal
- 21 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 2017, 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 Quality and Accreditation. 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 the Vice President and CMO or physician designee. The QIC brings multidivisional staff together with network providers including a behavioral healthcare practitioner.
The BCBSIL QIC and the Governance and Nominating Committee of the HCSC Board of Directors review and approve the annual QI Program Description. The QIC also reviews and approves the QI Work Plan and the annual QI Program Evaluation.

**Leadership Involvement and Practitioner Participation**

BCBSIL physician leadership is responsible for the QI Program. The Vice President and CMO or physician designee provides direction and oversight for the BCBSIL Clinical Quality Program and chairs the BCBSIL QIC. The BCBSIL QIC met 12 times in 2017 and 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 Provider Roundtable, Administrative Forum as well as a monthly Physician Advisory Committee. These conferences and meetings offer an opportunity to review quality data, share best practices and collaborate across organizations.

**Need to Restructure or Change the QI Program for 2018**

BCBSIL evaluated the results and resources from the 2017 QI Program. It was determined that the QI Program results and resources were consistent with a successful QI Program. Medical Director focus and clinical analytic activities were enhanced to provide additional focus on improving quality across our entire member population. Building on the success of 2017, an additional quality focus in 2018 will include providing timely, real-time quality performance data analytics to enable focused interventions and gap closures throughout the year.

**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® Condition Management
- Enterprise Lifestyle Management
- Enterprise Wellness Programs
- Clinical Pharmacy Programs
- Credentialing
- Communications (Marketing, Positioning and Targeted, and Public Affairs)
- Customer Service
- Delegation Oversight Programs
- Medical Directors
- Quality Improvement Program staff
- Accreditation Program staff
- HEDIS Program staff
- Reporting (Systems and Reporting and Analytics and Information Management)
- Claims, Membership, Medical Management and other systems/platforms as needed
- Utilization Management/Case Management (Medical Management)
- Special Beginnings®
- HCSC Behavioral Health
- Affinity Programs
- Network Management (e.g., provider services and provider contracting, and relations)
- Value Based Care Models: Intensive Medical Home (IMH); Accountable Care Organization (ACO)

**Quality Improvement Committee**
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The BCBSIL QIC and the Governance and Nominating Committee of the HCSC Board of Directors review and approve the annual QI Program Description. The QIC also reviews and approves the QI Work Plan and the annual QI Program Evaluation.

The BCBSIL QIC is responsible for providing oversight and direction to the QI Program. The QIC is chaired by the BCBSIL Vice President and CMO or physician designee. 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 Medical Management QI Projects
- Review and approval of summary reports from the Policy and Procedure Committee
- Review and approval of summary reports from the Enterprise Medical Management Policy and Procedure Committee
- 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 onsite 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 at least ten (10) times per year. Its membership includes: Practitioners from BCBSIL Networks (with at least 1 behavioral health specialist), BCBSIL Vice President and CMO (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.
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). 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:

<table>
<thead>
<tr>
<th>Plan</th>
<th>NCQA</th>
<th>URAC UM</th>
<th>URAC CM</th>
<th>URAC Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBSIL HMO</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td>BCBSIL PPO</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Exchange HMO</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Exchange PPO</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
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</table>

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.

In 2017, the methodology for six of the seven 2017 projects transitioned from retrospective to prospective. The prospective projects include: Weight Assessment and Counseling for Nutrition and Physical Activity (WCC), Childhood Immunizations (CIM), Adolescent Immunizations and Human Papillomavirus (IMA/HPV), Colorectal Cancer Screening (COL) and Diabetes. The seventh project, Prenatal Care and Postpartum Care was prospective. Payment thresholds were aligned with 2016 Quality Compass™ thus aligning project performance with national benchmarks. The 7 projects consisted of 12 quality indicators, results are summarized below.

Results and Quantitative Analysis

- Group - Of the 12 quality indicators for the Group QI Fund projects, 9/9 met or exceeded goal. The 3 diabetes indicators are still pending final results.
- Retail - Of the 12 quality indicators for the Retail QI Fund projects, 9/9 met or exceeded goal. The 3 diabetes indicators are still pending final results.

Opportunities for Improvement (OFI) In Order of Priority

- QI projects performing under the 50th percentile for Quality Compass™ were prioritized for 2018.
- IMA/HPV continues to be a priority and opportunity for 2018. Despite YOY improvements in HPV rates, BCBSIL rates fall short of Healthy People 2020 goal of 80%.
  - Marketplace rates for HPV improved from 11% in 2016 to 26.2% in 2017
  - Commercial rates for HPV improved from 16% in 2016 to 29% in 2017.

Effectiveness of Interventions Implemented in Previous Reporting Period

- The impact of the 2017 prospective methodology for 2017 QI projects on 2018 HEDIS results will be evaluated June 2018.
2018 Projects were aligned with HEDIS hybrid measures and NCQA Health Plan ratings with a focus on prevention and treatment.

**Illinois Medical Management Improving Utilization of Milliman Care Guidelines**

The focus of this project is to assess the consistency with the identification and application of Milliman Care Guidelines (MCG). MCG care guidelines provide evidence-based best practices and care-planning tools across the continuum of care, supporting clinical decision-making and documentation and enabling efficient transitions between care settings.

The 2017 case audit data collection cycle was conducted for the 2nd Quarter 2017. There was a change in the case selection criteria for this measurement period from, two (2) randomly selected cases per Clinical Staff to aggregate case selection from the Aerial Utilization Management (UM) Clinical Activity Reports. The clinical documentation is audited to determine the consistency with which health care professionals involved in UM apply criteria in decision making activities. Subsequent case collection cycles will be conducted in the 2nd and 4th Quarters. Case documentation that does not include or includes the inappropriate use of MCG care guidelines will be scored as non-compliant. The indicators for the project are: Did the Clinical Staff select the appropriate MCG care guidelines? and Did the Clinical Staff update the MCG care guidelines throughout the case as appropriate? The goal for the project for each indicator is a 10% improvement based upon the prior measurement period until a goal of 90% is reached. Once the goal of 90% is reached and sustained for 3 consecutive measurement periods, the project may be recommended for closure. Projected time for project completion is 4th Quarter 2018.

There was a total of 196 randomly selected Utilization Management cases from the Aerial Utilization Management Clinical Activity Reports for the 2nd Quarter 2017. The 2nd Quarter 2017 Audit results for Indicator #1 are 96% (188/196). This is a 3% increase (3 percentage point increase) from the 4th Quarter 2016 audit results of 93%. The goal of 90% for the 2nd Quarter 2017 was met. The 2nd Quarter 2017 Audit results for Indicator # 2 were not applicable for this measurement period as the MCG care guidelines did not have to be updated or changed within the cases under review.

Recommendations include providing 2nd Quarter 2017 audit results to the Management Team for coaching and development of the Clinical Staff. The Illinois Medical Management Utilization Management leadership has put several interventions in place to improve and sustain the correct selection of MCG care guidelines. These interventions included 8-hour MCG care guidelines workshops and regular refreshers by a MCG Certified Trainer, a webinar on MCG care guidelines through HCSC’s webinar based training modules, and a training session by a representative from MCG. The correct use of MCG care guidelines is addressed in monthly meeting updates, addressing specific issues as identified through audits.

**Quality of Service**

**HMO Service Project Initiatives**

BCBSIL annually monitors member satisfaction within our health plan services and healthcare delivery system and identifies opportunities for improvement. The 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 (AHRQ) 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 Getting Care as soon as needed when care was needed right away increased to 89%, Ease of getting care, test or treatment rate increased to 89% and Getting an appointment with specialist decreased three percentage points to 76%. Available appointment times may not be convenient for members and some Medical Groups (MG) may not be effective in arranging adequate after-hours access (evening or weekends) for members. BCBSIL has contractual requirements with MG for access to physicians and physicians have contractual agreement with the MG making implementation of interventions challenging.
Illinois Hospital Quality Initiative
The Illinois Hospital Quality Initiative (IHQI) was designed to measurably reduce the burden of healthcare-associated infections (HAIs), improve the quality of patient care and avoid unnecessary cost. Sponsored by BCBSIL and others, the program aids Illinois hospitals in efforts to optimize antimicrobial stewardship, and includes tools such as educational programs tailored to support infection prevention, pharmacy, and quality. Participating hospitals receive funding to help cover the costs of CareFusion MedMined® services. Offerings include a reproducible nosocomial infection case-finding tool, real-time customizable reports and notifications, streamlined mandatory reporting capabilities, peer-reviewed annual outcomes report and risk-adjusted objective benchmarking. In 2016 there were approximately 46 participating hospitals throughout the state. The 1st quarter of 2017 report provides nosocomial infection marker (NIM) data in an aggregate fashion or by hospital, not identified by name. This includes a summary of infection rates using a decent sample of Illinois hospitals, data on overall trends as well as infection source-specific NIM trend and more detailed drill down information. The program has demonstrated meaningful improvements in nosocomial infections at Illinois hospitals. As of the first quarter of 2017, nosocomial infections were reduced by 4.0% overall compared to the prior year. The largest decrease was observed in urine infections at down 7.9%. Only stool infections increased by 2.0% driven by Clostridium difficile infections. However, despite these improvements, Illinois hospital nosocomial infection rate at 3.62% was found to be slightly higher than the national average of 3.40%.

Illinois Surgical Quality Improvement Collaborative
The Illinois Surgical Quality Improvement Collaborative (ISQIC) is a collaborative partnership of the Illinois hospitals, the Illinois and Metropolitan Chicago Chapters of the American College of Surgeons, the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP), the Surgical Outcomes and Quality Improvement Center (SOQIC) at Northwestern University, and Blue Cross Blue Shield of Illinois. Since its inception in 2014, 55 Illinois hospitals have joined ISQIC making it the largest collaborative in ACS NSQIP. The mission of ISQIC is to continue to work together with the goal of improving the quality of surgical care in Illinois. ISQIC has become one of the most successful and recognized quality collaboratives in the U.S. ISQIC has been an extremely active and successful collaborative with several quality improvement initiatives undertaken. Listed below are some of the activities completed by ISQIC.
- Quality and Process Improvement Training
- Guided Implementation
- Process Measures Platform
- Benchmarking Reports
- Surgeon-Specific Reports
- Collaborative Engagement Visits
- Video Based Coaching Initiative
- Opioid Reduction Initiatives
- Collaborative Quality Improvement Projects (CQIP)
- Surgical Site Infection Bundle
- Venous Thromboembolism (VTE) Prophylaxis: resulting in a 28% decrease in post-operative VTE
- Appropriateness of Blood Transfusions
- Glycemic Control
- Quality of Colonoscopies

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, and Tobacco Cessation.

Member Mailers
In 2017, 303,299 mailings were sent to BCBSIL members covering topics of male and female 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 2017 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.
- **Men’s Birthday Card**: Mailer to males 50 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.
- **Mammogram Reminder Calls**: Outbound automated calls to female members 42-69 years of age who have not had a mammogram within the previous year to encourage breast and cervical cancer screenings.
- **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.

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<td>Colon Cancer Screening e-Message</td>
<td>Annual</td>
<td>73702</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>73702</td>
</tr>
</tbody>
</table>

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.

Common Measure Set
BCBSIL adopted the Common Measure Set 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 as part of a Common Measure set to track and trend results for BCBSIL.
## HCCS Common Measure Set

<table>
<thead>
<tr>
<th>Measure</th>
<th>Type of Measure</th>
<th>IL HMO Commercial (%)</th>
<th>IL HMO Marketplace (%)</th>
<th>IL PPO Commercial (%)</th>
<th>IL PPO Marketplace (%)</th>
<th>2017 Quality Compass National Avg. (All LOB)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDC: HbA1c Control (&gt;9%)</td>
<td>Hybrid</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>CDC: HbA1c Control (&lt;8%)</td>
<td>Hybrid</td>
<td>63.84</td>
<td>57.62</td>
<td>X</td>
<td>41.69</td>
<td>51.28</td>
</tr>
<tr>
<td>Controlling High Blood Pressure (140/90 mm hg)</td>
<td>Hybrid</td>
<td>69.09</td>
<td>60.36</td>
<td>X</td>
<td>41.46</td>
<td>58.71</td>
</tr>
<tr>
<td>Medication Management for People with Asthma (&gt;75% (5 – 64 years)</td>
<td>Admin</td>
<td>49.08</td>
<td>57.24</td>
<td>51.76</td>
<td>51.74</td>
<td>48.99</td>
</tr>
<tr>
<td>Persistent Beta Blocker Treatment after a Heart Attack</td>
<td>Admin</td>
<td>83.23</td>
<td>X</td>
<td>85.12</td>
<td>X</td>
<td>84.06</td>
</tr>
<tr>
<td>Well-Child Visits in the First 15 Months of Life (6 + visits)</td>
<td>Admin</td>
<td>71.49</td>
<td>56.04</td>
<td>X</td>
<td>52.59</td>
<td>78.41</td>
</tr>
<tr>
<td>Childhood Immunization Status – Combo 3</td>
<td>Hybrid</td>
<td>79.55</td>
<td>77.39</td>
<td>X</td>
<td>64.35</td>
<td>72.54</td>
</tr>
<tr>
<td>Appropriate Treatment of Children with Upper Respiratory Infection**</td>
<td>Admin</td>
<td>87.46</td>
<td>85.71</td>
<td>87.79</td>
<td>87.5</td>
<td>87.69</td>
</tr>
<tr>
<td>Avoidance of Antibiotics Treatment in Adults with Acute Bronchitis**</td>
<td>Admin</td>
<td>22.75</td>
<td>21.09</td>
<td>24.63</td>
<td>26.31</td>
<td>28.4</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>Admin</td>
<td>74.07</td>
<td>62.51</td>
<td>70.42</td>
<td>62.68</td>
<td>71.41</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>Hybrid</td>
<td>71.22</td>
<td>47.19</td>
<td>57.37</td>
<td>46.02</td>
<td>60.11</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>Hybrid</td>
<td>79.81</td>
<td>52.82</td>
<td>74.8</td>
<td>61.11</td>
<td>73.63</td>
</tr>
</tbody>
</table>

*HEDIS® Commercial HMO Measures with improvements
†HEDIS® Retail PPO Measures with improvements
‡HMO QI Project Performance Measures with improvements
NOTE: Medication Management for People with Asthma noted improvement for both reported rates.
### Commercial HMO and PPO, Marketplace HMO and PPO 2017 HEDIS & QRS Results Summary

<table>
<thead>
<tr>
<th></th>
<th>YOY performance improvement</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>in HMO Commercial</td>
<td>42.6%</td>
<td>(26/61)</td>
</tr>
<tr>
<td></td>
<td>(1 new measure and 1 NR)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>YOY performance improvement in HMO Retail</td>
<td>47.4% (18/38)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(2 new measures and 0 NR)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>YOY performance improvement in PPO Commercial</td>
<td>48.2% (27/56)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(1 new measure and 14 NR)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>YOY performance improvement in PPO Retail</td>
<td>57.9% (22/38)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(1 new measure and 0 NR)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Volume of Indicators

<table>
<thead>
<tr>
<th></th>
<th>Above 2016 Quality Compass values:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HMO Commercial: 53.8% (28/52)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PPO Commercial: 53.5% (23/43)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equal to 2016 Quality Compass values:</td>
<td>HMO Commercial: 1.9% (1/52)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PPO Commercial: 0% (0/43)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below 2016 Quality Compass values:</td>
<td>HMO Commercial: 44.2% (23/52)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PPO Commercial: 23.3% (10/43)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### BCBSIL Membership

<table>
<thead>
<tr>
<th></th>
<th>Commercial HMO</th>
<th>Marketplace HMO</th>
<th>Commercial PPO</th>
<th>Marketplace PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>577,758</td>
<td>66,634</td>
<td>2,076,675</td>
<td>109,580</td>
</tr>
</tbody>
</table>

Table 1: Year End Membership Counts for 2017 HEDIS® and QRS Reporting for BCBSIL Plan (As of December 31, 2016).

### 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. Results show that the average initial volume over the past three years was approximately 2,900 files per year. This volume is not abnormal for the Illinois Plan. The target of credentialing providers in 45 days was identified as an outlier for 2016. During 2016, the initial turnaround time was impacted by the hiring freeze of open positions due to the budget process. Work with the temporary agency to ensure staff assigned to the project have been evaluated for the skills needed to transition into full time positions to immediately assist with the credentialing inventory and turnaround times. Plan of Action to address inventory and compliance due to staffing:

- Temporary staffing was approved during 3rd Qtr. 2016.
- All temps are provided training through an expedited 5-week training program (as compared to our standard 12-week program).
- Open positions are being filled by trained temporary staff.
- Temporary assistance has been extended through Year End 2017.

<table>
<thead>
<tr>
<th>Credentialing Activity</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Volume</td>
<td>TAT</td>
<td>Volume</td>
</tr>
<tr>
<td>Initial: Target Avg 45 Days</td>
<td>3,698</td>
<td>40</td>
<td>2,212</td>
</tr>
<tr>
<td>Recredentialing in 36 months - Facilities</td>
<td>109</td>
<td>100%</td>
<td>92</td>
</tr>
</tbody>
</table>
Pharmacy

The Pharmacy Voice of the Customer (VoC) Program is an integrated approach to enhance cross-functional change using customer insight for short-term, tactical change; but also, to aid long-term strategic planning to reduce costs by improving processes and creating greater consistency, increasing revenue, decreasing costs through operational improvements, driving cultural change that will influence key business and customers’ key process input variables (KPIVs).

Although some overturns can be expected, the team-based cross-functional process improvement, utilizing the strategic approach of Lean Six Sigma, focused on reducing and/or eliminating the issues that cause inappropriate overturns. The team was able to gain consistency in the process and so results fell at or below the target of ≤10%. The SRU Quality Improvement team continuously seeks ways to eliminate inappropriate overturns, by analyzing wastes and defects that take place in the downstream flow of the process. One issue that was identified was the limitations of the Aerial system. In 2017, SRU assisted in the development of a new system called Smart UM. Smart UM is expected to positively impact the end-to-end medical J code review process by:

- Reducing (if not eliminating) the misrouting of reviews to non SRU UM departments
- Eventually hard code dose, frequency, and duration into the request as opposed to it being contained within a free-text notes section
- Eliminate the need for SRU staff to manually collect data
- Implement a “next” button for the clinical review staff which will eliminate reviewer case type variation
- Provide a more efficient means to update service lines therefore reducing the time and error rate for that function
- Eventually provide a live link to ECM for medical records
- Potentially improve authorization letters to include dose/frequency/duration specifics

Overall, the SRU department was 81% consistent in the application of medical policy and national recognized guidelines. The exclusion of ‘gray’ requests (< 70% consistent) would produce an overall departmental consistency level of 91% in the application of the medical policy and national recognized guidelines.

Requests without unanimous agreement will be targeted for a level setting discussion related to the medical policy, guidelines, applicable literature and best practices. The inclusion of the ‘gray’ requests allowed for the identification of areas of inconsistency that clear-cut requests may have not. Individuals < 90% consistent (with the exclusion of ‘gray’ requests) will attend a level-setting meeting and retrained if necessary. Consistency of NCCN Guideline update review, interpretation of NCCN Guidelines, consistency of required updated documentation of clinical benefit, application of continuation/retreatment criteria for Xolair for asthma.

The findings of this survey were communicated to and discussed with the SRU pharmacists 02/22/2017. The 2 pharmacists with < 90% consistency (with the exclusion of ‘gray’ requests) will attend a level-setting meeting with the SRU director and lead pharmacist to determine if retraining is necessary. Areas for improvement were identified and addressed. Those areas will be communicated to the medical directors to inform and ensure consistency across both departments. Between IRR surveys consistency variation will be addressed via a pharmacist meeting (currently held monthly) in hopes of resolving the conflicting application of medical policy and other opportunities for improvement. Conducting an IRR survey every 6 months will provide the mechanism to identify areas of inconsistency. The next survey will be conducted in Fall 2017.

Midyear analysis of the above IRR Survey resulted in identification and closure of several gaps. Both pharmacists who scored less than 90% with the group attended a level-setting meeting. Cases deemed ‘gray’ were discussed during the monthly clinical meetings following the survey between SRU pharmacists and the medical directors in order to discuss clinical decision consistency moving forward. Additionally, as part of the SRU AOC Expansion Initiative, several staff within the department are now in dedicated quality/clinical roles to
further increase clinical and operational consistency by conducting regularly scheduled auditing, surveying, and training.

**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 2017 HMO Utilization Management and Care Coordination Program annual evaluation was completed and presented to the BCBSIL QIC with associated analysis and action plans for 2017. The purpose of the annual evaluation is to document oversight of the Physician Groups or compliance with requirements set forth as outlined in the 2017 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

**Delegation Oversight Programs**
Delegation Activity for the 2017 reporting period is as follows.

- 9 Pre-delegation approvals- 4 Credentialing, 2 UM, and 3 Vendor
- 37 Annual Audit Program approvals- 21 Credentialing, 5 UM, and 11 Vendor
- 23 Corrective Action Plan approvals- 10 Credentialing, 1 QI, 5 UM and 7 Vendor
- 1 Credentialing Program pending
- 1 Credentialing Corrective Action Plan pending

**Issues from Delegated Activity Report.**

- MDLive Inc. did not achieve passing scores for the Annual Credentialing Audit. EDOP recommended to pend approval of the program until identified deficiencies regarding policies are resolved and quarterly audits are completed.
- West Suburban Health Partners did not submit General Liability Insurance, E&O Insurance, Sub-delegation Agreement, Sub-delegation Consent Agreement, and TPA Service Agreement for the Pre-delegation Audit. EDOP recommended to pend approval of implementation plan until identified deficiencies have been addressed.
- Effective 6/15/17, Vendor delegation oversight responsibilities for UM, QI and Vendor Audits were transitioned from EDOP to Government Program Oversight. GPO is responsible for presenting those Audit Results and closing Action Plans at IL QIC.

**Complaints and Appeals**

**Member Complaint 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 was 6.2 per 1000 members in 2017 compared to 8.2 in 2016 and 7.6 in 2015. A review of all HMO member complaints was performed and over 83% of the complaints are related to claims. Complaints related to “Quality of Care” and “Quality of Practitioner Office site” remain low at less than 2% of the total complaints.

In the first half of 2017, BCBSIL received 107 appeals. One hundred four appeals out of 107 met the turnaround time resulting in 97% compliance and 3% non-compliance. Majority of the appeals are related to Billing and Financial and the appeals per member rate remained consistently low at 3/1,000. MG/IPAs fail to pay professional
claims in a timely manner. BCBSIL has responsibility for paying claims such as inpatient and facility, while the MG/IPA is responsible for professional claims. The split risk model may contribute to the member’s complaints regarding claims payments in the following ways the split risk model requires that MGS be contacted to resolve outstanding claims or other issues and the split risk model may be confusing to members.

**REAM 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. No performance concerns for 2017. Recommendations include continuing to work with the Quality of Care areas with Quality of Care (QOC) complaints.

### Retail Complaints that met regulatory turnaround times

<table>
<thead>
<tr>
<th></th>
<th>1Q 2017</th>
<th></th>
<th>2Q 2017</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Met</td>
<td>Total</td>
<td>%</td>
<td>Met</td>
<td>Total</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td><strong>Illinois PPO</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On and Off REAM Combined</td>
<td>361</td>
<td>373</td>
<td>96.78</td>
<td>249</td>
<td>264</td>
<td>94.31</td>
<td></td>
</tr>
<tr>
<td>On REAM</td>
<td>155</td>
<td>161</td>
<td>96.27</td>
<td>130</td>
<td>134</td>
<td>97.01</td>
<td></td>
</tr>
<tr>
<td>Off REAM</td>
<td>206</td>
<td>212</td>
<td>97.16</td>
<td>119</td>
<td>130</td>
<td>91.53</td>
<td></td>
</tr>
</tbody>
</table>

| **Illinois HMO**     |         |         |         |         |         |         |         |
| On and Off REAM Combined | 136     | 140     | 97.14   | 127     | 130     | 97.69   |         |
| On REAM              | 76      | 79      | 96.20   | 80      | 82      | 97.56   |         |
| Off REAM             | 60      | 61      | 98.36   | 47      | 48      | 97.91   |         |

95%-100% green  
90%-94% yellow  
0%-89% red

**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 2017, a total 74 were QOC were reported, down from 157 in 2016. The reduction of 47% of QOC reported in 2017 was the result of internal initiatives to improve accuracy of triaging complaints. In 2017, BCBSIL was also successful at improving reporting by implementing and utilizing standardized reporting tools, Blue Squared and Enterprise Appeals Application (EAA). 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 and Behavioral Health Practitioner Site Visit Results**
An annual (2017) and a three-year comparison (2015-2017) were conducted for onsite chart and site audits completed on Primary Care Physician’s (PCP) and High Volume Behavioral Health (BH) Care Practitioner’s. The auditors evaluate the practitioner site for physical accessibility and physical appearance, appointment access, emergency preparedness, adequacy of record keeping, safety measures, preventative services and compliance with ADA requirements.

**Behavioral Health Care Practitioners**
In 2015, 97 BH Practitioners were audited against BCBSIL Quality Visit Standards Policy. In 2016, 69 BH Practitioners were audited and in 2017, 73 BH audits were completed. An evaluation of ADA Accessibility measures indicated that answering logs increased slightly in 2017 to 43.84%. Wheelchair access has increased to 100% in 2017, while handicapped access signage also increased to 84.93%. This measure continues to be low as many practitioner offices are lacking the signage that is high contrast, with raised lettering and in braille on their bathrooms. Restroom rear wall grab bar increased significantly from 66.18% to 82.19%. Medication storage measures continued to increase. In 2017, all measures were at 100% except for monitoring the expiration dates.
which increased from 85.71% to 97.14%. Medical Record structure measures indicated that adult and adolescent alcohol use updated annually has steadily increased every year. While Practitioners are addressing adult smoking annually, Practitioners are falling short in recommending smoking cessation for their patients. Coordination with PCP increased significantly to 87.99%. This was due to educating Practitioners and providing offices with release of information forms.

**Primary Care Physician**
From 2015-2017, there was a steady increase in the number of PCP's audited. In 2015, 1454 PCP’s were audited, with 1,619 audits completed in 2016 and 3,008 in 2017. A review of ADA accessibility measures indicated answering logs kept for 10 years continues to be below threshold for PCP’s as well. In 2016 and 2017 this measure scored at 45.46% and 49.00% respectively. Practitioners having lifts, transfer boards, or exam tables that lower to the floor for handicapped patients continues to be an issue, with a decrease from 71.16% in 2016 to 66.29% in 2017. Having office hours clearly posted was a new measure in 2016 and was at 53.42%. In 2017, the percentage of practitioner offices clearly posting office hours increased to 83.78%. The requirement of having a handicap scale was a new measure in 2016 and scored at 17.42% in 2016 and 19.29% in 2017 Handicapped Access Signage continues to be below the threshold as many practitioner offices are lacking the signage that is high contrast, with raised lettering and in braille on their bathrooms. Medication storage measures related to opened medications and opened Multi-dose vials have increased from 88.07% and 89.18% in 2016 to 92.18% and 90.69% in 2017.

An evaluation of medical record structure suggested that Practitioners addressing weight management counseling in adults and nutrition counseling in children age 2-17 continues to increase every year. While a Practitioner addressing adult alcohol use has continued to increase, Practitioners do not consistently administer an alcohol assessment tool for adults or adolescents. While Practitioners addressing smoking continues to be high for adults and adolescents, Practitioners struggle with recommending smoking cessation annually, especially with adolescents. Illicit/inappropriate substance use and treatment amongst adults and adolescents continues to not be addressed consistently among Practitioners. Identified opportunities for improvement include updating the audit tool to comply with regulatory guidelines. Provide education and training to IPA’s regarding updated audit tool. Discuss the use of release of information forms allowing for communication between the patient’s indicated PCP and BH specialist. Auditors providing continued education and resources to Practitioners regarding measures falling below the threshold.

**FHP/ICP/MLTSS/MMAI**
From July 1, 2016 to June 30, 2017, ADA compliance was conducted as part of the current provider site assessments of PCPs and high volume Behavioral Health Care providers. BCBSIL evaluated all twenty-eight elements listed in the CY 2015 CMS MMAI Performance Measure ADA Provider Assessment Tool and expand the review to include high volume as well as high impact providers. Overall ADA compliance was evaluated using 5 general ADA measures: wheelchair accessible entrance, handicap accessible exam room, handicap accessible restroom with signage, designated handicap parking and lastly, handicap accessible exam table/lift table. Compliance for four of the five measures ranged between 97% and 99% compared to handicapped accessible exam table was only present in 66% of the sites.

Identified opportunities for improvement included re-evaluating items on the audit tool that are evaluated but non-scored for appropriateness. Identify strategies and resources to improve compliance with the top 3 opportunities across all 3 plans including but not limited to handicapped scale (13-15%), main entry door opens with one hand (77-80%) and lifts, transfer boards and adjustable exam tables (62-66%).BCBSIL will incorporate both areas identified as opportunities for improvement into our CY 2018 program: appropriateness of non-scored items and resources available to improve ADA compliance.

**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 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 member's language and cultural needs or preferences. Quest Analytics Suite™ is the industry standard software for analyzing and communicating access of managed care networks. In 2017, we obtained a license for Quest Analytics Suite™; allowing the department to adjust queries as needed without relying on others for completed reports. Blue Focus Care was new in 2017 and in its baseline year most of the deficiencies reported were attributed to the new product for geographic accessibility. Pathology specialists and some BH Specialists were also reported as being below the 95% coverage standard set. The deficiencies identified were reported to appropriate departments however, no additional providers were contracted in 2017 using this information.

Behavioral Health Telephone Access
The Behavioral Health Telephone Access Report is intended to measure performance of the Contract Management Firms’ (CMF) Behavioral Health Telephone Access against BCBSIL standards. The CMF is required to report the quarterly average for screening and triage calls and show that telephones are answered by a non-recorded voice within thirty seconds. The quarterly average for screening and triage calls reflects a telephone abandonment rate within five percent. The reports received from are compiled by the ADS Program Coordinator and Network Programs Dept. Data is then aggregated and used to develop the quarterly and yearly reports. The Illinois QIC report has been updated to improve tracking of low performing CMFs on a quarterly basis and the standard operating procedure has been updated from the previous versions of the standard to reflect 2017 NCQA Standard Element NCQA QI.4.B, Behavioral Health Telephone Access Standards. Reporting is a manual process of compiling submitted statistics and are dependent on timely quarterly submissions from the CMFs. CMFs submissions are received 30 to 45 days after the end of each quarter. When the CMF is not performing at or above desired goals, the Provider Network Consultant assigned to the group the will reach out and work with them by notifying the CMF of unmet goals via an initial warning letter. PsycHealth, Ltd. performed outside of the 5% Abandonment Rate goal for the 1st, 2nd and 3rd quarters 2017. Arcadia Solutions performed outside of the Abandonment Rate Goal for the 2nd and 3rd quarters. Planned intervention will take place if the CMF continues to trend low.

HMO Member Survey
A random sample of Commercial and Retail members were selected from all Medical Groups to be surveyed. Members had to be 18+ and with the same Medical Group for at least a twelve (12) month period. The HMO Member Survey was conducted DSS Research; members were surveyed via paper, telephonic and internet surveys. Numerators consisted of the Top 2 box results where applicable and HMO Network rates are weighted by the Medical Group’s population. An additional sub-selection of the member population was surveyed, via electronic surveys, utilizing Blue Access for Members (BAM) accounts. Over a thousand additional members were surveyed. To re-align with the IL HMO Medical Service Agreement (MSA), specific questions were updated; requiring changes to question answer sets included changing “Excellent – Poor” to rating 0 – 10. This caused trend analysis from 2016-2017 to be unreliable for the MSA related questions. The rating of PCP, Specialists, and BH providers dropped significantly; PCP being rated the highest at 72% and BH the lowest at 47%. However, members’ provider preferences of race, ethnicity, gender and language have been met for over 90%. In 2016, a question regarding members’ Race was added to the survey by the vendor per our request. In trying to duplicate 2016, because of its success, this question did not make it on the 2017 survey because the changes were made on the vendor managed survey. These changes, along with the addition of gender, have been documented and updated for 2018. Since Federal Employee Program (FEP) has become more of a focal point over these last couple of years, a separate analysis of the HMO Member survey has been completed to meet these specific needs. Due to restrictions on surveying the FEP population, results have presented as affecting the FEP network the same as our HMO products. BAM was utilized in 2017 to prepare a process for surveying FEP separately in 2018.

Continuous Tracking Program Results
The Continuous Tracking Program (CTP) is a member satisfaction survey that has been conducted by BCBSIL’s Strategic Market Research area since 1999. In 2016, over 8,200 BCBSIL members were surveyed including 2,934 Group members and 551 Retail members. The CTP survey is a computer-aided telephone interviewing survey designed by HCSC Strategic Market Research and administered by a third-party research firm. Stratified random sampling is used to select participants with quotas set by product, account type and size, and
membership status to ensure sufficient sample to make comparisons and draw conclusions. Results are weighted to represent the membership book of business being analyzed. Below are the results for the key measures for the Group and Retail lines of business. BCBSIL Group HMO scores trending down on Overall Evaluation and Likelihood to Recommend. Group CDH scores decreased on Overall Evaluation. Group PPO scores remained steady although Likelihood to Stay decreased nominally. BCBSIL Retail PPO scores trending down on Overall Evaluation, Value, Likelihood to Recommend, and Likelihood to Stay. Retail HMO Likelihood to Recommend decreased while Overall Evaluation, Value and Likelihood to Stay were nominally, though not significantly, lower.

### BCBSIL Group Results

<table>
<thead>
<tr>
<th></th>
<th>Overall</th>
<th>Value</th>
<th>Likelihood to Recommend</th>
<th>Likelihood to Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPO</td>
<td>93</td>
<td>94</td>
<td>92</td>
<td>91</td>
</tr>
<tr>
<td>HMO</td>
<td>94</td>
<td>91</td>
<td>93</td>
<td>91</td>
</tr>
<tr>
<td>CDH</td>
<td>93</td>
<td>84</td>
<td>83</td>
<td>79</td>
</tr>
</tbody>
</table>

Rating indicates the percent of members responding Excellent, Very Good or Good
Number of respondents: PPO – 1,795; HMO – 751; CDH – 388

### BCBSIL Retail Results

<table>
<thead>
<tr>
<th></th>
<th>Overall</th>
<th>Value</th>
<th>Likelihood to Recommend</th>
<th>Likelihood to Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPO</td>
<td>84</td>
<td>78</td>
<td>77</td>
<td>70</td>
</tr>
<tr>
<td>HMO</td>
<td>85</td>
<td>74</td>
<td>79</td>
<td>69</td>
</tr>
</tbody>
</table>

Rating indicates the percent of members responding Excellent, Very Good or Good
Number of respondents: PPO – 180; HMO – 371

### HMO Care Coordination Survey

The purpose of the Disease Management (DM)/Care Coordination surveys is to obtain the Illinois member perspective of the program, assess the helpfulness of the program staff, the helpfulness of educational materials sent to members and assess self-care management. A sample of members was selected from the Commercial (HMOI & Blue Advantage) & Marketplace/Retail (Blue Precision) population that were enrolled in the program. The initial survey mailing was delivered in October 2017. This year’s survey was trimmed down from 6 to 1 page and a smaller population sample was utilized. This was a significant reduction in cost for the surveys in 2017. Over 90% of respondents were satisfied with program resources, treatment assistance and education material received. Response rates continue to decline. Timing may have been a factor, being sent at the beginning of the holiday season. Also, more people preferring electronic surveys and having an expectation for incentives. The program was also rated favorable at over 90% satisfied.

### Consumer Assessment of Healthcare Providers and Systems Survey

BCBSIL annually monitors member satisfaction within our health plan services and healthcare delivery system and identifies opportunities for improvement. The CAHPS survey is used in conjunction with member complaints and appeals data. CAHPS is a satisfaction survey governed by AHRQ and 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 Getting Care as soon as needed when care was needed right away increased to 89%, Ease of getting care, test or treatment rate increased to 89% and Getting an appointment with specialist decreased three percentage points to 76%. Available appointment times may not be convenient for members and some MGs may not be effective in arranging adequate after-hours access (evening or weekends) for members. BCBSIL has contractual requirements with MGs for access to Confidential
physicians and physicians have contractual agreement with the MG making implementation of interventions challenging.

2017 QHP (PPO and HMO) and Commercial CAHPS (HMO) Member Summary
Annual 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 23 and May 15, 2017. The samples were members, 18+, who were continuously enrolled in their plan for at least six months as of December 31, 2016 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 survey instrument contains four global rating questions, five composite measures, and three Healthcare Effective Data and Information Set (HEDIS®2) measures. Recommendations for 2018 include provide more information and resources on how to get information about members plans, easier access to specialists, increased awareness on treating members with courtesy and respect.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Sample size</td>
<td>1690</td>
<td>1690</td>
<td>1760</td>
</tr>
<tr>
<td>Completed surveys</td>
<td>253</td>
<td>257</td>
<td>318</td>
</tr>
<tr>
<td>Response rate</td>
<td>18%</td>
<td>19%</td>
<td>18%</td>
</tr>
<tr>
<td>Summary</td>
<td>CMS case-mix adjusted score shows improvement year-over-year against the national average, from “below average” to “average”</td>
<td>2017 Health Plan Rating on par with 2016 score</td>
<td>Health Plan Rating remains strong at 90th 2017 Quality Compass percentile.</td>
</tr>
<tr>
<td></td>
<td>Scores for Rating of Personal Doctor and How Well Doctors Coordinate Care and keep patients informed improved from average to above average year over year</td>
<td>No significant change in non-case mix adjusted scores</td>
<td>Scores were largely steady YOY</td>
</tr>
<tr>
<td></td>
<td>Non-case mix adjusted scores were steady year over year</td>
<td>CMS case-mix adjusted scores show YOY change in three measures compared to the national average</td>
<td>Plan information on Costs decreased</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Flu Vaccinations increased</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ratings of Health Care, Personal Doctor, Specialist, and Health Plan are at or above 2017 NCQA Quality Compass 75th percentile</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ease of Getting Appointment with Specialist, Getting Care Quickly and Getting Need Care below 25th percentile</td>
</tr>
<tr>
<td>Key Drivers for Health Plan</td>
<td>+Getting Care as soon as Needed</td>
<td>+Easy to get care believed necessary</td>
<td>+Health Plan handled claims correctly</td>
</tr>
</tbody>
</table>

Confidential
HMO PCP Survey

The PCP Survey is used to evaluate Medical Group (MG/IPA) sites, based upon HMO PCPs’ experience on various attributes, including BCBSIL services, MG Referral Procedures, Quality On-Site audits, Utilization of Electronic Medical Records, and MG Claims Payment. The initial survey is mailed in July 2017 to all PCPs in the HMO network which consist of a variable group of about 77 MGs. Specialties surveyed included Chiropractors, Family Practice, General Practice, Internal Medicine, Obstetrics-Gynecology and Pediatrics. PCPs with more than one MG affiliation were sent one survey per MG. Responses are analyzed and presented at an aggregate level. BCBSIL uses the results of the surveys to identify areas of strength as well as services that may need improvement. The overall rating of the MG/IPA and administrative services have remained over 90%. Adequacy, quality of the network and Access were also rated over 90% while knowledge on obtaining UM Criteria and familiarity with the BlueStar Report fell below 70%. Generally, Providers better understand the value of the information gathered and how it will be used. Response rates have remained consistent over the last few years. Those that do not respond may not have provided current mailing information or may have been too busy to respond; no follow-up was conducted.

Provider Satisfaction Survey Marketplace PPO

A random sample of 1,337 of BCBSIL Marketplace PPO providers were surveyed from August 14 to October 5, 2017. The survey methodology included a mail/telephone/internet protocol. In addition to rating BCBSIL Marketplace PPO, providers were asked to rate all other health plans, in aggregate, to compare results. A total of 351 surveys were completed yielding a response rate of 26%. Among BCBSIL Marketplace PPO providers, satisfaction with BCBSIL significantly exceeds the competition with a 91% positive rating. Ninety-eight percent were willing to recommend BCBSIL to patients or other physicians. BCBSIL outperformed competitors on all measures, most significantly. BCBSIL significantly outperformed competitors on all Claims and Member Eligibility, Provider Relations and Provider Network measures and nine of the 10 Utilization and Quality Management measures. Overall Satisfaction with Continuity of Care was also significantly higher than competitors.

BCBSIL Marketplace PPO UM Measures

<table>
<thead>
<tr>
<th></th>
<th>BCBSIL Marketplace PPO</th>
<th>Competitor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Top 3 Box %</td>
<td>N</td>
</tr>
<tr>
<td>Phone availability of UM staff</td>
<td>73*</td>
<td>213</td>
</tr>
<tr>
<td>Timeliness of the authorization process for non-emergent requests</td>
<td>79*</td>
<td>218</td>
</tr>
<tr>
<td>Explain the reasons for adverse review decisions</td>
<td>72*</td>
<td>202</td>
</tr>
<tr>
<td>Extent to which adverse review decisions reflect evidence-based medicine.</td>
<td>71*</td>
<td>175</td>
</tr>
<tr>
<td>Phone access to Case/Care Managers</td>
<td>64</td>
<td>162</td>
</tr>
<tr>
<td>Community resource options</td>
<td>83**^</td>
<td>122</td>
</tr>
</tbody>
</table>
Programs or resources for chronic disease management | 85* 127 150 75 106 141
Plan promotes the importance of preventive care | 86* 149 174 74 120 163
Rate your understanding of care management program (BCC) | 77* 168 218 68 138 203
Overall satisfaction with Utilization Management | 79* 207 262 63 158 250

*Rating is significantly higher than competitor
^Rating is significantly higher than 2016
Top 3 Box % indicates the number of providers that responded Excellent, Very Good or Good except for overall satisfaction with UM which is the percent of providers who responded Very Satisfied or Somewhat Satisfied.

HMO Contract Entity Survey
BCBSIL performs an annual Contract Entity (CE) Survey to obtain feedback about the HMO Services. Emails were sent in early July 2017 to the medical groups requesting them to complete our annual survey which was conducted through Survey Monkey. The survey included an evaluation of HMO Support Staff, Customer Assistance Unit (CAU), QI Fund Projects, the Blue Review Provider Newsletter, BCBSIL Provider Website, HMO Reporting and Services. This year’s response rate was at 81%, much lower than the 91% in 2016. Per the CE, there is room for improvement in many aspects of the business relationship, reporting and provider site. Results show significant decreases for the HMO Support Staff in several areas including Knowledge of HMO Policies/Procedures, Administrative/Operational Issues and Problem-solving ability. Some commented that they had to switch representatives because new staff was not familiar with policies and responses to inquiries was often over 30 days. Other notable deficiencies include: Courtesy of the CAU, Processing Claims payment, Timeliness and Accuracy of QI Fund reports. The BCBSIL Provider website rated poorly as well in overall appearance, organization/structure of the site, effectiveness of naming conventions and quality of information contained on the site.

Continuity and Coordination of Care

Continuity and Coordination of Medical Care--REAM
This survey is part of a national effort to understand how enrollees view their health plan experience. Results will help consumers make important choices about their health care and will help health plans improve the care they provide. The 2016 results include five high volume specialties. (Behavioral health specialties were excluded from the analysis). Comparing rates for statistical significance from 2015 to 2016, there was a significant decrease of four percentage points (p<.05) in the rating of feedback from Orthopedic Surgeons. Four other specialties had a not significant decrease of one to two percentage points (p>.05). In 2016, four of nine facility types scored >91%, and two (Outpatient/Surgicenters and Emergency Rooms) showed an increase of one to three percentage points. Feedback from two of the facility types (Hospitals, Immediate Care Facilities) remained unchanged from 2015 to 2016 at 94% and 88% respectively. Skilled Nursing Facilities and Home Health Care feedback decreased by two to three percentage points. The feedback from Rehab Facilities, Extended Care Facilities and Hospice represents baseline data and there are no benchmarks at this time. Comparing from 2016 to 2015, there was a statistical significance (p<.05) from two of the facility types Emergency Rooms and Home Health Care.

Continuity and Coordination of Care between PCP and Behavioral Health Practitioner
There was a slight decline in rate for the PCP rating of feedback from the BHS over the past three years which was not significant. The PCP rating of feedback provided in a timely manner from the BHS decreased in rate, significantly from 2015 to 2016. The PCP rating, "was the feedback provided helpful," from the BHS showed a 1% increase in rate from 2015 to 2016 which was not significant. The rate of coordination with behavioral health documented in the PCP medical records decreased, but not significantly, from 2015 to 2016. The number of records with documentation that the members received behavioral health care remains low. In 2016, only 60 out of 8,369 were included in this measure. Casual barrier analysis indicates that members may not want the PCP to know the details about their mental health treatment and/or may be unaware of the importance of collaboration between the PCP and the BHS who are involved in the member’s care. On the other hand, the PCP/BHS may not take the time to obtain member consent allowing them to share information. Findings also indicate, the PCP/BHS may not have a centralized or efficient means to communicate with each other. Possible interventions include, continuing to encourage BH practitioners in the HMO network to communicate with PCPs regarding Confidential
changes in medication, diagnosis, and/or clinical condition. In addition, BCBSIL provided educational materials to
the IPAs to improve communication between BHS and PCP. The following Information is posted on the BCBSIL
Provider Website: Sample of Authorization to Disclose Protected Health Information to PCP and Coordination of
Care form. An opportunity found is that the 2016 data includes only three quarters, while the 2017 data include a
full year. The number of members in CCM who have a behavioral health diagnosis increased significantly from
2016 to 2017. The interventions to enhance the CCM program have been effective.

Continuity and Coordination of Care between PCP and Behavioral Health Practitioner-REAM
Causal barrier analysis indicates that inconsistent communication between Special Beginnings staff and BHCM
continues to be a concern resulting in cases not being referred to BHCM. There are cases that are still not being
referred from the SB program to the BHCM program. Low referral volumes can be attributed to members not
scoring > 13 on the Edinburgh Postpartum Depression Scale to be referred for case management services.
Members may not fully understand the benefit of consulting with a BH professional regarding the signs and
symptoms of Postpartum Depression. Staff may not be able to effectively 'sell' the benefits of the BH program, or
may not think the BH issues require interaction with a specialist. A few opportunities for improvement found
include, Claims data needs to be analyzed to determine if primary care clinicians are screening for ADHD.
Reporting needs to be investigated to ensure all ADHD screenings are being accounted for in the reporting
process. Referral process from Behavioral Health to Medical continues to be inefficient and results in lost
referrals. IL total referrals experienced a 54.3% decrease from ninety-four (94) to forty-three (43) and enrollments
experienced a 56.8% decrease from thirty-seven (37) to sixteen (16). Continue working with reporting
departments to develop reporting capability for identifying index events in real time to allow for interventions that
can impact outcomes on AMM and ADHD HEDIS metrics. Research Coordination of Care CPT codes to educate
providers on the ability to use these codes and receive compensation to increase coordination of care efforts.
Send out communications that target bipolar and schizophrenic members with diabetes. Explore the possibility of
partnering with PRIME Therapeutics to send reminders to members regarding taking their Antidepressant
medication.

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 2017. 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 2017 QI Program Evaluation on March 7, 2018.