Act 68 of 1998 (Quality Health Care Accountability and Protection Act)

This Act, which became effective January 1, 1999, provides for the access by enrollees of managed care health plans to health care services; specifies certain standards relating to financial incentive programs of managed care plans; prohibits managed care plans from restricting providers from disclosing appropriate health care information to enrollees; specifies certain standards of managed care plans relating to emergency services; termination of contracts and confidentiality; requires certain disclosures to enrollees of managed care plans; and imposes penalties.

- Requires a two-step enrollee grievance process to address enrollee and provider disputes, and a further appeal to an independent external grievance process.
- Requires a two-step enrollee complaint process followed by the appeal to the Department of Health or Insurance.
- Requires direct access for OB/GYN and maternity services.
- Provides procedure for standing referrals to specialists for life-threatening, degenerative or disabling diseases.
- Prohibits the use of financial incentives to providers for rendering care.
- Prohibits penalizing providers for discussing health care options with Plan members.
- Imposes a prudent lay person standard emergency care reimbursement.
- Provides continuity of care for up to 60 days in the event a provider is terminated by the Plan for the reasons other than fraud, criminal activity or contract violations.
- Ensures confidentiality of enrollee medical information.
- Details disclosure of information to both enrollees and prospective enrollees.
- Provides for the certification of utilization review entities by the Department of Health and establishes operating standards for these entities.
- Provides for the payment of clean provider claims within 45 days.

To obtain more information on the various Acts by year, please refer to http://www.legis.state.pa.us/WU01/LI/LI/CL/ACT.HTM.
MEDICAL MANAGEMENT REVIEW

DRG VALIDATION REVIEW UNIT
Diagnosis Related Group

The DRG Review Unit performs on-site retrospective review to determine if the admission was medically necessary and appropriate. It also verifies that the diagnostic and procedural information that led to the DRG assignment is accurate and substantiated by documentation in the medical record.

DRG Review Process

A focused DRG validation review is performed on a retrospective basis at the facility site to verify the following:

1. Medical necessity and appropriateness of the service/admission
   
   A. “Medical necessity” is defined as services or supplies rendered by a facility that BCNEPA determines are:
      • appropriate for the symptoms and diagnosis or treatment of the member’s condition, illness, disease or injury;
      • provided for the diagnosis, or the direct care and treatment of the member’s condition, illness, disease or injury;
      • in accordance with current standards of medical practice;
      • not primarily for the convenience of the member, or his/her provider; and
      • the most appropriate source or level of service that can safely be provided to the member. When applied to hospitalization, this further means that he/she requires acute care as an inpatient due to the nature of the services rendered or his/her condition, and he/she cannot receive safe or adequate care as an outpatient.

2. Validity and accuracy of diagnosis, procedure and DRG codes
   
   • The principal diagnosis is verified as the condition established after study to be chiefly responsible for the admission of the patient to the hospital for care.
   • Other diagnoses are those reported as affecting the current hospital stay.
   • Codes for diagnoses that are reported by the provider for statistical or Uniform Hospital Discharge Data Set (UHDDS) purposes and do not impact on the current stay, i.e. diagnoses which are not treated nor affect the length of stay as supported by documentation in the medical record, will be eliminated and adjustments will be made accordingly.
   • The principal procedure is one reported as performed for definitive treatment rather than diagnostic or exploratory purposes, or that was necessary to treat a complication.

3. Validity of attested conditions and procedures
   
   • All conditions and/or procedures attested to by the attending physician, and coded by the coders for reimbursement, must be supported by documentation within the medical record.
4. Accuracy of other pertinent data

- Other data verification includes, but is not limited to: admission and discharge date, discharge status code, and patient’s age.

**DRG Validation (Post Payment Review)**

A post-payment audit sampling will be conducted by the staff nurses of the Retrospective Review Department based on focused sample selection of claims. The purpose of the audit is:

- to determine the medical necessity of the admission and appropriateness of setting;
- to validate correct diagnoses, procedure data and appropriate sequencing;
- to verify medical information provided during the pre-admission certification review;
- to review day outliers for identification of medical necessity; and
- to examine inpatient and/or outpatient readmissions within a thirty (30) day time frame for clinical correlation.

**DRG/ Per Case Payment Validation Procedure**

The DRG/per case payment validation procedure consists of four (4) parts:

1. **Sample selection** focuses on error-prone areas as determined by previous audit studies and an analysis of utilization trends. Sample selection is under constant review with appropriate revisions on a continuing basis.

   Hospitals are notified at least eighteen (18) days before the audit dates and are supplied with an advance listing of the medical records to be reviewed. Hospitals are expected to retrieve all records requested and to provide suitable private accommodations for the review.

   Should a hospital fail to locate medical records on the advance listing, a second request will be made at a subsequent date. Failure to provide requested records after the second request will result in adjustment of payment for the services in question. This adjustment is final and not subject to reconsideration at a later date.

2. **Case Review** is performed on-site at the hospital using the source medical record and, when necessary, in the Plan using copies of pertinent aspects of the provider medical record.

   If the Blue Care pre-admission certification is not supported by documentation within the medical record, and it has been determined that the inpatient admission was not medically appropriate, the admission will be reviewed and payment may be adjusted.

   All admissions, when the patient remains after the day outlier threshold is attained, will be reviewed by Retrospective Review Department to determine the appropriateness of the length of stay (applicable to DRG validation only). If the length of stay is considered to be medically inappropriate, no additional payments will be made.

   Readmissions within thirty (30) days of a preceding discharge will be reviewed to determine the medical appropriateness of the initial discharge. If the initial discharge is determined to be inappropriate, payment will be adjusted.
3. **Validation Report** to the hospital is a direct result of the case review analysis and is a compilation of proposed changes to information originally submitted by the hospital. The findings are forwarded to the hospital and a written response is required within forty-five (45) days.

4. **Finalization** begins when the hospital responds, in writing, to the Retrospective Review Department indicating either agreement or disagreement with the audit findings. When the hospital appeals a validation review report, additional documentation from the medical record, or from other sources, must be forwarded to the Plan to unequivocally support the appeal. These cases are reviewed by the DRG review nurses who consult with the medical director and respond to the hospital in a final report. This report can indicate agreement based upon additional supporting documentation or continued disagreement with the hospital and the reasons for disagreement.

5. If no response is received from the hospital or if additional supporting documentation is lacking or insufficient, claims will be adjusted. There will be no appeal to these cases and the decision will be final.
MEMBER OVERVIEW

ROLE OF THE MEMBERS

BlueCare HMO members are also responsible for understanding their benefits and exclusions as stated in their contract.

Identification Cards – All BlueCare HMO members receive an identification card which must be presented at the time of service. A separate card is issued for each family member.

SAMPLE MEMBER ID CARD

![Sample Member ID Card](image)

MEMBER NAME

- Last Name, First Name, and Middle Initial

MEMBER IDENTIFICATION NUMBER

- The member ID will always include the alpha prefix in the first three positions.
- Following the three-character alpha prefix, the ID card may include any combination of alpha/numeric characters (letters or numbers) for a maximum length of 17 characters total. You may see cards with ID numbers that are fewer than 17 characters in total. (Ex. Card # ABCDEF123456789 – Alpha Prefix would be ABC and ID# would be DEF123456789)
PRIMARY CARE PHYSICIAN NAME

- Name of Primary Care Physician office member has selected. If card indicates “NO PHYSICIAN SELECTED,” member may be responsible for charges.

PCP TELEPHONE NUMBER

RX (PRESCRIPTION) IDENTIFICATION NUMBER

RX (PRESCRIPTION) GROUP NUMBER

COPAYMENTS (The following copayments may appear)

- PP (Primary Care Physician Copay)
- SP (Specialist Physician Copay)
- ER (Emergency Room Copay)

The following information can be found on the reverse side of the member’s card.

- How to handle an emergency situation.
- Telephone numbers for:
  - Customer Services
  - Prescription Drugs
  - Regional Referral Center
  - BlueCard information
  - Prior Authorization
  - Pharmacist Inquiries
  - Blue Dialog

CUSTOMER SERVICE

The purpose of the Customer Service Department is to communicate with and to educate members, employer groups, and providers, whether by telephone, walk-ins, written or faxed correspondence. Customer Service Representatives can be reached at 1-800-822-8752, Monday through Friday, 8 a.m. to 5 p.m., or (TTY/TDD) 1-800-413-1112 for the hearing and/or speech impaired.

If a member is questioning his/her eligibility or benefits, please refer him/her to this department or to the number on the back of their identification card. The Member Customer Service Department can also assist in filing complaints and appeals.

All inquiries to the Member Customer Service Department will be documented on-line by a representative to maintain consistency and meet reporting purposes. This measure will ensure that our providers and members receive quality service and timely responses. The Member Customer Service Department representatives are specially trained to answer questions concerning all phases of BlueCare product operations and to provide assistance to providers and members.

For a detailed description of benefits, members should consult their handbook or contact their employer.
OTHER TYPES OF PRODUCTS

BlueCHIP Program

The Children’s Health Insurance Program (CHIP) was established by the Commonwealth of Pennsylvania and is offered to children in Northeastern Pennsylvania through the Caring Foundation of Northeastern Pennsylvania.

The goal of CHIP is to keep children healthy through regular preventive checkups and immunizations. The program was designed to provide children access to quality health care so that their lives will be enriched now and for years to come. The BlueChip Program is a HMO product and utilizes the current First Priority Health (FPH) provider network.

- CHIP was established as a result of the Children’s Health Care Act signed into law December of 1992 (available through [http://www.legis.state.pa.us/WU01/LI/LI/CL/ACT.HTM](http://www.legis.state.pa.us/WU01/LI/LI/CL/ACT.HTM)) and is funded by the cigarette tax.
- Benefits are available to children up to age 19* who are ineligible or enrolled in Medical Assistance.
- In order for a child to receive CHIP coverage, he/she cannot be enrolled in a private insurance plan.
- All CHIP members must choose a Primary Care Physician and coordinate all care through him/her.
- CHIP members have First Priority Health coverage with a modification:
  - Highmark Blue Shield: dental and vision.
- $0 copay for all services.
- To verify benefits and exclusions, please call the Customer Services Department at 1-800-822-8752, Monday through Friday, 8 a.m. – 5 p.m or via NaviNetSM. (Note: for any product with special benefits a redline message will appear on screen indicating to contact the Customer Services Department for further information.)
- For chemical recovery and mental health benefits, CHIP members must utilize the Behavioral Health Care Network of Northeastern Pennsylvania (Regional Referral Center).

* Terminated at the end of the month of the 19th birthday.

adultBasic Program

First Priority Health, has entered into agreement with Pennsylvania Insurance Department to offer an adultBasic health insurance product to adults 19 – 64 residing in First Priority Health’s 13-county service area. The adultBasic Program is a HMO product and utilizes the current First Priority Health provider network.

Recently, Pennsylvania signed into law the Health Investment Insurance Act (Act 77 of 2001 - available through [http://www.legis.state.pa.us/WU01/LI/LI/CL/ACT.HTM](http://www.legis.state.pa.us/WU01/LI/LI/CL/ACT.HTM)) that takes proceeds from the state’s tobacco settlement and invests them in the health of Pennsylvania adults. The program provides health insurance for low income adults who have jobs but cannot access coverage or are between jobs. There is a monthly premium for this coverage.

Eligibility is based upon certain requirements including, but not limited to:
- no coverage under any other insurance plan for at least 90 days (except when unemployed)
- age between 19 and 64
- income within the eligible limits
- living in Pennsylvania for at least 90 days
- U.S. Citizen or a permanent legal alien
• To verify benefits and exclusions, please call the Customer Services Department at 1-800-822-8752. Business hours are Monday through Friday, 8 a.m. to 5 p.m. or via NaviNet®. (Note: for any product with special benefits a redline message will appear on screen indicating to contact the Customer Services Department for further information.)

**Point of Service Account - POS**

Point of Service (POS) refers to the type of product offered by FPH and chosen by the employer group.

- The member can choose:
  - to have his/her care coordinated through the PCP; or
  - to self-refer for covered services.
- When the PCP is chosen and all care is coordinated through the PCP, the member receives the highest level of benefits, which may include deductibles and co-insurances.
- When a member “self-refers,” the claims pay at a lower level with the member being responsible for deductibles and co-insurances.
- The member is responsible for knowing his/her benefits and exclusions.
- **To verify benefits and exclusions, please refer to the back of the member’s identification card for the appropriate toll-free number to call or via NaviNet®.**
- BlueCare HMO Plus is a POS product designed by First Priority Health (FPH) that allows members to “self-refer” with a lower payment on claims. There are set packages of benefits that an employer group chooses.

**Self – Funded Account**

The term self-funded refers to the financial arrangement between an employer group and FPH.

- A self-funded product is a health plan where the risk for medical cost is assumed by the employer.
- FPH operates as an administrative unit only for self-funded accounts.
- Self-Funded POS groups have benefits that are designed by the group or Control Plan, including:
  - **Two-tier POS**—First Priority Health processes the claims, pays the providers and sends the Explanation of Benefits to the member.
  - **Three-tier POS**—First Priority Health enters the claims into its system and then the claims are transmitted to the Control Plan who advises the amount of payment. FPH pays the claim and the Control Plan sends the Explanation of Benefits to the member.
- The plan sponsor/employer is responsible for providing benefits and exclusions to their employees.
- **To verify benefits and exclusions, please refer to the back of the member’s identification card for the appropriate toll-free number to contact or via NaviNet®.**
POLICIES

ACCESS TO MEDICAL RECORDS

A medical record is the property of the entity who generated the record. However, the information contained in the record belongs to the patient.

Members have the right to access their medical records unless access is specifically restricted by the attending physician for medical reasons. If a member needs a copy of his/her medical records, the member is instructed to contact the treating physician.

First Priority Health (FPH) may obtain complete or partial copies of member’s medical records from providers. Members authorize FPH access to their medical records when they sign their enrollment application.

CLAIM ADJUSTMENTS

Blue Cross of Northeastern Pennsylvania (BCNEPA)/First Priority Health (FPH) will not honor any provider (professional/organizational) adjustment requests nor will initiate adjustments if the date of the requested adjustment is:

1. Greater than four years from claim receive date, or
2. Ninety days from the last processed date, provided, however, that no less than four years has elapsed from the original claim receive date.

This claim adjustment policy is for all product lines. This process will be applicable to provider initiated and BCNEPA initiated adjustments.

CONFIDENTIALITY

First Priority Health contractually has access to member’s records that contain private and privileged information. This information is used to provide benefits, ensure and improve quality and to identify member health care needs. Maintaining the confidentiality of this information in accordance with relevant state and federal laws and professional ethical standards is very important to all parties involved: the member, you and your staff and FPH.

FPH has adopted policies to ensure both timely access to and the confidentiality of member information and records including, but not limited to: identifiable information regarding member’s health, diagnosis, and treatment. Information contained in member’s medical records and received from physicians and other network health care practitioners, hospitals or health professionals instrumental to the doctor-patient relationship, are kept confidential by FPH.

Nothing in this policy is intended to:

1. Prevent disclosure necessary to determine coverage, review complaints or grievances, conduct utilization review or facilitate payment of a claim.
2. Deny the Pennsylvania Department of Health, the Pennsylvania Insurance Department or the Department of Public Welfare access to records for purposes of quality assurance, investigation of complaints or grievances, enforcement or other activities related to compliance with state or federal laws. Records shall be accessible only to Pennsylvania Department of Health employees or agents with direct responsibilities.
3. Deny access to information necessary for a utilization review entity to conduct a review under this article.
4. Deny access to the managed care plan for internal quality review, including reviews conducted as part of the plan’s quality oversight process. During such reviews, enrollees shall remain anonymous to the greatest extent possible.
5. Deny access to managed care plans, health care providers and their respective designees for the purpose of providing patient care management, outcomes improvement and research. For this purpose, enrollees shall provide consent and shall remain anonymous to the greatest extend possible.

FPH has implemented a Code of Business Conduct, which is distributed annually to our employees to address the confidentiality of all member’s information.

FPH, also, requires that all participating providers and other organizations involved in plan administration activities maintain the confidentiality of member information as required by state and federal laws.

If a member has a concern regarding the confidentiality of his/her information, the member may file a complaint with FPH.

RETRO AUTHORIZATION

First Priority Health (FPH) requires notification from the provider in order to prior authorize all medically necessary and appropriate services being rendered, except in emergency situations. When authorization is attempted five (5) calendar days or less after the service start date (retro authorization), circumstances will be reviewed by FPH Utilization Management for the following situations:

1. Provider was not given accurate insurance information;
2. Patient’s level of awareness was such that no information could be obtained and patient was not accompanied by a responsible party who would have the insurance information;
3. Patient was in need of immediate medical stabilization due to life-threatening circumstances; and
4. FPH was unavailable to take the authorization request.

A determination will be made if retro authorization will be approved within one (1) business day of the receipt of all information necessary to make the determination. If the retro authorization is not approved, written notification is sent to the attending physician, PCP, appealing provider/facility and the member within five (5) working days of the determination. The notification will include the principal reason(s) for the determination, the method of appeal, and the availability of the criteria for the decision upon oral or written request.
TERMINATIONS

First Priority Health (FPH) strives to build a supportive relationship with your facility. Issues are addressed in a professional manner and as timely as possible. Unfortunately, terminations may take place, whether voluntary or involuntary.

1. **Voluntary** - In accordance with the executed agreements (FPH) terminations require a ninety (90) day written notice of reason for the termination. The termination will be effective 90 days from the date of receipt of the written notice. This time frame is important for FPH to address many issues including membership notification. Please mail the termination letter certified return receipt to:

   Provider Services  
   First Priority Health  
   19 North Main Street  
   Wilkes-Barre, PA 18711-0302

2. **Involuntary** – FPH may initiate termination, pursuant to the termination section of the facility agreement for circumstances, including, but, not limited to:
   
   a. Provider no longer satisfies the FPH participation criteria for continuing participation;  
   b. Loss of state licensure;  
   c. Providing inadequate or poor quality care or is found to be harming members;  
   d. Provider is sanctioned by federal and/or state agencies;  
   e. Loss of malpractice insurance coverage.

The effective date of the involuntary termination is to be determined by FPH in accordance with contractual provisions and policies and procedures.
QUALITY MANAGEMENT

I. Introduction


B. First Priority Health contracts directly with individual primary care physicians, specialist physicians, non-physician specialists, and group practices. FPH contracts directly with hospitals, skilled nursing facilities, home care agencies, freestanding surgery centers, and other health care providers to provide and/or coordinate health care services to FPH Members. This system of health care delivery provides a full range of inpatient and outpatient services for First Priority Health Members.

C. FPH's Quality Improvement Program utilizes continuous quality improvement processes to evaluate the quality and appropriateness of care and services provided to FPH Members. It is FPH's philosophy that the delivery of quality care and service is the foundation for the achievement of desired health outcomes with the most efficient use of healthcare resources.

II. Mission Statement:

The mission statement of the Blue Cross of Northeastern Pennsylvania’s Medical Affairs Department is to lead the organization in improving health care delivery by managing quality, access, and cost.

The Medical Affairs Department works collaboratively with internal and external customers to ensure that members receive accessible, cost effective quality care. The interface among these constituencies is critical to developing valued relationships, which have contributed so greatly to our success as an organization.

By proactively partnering with our customers, we are able to understand their concerns and respond with solutions to provide meaningful results. We are committed to ensuring a balance between access, quality, and cost through integration of the following:

• Strong Leadership Principles
• Education
• Quality Improvement
• Management of Care
• Sound Financial Arrangements
• Network Access
• Information Management

III. Goals

A. To improve the health status of the population within our service area through delivery of quality, cost effective and accessible health care services while building effective partnership with our customers.

B. To measure outcomes of care and service and to apply interventions that continuously improve the level of care and service provided to FPH members.
IV. Objectives

A. Design and maintain a Quality Improvement structure and process that supports continuous quality improvement, including measurement, analysis, intervention and remeasurement.

B. Comply with NCQA, URAC and other Accreditation Standards.

C. Develop and maintain organizational structure and processes to meet requirements of Pennsylvania Department of Health, Department of Insurance, Pennsylvania Act 68 legislation and Federal Regulations, which include HIPAA and Department of Labor (DOL) regulations.

D. Establish clinical and service monitors that reflect demographic and epidemiologic characteristics of the membership, including benchmarks and performance goals for periodic monitoring and evaluation.

E. Establish clinical and service monitors that reflect specific behavioral health care needs of the FPH Membership.

F. Promote Practitioner/Provider practice patterns/environment that improve clinical quality and maximizes safe clinical practices.

G. Maintain an ongoing up-to-date credentialing and recredentialing system that complies with NCQA Standards and other state and federal regulations.

H. Measure availability and accessibility to care and service including Behavioral Healthcare at least annually.

I. Measure patient satisfaction and identify and address sources of dissatisfaction through:
   • analysis of member complaint and grievance data.
   • annual member satisfaction surveys.

J. Measure provider satisfaction annually and identify and address sources of dissatisfaction with the organization’s services.

K. Establish practice guidelines for preventive health, acute and chronic care including behavioral health care that are pertinent for the population. Measure compliance with a minimum of six (6) guidelines annually, including three (3) in the area of preventive health and four (4) in acute and chronic care including two (2) behavioral health practice guidelines.

L. Measure the conformance to medical record standards annually via the recredentialing process.

M. Establish standards for and maintain oversight of delegated utilization management.

N. Coordinate Quality Improvement activities across the corporation through activities such as focused work groups for evaluation of member benefits, the provider network and customer service.

On an annual basis, evaluate and modify as necessary:
• patient safety initiatives.
• quality improvement interventions for the previous year (demonstrated improvements in care and service) and trending of clinical and service indicator data.
• the appropriateness of the program structure, processes and objectives.
• re-establish a work plan for the upcoming year that includes a schedule of activities for the year, measurable objectives, and monitoring of previously identified issues.
• any quality improvement, utilization management, credentialing, member rights and responsibilities delegation to contracted entities.

V. Scope of Quality Improvement Program

A. Health and Disease Management Activities

1. Health Management programs geared toward promotion of healthy lifestyle choices and behaviors.
2. Disease Management programs to identify and manage targeted populations with chronic conditions.
3. Health and Disease Management activities related to targeted preventive and chronic care issues based on relevance to the population.
4. Health and Disease Management activities linked to Quality Improvement activities which promote consistent educational resources to the members and providers.
5. Collaboration with employer groups.
6. Collaboration with Community and Government Agencies as appropriate.

B. Quality of Care Monitoring

1. Services provided by Primary Care Physicians, Specialist Physicians and Non-physician specialists.
2. Services provided by Behavioral Health Practitioners/Providers.
3. Services provided by agency providers - hospitals, home health agencies, skilled nursing facilities, pharmacies, free standing surgery centers, laboratory and radiology services.
4. HEDIS monitoring.
5. Practice guideline monitoring. (Medical and Behavioral Health)
6. Services reflective of high risk, high volume services identified through a review of demographic and epidemiologic needs of membership.
7. Services reflecting acute and chronic care. (Medical and Behavioral Health)
8. Continuity and coordination of care. (Medical and Behavioral Health)
9. Patient Safety including environmental safety controls in practitioner offices.
10. Medical Records review.
11. Collaboration with Community and Government Agencies as appropriate.
12. Quality of Care and Service issues & adverse outcomes.

C. Quality of Service Monitoring

1. Physician accessibility and availability. (Medical and Behavioral Health)
2. Plan accessibility.
3. Member Satisfaction which includes members’ satisfaction with the UM process.
4. Provider Satisfaction which includes provider satisfaction with UM process.
5. Complaint/Appeal and Grievance Review.
7. PCP Change Data.
8. Member Touch Point (MTM) monitoring for Customer Service, Utilization Management and Claims, which includes telephone access, claims for payment timeliness and accuracy.


VI. Quality Improvement Program Structure

A. Committee Structure

1. Governing Body

The First Priority Health Board of Directors assumes general charge of the affairs, funds, and property of FPH. The Board has full power to carry out the purpose of the organization according to its by-laws and the ultimate authority for the oversight of the First Priority Health Quality Improvement Program.

The Board of Directors has delegated the design and ongoing review of First Priority Health’s Quality Improvement Program as well as responsibility for the monitoring of quality and appropriateness of clinical and administrative service provided by the Plan and Contracted Plan providers to the Directors’ Quality Assurance Committee (a committee of the FPH Board of Directors). The President and Chief Executive Officer (CEO) of BCNEPA serves as chairperson of this committee.

The First Priority Health Board of Directors reviews and approves the Quality Improvement Program, Annual Evaluation of the Quality Improvement Program, Annual Quality Improvement Work Plan and all oversight arrangements with delegated entities. The Chairperson of the Director’s Quality Assurance Committee regularly reports the activities and actions of the committee to the Board of Directors.

2. Directors’ Quality Assurance Committee

The Committee is comprised of three (3) Members of the Board of Directors and meets at least two (2) times per year. The Vice President Medical Affairs, Medical Director for Quality, Manager Quality Management, Manager Credentialing, Manager Health Status and Wellness and Manager HEDIS Reporting and Analysis attend all regular meetings of the Committee.

The committee is chaired by The President and Chief Executive Officer (CEO) of BCNEPA. The purpose of the committee is to provide a detailed and focused review of quality improvement activities related to Members’ health status, key quality improvements to care and services and member satisfaction that are critical to the organization’s Mission, vision and strategic and operational goals. The committee reports directly to the FPH Board of Directors and receives reports from the EQMC.

3. Executive Quality Management Committee (EQMC)

The Executive Quality Management Committee is comprised of executive level management including the Executive Vice President and COO, Senior Vice President of Provider Advocacy, Senior Vice President Member Advocacy, Vice President of Account Advocacy, Vice President Medical Affairs, Vice President and Chief Information Officer of Information Technology, Director of Project Management, General Auditor and Corporate Compliance Officer, Chairpersons of the Credentialing Committee, Quality Improvement Committee, Patient Care Management Committee and Service Quality
Management Committee, and Medical Director of Care Coordination.

The Executive Quality Management Committee reports to the Directors’ Quality Assurance Committee and receives reports from the Quality Improvement Committee, Patient Care Management Committee, Credentialing Committee, Pharmacy and Therapeutics Committee, Disease Management Committees, and Service Quality Management Committee.

The committee meets a minimum of four (4) times per year and is chaired by the Vice President of Medical Affairs. The purpose of this committee is to lead and assume responsibility for the organizational quality improvement program.

4. Quality Improvement Committee (QIC)

The Quality Improvement Committee is comprised of participating network practitioners representative of the geographic service area of FPH including a minimum of four (4) and maximum of six (6) Primary Care Physicians, a minimum of two (2) and maximum of five (5) Specialists and Non-physician Specialists and at least one Behavioral Health Practitioner. The purpose of this committee is to provide oversight for all medically related quality improvement initiatives for First Priority Health and to monitor the appropriateness of medical care for First Priority Health Members. The Quality Improvement Committee reports to the Executive Quality Management Committee. The committee meets a minimum of four (4) times a year and is chaired by the Vice President of Medical Affairs or an FPH Medical Director.

5. Credentialing Committee

The Credentialing Committee is comprised of participating network practitioners’ representative of the geographic service area of FPH including four (4) Primary Care Physicians, three (3) Specialist Physicians, one (1) Behavioral Health/Chemical Recovery practitioner and two (2) Non-physician Specialists. The purpose of the committee is to carry out the credentialing and recredentialing process for First Priority Health practitioners and providers using criteria for Initial and Continuing Participation and Credentialing/Recredentialing policies.

The Credentialing Committee reports to the Executive Quality Management Committee and receives reports from the Appeals Committee. The committee meets a minimum of six (6) times a year and is chaired by the Vice President of Medical Affairs or an FPH Medical Director. The Appeals Committee is an ad hoc committee reporting to the Credentialing Committee. The purpose of this committee is to carry out the appeal process as outlined in practitioner contracts. The committee is convened when an appeal is submitted to First Priority Health. An FPH Medical Director chairs the committee. The Appeals Committee is a decision making body.

6. Service Quality Management Committee (SQMC)

The Service Quality Management Committee is comprised of representatives of First Priority Health internal service departments with responsibility for reporting of service indicators, delegated vendor performance and service quality improvement activities. Departments represented include, Service Operations, Project Management, HEDIS Customer and Reporting, Medical Management, Quality Management, Quality Improvement, Data Management and Reporting, Provider Relations, Alternative Benefits, Behavioral Healthcare, Statistical Services, Information Technology, Privacy and Security, Corporate Compliance, Marketing, Sales, Pharmacy, Blue Card Executive,
Claims, Member Services, Care Coordination and the Medical Director Department. The purpose of this committee is to act on performance reports from the two (2) internal service subcommittees. The Service Operations subcommittee and the Clinical Operations subcommittee will each collect pertinent reports and perform quantitative and qualitative analysis to identify opportunities for process improvement. Each subcommittee will have service operations and clinical care/service members to ensure interdepartmental assessment of data. SQMC will remain responsible for oversight of delegated vendors, performance monitoring and service quality improvement activities across the organization.

The Service Quality Management Committee reports to Executive Quality Management Committee. The committee meets at least four (4) times per year and is chaired by the Senior Vice President of Member Advocacy.

7. Disease Management Committee

The Disease Management Committee is a multidisciplinary committee within FPH responsible to oversee the development and implementation of programmatic initiatives for targeted populations. Departments represented on this committee include: Medical Director, Quality Improvement/Management, Health and Disease Management, Pharmacy, Provider Relations, Care Management, Statistical Services, Product Development and Corporate Communications.

The Disease Management Committee reports to the Executive Quality Management Committee. The committee meets a minimum of six (6) times a year and is chaired by the Manager, Health Improvement.

8. Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics Committee is comprised of a minimum of four (4) and a maximum of eight (8) participating First Priority Health physicians and a minimum of one (1) and maximum of two (2) participating pharmacists that are representative of the FPH geographic service area. The purpose of this committee is to provide oversight for all FPH pharmacy programs, develop and maintain a formulary and make recommendations for new drug therapies or changes to current drug therapy. The committee reports to the Executive Quality Management Committee. The committee meets a minimum of four (4) times a year and is chaired by an FPH Medical Director.

9. Patient Care Management Committee

The Patient Care Management Committee is comprised of at least five (5) and no more than ten (10) Board Certified/Board Eligible participating physicians. The purpose of this committee is to approve utilization management criteria, recommend new technology or new approaches to existing technology and new benefits. The committee reports to the Executive Quality Management Committee. The committee is a recommending body for technology and benefits to the Benefits Committee. The committee meets a minimum of three (3) times a year and is chaired by an FPH Medical Director.
VII. Continuous Quality Improvement

The First Priority Health Quality Improvement Program is operationalized using quality improvement concepts derived from the Shewhart Cycle of quality improvement (now popularized as the Deming Cycle) and described as the Plan, Do, Check, Act Cycle. This Quality Improvement process is also similar to the basic scientific method employed in the training of most health care practitioners and is readily applicable to the study of complex administrative and clinical processes.

Components of the cycle include the identification of structure or process issues through systematic monitoring (observable symptoms); data collection and analysis to identify root causes or barriers for structure or process issues; development of theories and solutions to address the structure or process barriers; implementation of interventions to address the barriers; observation of effects of the interventions and evaluation of results in order to repeat the quality improvement cycle as necessary.

VIII. Confidentiality/Privacy

Information and data collected during quality-related activities are confidential and shall be made available only to those persons directly involved in preparing, analyzing, evaluating or acting upon the information. These include, but may not be limited to, Members of the Grievance Review Committee, the various Quality Management Committees, and the staff of the Quality Management Department and the Medical Director Department.

All information in the possession of the above named parties obtained during quality management activities shall not be disclosed in any manner except to:

1. A member’s primary care physician.
2. Authorized representatives of insurance companies.
3. Federal or state agencies as required by law.
4. Authorized representative (administrator) of group practice
5. Physician organization representative that is responsible for the care of specific members.

First Priority Health shall adhere to any state or federal laws governing the disclosure of confidential protected health information.

IX. Patient Safety

A commitment to promoting environments that improve clinical quality and maximize safe clinical practice has been an essential component of the overall quality initiatives of FPH. With recent statistics released by the Institute of Medicine’s (IOM) Committee on Quality of Health Care in America, a greater emphasis on patient safety is occurring. Accordingly, FPH has increased efforts to foster a supportive environment to help practitioners and providers improve the safety of their practices and to improve members understanding of safety and prevention of adverse events.

X. Quality Improvement Work Plan

First Priority Health will develop an annual Quality Improvement Work Plan based on the outcomes and recommendations of the previous evaluation of the Quality Improvement Program. The Work Plan will include identified maintenance and quality improvement activities for the coming year. Each objective will be measurable and will include time frames for completion.
The Quality Improvement Work Plan will be evaluated on an annual basis during the first quarter of each year. Results will be reported to the Executive Quality Management Committee, First Priority Health Board of Directors and Pennsylvania Department of Health. The results will provide the basis for the next year’s Work Plan.

XI. Approval

The annual evaluation of the Quality Improvement Program description and development of the new Quality Improvement Work Plan will be approved in the first quarter of each year by the Executive Quality Management Committee, Directors Quality Assurance Committee and the FPH Board of Directors.

CREDENTIALING/RECREREDENTIALING

First Priority Health (FPH) utilizes and adheres to Pennsylvania Department of Health and the National Committee for Quality Assurance (NCQA) standards on credentialing and recredentialing for practitioners and facility providers. The organization has very well defined policies, procedures and criteria that outline the selection process. The criteria have been designed to assess a practitioner’s or facility’s ability to provide care. They include but are not limited to:

- verification of licensure;
- relevant training and experience; and
- disclosure of health issues that may interfere with the delivery of care to members.

The policies define the appropriate documentation to verify each piece of criteria. FPH verifies information from primary sources as defined by NCQA, where applicable, in order to validate that the information received from the practitioner or facility is accurate and valid. For recredentialing purposes, in addition to credentials verification, the managed care organization incorporates quality of care information into the practitioner’s and facility’s file. The quality criteria include but are not limited to:

- quality of care issues;
- complaints;
- grievances; and
- medical record reviews and QI data.

FPH’s Medical Director has oversight responsibility for the credentialing and recredentialing process. All information for credentialing and recredentialing of practitioners and facility providers is reviewed and approved by the Credentialing and Recredentialing Committee, which is composed of network physicians, podiatrists, behavioral health care professionals and chiropractors. All practitioners and facility providers must meet FPH’s standards for participation in order to initially treat and continue to treat FPH members.
First Priority Health (FPH) recognizes the need to address regional community needs while maintaining network continuity and balance. It is FPH’s effort to meet the needs of its members through innovative programming within the network. FPH’s 13-county service area includes:

- Bradford
- Carbon
- Clinton
- Lackawanna
- Luzerne
- Lycoming
- Monroe
- Pike
- Sullivan
- Susquehanna
- Tioga
- Wayne
- Wyoming

LACKAWANNA REGION

This part of FPH’s network is comprised of the following counties:

- Lackawanna
- Monroe
- Pike
- Susquehanna
- Wayne

Outpatient Laboratory Program: FPH has implemented an outpatient laboratory program with Pennant Laboratory Services, a service of Wyoming Valley Health Care System, for BlueCare HMO members whose Primary Care Physician (PCP) is located within Lackawanna County. The BlueCare HMO member will only need to obtain a script from their PCP or Specialist for these services to be performed at a Pennant Lab site. For a current listing of the sites and availability, check the BCNEPA Provider Center (on NaviNet℠), or contact your provider relations consultant. Care must be coordinated with the BlueCare HMO member’s PCP.

Services included in this program are:

- STAT – must be indicated on the script and performed at a par facility,
- Pre-admission testing,
- House calls, and
- Services associated with skilled nursing/personal care facility.

LUZERNE REGION

This part of FPH’s network comprises the following counties:

- Carbon
- Luzerne
- Wyoming

Programs:

1. Outpatient Radiological Program: FPH has implemented an outpatient radiological program to render integrated, high-quality, cost-effective care to BlueCare HMO members. This program serves BlueCare HMO members whose PCP is within Luzerne County (excluding Berwick and Hazleton areas). The member will only need to obtain a script from their PCP or Specialist for these services to be performed at Wyoming Valley Health Care System (WVHCS) designated sites. Care must be coordinated with the member’s PCP. Services for members in the remaining Luzerne Region counties can be obtained from any participating hospital facility.
2. **Outpatient Laboratory Program:** FPH has implemented an outpatient laboratory program with Pennant Laboratory Services, a service of Wyoming Valley Health Care System, for BlueCare HMO members whose PCP is located within Luzerne County. The member will only need to obtain a script from their PCP or Specialist for these services to be performed at a Pennant Lab site. For a current listing of the sites and availability, check the BCNEPA Provider Center (on NaviNetSM), or contact your provider relations consultant. Care must be coordinated with the member’s PCP. Services included in this program are:

- STAT lab – indicated on the script (if the Hazleton draw site is unavailable, physicians may use the Hazleton hospitals for STAT services),
- Pre-admission testing,
- House calls, and
- Services associated with skilled nursing/personal care facility.

For BlueCare HMO members whose PCP is within the remaining Luzerne Region counties, lab services can be obtained through any participating hospital facility. The member will only need to obtain a script for these services. Care must be coordinated with the member’s PCP.

**LYCOMING REGION:**

This part of FPH’s network is comprised of the following counties:

- Bradford
- Clinton
- Lycoming
- Sullivan
- Tioga

There are no designated programs for this region. BlueCare HMO Members can obtain laboratory and radiological services through any participating hospital facility. The BlueCare HMO members will need to obtain a script for these services from their PCP or Specialist provider. Care must be coordinated with the member’s PCP.