2022 Policy Memo 4

Quality of Care

BlueCross BlueShield Kansas

bcbsks.com

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An integral component of the Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) quality improvement program is the evaluation of the health care services rendered to members by contracting providers through medical peer review. Potential quality of care concerns, including adverse events, may be identified and referred by members, providers or other persons who have such information. All such quality of care concerns shall be referred to the Nurse Coordinator of Quality Improvement, who serves as the designated peer review officer for BCBSKS as defined in K.S.A. 65-4915.

I. Quality Improvement Process

The initial step in improving health care is identification of areas needing improvement. Once identified, medical records are requested and reviewed to evaluate the appropriateness and effectiveness of health care.

Pertinent data collected from the medical record is analyzed according to established criteria and current standards of care by quality improvement staff and peer reviewers. Providers are encouraged to take an active role in the review process, providing additional information and clarification when appropriate. Failure by a contracting provider to respond to a request from BCBSKS for additional information during a quality of care review process constitutes grounds for further actions by BCBSKS, up to and including termination of the provider's participation agreement for cause.

The second step is to work cooperatively with providers in the development of solutions to the identified problems.

The third step requires solutions be evaluated to ensure the provider's future performance meets established standards.

The final step in quality improvement through medical record review is to revise or enhance solutions which are not improving or maintaining the quality of care as planned.

Emerging patterns of confirmed inappropriate or substandard care provided by contracting providers are monitored within the quality improvement department. Once a problem or pattern of problems is identified, a corrective action plan may be requested as an educational effort to correct a specific problem relating to the care rendered by contracting providers. All cases in which the quality of care is either questionable or may be substandard are referred for external review by a contracted quality improvement and peer review organization for a final determination. BCBSKS may report providers to the appropriate licensing authority based on peer review organization's final determination. BCBSKS may also take further action up to and including termination of the provider's participation agreement.

Corrective action plans are requested when an individual case or pattern of cases is identified with quality concerns. Corrective action plans may be requested for facility, physician, or ancillary providers depending upon the problem focus. If the provider or other entity submits a corrective action plan that is accepted by BCBSKS, the ongoing evaluation of the corrective action plan process is performed by the provider or other entity. The BCBSKS peer review process is complete.

When there is not a corrective action plan submitted and implemented by the provider or another entity, a Quality Improvement Plan (QIP) may be developed by BCBSKS for implementation. Evaluation of the effectiveness of a BCBSKS-developed QIP will be performed at intervals

appropriate to the identified problem or deficiencies, but not to exceed one (1) year. BCBSKS will notify the provider when a BCBSKS-developed QIP and peer review process is complete.

II. Member Satisfaction Survey

Members' perceptions are an essential source of information for BCBSKS. A satisfaction survey is not only a good management tool, but also a key indicator of the quality of care being provided. Surveys may be conducted to comply with performance standards and/or to gain insight into specific issues. BCBSKS is committed to continuous quality improvement and survey results are analyzed to determine areas of strength and areas of concern. Root causes are identified and action plans implemented so improvements can be achieved.

III. Disease Management/Wellness

BCBSKS has telephone-based Disease Management and Wellness programs designed to help members improve quality of life and overall health by understanding health risks and possible complications, making healthy lifestyle choices, improving gaps in care/preventive care, and communicating with the health care team to make informed decisions in care. Disease Management programs offered may include but are not limited to diabetes, coronary artery disease, asthma, chronic obstructive pulmonary disease, congestive heart failure, hypertension, and hyperlipidemia. Wellness programs offered may include but are not limited to maternity, weight loss, tobacco cessation, and stress management. Through these programs, registered nurses provide one-on-one support, coaching, and educational tools to assist members in self-management skills to improve overall health.

The Disease Management Program is URAC accredited. Both the Disease Management and Wellness programs are HIPAA compliant.

Members are identified for participation in one or more of the Disease Management programs by diagnoses codes on claims and will be invited to participate by letter or telephone. Additionally, members can self-enroll for any Disease Management or Wellness program, and providers may refer members for participation. Participation in the programs is voluntary. Members may choose to discontinue participation in the programs at any time. Participation in the programs will not affect any health insurance benefits. For additional information, go to bcbsks.com/BeHealthy/DiseaseMgmt or bcbsks.com/BeHealthy/Wellness-Management.

IV. Health Insurance Portability and Accountability Act (HIPAA)

According to the HIPAA Privacy Rule, health care providers can disclose protected health information (PHI) to health plans pertaining to credentialing, retrospective review, office record reviews, and HEDIS (Healthcare Effectiveness Data and Information Set) data collection for the following types of health care operations:

A. Quality assurance and quality improvement activities
B. Accreditation activities (e.g., HEDIS data collection)
C. Case management, care coordination, and related functions
D. Disease management
E. Protocol development

F. Credentialing provider or health plan performance evaluation

G. Training

H. Certification

I. Licensing

Providers are permitted by HIPAA to disclose PHI to health plans for the above purposes without authorization from the patient when both the provider and health plan have or had a relationship with the patient and the information relates to that relationship.

V. Health Information Exchange (HIE)

BCBSKS believes in the value of health information exchange to support delivery of high-quality and cost-effective health care. BCBSKS is committed to supporting electronic sharing of clinical information that is HIPAA compliant and designed to achieve the goals of improving member experience, quality of care, and the health of our member population. BCBSKS may require electronic submission when requesting clinical information.

VI. Quality Reporting and Transparency

BCBSKS may establish quality initiatives and programs to monitor and report performance results of participating providers, and make available such results in web based and/or written form to the general public, enrolled employer groups, and members.

VII. Credentialing

A. Overview

1. Before a health care provider is eligible to become a contracting provider in the BCBSKS network, he/she must apply for and be granted credentialing status through the BCBSKS credentialing process as more fully described in the Credentialing Program Plan Description and BCBSKS policies and procedures (collectively, Program).
2. For providers who are not currently credentialed, he/she must submit application and undergo a full review as described in the Program. For providers who are currently credentialed, they must undergo the recredentialing process described in the Program at least every 36 months.
3. BCBSKS will monitor all network providers for continual compliance with established criteria as needed but at least monthly. If any derogatory information is identified during monthly monitoring, credentialing staff will report such findings to the Committee that will follow the process outlined below.

B. Initial Consideration by BCBSKS Credentialing Committee

1. In order for an applicant to be considered for credentialing by the Committee, he/she must meet all applicable criteria as set out in the Program and that are available on the BCBSKS website*. An applicant who does not meet all applicable criteria may not be considered by the Committee. The reconsideration and appeal process described below is not available to applicants who do not meet all applicable criteria.

*Credentialing criteria are available on the BCBSKS website at http://www.bcbsks.com/CustomerService/Providers/Publications/professional/PolicyMemos/credentialing-criteria.htm

2. The Committee reviews each provider's credentialing file in accordance with BCBSKS criteria and URAC standards. If a provider does not meet these standards or there is evidence that he/she does not adhere to BCBSKS policies and procedures, the Committee may deny or restrict participation in a BCBSKS network. If the provider disagrees with the denial or restriction and has additional information, he/she may request reconsideration by the Committee. In the absence of additional information, the provider may submit a written request for a first-level appeal within 30 calendar days of the date BCBSKS sends notice of the denial or restriction to the provider.

C. Suspension for Member Safety – BCBSKS will review any action taken against a contracting provider where the provider has engaged in conduct or is practicing in a manner that raises competency concerns or appears to pose a significant risk to the safety of BCBSKS members. The contracting provider will be offered appeal rights if his/her contracting status is suspended.

D. Circumstances When Reconsideration/Appeal is not Available

1. If the Committee denies or cancels credentialed status for a provider because of one or more of the following reasons, the reconsideration and appeal process described below in Subsections E through G will not be available to such provider.
   a. Provider's professional license is not at full clinical scope of practice;
   b. Adverse action against the provider's DEA registration;
   c. Provider is unable to supply credentialing staff with documentation of successful completion of at least three years post-graduate training or equivalent work experience; or
   d. Provider is currently subject to any sanctions imposed by any CMS program or by the Federal Employee Health Benefit Program, including but not limited to being excluded, suspended, or otherwise ineligible to participate in any state or federal health care program.
2. If a provider's regulatory board suspends or revokes his/her license, that provider's BCBSKS network contract is canceled by operation of the terms of the contract. When credentialing staff members become aware of such suspension or revocation, they shall notify the Committee, but the Committee is not required to take any specific action since the provider's contract will terminate of its own accord. Credentialing staff shall also notify the appropriate internal departments of such suspension or revocation to ensure that appropriate administrative action is taken.

E. Reconsideration – If the Committee denies or restricts a provider's participation status, the Committee will allow the provider to submit additional supporting documentation for reconsideration. If the denial or restriction is upheld by the Committee, the provider may submit a written request for a first-level appeal within 30 calendar days of the date BCBSKS sends notice of the denial or restriction to the provider.

F. First-Level Appeal Panel – All appealed disputes are referred to a first-level appeal panel consisting of at least three qualified individuals, of which at least one must be a participating provider who is not otherwise involved in network management and who is a clinical peer of the provider that filed the dispute. BCBSKS will have 60 days from receipt of the first-level appeal request to convene a first-level appeal panel.

G. Second-Level Appeal Panel – If the first-level appeal panel upholds the denial or restriction, the provider may submit a written request for a second-level appeal. BCBSKS will convene a second-level three-member appeal panel consisting of at least one member who must be a contracting provider not otherwise involved in network management and who is a clinical peer of the provider who filed the dispute. None of the second-level panel may have been members of the first-level appeal panel. BCBSKS will have 60 days from receipt of the second-level appeal request to convene a second-level appeal panel.

H. Second-Level Appeal Panel Decision – The result of the appeals process shall be binding on both the provider and BCBSKS subject only to the provision for binding arbitration previously stated in Policy Memo No. 1.

   For every provider whose denial or cancelation of credentialing status is upheld, credentialing staff will report the decision to the provider's regulatory board and the National Practitioner Data Bank.