	PM/Delivery sponsor	Risks
Significant Customer Impact		
Xchg Carryover	Josh Hecht/Christine Hartman	Exchange enrollment info - reliant on them, right info at right time, not contradict exchange. If it goes wrong, claims and auths may not go properly. If enrollment doesn't come through - then not have coverage. Payment not tracked accurately, member termed.
BSH Customer experience	Sophin Khamvogsa/Max Arbow	Lack of mobile, lack of engagement, reduced CX
Epiphany	Amar Shabbir and Stephen Kendrick/Marja Wilson	Transparency - understanding who is Alignment how do they work with regence, privacy? Process of care coordination - in/out of alignment, will providers feel like we are taking patients away ?

CDO	Jeff Burke/John Gasper (andrea as pm?), Sharon Richardson, Joelle Martins working on coordination right now, Floy Saavitra (FI biz intel)	Cambia Experience needs to choose the right focus and investment, personalization needs to be accurate, customers may not be interested in interacting with us as more than an insurance company
NPP Mobile	xx/Kat Kozitza, Rich Whitten	
Palliative Care	Tareyn Gillian/Torrie Fields - Lee Spears	
Clinical editing project **Technical Fix with CX Impact**	Andrea Brahms, Ray Laurence, Donna Dehrkoop, Jane Vervalin	
FACETS Stabilization	Ravi Illuri and David Grindy/John Wilson	

CyberSecurity Risks Management?	xx/Kirk Anderson	new technology potential consequences. Mitigation: deploy in non-prod first, built in fault tolerance. Issues triaged and managed via incident mgmt process. Employee or member have process impacted if it goes as planned? Not anything they can think of. Has been done before.
ICD-10	Karen Steely/Mark Jackson/ Laxmi (provider relations), Ed Alison - IT, Anne Busse	Financial and operational impact - risk of provider readiness. What can we reasonably do to support provider readiness? Ops: if provider not ready, or not coding well - may see claims rejected. Then may see hi vol of claims coming in (worried about claims tsunami). Assess readiness - each state has clearnghouse. WA - survey of some kind to assess where small providers are. know who and what challenges. Company risk/member risk: cost - provider coding for highest pay out
Stop Loss? - new project not carryover	xx/Jeff Burke, Cathy Bolstead, Mark Sjolin (new PM), Mike Dorman, Directing sponsir, Henry Rico HI tech lead, David Grindy (EA) but transitioning - **talk with Mike and David**	better answered by Mike D.

BCBSA payment innovations	Terri Nehorai + Ray Laurence+ Kay Corzun, Dave White, John Irwin, Pat Hamill	Increased outreach from providers, why am I getting this? Provider discretion to remind patient to get needed services. Inform of necessary care.
MMSi	Chena Mesling/Melanie Westrick and Sharon Arneson +Ray Laurence	UM: Middle of risk review. Worst case - impact timelines - member: how quickly things are responded to. Provider end: if high medical need - do procedure w/o prior auth. More serious with inpatient issues. Could affect claims payment - timing and payment at all.
Revenue Management	Tracy King (EAnalyst), Janice Lefebrve (PM), Brent Zenobia (product manager),	manual work, well visit not covered?

Medicare Secondary Payor/Working S	Zachary Aulson, Rosie Reeve, **Elizabeth Drago**, Stephen Putt, Tareyn gillian.	Biggest risk: compliance - get incorrect status based on incorrect interpretation, we will pay less and CMS will pay more b/c we think someone has a working status that favors us. (e.g., think someone is retired, but employer continues to pay on that person - teacher tenured - Cms can't be primary for this) Us and group need agreement Financial: lives change - need to understand what group means when they give us info. We may be paying primary where we should be paying secondary. Errors of Omission and errors of interpretation. Similar to COB.
BCBSA Interplan and Carry over -ITS - system for Blues Plan	John Coutu (PM), Kay Corzun (pm for payment innovations- integrates into this team) Angie Blewett (DS), Belinda and Angie responsible for biz readiness comms - Tegwen Kaufman, Belinda Turner for business impact	If things don't work - 1 component = defect. If system doesn't go up, lose license to participate with blues. In the past, worst thing? Tech issue, someone had experience took 1-2 days, 1 week. Customer impact? Doesn't get escalated out far enough -- typically resolved before it gets to member. John Coutu ITS upgrade.

FEP total cost of care phase 2 Stephanie Joens, Matt Fike

Impact	People	Processes
enrollment, claims - opportunity to gather insights and create best in class experiences. No BIA set.		
web, mobile other?	Customer, broker?	digital
providers - contracts may be different, may not appreciate new docs coming into the ppo, HMO members, employers? Specialists won't like it, taking patients away		Hand off between alignment and Regence, CS. Retaining claims process at Regence. Pay claims out of alignment bank account - lots of back and forth, potential for things to go wrong. Match up of codes from pcp and specialist.

Medical management, MMSI - enhanced UM programs	Member, employer (via emember), employer based reporting will benefit from data integration (ASO esp), provider engagement - risk management,	Data Lake - enable reporting. Digital, push, targeted marketing campaigns, segment analysis, campaign analytics.
	Members, employers? Providers?	
internal screens may change		live July 4

member - security breach could impact data. (but that's a positive outcome) Server slower than before is possible impact. No across the board outages - rare and unlucky.

Kirk's team is working on this. Or third party consultants. Next impacted Linda Carrier's team.

employees, cs, members, providers

painful automation and manual to be improved

Change in communication. Change in provider incentive.	provider, member and employer (employer pays provider for reduced cost of care)	data from assn ACORS database our data from FACETS
Change control add objectives to do RV audit for risk adjustment and new vendor for chart reviews. Provider behavior change. (give all diagnosis codes first time a member sees the doc - avoid chart review, increase speed, accuracy and completeness) Need to re-prove every year HBP, diabetes, etc. Reduce cost to	provider, member Providers- nancy has group of people who educate providers - known path for information flow.	Med mgmt data into data lake manual input into Sales force. CS has scripts if a member in a pilot group calls in and can look at diagnosis codes submitted so they can recommend provider based on diagnosis.

Is this just reporting from employer? Is there an ask of the member ? How does info get from employer to Regence?	Employer - group administrator, member, sales, internal groups (but is sales really the right team to carry this?) bypassed sales, stood up group with Brian Finn to communicate - working status collection group. Holly Parks and 4 temps to do the work. Commercial. ASO continues to go thru acct reps for validation. also, Claims and COB groups. Provider potential effect - about 400 errors where working status was incorrect therefore provider payment would need adjusting.	Potential to change membership process - change so they all allow working status to be collected at that point. Technical change and culture change internally to work on interpretation. Update membership channels through paper/834/spreadsheet. Map extensions for each group?
should be no impact to member. More on provider. Recognition of ACO plans, be able to share info about rates, payments, charge backs to providers.CS answers calls- **could impact volume. Can info go on the website to mitigate calls?** May be info on BCBSA site	provider and member impact. **Who answers if providers have questions?** Who do they call? CS, provider services, bcbsa?	**New UI finance.** From green screen to web UI. Claims could be delayed. Team that meets to talk about who needs training, comms, Sarah Peterson (BE), config team, Provider relations for comms to them, filter through EDI blue card team. Review which systems are impacted. Part of process before every release. Gayleen Jackson managed previous training. Trying to nail down who trains finance team. They are saying they do own training.

Not sure. Looks like some impact moving FEP>ACOs, but is it any different than the research we already did with members moving to ACOs? // it's the same thing as BCBSA payment innovations

Structure	ROI S/M/L - metrics for success in program	Does a member need a new skill, insight/information to understand this structure?
	Analytics for data. Visits, KPI across many channels. Sr. analyst to help define metrics for success. Behavioural analytics. Customer growth and retention. PRO measurements? Metrics from CX?	Seeking patient who is looking for hi touch, set expectations from first sales call, members need to understand by seeing an alignment doc they are going to be asked to engage more - be more accountable.

data lake (MDM) - rules for data structure, api hub - with apogee 2014 connection point for external data sources- more seamless interactions,		no
	Benefit expansion - % of members who have had a goals of care discussion. Collect metrics from providers who are able to bill for those convos. What % of hospice eligible are in hospice. Increase in home health aid visits-in pt and ER decrease. # of legislative contracts (Ganz looking more at feel than $)	Member needs to understand value and options for palliative care
nothing changing other than ops		

Completion. Reduce likelihood of breach - hard to tie to project.

providers need to understand icd-10 (who teaches them?) What does availity do? Are there resources? (Kate Nees-Hove)

Need to do current to future state mapping. (could be a space CX)

Increased quality of care and decreased costs	no	
what's in the way of doing it well today? Info not carrying forward through a chart to carry over, how much tech used and what kind of record keeping,		

different solutions in play - but goal is to be in compliance, making more accurate claims determinations.

This has been happening for 30+ years. Every 6 mos. April and oct. Well documented repeatable. Dependencies on second release - FACETS upgrade and Payment innovations project

How do current practices need to change to support the change?	What needs to happen to enable our customers to have the kind of experience we want them to have?	What might keep a customer from having an optimal experience?
no member for life capability. Re enrolling need to re-register on site. ACH need to re-register. Better communication between depts/projects and to member.	Member touchpoints - stratcomm and membership involved, but need overall strategy?	
Mobile dev, push notifications, primary ID is email, use apple pay and google wallet. Optimize for mobile web, mobile platform.	upgrade digital and mobile experience to help people on the go and away from a computer. Engage.	Poorly designed experience, not understanding the extent of the need, not understanding when to push info out
Whole org (regence) needs to understand HMO capitation - change management	Set expecations right from sales call, right from the start	Not understanding engagement model

Data not currently shared between us and DHS.

Know the customer through all lines of business and products.

internal - need better comms between biz units, need agility to move quickly to keep up with market pace. Education and understanding about internal programs - visibility and overlap. External - no agreed upon definition of palliative care - most think it's hospice or end of life and it's not just that. Reimbursement model only for cost saving not incentivizing quality.

Lack of provider education - don't know what case management is to can't refer. Essence of palliative care - informed decision making. Needs to be consistent messaging (internal and external) understanding not a benefit - includes case management.Capacity: program size and budget. Case managers at capacity - may be full- no more referrals. lack of access to palliative care physician.

		Customers and employees won't know anything was done if all goes well.
how do we know if new Regence contact signed, are they icd-10 compliant? Also see attestation document.	Inform - let them know this ma	if ICD10 will have impact on response times? So far testing has not shown impact, provider and member.Not sure of which stakeholders or messages as of 12/1. claims delayed/denied.
exists today, this project formalizes the technical solution to provide and improve reporting. We have reports and home built application. Formalize the application (tech to support reporting), and create future state - March, Steve Gaspar review to understand how this operation continues in 2016. Mike and Henry support. Like it to be more formal and repeatable. not just 2 owners.	ASO administators (employer), should be transparent to them,	Not sure. Stop loss not part of determination of how claim is paid. Unlikely member impact?

Internal education - we are we doing this and why? Change in payment models. IT doesn't change, but data is pulled from It resources

Whole new system, current practices are out the door. Get to big wins for using pega.

May be no discernable impact to customers. Implement automations and leveraging the system as much as they can. Hire more people to get it right at the outset.

Question about preventive visit and coding? What if I have a well visit and coding. Doctors need to be proactive about marking ALL diagnosis codes at the first visit of each year.

Focus on reimbursement for member disease states.

Do have good codes - interpretation comes in when thinking about what does my relationship with my employee mean in re: regulatory for CMS or COB interpretation. Hesitation from sales to communicate - FACETS fields not populated correctly, difficult for sales to go back to group and re-ask them to populate < culture change and education

Standing this up in support of payment innovations

Assn puts out things that are optional for us to do. We wait for things to

Visibility - none, harmless, potential impact	How much help do they need?	Project Goal	Has research or CX support?
			No
high	Significant front end support from CX. As they get to implementation, $ are budgeted for testing, should have FTE to manage and implement	Engage the member. Member can walk away at any time with Exchange.	Yes - UX Researcher TBH
Need: provider research, member research		Goal: drive down expensive specialist utilization, accurate coding for reimbursement, Accomplish most before OE in 10/1.	No

Health platform of the future, unique products and services with multiple cambia products (not just insurance). Personalization. Generate customer focused insights. Growth, retention (new and existing products and services). Bundled products -multiple products and services per customer.

Does Regence need something different than what BSH needs?

Capture member stories, community engagement, how to communicate to members

yes, Qual Quant FTE TBH

no

	1. reduce likelihood of cambia experienceing major security breaches. People, process and tech investments. 2. Efforts for Cambia to receive sock2 cert, best in class. Demos to new biz who are concerned - DHS too.	no
High if it goes wrong, low if you are a member and not aware of it.	Gov/t mandate, keep the member out of the middle of the mandate	no but Tami, Michele and Julie M engaged
	insurance against more costs than aso group has available. Internal - actuarial risk, external - they have external stop loss provider	no

		Stay in BCBSA mandate, ability to compete with national payers, member retention - members getting quality cost effective care. Member Surveys - timely care, options for care.	no
Initial plan to implement system - no notification, should be transparent. Incremental step as opposed to the larger plan for implentation.	Will be doing time studies (scheduled).	Get off of CCA (version of trizetto is no longer supported) initiate move towards a more complete solution for HC management. May be able to get rid of vendors. Move towards automation for auth. CCA manual forms PEGA biz process management - cross functional.	no
		ensure we are getting most reimbursements from CMS. Way to do that is through condition codes. Proven condition codes. (not currently looped into epiphany) - Can't force a member to go to a new doc.	

		Be in compliance with CMS regs and obtain correct working status on all employees - Can be active, can be retired, COBRA or disabled. Don't currently have a way to determine that. We thought we were able to determine working status but we	
limited list - more th		weren't.	no - Tami has
		ITS - if you are member, they process thru bcbsa, mandate to update system 2x/yr. if we don't we can't move forward with other	
	maybe sit in JRP	states. Claims processing. 1/3 of	
be mandated. Can CX help s	session?	claims - 1.3 mil claims per month.	No,

Financial impact	CX impact	Follow up
?	Med/Hi	
Medium		
High	High	journey maps
		how long and how many hours per week - not to exceed - how to bill

low? Or will util of palliative care drive costs down?	partner for support/**SME** - April, nat'l heatlh decision month for some qual eval- can manage qual and vendor. They have bandwidth to manage and support. Has consulting budget. Also has her own actuary.	need from torrie - copy of budget, ROI document, scenarios

If there are implementation issues

No significant need for support.

get involved
to see

helped with FAQ in past