Scripps Health Plan
Quality Management
Program Description
2025

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I. Mission, Vision and Values

Mission

Scripps strives to provide superior health services in a caring environment and to make a positive, measurable difference in the health of individuals in the communities we serve.

We devote our resources to delivering quality, safe, cost effective, socially responsible health care services. We advance clinical research, community health education, education of physicians and health care professionals and sponsor graduate medical education.

We collaborate with others to deliver the continuum of care that improves the health of our community.

Vision

Scripps Health will continue to be the leading health care delivery system in the greater San Diego community, as evidenced by the highest clinical quality, patient safety, and patient, physician and employee satisfaction. This will be achieved through unending focus on patient-centered and compassionate care, cost-effective operations, research, advanced technology, innovation, and health equity.

Values

We provide the highest quality of service

Scripps is committed to putting the patient first and quality is our passion. In the new world of health care, we want to anticipate the causes of illness and encourage healthy behavior for all who rely on us for service. We teach and encourage patients to participate in their care and to make well-informed decisions. We will be their advocate when they are most vulnerable. We measure our success by our patients' satisfaction, their return to health and well-being, and our compassionate care for dying patients, their families and friends.

We demonstrate complete respect for the rights of every individual

Scripps honors the dignity of all persons, and we show this by our actions toward one another and those we serve. We embrace the diversity that allows us to draw on the talents of one another. We respect and honor the cultural, ethnic and religious beliefs and practices of our patients in a manner consistent with the highest standards of care. All this is done in a compassionate setting. Our goal is to create a healing environment in partnership with all caregivers who are committed to serving our patients.

We care for our patients every day in a responsible and efficient manner

Scripps serves as a major community health care resource for San Diego County and, as such, we are accountable for the human, financial and ecological resources entrusted to our care as we promote healing and wholeness. We begin from a base of excellence and collaborate with co-workers, physicians, patients, and other providers to find new and creative ways to improve the delivery of health care services. All members of our community will have access to timely, affordable and appropriate care.

Member Rights and Responsibilities

As a member, you have the right to:

1. Receive considerate and courteous care, with respect for your right to personal privacy and dignity.
2. Receive information about all health services available to you, including a clear explanation of how to obtain them.
3. Receive information about your rights and responsibilities.
4. Receive information about your Scripps Health Plan (SHP), the services we offer you, and the physicians and other practitioners available to care for you.
5. Select a PCP and expect his/her team of health workers to provide and/or arrange the care that you need.
6. Have reasonable access to appropriate medical services.
7. Participate actively with your physician in decisions regarding your medical care. To the extent permitted by law, you also have the right to refuse treatment.
8. A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
9. Receive from your physician an understanding of your medical condition and any proposed appropriate or medically necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
10. Receive preventive health services.
11. Know and understand your medical condition, treatment plan, expected outcome and the effects these have on your daily living.
12. Have confidential health records, except when disclosure is required by law or permitted in writing by you. With adequate notice, you have the right to review your medical record with your PCP.
13. Communicate with and receive information from Customer Service in a language you can understand.
14. Know about any transfer to another hospital, including information as to why the transfer is necessary and any alternatives available.
15. Obtain a referral from your PCP for a second opinion.
16. Be fully informed about the SHP grievances procedure and understand how to use it without fear of interruption of health care.
17. Voice complaints about the SHP or the care provided to you.
18. Participate in establishing public policy of SHP, as outlined in your Evidence of Coverage and Disclosure Form or Health Service Agreement.
19. Make recommendations regarding SHP member rights and responsibilities policy.

As a member, you have the responsibility to:

1. Carefully read all SHP materials immediately after you are enrolled so you understand how to use your benefits and how to minimize your out-of-pocket costs. Ask questions when necessary. You have the responsibility to follow the provisions of your SHP membership as explained in the Evidence of Coverage and Disclosure Form.
2. Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when it is needed.
3. Provide, to the extent possible, information that your physician, and/or SHP need to provide appropriate care for you.

4. Understand your health problems and take an active role in making health care decisions with your medical care provider, whenever possible.
5. Follow the treatment plans and instructions you and your physician have agreed to and consider the potential consequences if you refuse to comply with treatment plans or recommendations.
6. Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given.
7. Make and keep medical appointments and inform your physician ahead of time when you must cancel.
8. Communicate openly with the PCP you choose so you can develop a strong partnership based on trust and cooperation.
9. Offer suggestions to improve SHP.
10. Help SHP to maintain accurate and current medical records by providing timely information regarding changes in address, family status, and other health plan coverage.
11. Notify SHP as soon as possible if you are billed inappropriately or if you have any complaints.
12. Select a PCP for your newborn before birth, when possible, and notify SHP as soon as you have made this selection.
13. Treat all SHP personnel respectfully and courteously as partners in good health care.
14. Pay your dues, copayments and charges for non-covered services on time.
15. For all mental health and substance use disorder services, follow the treatment plans and instructions agreed to by you and the MHSA and obtain prior authorization for all non-emergency mental health and substance use disorder services when applicable.

II. Purpose

The purpose of the SHP Quality Management (QM) program is to maintain a comprehensive, coordinated process which continually evaluates, monitors and improves the quality of clinical care and service provided to members within the SHP health care delivery system. The QM Program Description and all related QM policies and procedures are available to providers upon request.

SHP is committed to treating members in a manner that respects their rights. Also, SHP has certain expectations of members' responsibilities. Both these commitments will be upheld at all times by all staff in all activities.

III. SHP QM Goals

SHP QM program goals are:

1. To improve the safety and quality of care and service to all members by ensuring that the level of care provided meets professionally recognized standards of practice and is being delivered to all members.
2. To coordinate with the care delivery system in order to improve the clinical care and services provided to members.
3. To maintain a comprehensive, ongoing and multi-disciplinary QM program.

4. To objectively and systematically measure, assess, and evaluate all aspects of clinical care and services provided to members through the SHP health care delivery system.
5. To address service elements, including accessibility, availability, and continuity of care as well as to monitor whether the provision and utilization of services meets professionally recognized standards of practice.
6. To ensure that care is appropriate and consistent with professionally recognized standards of practice and to ensure that such care is provided to all members.
7. To ensure that care is not withheld or delayed for any reason, including a potential financial gain and/or incentive to participating providers or others.
8. To ensure that the compensation to individuals or entities that conduct utilization management and concurrent review activities is not structured so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any member.
9. To ensure that health care providers and institutions are not required to provide care beyond the scope of their training or experience.
10. To objectively participate in the investigation of cases of potential fraud and/or abuse of the SHP delivery system and to implement corrective action where necessary.
11. To maintain a data collection, reporting and follow-up system that is adequate to produce reliable and timely data and reports from various business units and to ensure that appropriate follow-up actions are taken.
12. To review existing policies and procedures against all external requirements and standards, creating new policies as required.
13. To monitor procedures to ensure that members are not discriminated against based on race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, disability or any of the following health status-related factors: medical condition, including physical and mental illnesses, claims experience, receipt of health care, medical history, genetic information or evidence of insurability, including conditions arising out of acts of domestic violence.
14. To provide care that promotes wellness.

IV. Activities & Objectives

SHP QM program goals can be achieved by performing the following QM activities and objectives:

1. Assess the quality and safety of clinical care, quality of service and member satisfaction.
2. Identify, prioritize and implement improvement opportunities with the ongoing participation of all areas of the health care delivery system (participating practitioners, hospitals, ancillary providers, SHP administration, etc.).
3. Establish and define the scope of activity for multi-disciplinary problem-solving teams.
4. Monitor and evaluate multi-departmental clinical and service quality indicators.
5. Develop a systematic, on-going process for objective evaluation of member care and identify opportunities for improvement which have the most impact on the health care delivery network and population served.
6. Track the results of quality improvement activities, reassess and redesign as necessary. SHP utilizes the Plan-Do-Study-Act process for evaluating activities.

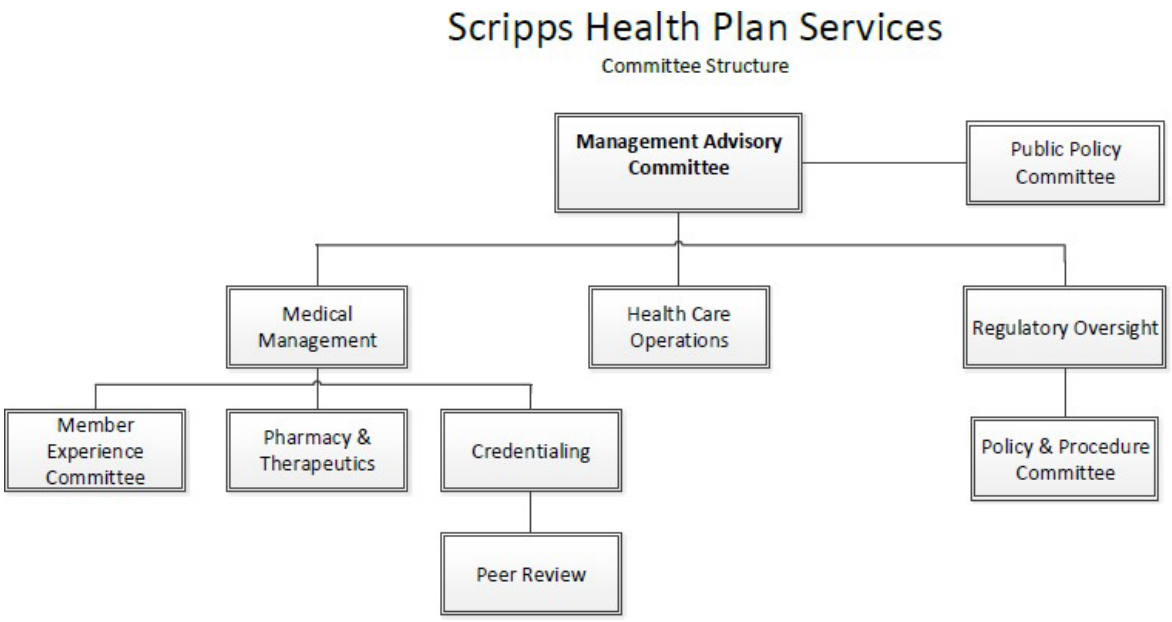
7. Maintain processes for the use and follow-up of QM information from member and provider satisfaction questionnaires, member and provider appeals and grievances, risk management reports, utilization management (UM) reports, credentialing and re-credentialing results, audits and studies.
8. Maintain mechanisms for effective communication and reporting of all QM activities to the governing body, administration, practitioners, hospitals and ancillary providers.
9. Comply with federal, state and accrediting body requirements.
10. Educate members, practitioners, hospitals and other ancillary providers about SHP's QM goals and activities.
11. Identify and evaluate members with complex health needs to ensure needs are met and referred to complex case management.
12. Ensure that member cultural and linguistic preferences are assessed and met.
13. Ensure that adequate staff and resources are available for implementation and maintenance of the QM program.

V. Program Authority and Accountability

The SHP Management Advisory Committee (MAC) has ultimate accountability for the oversight and effectiveness of the QM program. The governing body has delegated responsibility for QM program implementation and planning to the Medical Management Committee (MMC). The MMC is responsible for the ongoing monitoring, evaluation, and improvement of the QM Program.

The SHP Medical Director acts as the Chair of the MMC and is the Senior Officer responsible for the direction and overall functioning of the QM program and ensures allocation of adequate resources and staffing. The MAC will receive, at a minimum, a quarterly summary of all QM activities, including findings and actions taken by the MMC. At least annually, the QM Program Description and the QM Work Plan is evaluated and approved by the MMC and the MAC and revised as necessary.

VI. Committees



A. Management Advisory Committee

The Management Advisory Committee (MAC) is responsible for adopting and implementing the policies governing SHP, monitoring and evaluating the effectiveness of the management of SHP's business operations, and maintaining its financial stability. The MAC shall meet at least quarterly and review reports and recommendations from the various subcommittees as appropriate. Minutes with actions taken, responsible persons, and recommendations will be maintained.

MAC Membership:

President is responsible for the oversight and monitoring of SHP. The President has the authority and responsibility for SHP's administrative, fiscal, and managed care operations. Within these areas are financial analysis, contracting/provider relations, claims operations, regulatory compliance, and other administrative functions. He is currently responsible for all health plan contracting, including Health Care Service Plans (HCSPs) that contract with Scripps Health Plan Services (SHPS) under its Full Knox-Keene license.

Vice President (VP) of Managed Care Operations reports to the President on fiscal, operational, and administrative matters. Specifically, acts as the Chair of the Healthcare Operations Committee (HOC) and the Public Policy Committee (PPC) and is responsible for general oversight of managed care operations, such as compliance, customer service, claims, credentialing, enrollment, utilization, clinical operations, performance improvement, contracting, provider relations,

systems, reporting, program reconciliation, network management, sales, health plan operations, risk adjustment, and electronic data exchange.

The VP, Managed Care Operations, works closely with the Medical Director regarding medical management matters. In this way, the VP, Managed Care Operations, acts as a liaison between managed care operations and clinical activities by resolving issues or concerns that may arise in the health care delivery system. Moreover, she understands the capabilities of leveraging information systems, manages ongoing data analysis, physician trends, and other valuable information used in developing policies and improving programs.

MAC membership is composed of representatives nominated and approved by the MAC from key departments within SHP. All regular MAC members shall be voting members (i.e., ad hoc members do not have voting rights). In order for business to be conducted, a quorum must be present. A quorum is defined as a simple majority of voting members. Each committee member is expected to attend a minimum of 75% of the committee meetings on an annual basis. Minutes of all meetings shall be considered confidential and are maintained in SHP administrative offices and/or on a secure cloud-based repository. Minutes will be available for review by regulatory and accrediting body representatives upon request.

B. Healthcare Operations Committee

Chaired by the VP, Managed Care Operations and Co-Chaired by the Sr. Director, Service Operations, meetings are held at least quarterly, and additional meetings may be scheduled as required.

The Healthcare Operations Committee (HOC) is a multi-disciplinary group which reviews all health care delivery system issues that affect members. This committee oversees SHP operations, including reimbursement and recoveries, member and provider services, and administrative functions. This committee also guides SHP's financial planning, including product design, underwriting, premium rating, risk arrangements, and reinsurance.

C. Medical Management Committee

Chaired by the Medical Director, meetings are held at least quarterly, and additional meetings may be scheduled as required. The Medical Management Committee (MMC) provides a coordinated process for the ongoing monitoring and evaluation of the effectiveness in the utilization and cost of clinical services rendered to members. In its role as the key clinical decision-making body, the MMC receives, at a minimum, a quarterly summary of all QM and UM activities, including findings and actions taken by all subcommittees. A summary of QM and UM activity will also be included in the quarterly QM and UM program reports submitted to the MAC. Annually, the QM and UM Program Descriptions are evaluated and approved by the MMC. This committee is also responsible for monitoring clinical practices, evaluating provider utilization and adherence, and reviewing and making recommendations to member appeals and grievances trends.

1. MMC Membership:

Membership is composed of SHP staff and participating providers reflecting an appropriate mix of the major practice specialties provided within the SHPS provider network. In order for business to be conducted, a quorum must be present. A quorum is defined as a simple majority of voting members

but may never be less than three (3) voting members. Each committee member is expected to attend a minimum of 75% of the committee meetings on an annual basis. Failure to attend may result in replacement of the member.

The Medical Director shall nominate community providers to be member(s) with the appropriate specialty background and experience for the committee. Nominees are reviewed and approved by the MMC. A review will include assessment of available practice information, past experience, and professional reputation for medical expertise. Each physician member of the MMC will serve a two-year term and may be re-appointed by the Medical Director. The MAC shall have the authority to approve or deny membership of a provider to join the committee. While no special training or certification will be required of committee members, physician members must have an unrestricted license in the state of California and be a fully credentialed member of the SHPS provider network. A psychiatrist or qualified mental health representative will be a member of the MMC for coordination of medical and mental health care.

The committee members must sign a confidentiality statement prior to attending their first meeting, and annually thereafter. Minutes of all meetings shall be considered confidential and are maintained in SHP administrative offices and/or on a secure cloud-based repository. Minutes will be available for review by regulatory and accrediting body representatives upon request. Peer reviews of sensitive quality of care concerns will be conducted in executive sessions and those minutes retained separately.

2. MMC Responsibilities:

   a. Annually review and evaluate the effectiveness of the SHP QM program.
   b. Annually review and approve the QM Program Description and annual QM Work Plan and evaluate the previous year's QM Work Plan.
   c. Monitor and evaluate adherence to evidence-based standards of practice for practitioners and other healthcare providers and implement corrective action plans, when applicable.
   d. Conduct confidential peer reviews and quality of care investigations under the QM program guidelines.
   e. Identify areas requiring focused review, evaluate the results of the review, implement clinical improvement initiatives, and evaluate results of the initiative.
   f. Review and investigate provider utilization adverse trends, including corrective action recommendations, when applicable.
   g. Annually review, approve, and disseminate nationally recognized clinical practice guidelines in addition to any changes to those guidelines that may occur during the year.
   h. Identify, approve, evaluate, and modify key performance indicators and benchmarks for member and provider services and value-based outcomes and implement corrective action plans for variances based upon findings.
   i. Ensure follow-up is completed on all required actions.
   j. Evaluate trends and communication with other departments during integrated meetings or the Member Experience Committee (MEC), ensuring emphasis on the member experience and quality.

k. Review QM policies, procedures, and standards.
l. Review delegation oversight reports and monitor delegated activities and corrective action plans, when applicable.
m. Partner with the Chief Compliance Officer when there is potential fraud, waste, or abuse, in compliance with state and federal regulations.
n. Provide oversight of provider credentialing, re-credentialing, terminations, and appeals.
o. Review, trend, and analyze grievance and appeal reports to include the development, implementation, and re-assessment of action plans.
p. Assess the characteristics and needs of the member population and relevant subpopulations.
q. Review and evaluate the disease management/complex care management programs, including outcomes of the programs and the need to modify interventions based upon those evaluations.
r. Revise and update case management processes to address member needs as necessary.

D. Pharmacy and Therapeutics Committee

Chaired by the Medical Director and Co-Chaired by the Manager, Pharmacy, meetings are held at least quarterly, and additional meetings may be scheduled as required.

The Pharmacy and Therapeutics (P&T) Committee is organized to review and approve the drug formulary and new medical technologies based on clinical scientific evidence and standards of practice, considering drug therapeutic advantages in terms of safety and efficacy. The P&T Committee is a policy-recommending body on matters related to the safe and therapeutic use of medications and provider prescribing practices. The P&T Committee recommendations are subject to the administrative approval process, and summaries are brought to the MMC.

SHP may delegate the development and execution of pharmaceutical management procedures to a Pharmacy Benefits Manager (PBM). SHP and SHP P&T Committee will retain primary responsibility for pharmacy benefit policies and procedures and development of the formulary. The PBM will serve as a resource for information regarding the formulary, preferred drug lists, prior authorization lists, medication requests, restrictions, and copays. The process of the development and execution of pharmaceutical management procedures delegated to the PBM will be reviewed on a regular basis and reported to the P&T Committee.

1. P&T Committee Membership:

Membership consists of primary and specialty care representation. At the discretion of the Chairperson, the P&T Committee may include additional non-voting members who may be employees of SHP or the PBM. All committee members shall complete a conflict of interest statement pertaining to any financial or other relationships with any pharmaceutical or device manufacturers.

In order for business to be conducted, a quorum must be present. A quorum is defined as a simple majority of voting members but may never be less than three (3) voting members. Each committee

member is expected to attend a minimum of 75% of the committee meetings on an annual basis. Failure to attend may result in replacement of the member.

2. P&T Committee Responsibilities:

    a. Meet the responsibilities of a P&T Committee, as provided for in HSC §1367.41 and 45 CFR §156.122.
    b. Maintain the drug formulary to promote safety, effectiveness, and affordability according to drug selection process.
    c. Review new drugs, drug classes, new clinical indications, therapeutic advantages, new chemical entities, and new safety information. Base clinical decisions on the strength of the scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmaco-economic studies, outcomes research, and other related information.
    d. Recommend formulary status and what position or tiered covered medications should occupy on formulary.
    e. Review the drug formulary and therapeutic classes at least annually.
    f. Interface with other SHP QM and UM committees as appropriate.
    g. Ensure the delegated PBM P&T Committee performs the following major functions:
        - Maintains the drug formularies to promote safety, effectiveness, and affordability according to drug selection process.
        - Reviews new drugs, drug classes, new clinical indications, therapeutic advantages, new chemical entities, and new safety information.
        - Recommends formulary status and what position or tiered covered medications should occupy on formulary.
        - Reviews the drug formulary and therapeutic classes at least annually.
    h. Review the process of the development and execution of pharmaceutical management procedures delegated to PBM at least annually.
    i. Enforce the appropriate Average Wholesale Price discounts and rebate(s) back to the health plan.
    j. Promote the appropriate use of high quality and cost-effective pharmaceuticals for SHP members.
    k. Ensure compliance with appropriate standards and state and federal regulations.
    l. Review policies that guide clinical prior authorization criteria, step therapy protocols, exceptions, and other UM processes, including drug utilization review, quantity limits, and therapeutic interchange.
    m. Ensure that the formulary drug list or lists cover a range of drugs across a broad distribution of therapeutic categories and classes and recommended drug treatment regimens that treat all disease states and do not discourage enrollment by any group of members.
    n. Serve as a policy recommending body on matters related to the safe and therapeutic use of medications.
    o. Monitor drug shortages and recalls and ensure appropriate communication to SHP members.

p. Make consensus decisions on all formulary additions and deletions and drug use/benefit policies. If no consensus is established, the issue is put to a vote with the decision determined by majority vote of the quorum. Quorum is defined as 50% of voting members plus one.

E. Public Policy Committee

Chaired by the VP, Managed Care Operations and Co-Chaired by the Sr. Director, Service Operations, meetings are held at least quarterly, and additional meetings may be scheduled as required.

The Public Policy Committee (PPC) provides members and providers a forum with senior leaders of SHP to identify, evaluate, and monitor social, legislative, and regulatory or public policy issues that affect or could affect the delivery of compassionate care, the rights and dignity of members and providers, and the accessibility of services. Committee recommendations and summary reports outlining activities are submitted to the MAC.

PPC Membership:

Membership shall consist of: (1) at least 51% of the members shall be subscribers and/or members (subscribers and/or members shall not be SHP employees, network providers, subcontractors, or group contract brokers or persons financially interested in SHP); (2) at least one member of the MAC; and (3) at least one provider. At the discretion of the Chairperson, the committee may include additional non-voting members who may be employees of SHP, network providers, or other individuals as may be necessary.

F. Policy & Procedure Committee

Chaired by the Director, Regulatory Compliance, and Co-Chaired by the Manager, Coding, meetings are held at least quarterly, and additional meetings may be scheduled as required.

The Policy & Procedure (P&P) Committee responsibilities are to create a well communicated process for creating new policies, changing existing policies, ensuring annual policy review, and adhering to the regulatory agencies that govern health plans. This committee ensures participation from key stakeholders within SHP. This committee assesses policies to ensure regulatory compliance, creates a policy repository to serve as an authoritative source for policies, assists in communication of policies, and ensures a summary of changes are presented further to the other governing committees. All clinical policies will have direction from clinicians, including but not limited to, the Medical Director. Committee approval, minutes, and summaries may be brought to other committees for review.

G. Credentialing & Peer Review Panel

The Credentialing & Peer Review Panel (CPRP) is Chaired by the Medical Director and Co-chaired by a network provider/specialty/etc. Meetings are held at least quarterly, and additional meetings may be scheduled as required. The panel is composed of practicing physicians and reports to the MMC. This panel is responsible for the oversight of provider credentialing and re-credentialing activities, including the review and approval of credentialing policies and procedures and the peer review of cases referred to the panel regarding potential quality issues. This panel has been delegated to make all final decisions regarding

provider credentialing and peer review activities. Significant trends and quality of care concerns are escalated to the MMC.

1. CPRP Membership:

All physicians are voting members. The MMC shall nominate physician member(s) with the appropriate specialty background and experience for the panel. Nominees are reviewed and approved by the CPRP. A review will include assessment of available practice information, past QM, UM, or credentialing committee experience, and professional reputation for medical expertise. Each physician member of the CPRP serves a two-year term and may be re-appointed by the Medical Director. While no special training or certification will be required of panel members, physician members must have an unrestricted medical license in the state of California and be fully a credentialed member of the SHPS provider network. Panel members may not vote on any providers when there is a conflict of interest.

In order for business to be conducted, a quorum must be present. A quorum is defined as a simple majority of voting members. Each panel member is expected to attend a minimum of 75% of the panel meetings on an annual basis. Minutes of all meetings shall be considered confidential and are maintained in SHP administrative offices and/or on a secure cloud-based repository. Minutes will be available for review by regulatory and accrediting body representatives upon request.

2. CPRP Responsibilities:

a. Make credentialing and re-credentialing decisions for providers and practitioners within the SHPS provider network.
b. Perform annual review of the effectiveness of SHP credentialing and re-credentialing program.
c. Monitor performance of peer review activities, including identification, action, and resolution of potential quality issues, and confirmation of corrective actions arising from quality of care cases.
d. Perform peer review of credentialing and re-credentialing issues.
e. Address provider credentialing and re-credentialing compliance issues, including corrective action recommendations.
f. Review and make recommendations on credentialing and re-credentialing policies and procedures and standards, in compliance with regulatory and NCQA guidelines.
g. Review areas concerning over/under utilization, quality of care, clinical practice guidelines, and other pertinent aspects of clinical care.
h. Approve credentialing and re-credentialing of organizational provider (e.g., hospitals, home health agencies, skilled nursing facilities, nursing homes, free-standing surgical centers, etc.) appointments to the provider network.
i. Provide for the rights to an appeal from a provider who is denied acceptance to the network, is forced to no longer participate in the network, or who has been reported to the state medical board, pursuant to BPC § 805 and 805.1.
j. Review and monitor delegated credentialing and re-credentialing activities.

H. Regulatory Oversight Committee

Chaired by the Chief Compliance Officer, and Co-Chaired by the Director, Quality, meetings are held at least quarterly, and additional meetings may be scheduled as required.

The Regulatory Oversight Committee (ROC) provides oversight, prioritization, resources, guidance, and advocacy for the SHPS Compliance Plan and related work activities. This committee provides advice and assistance to the Chief Compliance Officer in their responsibilities for the design, implementation, and operation of an effective compliance program. The ROC meets on at least a quarterly basis to review compliance concerns, implementation, and performance of the Compliance and Anti-Fraud Plans; fraud, waste, and abuse activities; oversight of delegated entities; privacy concerns; and trends and regulatory updates with applicable guidance and interpretations. With the medical direction of the Medical Director, the ROC also reviews annual delegation audits to ensure adequate ongoing monitoring of delegated entities. The ROC reviews all program descriptions for services delegated to the delegate, annual work plans, evaluations, and related administrative policies for compliance with applicable UM, QM, credentialing, and claims payment protocols. The ROC is responsible for ensuring delegated entities remain in good standing and respond to audits and corrective action plans timely and satisfactorily to address any identified deficiency. The ROC further reviews topics related to access and availability and appeal and grievance trends.

I. Member Experience Committee

Chaired by the Sr. Director, Service Operations, and Co-Chaired by the Manager, Customer Service, the meetings are held at least quarterly, and additional meetings may be scheduled as required.

The Member Experience Committee (MEC) is responsible for overseeing the member experience across the continuum of care, including overseeing strategy, recommending best practice standards, and monitoring the performance and progress of health plan operations that impact the member experience. This committee reviews various sources of information, such as member inquiries, appeals and grievances, and potential quality issues, to identify improvement initiatives and mitigate risk.

The Performance Improvement Taskforce is a subcommittee of the MEC and reviews member correspondences to identify grievances and opportunities for improvement. Member correspondences, which may constitute a grievance, are reviewed by the Director, Quality, and confirmed grievances are processed accordingly. The Manager, Customer Service, reviews telephone calls and associated documentation for opportunities to improve member inquiry resolution. Member telephone calls are also screened for potential quality issues and reviewed by the quality team.

J. Committee Minutes

Minutes will be documented for all committee and panel meetings and will be completed prior to the date of the next meeting. Minutes of all meetings shall be considered confidential and maintained in SHP administrative offices and/or on a secure cloud-based repository. Minutes will be available for review by regulatory and accrediting body representatives upon request. Copies of all attachments and handouts from meetings will be included with the filed meeting minutes. Minutes shall not be copied or removed from the SHP administrative offices and/or secure cloud-based repository without the express consent of the Medical Director or Chief Compliance Officer. Contents of the minutes will include, at a minimum, the following elements:

1. Date, time, and location of meeting.
2. Time meeting called to order and by whom.
3. List of members present.
4. List of guests present.
5. Approval of previous meeting minutes.
6. Items of old business, including topic, action taken, and status/responsible party.
7. Items of new business, including topic, action taken, and status/responsible party.
8. Time meeting adjourned and by whom.
9. Date, time, and location of next scheduled meeting.
10. To ensure appropriate follow-up and the ability to track issues through the resolution process, all committee minutes will follow the specific format approved by the HOC. This format calls for minutes to be documented in a grid format with the following column headings:

    a. Topic – A brief description of the agenda item.
    b. Action Taken – A summary of the discussion, any data or handouts presented, and issues needing improvement (if applicable). To also include a summary of recommendations made by the committee and any barriers to completion (if applicable).
    c. Status/Responsible Party – The specific name of the party responsible for ensuring that the action item(s) is/are completed, and the current status of the action item(s) identified.

VII. QM Roles and Responsibilities

QM activities will be coordinated and performed by the SHP QM Department staff under the direction of the Medical Director and the Chief Compliance Officer.

A. Medical Director

Responsibilities include the following:

1. Provide senior executive oversight of the development and implementation of the QM program.
2. Oversee the overall allocation of adequate resources to support the QM program.
3. Chair the MMC and CPRP.
4. Review and assess trended grievance data for identification and implementation of care, service, access and/or process improvements.
5. Review and assess trended appeal data for identification of medical necessity, coverage disputes and/or process improvements.
6. Utilize any emerging patterns of grievances, focused studies, and medical record reviews in the formulation of policy and procedure changes.
7. Monitor the implementation of the QM and Credentialing programs.
8. Analyze QM data and establish priorities for focused studies.
9. Present quarterly QM reports to the MMC and MAC.
10. Serve as liaison to participating medical groups and network providers.
11. Review and evaluate fraud prevention and detection activities in conjunction with the Chief

Compliance Officer.

12. Review all clinical indicators for ambulatory and inpatient care.
13. Attend contracted provider operations meetings as needed.
14. Participate in workgroups as needed.
15. Champion process improvements to improve compliance with preventive medicine guidelines.
16. Implement performance improvement projects.
17. Participate in the development of the QM program, QM Work Plan, Credentialing program and annual QM program evaluation.
18. Coordinate and communicate peer review information and decisions to network physicians.
19. Perform individual clinical case reviews (including grievances and appeals) and make corrective action recommendations on quality of care, quality of service and access issues.
20. Contribute to the development, review and dissemination of clinical studies and practice guidelines/standards to participating providers.

B. QM Department Responsibilities

QM activities are coordinated and performed by SHP's QM Department staff under the direction of the Medical Director and the Chief Compliance Officer. QM activities are coordinated with and/or reported to the providers as applicable.

1. Chief Compliance Officer

The Chief Compliance Officer is responsible for developing and coordinating the operational components of the QM program as well as ensuring the implementation and monitoring of these components. The Chief Compliance Officer's responsibilities include, but are not limited to:

a. Coordinate with SHP management in the overall implementation of the QM program.
b. Coordinate fraud prevention and detection activities.
c. Provide education on QM principles at all levels of the organization.
d. Prepare, present and coordinate the development of the annual QM program evaluation, annual QM Work Plan and revisions as necessary of the QM Program Description, QM Work Plan and annual evaluation.
e. Participate in MMC meetings.
f. Ensure compliance with state, federal and accrediting body requirements.
g. Provide the MMC with administrative staff and support.
h. Trend and report member and provider annual satisfaction survey results in collaboration with the Senior Director of Service Operations and the Senior Director of Network and Payment Services, and report to the MMC.

2. Director of Quality
   a. Coordinate with SHP management in the overall implementation of the QM program.
   b. Promote, coordinate, and communicate QM activities throughout the health care delivery system.
   c. Oversee QM department management and staff activities including the provision of

education.

d. Monitor and analyze internal/external data trends and patterns that affect the quality of care and service delivery.
e. Participate in MMC meetings.
f. Prepare quarterly QM and grievance trending reports for the MMC.
g. Ensure compliance with state, federal and accrediting body requirements.
h. Coordinate QM activities as specified to the handling of grievances and appeals.
i. Manage the member grievance and appeal process.
j. QM Coordinators and other QM Department staff.

3. QM Coordinators and other QM Department staff responsibilities include, but are not limited to:

   a. Perform facility assessments of PCPs and OB/GYNs as required by industry standards and regulatory agencies.
   b. Perform quality assessments for contracted facilities and ancillary providers as required by industry standards and regulatory agencies.
   c. Perform access and availability audits as needed.
   d. Conduct quarterly inter-rater reliability audits.
   e. Perform focused studies as directed by the MMC.
   f. Track and analyze risk management and potential quality of care issues.
   g. Administer the provider sanction and/or termination policies.
   h. Monitor all delegated functions.
   i. Identify opportunities for improving care and service.
   j. Investigate and provide information on member grievances and appeals.
   k. Identify and trend quality, service, and access issues in member grievances.

4. Credentialing Staff

   Credentialing staff responsibilities include, but are not limited to:

   a. Perform credentialing and re-credentialing activities for practitioners, allied health providers, healthcare professionals, and organizational providers.
   b. Collect and analyze provider-specific performance activities for CPRP consideration.
   c. Monitor Medical Board of California (MBOC) actions monthly.
   d. Provide administrative support for the CPRP.
   e. Conduct credentialing audits for delegated entities.
   f. Track and trend quarterly and semiannual credentialing activity reports.

VIII. Scope of the QM Program

SHP's QM Program incorporates review and evaluation of all aspects of the health care delivery system. The QM Program is designed to provide a multi-disciplinary, integrated framework for designing, measuring,

assessing and improving the delivery of health care and services to members.

A. Areas of QM Program Focus

The SHP QM Program focuses on the following:

1. Care and safety of care of members.
2. Continuity of care.
3. Compliance with applicable state, federal and accrediting body requirements.
4. Access and availability of care and service.
5. Health care outcomes.
6. Member and provider satisfaction including grievances/appeals process.
7. Member and provider education.
8. High risk/high volume or problem-prone diagnoses and procedures.
9. Provider credentialing and re-credentialing.
10. Fraud and abuse prevention and detection.
11. Monitoring of over and under-utilization.
12. Ensuring members are not discriminated against in the provision of health care services consistent with the benefits covered in their policy based on race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, disability or any of the following health status-related factors: medical condition, including physical and mental illnesses, claims experience, receipt of health care, medical history, genetic information or evidence of insurability, including conditions arising out of acts of domestic violence.
13. Ensuring provider organizations do not prohibit health care professionals from advising or advocating on behalf of a member.

B. QM Program Components

Key Performance Indicator Monitoring

Member diagnosis and utilization patterns by demographic groupings will be measured and reported to the MMC on an annual basis. Clinical performance monitors based on requirements, past performance and prevalence of disease and/or utilization of services (high risk, high volume, chronic) of the population served. Data will be analyzed to identify trends, over-utilization and underutilization issues and improvement opportunities. The clinical indicators will be objective, measurable, and benchmarked to an internal, regional, or national norm. This is reviewed by the MMC and reported to the MAC annually, revised as needed and analyzed by appropriate clinicians.

A performance goal will be established for each indicator. Multi-disciplinary teams will be involved in the analysis of performance gaps and the development of improvement action plans. Monitoring results for these indicators will be reported to the ROC (delegates), the MMC and the MAC on an annual basis and included in the annual program evaluation.

All HEDIS data will be collected and reviewed throughout the year and on an annual basis. This

information is analyzed to identify multiple areas, or measures for improvement. Areas of key monitoring will include, but not be limited to:

Inpatient Care

a. Hospital readmissions within thirty (30) days of hospital discharge.
b. SNF readmissions directly from SNF and within thirty (30) days of hospital discharge.
c. Avoidable hospitalizations by practice group.
d. Transitions of care of members moving between health care practitioners and across settings.

Ambulatory Care

a. Collection and analysis of HEDIS measures.
b. Member preference – analysis of annual HEDIS Adult Commercial Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the Press Ganey survey with goals established annually for key measures.
c. Access – analysis of annual HEDIS Adult CAHPS and the Press Ganey survey with goals established annually for key measures.
d. Provider satisfaction with the UM process – survey and analysis of provider satisfaction with the referral process and access to clinical criteria.

Chronic Disease

a. Comprehensive Diabetes care including: Diabetic retinal exams, HgbA1c measurement and control, LDL-cholesterol measurement and control, urine micro-albumin measurement, and respiratory conditions, including COPD, asthma, etc.
b. PCP performance in management of diabetics (labs, education, etc.).
c. Safety of clinical care through assessment of measures determined by MMC.

Mental Health

a. Ambulatory follow-up after hospitalization for major affective disorders.
b. Coordination of care between mental health providers and medical providers.

The performance indicators listed above will be reported by each provider group and total SHP managed care membership.

Monitoring for Over- or Under-Utilization

Appeals

Data related to appeals are tracked and trended to identify delays in care or service. A summary report is presented to the MEC and MMC quarterly. Adverse trends are addressed through identification and implementation of education and appropriate corrective action.

Utilization Statistics Monitoring

Utilization statistics are reviewed and monitored for identification of high-risk, high-volume utilization. Statistics monitored include inpatient statistics for both acute hospitalizations, emergency department and skilled nursing facility stays, as applicable. Inpatient UM may focus on specific high volume or problem prone diagnoses. Outpatient ambulatory statistics are also monitored. When adverse trends are noted, focused review may be recommended by the MMC including a corrective action plan development.

Readmission Monitoring

Readmissions to acute and skilled nursing facilities are monitored with a quarterly report submitted to the MMC. If the committee identifies adverse trends, a corrective action plan will be recommended.

Medical Record Review/Documentation Audits

SHP will use approved standards that are communicated to providers. Medical record audit activities will include:

a. Medical record documentation audits are performed to assess medical record keeping practices and ensure that medical records are legible, contain accurate and comprehensive information, and are readily accessible to healthcare providers.
b. Medical record reviews are performed to ensure that medical records are maintained in a current, organized, and detailed manner and are in conformance with evidenced based medical practices and preventive health management and for evidence of continuity and coordination of care.
c. More frequent medical record reviews may be performed to study a particular issue or to correct a problem situation.
d. Medical record audits will be performed on an as needed basis to collect data (e.g. HEDIS data).
e. Other practitioners and ancillary providers will be audited as directed by the MMC.
f. The MMC will receive a quarterly summary report including the number of providers assessed, the number in compliance and the number requiring corrective action. Aggregated results will be evaluated to identify opportunities for improvement.

Facility Assessments

SHP will perform on-site facility assessments when any provider has three (3) or more related grievances in a six-month period and as required by regulatory agencies. Facility re-assessments will be performed until corrective action is complete. Facility assessments will also be performed on an as needed basis to collect data requested for HEDIS measures. Assessment criteria will be approved by the MMC and communicated to providers. Criteria includes, at a minimum:

a. Physical accessibility and appearance.
b. Adequacy of waiting and examining room space.
c. Adequacy of medical records filing including confidentiality.
d. Availability of appointments.
e. Adequacy of medical record keeping practices.

The MMC will receive a semi-annual summary report including the number of providers assessed, the number in compliance and the number requiring corrective action. Aggregated results will be evaluated to

identify opportunities for improvement. Findings will be reported through the Credentialing and Peer Review Panel, as well as the MMC.

Access & Availability

SHP will monitor key indicators of access to care and services. Access and availability standards will be communicated to providers upon hire and in the provider manual. Changes to the access standards will be communicated as they occur. Providers will be evaluated against these standards as part of the re-credentialing process. The provider will be evaluated overall through the annual Provider Access & Availability Survey (PAAS). Corrective action will be implemented and followed up as appropriate. In addition, providers will be surveyed annually to assess their adherence to after-hours service standards. Quarterly summary reports are submitted to the MMC and the MAC for evaluation of improvement opportunities. This will include member to PCP and specialist ratios.

a. SHP ensures appointment availability with the standards below and requiring that Advanced Access Programs are available through contracted providers, medical groups and IPAs for medical and mental health care.
b. SHP contracted PCPs, specialists, IPAs, medical and mental health providers and ancillary providers will be made aware of access standards through the Provider Manual, website, and Provider Portal updates.
c. SHP providers comply with access guidelines or the current DMHC guidelines.

Appointment availability standards are:

a. **Emergent:** Immediate, 24 hours a day, 7 days a week.
b. **Urgent care not requiring prior authorization:** Within 48 hours of request for appointment.
c. **Urgent care appointments requiring prior authorization:** Within 96 hours of request for appointment.
d. **Non-urgent appointments for primary care:** Within 10 business days of request for appointment.
e. **Non-urgent appointments with specialist physicians:** Within 15 business days of request for appointment.
f. **Non-urgent appointments with a non-physician mental health care provider:** Within 10 business days of request for appointment.
g. **Non-urgent appointments for ancillary services:** Within 15 business days of request for appointment.
h. The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member.
i. **Preventive care services and periodic follow up care**, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of

practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

Telephone Access	24 hours per day via live operator or answering service; return call within 30 minutes after hours

In addition, SHP will maintain a data system to identify specific characteristics of PCPs to ensure cultural, ethnic, racial and linguistic needs of its members are met.

Preventive Health Services

SHP will adopt preventive health services guidelines which address the characteristics of the member population and align with national standards. The guidelines will be distributed to all providers with changes or updates communicated to providers. SHP has adopted use of the US Preventive Services Task Force (USPSTF) guidelines as approved by MMC. Access has been provided to the providers for use.

SHP will assess its performance annually (using HEDIS methodology where applicable) on at least the following preventive care services:

a. Childhood immunizations.
b. Statin therapy for members with cardiovascular disease.
c. Prenatal care in the first trimester.
d. Mammography.
e. Cervical cancer screening rate.
f. Asthma medication ratio.
g. Diabetes care.
h. Other preventive screenings as currently recommended by the USPSTF, CDC, professional medical societies or as required by state and federal law.

Data will be analyzed to identify trends, over-utilization and underutilization issues and improvement opportunities. The performance indicators listed above will be reported by specific provider groups and in aggregate for the total population.

Results will be submitted to the MMC to evaluate and identify opportunities for improvement. Summary documents will be provided to the MAC for review and recommendations.

Mental Health & Substance Use Disorder Services

Mental health services are provided by a licensed organization or professional providing diagnostic, therapeutic, or psychological services for the treatment of mental health and substance use disorders. Mental health or substance use disorder providers include psychiatric hospitals (and psychiatric units within general acute care facilities), residential treatment facilities, psychiatrists, psychologists, licensed clinical social workers (LCSW), marriage and family therapists (MFT) and qualified autism service professionals and

paraprofessionals.

SHP delegates mental health services as defined above such as:

a. Mental health and substance use disorder services (all inpatient and partial hospital care).
b. Mental health evaluations and treatment as well as treatment for substance use disorder services (all outpatient services).

SHP shall monitor the continuity and coordination of care that members receive and act, when necessary. SHP will monitor, as often as necessary, but not less frequently than once every year, the collaboration between medical and mental health providers including, but not limited to, the following:

a. Exchange of information between medical (e.g. PCPs, medical/surgical specialists, organizational providers) and mental health providers, in accordance with members' rights regarding confidentiality and protected information.
b. Appropriate diagnosis, treatment and referral of mental health and substance use disorders.
c. Appropriate use of psychotropic medications.
    - Pharmacy data is analyzed and reviewed to ensure appropriate use and adherence to prescribing guidelines for psychotropic medications and that follow-up appointments are made with a member's PCP within thirty (30) days of being prescribed psychotropic medications.
d. Management of coexisting medical and mental health conditions.
    - Appropriate use of psychotropic medications and adherence to guidelines for prescribing are reviewed using pharmacy data on issues around management of multiple conditions where there are both medical and mental health conditions and management across the continuum of care is an issue.
    - Appropriate screening and management of member with co-existing medical and mental health or substance use disorders.
e. Prevention programs for mental healthcare.
    - Collaborative development and implementation of primary or secondary prevention programs (i.e. autism or depression screening) for mental healthcare.
f. Severe and persistent mental illness.
    - Continuity and coordination of services for members with severe and persistent mental illness is monitored.

Maternal Mental Health

In accordance with California SB 1207 and the Health and Safety Code Section 1367.625, SHP encourages its providers to perform the screening, diagnosis, treatment, and referral to appropriate mental health services, including maternal mental health. Efforts and outcomes of the maternal mental health program are monitored and designed to promote quality and cost-effective outcomes.

SHP members with a positive screening can be referred to our Magellan network of providers and/or be referred to SHP's Care Management Program, which includes maternal mental health, and is designed to

assist with healthcare needs, care coordination, and connecting members with appropriate resources. No prior authorization is required to access care with our behavioral health care network of providers.

SHP shall retain full responsibility for ensuring continuity and coordination of care, in accordance with the requirements of this subsection, notwithstanding that, by contract, it has obligated a specialized HCSP to perform some or all of these activities.

Member Safety

SHP QM Program advocates a collaborative approach to establish a culture of member safety, reduce medical errors and promote high quality care for the welfare of its members. The QM staff focus includes, but is not limited to:

a. Continuity and coordination of care between practitioners that may lead to miscommunication or poor outcomes.
b. Continuity and coordination of care between sites of care such as hospitals and nursing homes to ensure timely and accurate communication.
c. Evaluation of clinical practices against care standards that improve safe practices.
d. Tracking and trending of adverse event reporting and complaint data to identify systems issues that contribute to poor safety.

Potential Quality of Care and Grievances and Appeals Resolution

SHP has developed its grievance and appeal system so that it ensures adequate consideration of members' grievances and appeals in accordance with statutory requirements of Section 1368 et seq. of the California Knox-Keene Health Care Service Plan Act of 1975 as amended and Rules 1300.68 and 1300.68.01 of Title 28 of the California Code of Regulations.

Members are entitled to have their grievances and appeals heard through a grievance and appeal process and have a contractual right to arbitrate issues that are not resolved to the member's satisfaction. SHP's grievance and appeal process provides a written acknowledgment of a member's routine grievance or appeal within five (5) days of receipt. SHP's grievance and appeal process shall provide the acknowledgement of the case, investigation, and resolution of the case within thirty (30) days of receipt. SHP's grievance system allows members to file grievances or appeals for at least 180 calendar days following any event or action that is subject to the member's dissatisfaction. Grievances and appeals received by telephone, by facsimile, by e-mail, or online through the Plan's website, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment, and that are resolved by the next business day following receipt, are exempt from completing the standard grievance process.

Members also have the right to submit their appeal or grievance to the Department of Managed Health Care's Help Center or the independent medical review (IMR) system and are considering "pending" until a resolution is achieved. Written documentation begins the date the grievance or appeal is received in SHP's office. Upon conclusion/resolution, the system is complete with all dates and actions included.

Procedures are in place to elevate grievances and appeals for all urgent care needs, including quality of care concerns 24/7 to the Medical Director and/or the Chief Compliance Officer, both having the authority to approve medical care for SHP members. For expedited grievances and appeals, SHP will acknowledge the

grievance or appeal within 24 hours of receipt. All levels of urgent grievances and appeals will be resolved and responded to within three (3) calendar days or less, upon receipt of the grievance or appeal. An urgent grievance or appeal is a case requiring expedited review because it involves an imminent and serious threat to the health of the member, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function, or if the member believes their enrollment has been or will be improperly canceled, rescinded, or not renewed.

SHP's grievance and appeal processes are designed to document and resolve member issues expeditiously and equitably in accordance with regulatory guidelines. To meet the required 30 calendar day routine resolution timeframe, the SHP Appeals & Grievances team will review the issue, obtain the appropriate documentation from the providers involved, facilitate the Medical Director review, and respond to the member with the determination and/or results of the investigation. Supporting documentation and findings may also be forwarded to QM staff for further review.

All grievances and appeals will be tracked, trended, prioritized, and reported at the MMC on a quarterly basis. The information presented in the reports will be sufficient, detailed, and inclusive of findings and action taken and identifies our internal or contracting provider components which could present as a significant or chronic quality of care issue. When trends are identified, the MMC will recommend an action plan.

Potential quality of care/risk management issues will be submitted to QM staff for tracking, review, investigation, and reporting. All escalated cases with quality of care or risk management issues, including corrective action plans, will be reviewed with the Chief Compliance Officer and/or Medical Director. Summary quarterly reports identifying number and types of issues by severity level will be provided to the Credentialing and Peer Review Panel and the MMC. Potential quality issues may come from a variety of sources including, but not limited to:

Members

Providers

UM staff

Regulatory agencies

Claims staff

Customer Service staff

Case Management staff

Types of data accessed to identify potential quality issues may include, but not limited to:

Medical records

Grievances and appeals

Member surveys

UM statistics

Provider surveys

Laboratory reports

Financial data

All grievances, appeals, and quality issues are assigned one (1) or more acuities. All cases with an assigned acuity of "2B" or higher will to go peer review.

System for Prioritizing Problems

Potential quality of care concerns identified via the QM process will be categorized for assessment, intervention and resolution as follows:

LEVEL 0	**NO QUALITY ISSUE**
0-A	No quality-of-care issue identified.
0-B	No quality-of-service issued identified.
LEVEL I	**QUALITY ISSUE WITH THE POTENITAL FOR LOW ADVERSE EFFECTS ON THE PATIENT**
1-A	Medical records documentation including omission or non-completion.
1-B	Communication issue(s) and/or art of caring office staff or nurse.
1-C	Communication issue(s) and/or art of caring physician.
1-D	Communication issue(s) and/or art of caring ancillary provider or facility.
1-E	Quality issue of practitioner office site.
1-F	Delay in office entering referral (behavioral health, pharmacy, or medical).
1-G	Delay in utilization management timeliness (behavioral health, pharmacy, or medical).
1-H	Timely access to schedule an appointment and/or wait time in office.
1-I	Surgical or post-surgical events which are not determined to be due to negligence or poor technical ability.
LEVEL II	**QUALITY ISSUE WITH THE POTENTIAL FOR MEDIUM - MODERATE ADVERSE EFFECTS ON THE PATIENT**
II-A	Case reflects a health delivery system problem and can be resolved with system implementation within the Group or with Group-wide education.
II-B	Clinical issue and/or clinical judgment directly impacting patient care with the potential or demonstrate ***medium to moderate*** adverse effect on the patient. (PEER REVIEW RECOMMENDED)
LEVEL III	**QUALITY ISSUE WITH THE POTENIAL FOR SERIOUS ADVERSE EFFECT ON THE PATIENT (PEER REVIEW REQUIRED)**
III-A	Misdiagnosis (includes delayed or missed).
III-B	Unnecessarily prolonged treatment, complication, or readmission.
III-C	Anatomical or physiological impairment, disability, or death.

Fraud, Waste and Abuse Prevention and Detection

The SHPS Anti-Fraud Plan is a component of the SHPS Compliance Plan. The purpose of the Anti-Fraud Plan is to establish methods for objectively and systematically detecting, preventing, evaluating, and investigating potential and actual fraud, waste, and abuse (FWA) within SHP's health care delivery system.

The Anti-Fraud Plan has been implemented in conjunction with other internal monitoring activities to provide a comprehensive approach to preventing and detecting potential and actual misconduct. The Anti-Fraud Plan relies on independent oversight and accountability and integrates the activities of all managed care departments.

Potential and actual FWA cases shall be promptly reported to the SHPS Compliance Department for review and investigation. Cases will be reported to the ROC as necessary and referred to peer review when indicated. Quarterly summary reports identifying the number and types of FWA issues will be provided to the MAC. FWA cases may come from a variety of sources, including but not limited to:

a. Claims data, including accounts payable records, adjudication history, and linked referrals.
b. Medical record audits for proper clinical documentation practices and evidence of provision of service.
c. Ongoing monitoring and auditing of providers identified as greater relative compliance risk (e.g., coding outliers).
d. Member and provider appeals and grievance trends.
e. Potential quality issues and peer review referrals.
f. Utilization management over- and under-utilization reports.
g. Provider utilization profiles and claims experience.
h. Evaluation of the panel capacity of a provider's practice.

Refer to the SHPS Anti-Fraud Plan for further details.

Provider Peer Review, Credentialing and Re-credentialing

All licensed independent practitioners, including MDs, DOs, DDSs, DMDs, DCs, DPMs, NPs, PAs and mental health providers licensed to practice independently in the state of California who are contracted with SHP and are not hospital based, as defined by NCQA credentialing standards, must be credentialed prior to participation in the SHP provider network. Participating providers will be re-credentialed at least every 36 months. The re-credentialing process may include a review of provider specific information in the areas of:

a. Quality of care issues, including actions taken by the MMC.
b. Peer review referral history and findings.
c. Utilization management performance.
d. Compliance issues.
e. Results of medical record reviews, facility assessments and other focused audits, as applicable.
f. Member satisfaction information (e.g. complaints, grievances, surveys).

Each provider's file will also be reviewed to ensure the education and training, licensure status, board certification, hospital privileges, and malpractice history are in good standing.

The CPRP will review any grievance or potential quality inquiries with a "2B" acuity or higher. The case will be assigned a final acuity, and the CPRP Chair will work with the QM Department for any follow up tasks or corrective action that is needed to close out the case.

The CPRP will make credentialing decisions and report such decisions to the MMC for final review.

Healthcare Organizations Quality Assessments

Prior to contracting with a hospital, skilled nursing facility, free standing surgical center, or home health agency, SHP will confirm that the facility has obtained accreditation from a recognized accreditation body and has met all state and federal licensing requirements. For those facilities without accreditation from a recognized accreditation body, an on-site quality assessment will be conducted using defined criteria approved by the CPRP for each type of facility. Re-verification of this information is performed at least every 36 months.

Credentialing Delegation

SHP may delegate the responsibility for performing provider credentialing and/or organizational provider credentialing functions to contracted entities that meet SHP's standards for delegation. SHP performs annual audits of delegated entities to ensure compliance with standards, and that the care provided by the delegated entity is based on professionally recognized standards of practice. Delegation oversight is performed by the Delegation Oversight Department or designated area. Delegation oversight activities include:

a. Perform a pre-delegation assessment to verify the delegation candidate has the appropriate mechanisms and processes in place to fulfill its responsibilities and meet the SHP standards for delegation. The assessment will include a review of the candidate's administrative capacity, technical expertise, budgetary resources, program policies and procedures, service capabilities and the clinical criteria/guidelines used in providing care to members.

b. Conduct annual on-site or desktop reviews and approve the delegate's UM/QM/Credentialing programs, work plans and policies and procedures. The HICE Credentialing audit may be utilized in lieu of on-site audit.
c. Execute the delegation agreement (part of provider contract, if applicable), as needed, which describes functions delegated, areas of responsibility, oversight procedures and reporting requirements. Detailed delegation requirements and responsibilities will be included in a SHP manual developed for providers.
d. Evaluate regular (monthly, quarterly, semiannually and annually as listed in the specific delegation agreement) credentialing reports and monitoring of system controls from the delegated entity and develop corrective action plans, as needed.
e. Provide at least semi-annual reports of delegation activity, including findings and actions taken as a result of credentialing activities, to the ROC. Delegated activities will also be addressed in at least semi-annual reports provided to the MAC.

Member Satisfaction Surveys

Member satisfaction surveys are used as a research tool to assess member perceptions about the services provided by SHP physicians in terms of access to providers and services, appointment availability, timeliness and the quality of care and service received. SHP participates in the annual HEDIS Adult CAHPS and Press Ganey surveys which are reviewed by the MMC. Opportunities for improvement are identified and an appropriate corrective action is identified. The QM staff is responsible for facilitating implementation of the recommended corrective actions.

Health Education and Health Management Promotion

SHP has services/programs that encourage members' appropriate use of services and informs and educates identified high-risk members on ways to manage their illnesses, conditions, or risk factor(s). SHP communicates and educates its participating providers about health education and health management promotion services/programs provided by SHP.

IX. Confidentiality and Conflict of Interest

All aspects of QM activities, including but not limited to, related discussions, documentation, and committee minutes, are confidential and protected from disclosure under state and federal law. All SHP employees, committee members, and committee guests (as applicable) must understand and agree to comply with confidentiality policies. These individuals must sign a Conflict of Interest, Nondisclosure, and Nondiscriminatory Statement on an annual basis. Signed statements are maintained in the Scripps Health Learning Management System and by the SHPS Compliance Department.

Conflict of interest is defined as having any involvement with the provider under review, having any fiduciary or other business relationship with the provider under review, having any other involvement in the case which impairs judgment in performing peer review of another provider, or voting on a credentialing or recredentialing application. No person in the review process will review cases in which he/she was actively or personally involved. If a potential for conflict of interest is identified, another qualified reviewer will be designated. Where there is a conflict between consideration of cost and quality care, it will be the responsibility of the MMC to resolve the matter in favor of quality care.

X. Corrective Action Process

SHP QM decision making is based on appropriateness of care and service.

When the MMC or one of the related committees determines that inappropriate care or sub-substandard services have been provided or services that should have been furnished have not been provided, the Medical Director is responsible for communicating concerns identified by the MMC or one of the related committees and working with the provider to develop a corrective action plan. The SHP Credentialing and Peer Review Panel and MMC reserve the right to terminate individual providers contracted via a group contract. Sanction activities currently used by SHP are described in the sanction monitoring policy.

In accordance with the State of California Business and Professions Code, Section 805/805.01, SHP will report to the appropriate licensing agency and the National Practitioner Data Bank (NPDB) any disciplinary measures taken upon a licensed medical professional by a SHP peer review body based on medical disciplinary cause or action. SHP will not contract with a provider who has sanctions or restrictions placed on his/her professional license which impacts their ability to provide care services to any SHP member.

The procedural rights specified in this policy apply only to the extent that (1) an action is taken or recommended on the basis of medical disciplinary cause or reason, and (2) the action is reportable under Section 805 of the California Business and Professions Code. Please refer to credentialing policy *SHPS 406 Notification to Authorities and Practitioner Appeal Rights* for complete details.

1. Conditions under which an 805/805.01 report is filed:
    a. A practitioner's application for participation is denied or rejected for a medical disciplinary cause or reason.
    b. A practitioner's participation is terminated or revoked for a medical disciplinary cause or reason.
    c. Restrictions are imposed, or voluntarily accepted, on participation for a cumulative total of thirty (30) days or more in a 12-month period, for a medical disciplinary cause or reason.
    d. A practitioner, after receiving notice his/her application will be/is denied or of a pending investigation initiated for a medical disciplinary cause or reason, resigns, takes a leave of absence, or withdraws his/her application.
    e. The report shall be filed within fifteen (15) days after the effective date of the aforementioned conditions.

XI. Annual QM Work Plan

At the beginning of each year, a QM Work Plan will be developed. The QM Work Plan will include QM goals and objectives, related to quality of clinical care, safety of clinical care, quality of service and member experience, and identify specific QM related activities scheduled for the upcoming year. Scheduled activities include target date for completion and responsible party as well as the tracking of previously identified issues and planned evaluation of the QM program. Projects may be modified, enhanced, or deleted as demands and/or priorities change. The QM Work Plan shall be submitted to the MMC and the MAC for review and approval.

XII. Program Evaluation

The annual Quality Management Evaluation (QM Evaluation) describes the overall effectiveness of the QM Program including the activities and projects initiated during the prior year and their results. The evaluation contains a written description of completed and ongoing quality improvement activities that address quality and safety of clinical care and quality of service. Measures are trended to assess performance in the quality and safety of clinical care and service with analysis of the results of quality initiatives, including barrier analysis. The identity of the staff responsible for the evaluation is also listed within the document.

The QM program shall be evaluated quarterly by the MAC and MMC. The QM Program Evaluation will address all components of the QM program as listed in the Program Description. The QM Program Evaluation is presented to the MAC for review and approval. QM Program Evaluation findings are used to develop the yearly action plan for the upcoming year.

APPROVAL SIGNATURES

SUBMITTED BY:

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2/11/2025

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Chairperson, MAC — Date