Scripps | Scripps Health Plan

2025 Utilization Management Program Description

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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.

II. Purpose

The purpose of the Scripps Health Plan (SHP) Utilization Management (UM) Program is to meet members' needs by providing access to necessary care in the most direct, cost-effective and coordinated manner to improve the health of our members. SHP is committed to meeting member needs and assuring that they are receiving quality care and appropriate utilization of resources without barriers.

Health care services will be provided by SHP's integrated network of participating providers (including hospitals, physicians, and ancillary providers). SHP may delegate various UM functions to Independent Physician Associations (IPAs) or Pharmacy Benefit Managers (PBMs) to provide certain health care services to SHP members.

III. Goals

SHP's UM program goals are:

1. To maintain systematic, comprehensive, and ongoing UM processes for the timely and effective delivery of health care services to SHP members.

2. To optimize health care resource utilization and ensure the delivery of quality health care services at the appropriate level of care.

3. To assure that appropriate care based on the member needs and benefits, consistent with professionally recognized standards of practice, is provided to all members and not withheld or delayed for any reason, including a potential financial gain and/or incentive to participating providers or others.

4. To coordinate with practitioners, IPAs, hospitals, and ancillary providers in the provision of outpatient and inpatient services provided to SHP members.

5. To engage members in their health care through disease management and self-education programs.

6. To assist members in navigating the health system and community resources using the providers and case management program.

7. 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.

IV. Objectives

SHP UM program goals are achieved by accomplishing the following objectives:

1. Monitor and evaluate the timeliness, efficiency and effectiveness of the delivery of health care services while providing quality care, including timely access to care and accessibility to health services.

2. Monitor, evaluate and improve utilization practice patterns of participating practitioners, hospitals and ancillary service providers.

3. Monitor and evaluate the utilization of services to assure that services are not over or under-utilized and intervene with practitioners and members when appropriate.

4. Educate members, practitioners, hospitals and ancillary providers about quality and cost-effective management of health care services.

5. Assure member care transitions are managed to prevent adverse events.

6. Provide outpatient case management and complex case management (CCM) for members and providers.

7. Perform peer to peer clinical reviews and other UM activities.

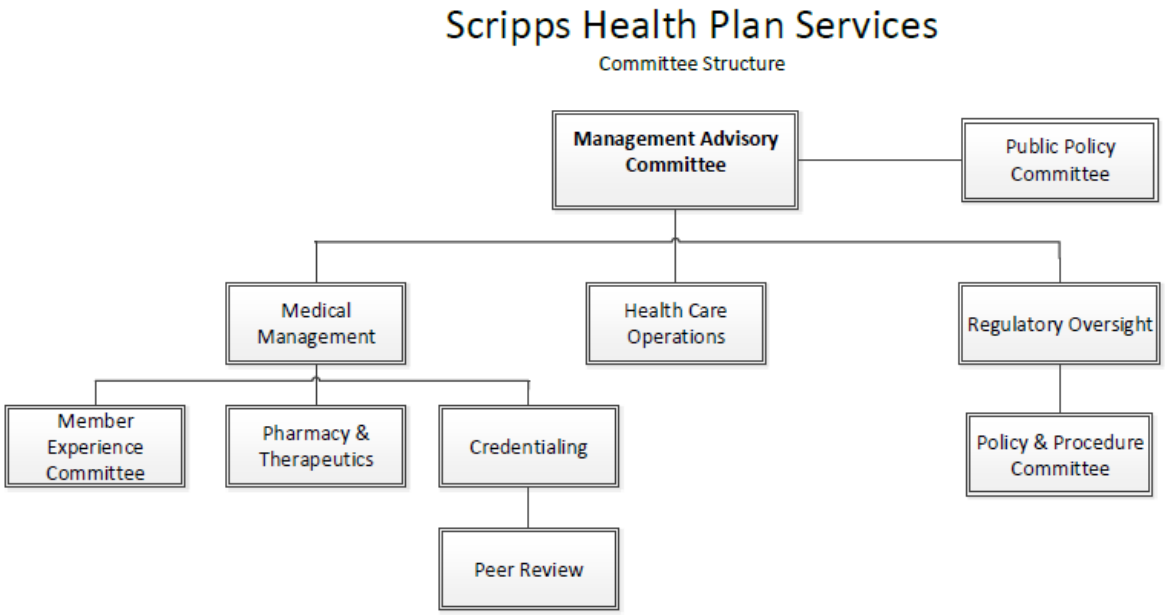
8. Comply with federal and state law and accrediting body requirements.

V. Program Authority and Accountability

The SHP Management Advisory Committee (MAC) has ultimate accountability for the evaluation and oversight of the quality and cost-effectiveness of the UM program. The MAC has delegated authority for UM program direction and monitoring to the multi-disciplinary Medical Management Committee (MMC) which is responsible for oversight of SHP's UM program. The MMC is responsible for the ongoing monitoring, evaluation and improvement of the UM program.

The SHP Medical Director is Chair of the MMC and is the Senior Plan Officer responsible for the direction and overall functioning of the UM program and ensures allocation of adequate resources and staffing. A summary of UM activity will be included in the quarterly UM program report submitted to the MAC. At least annually, the UM Program Description and the UM Work Plan are evaluated and approved by the MMC and the MAC and revised, as necessary. A semi-annual UM Work Plan report is also prepared and reviewed and approved by the MMC and the MAC.

VI. Committees



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, the VP 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.

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.

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. Providers involved in medical management decisions will not make decisions based upon financial interests or incentives.

2. MMC Responsibilities:

   a. Annually review and evaluate the effectiveness of the SHP UM program.

   b. Annually review and approve the UM Program Description and annual UM Work Plan and evaluate the previous year's UM Work Plan.

   c. Monitor and evaluate adherence to evidence-based practice standards for practitioners and other healthcare providers and implement corrective action plans, when applicable.

   d. Identify areas requiring focused review, evaluate the results of the review, implement clinical improvement initiatives, and evaluate results of the initiative.

   e. Review and investigate provider utilization adverse trends, including corrective action recommendations, when applicable.

   f. Annually review, approve, and disseminate nationally recognized clinical practice guidelines for making medical necessity decisions, in addition to any changes to guidelines that occur during the year.

   g. Identify, approve, evaluate, and modify key performance indicators and benchmarks for utilization of services and value-based outcomes and implement corrective action plans for variances based upon over and under-utilization of services.

   h. Ensure follow-up is completed on all required actions.

   i. Evaluate trends and communication with other departments during integrated meetings or the Member Experience Committee (MEC), ensuring emphasis on the member experience and quality.

   j. Provide feedback and education to providers on adverse utilization findings.

k. Review UM policies, procedures, and standards.

l. Review delegation oversight reports and monitor delegated activities and corrective action plans, when applicable.

m. Oversee Physician and UM Nurse Reviewers responsible for ongoing individual case review.

n. Partner with the Chief Compliance Officer when there is potential fraud, waste, or abuse, in compliance with state and federal regulations.

o. Review, trend, and analyze grievance and appeal reports, including the development, implementation, and re-assessment of action plans.

p. Assess the characteristics and needs of member populations and relevant subpopulations.

q. Assess new technologies and new applications of existing technology and provide recommendations for adoption.

r. Review and evaluate the disease management/complex care management programs, including outcomes of the programs and the need to modify interventions based upon the evaluations.

s. Revise and update case management processes to address member needs as necessary.

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.

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.

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.

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 a fully 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.

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 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.

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 risks.

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.

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 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. UM Functions and Roles

UM activities will be coordinated and performed by SHP's UM Department staff under the direction of the Medical Director and the Director of Utilization Management.

Medical Director

Responsibilities include the following:

1. Provide senior executive oversight of the development and implementation of the UM program.

2. Maintain a current unrestricted medical license in the state of California and maintain full credentialed status within the SHPS provider network, regardless of full-time practice status.

3. Ensure the implementation of the UM Program Description and the UM Work Plan.

4. Provide oversight and coordination of UM activities with IPA Medical Directors, as applicable.

5. Participate in the development of the UM Program Description, the UM Work Plan and evaluation of the UM program's effectiveness.

6. Monitor compliance with UM program authorization and referral criteria.

7. Provide oversight of the consistency of criteria in making service determinations, review results and ensure remedial action is implemented for any issues identified.

8. Ensure that internal and external corrective actions are taken when problems are identified.

9. Oversee Physician Reviewers' review of medical necessity denials and obtain specialist physician review for questionable or difficult cases. Physician consultants from the appropriate specialty areas of medicine and surgery who are certified by the American Board of Medical Specialties (ABMS) will

be utilized as appropriate in the review process to make recommendations to Physician Reviewers on authorization requests.

10. Provide oversight of provider groups' UM committee activities and report pertinent information to MMC.

11. Coordinate and communicate information and decisions to network physicians.

12. Chair the MMC and the P&T Committee.

13. Analyze UM data and establish priorities for focused studies (high volume, high risk and high cost areas).

14. Contribute to the development, review and dissemination of clinical studies and practice guidelines/standards to participating providers. Monitor provider adherence to professionally recognized standards of clinical care adopted by the MMC.

15. Evaluate clinical performance outcomes and service indicators for ambulatory and inpatient care.

16. Evaluate data for variances that may represent potential under and over utilization of services.

17. Present semi-annual UM summary reports to the MMC and the MAC.

18. Serve as a liaison to affiliated medical groups and network providers.

19. Attend contracted provider operations meetings.

20. Participate in sub-committees and workgroups.

21. Champion process improvements to improve compliance with preventive medicine guidelines.

22. Implement performance improvement projects.

Physician Reviewers

As deemed appropriate by the Medical Directors of the affiliate medical groups, additional Physician Reviewers may be appointed to assist with day-to-day authorization review and/or act as a back-up in the absence of the Medical Director. All such Physician Reviewers must be board certified in their practice specialty and maintain an active, unrestricted medical license in the state of California. In addition, all Physician Reviewers must be fully credentialed by the CPRP. While no special training is required for appointees, they must agree to abide by all the policies, procedures and guidelines established by the SHP UM program in conducting clinical reviews and will be monitored and subject to inter-rater reliability testing when applying clinical criteria. Physician Reviewers are never incentivized to restrict care in compliance with all federal and state regulations. No formal minutes will be maintained of individual Physician Reviewer

daily activities, but Physician Reviewers are required to clearly document review decisions in writing on authorization requests, including specific reasons for denial if applicable, signature and date of decision. All denial decision documentation issued by Physician Reviewers will be maintained by SHP operational staff for a minimum ten (10) year period or as required by current regulations.

Sr. Director of Utilization Management

The Sr. Director of Utilization Management is responsible for the implementation and monitoring of the UM program.

The Sr. Director's responsibilities include, but are not limited to:

1. Provides oversight and leadership within assigned area of responsibility. Assists in the management of the overall operational, budgetary, and financial responsibilities and activities.
2. Plans and implements systems that accomplish work objectives and fulfill the mission and goals efficiently and effectively.
3. Plans and allocates resources to effectively staff department and meet productivity and annual goals. Plans, evaluates, and improves the efficiency of processes and procedures to enhance speed, quality, efficiency, and output.
4. Formulates business decisions that are cost effective, responsible, accountable, justifiable, and defensible in accordance with organization policies and procedures.
5. Reviews performance data that includes timeliness, quality, satisfaction surveys, engagement, utilization trends, and interrater and audit reports.
6. Participates in the preparation and maintenance of reports necessary to carry out the functions of the area of responsibility.
7. Prepares periodic reports for management to track goal accomplishment. Leads colleagues using performance management and development process.
8. Oversee UM department management and staff activities.
9. Participate in all required regulatory meetings including but not limited to MMC and MAC meetings.
10. Participate in the annual evaluation of the UM program's effectiveness and recommend revisions to the UM Program Description and the UM Work Plan when applicable.
11. Monitor and analyze internal/external data trends and patterns that affect UM activities.
12. Ensure compliance with state, federal and accrediting body requirements.
13. Implement changes to the UM program utilizing member and provider satisfaction data as well as MAC recommendations.

14. Monitor and analyze internal and external data trends and patterns that affect or inform UM activities.

Director of Utilization Management

The Director of Utilization Management is responsible for the implementation and monitoring of the UM program. The Director of Utilization Management is responsible for the operation of the UM staff functions, including prior authorization and data analytics reporting. The Director of Utilization Management is responsible for the day to day operations of the UM functions in prior authorization.

The Director's responsibilities include, but are not limited to:

1. Coordinate with SHP departments and IPAs in the implementation of the UM program functions.
2. Oversee UM department management and staff activities.
3. Participate in MMC meetings.
4. Participate in the annual evaluation of the UM program's effectiveness and recommend revisions to the UM Program Description and the UM Work Plan when applicable.
5. Monitor and analyze internal/external data trends and patterns that affect UM activities.
6. Coordinate inter-rater reliability reviews to monitor the consistency of criteria application on at least a quarterly basis.
7. Ensure compliance with state, federal and accrediting body requirements.
8. Prepare quarterly UM reports for the MMC and the MAC.
9. Implement changes to the UM program utilizing member and provider satisfaction data as well as MAC recommendations.
10. Promote, coordinate, and communicate UM activities throughout the health care delivery system.
11. Monitor and analyze internal and external data trends and patterns that affect or inform UM activities.
12. Participate in staff training, monitor for consistent application of UM criteria by staff, for each level and type of UM decision and monitor documentation for adequacy.

Manager Utilization Management

Qualified licensed health care professional supervises the daily clinical and non-clinical UM activities. Daily supervision includes, but is not limited to:

1. Provides day to day supervision of assigned UM staff.

2. Provides day to day monitoring of timeliness and work queues.
3. Monitors for consistent application of UM criteria by the UM staff, for each level and type of UM decision.
4. Monitors documentation for adequacy.
5. Monitors for UM controls.
6. Participates in staff training and interrater audits including providing feedback as applicable.
7. Participate is policy and procedures review and updates as necessary.
8. Available to staff onsite or telephonically.

Utilization Review Nurses, Concurrent Review Nurses, Retrospective Review Nurses, and UM Support Staff Responsibilities

Staff who are not qualified health care professionals are under the supervision of an appropriately licensed health professional, when there are explicit UM criteria, and no clinical judgment is required. Qualified, licensed medical professionals will oversee or perform all functions listed below:

1. Verify member eligibility, benefits, coverage and treatment arrangements for members.
2. Authorize inpatient and outpatient hospital admissions in coordination with the member's Primary Care Physician (PCP) or other treating physician.
3. Authorize services, including referrals to specialist physicians for consultation and treatment, when applicable, based upon guidelines.
4. Authorize other outpatient and ancillary services including, but not limited to:
    a. Outpatient (ambulatory) surgery.
    b. Skilled nursing facility and long-term inpatient care.
    c. Home health.
    d. Durable medical equipment – prosthetics, orthotics and supplies (purchase/lease).
    e. Diagnostic testing.
    f. Laboratory and radiology services.
    g. Rehabilitative services.
5. Perform prospective, concurrent and retrospective review for medical necessity, appropriateness of

service and level of care and continued delivery of services.

6. Consistently apply medical necessity criteria in approving, modifying or denying a referral request.
7. Coordinate discharge planning activities in coordination with the attending physician, hospital discharge planning staff and member/family.
8. Provide psychosocial support and crisis management intervention as needed for members and families.
9. Assist in claims review when accuracy, appropriateness of charges or authorization information is required.
10. Collect data on sentinel events or potential quality issues (PQIs) and report to QM staff and the Chief Compliance Officer.
11. Collect and report UM and quality information to be used in the re-credentialing process.
12. Refer all potential denial or modification determinations to the appropriate Physician Reviewer including review summary and medical notes.

Sr. Director of Case Management

The Sr. Director of Case Management is responsible for the implementation and monitoring of the CM program.

The Sr. Director's responsibilities include, but are not limited to:

1. Provides oversight and leadership within assigned area of responsibility. Assists in the management of the overall operational, budgetary, and financial responsibilities and activities.
2. Plans and implements systems that accomplish work objectives and fulfill the mission and goals efficiently and effectively.
3. Plans and allocates resources to effectively staff department and meet productivity and annual goals. Plans, evaluates, and improves the efficiency of processes and procedures to enhance speed, quality, efficiency, and output.
4. Formulates business decisions that are cost effective, responsible, accountable, justifiable, and defensible in accordance with organization policies and procedures.
5. Reviews performance data that includes timeliness, quality, satisfaction surveys, engagement, and interrater and audit reports.
6. Participates in the preparation and maintenance of reports necessary to carry out the functions of the area of responsibility.
7. Prepares periodic reports for management to track goal accomplishment. Leads colleagues using

performance management and development process.

8. Oversee CM department management and staff activities.
9. Participate in all required regulatory meetings including but not limited to MMC and MAC meetings.
10. Participate in the annual evaluation of the CM program's effectiveness and recommend revisions to the Program Description and the Work Plan when applicable.
11. Monitor and analyze internal/external data trends and patterns that affect CM activities.
12. Ensure compliance with state, federal and accrediting body requirements.
13. Implement changes to the CM program utilizing member and provider satisfaction data as well as MAC recommendations.
14. Monitor and analyze internal and external data trends and patterns that affect or inform CM activities.

Manager of Complex Care Management

Responsibilities include the following:

1. Develop, implement and monitor the effectiveness of the CCM program standards and disease management.
2. Promote, coordinate and communicate CCM and disease management activities throughout the health care delivery system. Promote the referral of members who could benefit from CCM services.
3. Oversee CCM staff activities and performance of these functions.
4. Participate in MMC meetings.
5. Participate in the annual evaluation of the CCM and disease management program effectiveness and recommend revisions when applicable.
6. Monitor and analyze internal and external data trends and patterns that affect CCM, concurrent review and disease management activities.
7. Oversee the transition of care functions impacting members who are hospitalized or use emergency services.
8. Oversee the disease management programs offered to SHP members.
9. Participate in staff training, monitor for consistent application of UM criteria by staff, for each level and type of UM decision and monitor documentation for adequacy.
10. Ensure compliance with state, federal and accrediting body requirements.
11. Prepare CCM and disease management reports for the MMC.

Case Management Staff Responsibilities

Staff who are not qualified health care professionals are under the supervision of an appropriately licensed health professional, when there are explicit criteria, and no clinical judgment is required. Qualified, licensed medical professionals will oversee or perform all functions listed below:

1. Identifies members with complex needs through the case management evaluation process, enrolls the member in case management when delegated, or refers to the member's health plan Case Management department when not delegated.
2. Acts as a primary source of care for members with complex health needs, with a wide range of engagement including collaboration with discharge planning, reviews current and historical clinical history, coordinates referral needs, mental health status and conducts transitions of care.
3. Serves as a subject matter expert, consults, trains and educates other clinical and non-clinical support staff when needed.
4. Conducts clinical assessments, health screenings (depression, fall risk, etc.) and member outreach within the regulatory timeframes to address the medical, mental health and wellness needs of members using a set of clinical interviewing skills to incorporate community and social determinants, support services, lifestyle improvement and prevention opportunities into member's interactions.
5. Develops comprehensive plan of care and individual care plans based on member's specific needs by using the clinical complex care management information system to establish treatment goals.
6. Identifies and coordinates discharge need and transition to alternative levels of care by interfacing with providers, physicians, and family.
7. Assure appropriate referrals for care and services are directed to appropriate network providers and obtains prior authorization for in network and out of network services as appropriate.
8. Refers care to network providers and/or assists with redirection in network when appropriate.
9. Educates plan participants, providers, and physicians about community resources.
10. Evaluates the process periodically within the mandatory timeframes making adjustment to improve outcomes as needed and communicates as indicated with providers and health plan partners to obtain the necessary authorization for reimbursement of services or maximizing health care benefits.

Supervisor, Complex Case Management

Qualified licensed health care professional supervises the daily case management activities. Daily supervision includes, but is not limited to:

1. Provides day to day supervision of assigned Case Management staff.

2. Provides day to day monitoring of care plan timeliness and case assignments.

3. Monitors for consistent documentation and application of acuity levels, goals, and implementation of care plan.

4. Monitors documentation for initiation and completion of initial health screening and required documentation standards.

5. Participates in staff training and interrater audits including providing feedback as applicable.
6. Participates in policy and procedures review and updates as necessary.
7. Participates in workflow enhancements and process improvements as necessary.
8. Available to staff onsite or remotely.

VIII. Scope of the UM Program

SHP's UM program is designed to encompass all levels of utilization review activity within SHP's health care delivery system. The UM program is designed to provide a multi-disciplinary, integrated framework for designing, measuring, assessing, and ensuring compliance with benefit coverage and medical necessity of care and improving the delivery of health care and services. Activities within the scope of the UM program will be coordinated with plan providers and reported to the appropriate committees within SHP.

Members shall not be 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.

For additional details on this section, refer to the following policies:

1. SHPS 800 Prospective Authorization Review
2. SHPS 802 Concurrent Inpatient Management
3. SHPS 803 Continuity of Care
4. SHPS 804 Retrospective Authorization Review
5. SHPS 809 Denials and Modifications
6. SHPS 825 Specialist Referral Authorization and Tracking
7. SHPS 828 Out of Network Referrals
8. SHPS 830 Standing Authorizations
9. SHPS 875 UM Turnaround Time Standards
10. SHPS 885 Emergency, Post Stabilization Care and Transfer Utilization Review

Elective Inpatient Admission Authorization

Pre-admission authorization involves an assessment of the medical necessity (evaluation of the proposed treatment plan, appropriateness of setting and level of care) and the application of medical necessity criteria for a member's admission to a hospital prior to the admission.

This process is initiated by the member's PCP or other treating physician, preferably ten (10) business days prior to an elective admission. SHP uses nationally recognized clinical criteria to review the proposed admission, and if considered medically necessary, the admission will be authorized. Admission authorizations are subject to the following guidelines and limitations:

1. The admitting facility should verify authorization of all elective admissions with SHP prior to admitting a SHP member to that facility.

2. All authorizations are subject to a member's eligibility at the time services are rendered; this includes retrospective review for medical necessity. It is the responsibility of the rendering provider to confirm eligibility at the time of service.

3. Outpatient pre-admission test results may be required prior to an elective admission.

4. If the proposed admission does not meet SHP's established criteria for admission, the case will be referred to the Medical Director or Physician Reviewers for review and final determination. Any denial decision of a service will be made by a qualified health care professional.

5. SHP adheres to all regulatory guidelines on decision turnaround timeliness.

Concurrent Review

Concurrent review is the process by which the UM Nurse or Physician Reviewer assesses the medical necessity of a member's need for continued inpatient care or ancillary service continuation. In addition, it facilitates early intervention to ensure that the member's treatment plan promotes quality, cost-effective care and safe discharges. The Physician Reviewer is responsible for determining medical necessity and making denial or modification determinations. The following standards are used in performing concurrent inpatient management:

1. California licensed registered nurses or physicians perform the concurrent review process utilizing approved criteria based on professionally recognized standards of practice. The process involves review of the member's medical records, contact with the attending physician and, if appropriate, speaking with the member and family.

2. Concurrent review is initiated for all diagnoses within the first business day after SHP is notified of an admission (or service requiring continuing review).

3. Concurrent reviews are performed as dictated by medical necessity and may be performed on-site, electronically, or telephonically in coordination with the hospital or ancillary provider for all continued stays or services.

4. SHP staff will conduct themselves in a professional manner, following all HIPAA and other federal, state and hospital-specific regulations at all times while conducting onsite or telephonic review.

5. Out-of-network (non-contracted) admissions are reviewed via telephone, EHR, or received medical records by a UM Nurse or Physician Reviewer.

6. The concurrent review nurse, member's PCP or other treating physician will work with the out-of-network or non-contracted provider to bring the member back into the care of contracted providers and facilities as soon as the member's condition is medically stable and appropriate for transfer (or transition, in the case of ambulatory services).

7. The concurrent review nurse will monitor services provided by the out-of-network or non-contracted provider for PQIs and intervene as needed. Concurrent review is based upon nationally recognized standards of care and are used to ensure that medically necessary care is provided as well as to avoid any duplication of services, gaps in care or other events which could lead to poor patient outcomes. Quality issues will be referred to the QM Department for investigation and resolution where appropriate.

8. The concurrent review nurse refers all questionable cases or potential medical necessity denials to the Medical Director or Physician Reviewer for review and action as appropriate.

9. The concurrent review nurse, the Medical Director or the Physician Reviewer will contact the provider before making denial decisions regarding care that is already underway (concurrent review) and that care shall not be discontinued until the provider has been notified and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that member.

Concurrent Review Decision Making Timeframes:

1. SHP will make concurrent review decisions within twenty-four (**24) hours** of obtaining all necessary information.

2. SHP will notify practitioners within twenty-four (**24) hours** of making concurrent review decisions.

3. SHP will provide members and practitioners with written or electronic confirmation of review decisions within twenty-four (**24) hours** of making concurrent review decisions.

Discharge Planning

Discharge planning is an integral component of the concurrent review process that is initiated at admission (or earlier when possible) with an assessment of the member's potential discharge care needs. It includes preparation of the member and the member's family for continuing care needs and initiation of arrangements for placement or services needed after discharge. SHP staff will coordinate with hospital discharge planners, the attending physician and appropriate ancillary service providers to assist in making necessary arrangements for post-discharge care needs.

Case Management

SHPS case management programs incorporate the dynamic processes of assessment, problem identification, care planning, intervention, monitoring, and evaluation. The programs use an interdisciplinary team approach to meet the Member's health care needs. Members who are identified for case management and agree to participate will be assessed for needs when the case is initially opened. Upon completion of the initial assessment, the case will be assigned to the appropriate level of case management based on the Member's needs. Communication and collaboration will occur with the Primary Care Provider (PCP) as needed, as well as with any specialty-care Participating Providers that may be involved in the Member's care.

The Member and family, as appropriate, will be actively involved in the care plan, which will be documented and updated on a periodic basis or when there is a change in health status. Both short-term and long-term goals will be formulated, and the Member's progress toward those goals will be monitored. Outcomes are documented when the case is closed, and Member satisfaction with the case management process will be assessed periodically. All pertinent information is relayed in a timely manner to the PCP, as necessary, throughout the case-management process.

Case management programs for Members at risk of poor health outcomes:

- General Case Management
- Post-Discharge/Transitions of Care Case Management
- Telephonic Disease Management, and Advance Care Planning
- Complex Case Management

General Case Management is a collaborative, Member-centered process of assessment, care planning, care coordination, health education, and advocacy to reduce or eliminate barriers to care. The assigned Case Manager works directly with the Member and the family/caregiver(s) to develop an Individualized Care Plan (ICP) that is focused on increasing access to resources and services that support the Members health needs. The Case Manager is responsible for coordinating benefits and services with other agencies/ providers, monitoring progress, and ensuring interventions are in place to support the Member's Individualized Care Plan.

Post-Discharge and Transitions of Care Case Management is a subset of the General Case Management program. This program focuses on those Members discharged from a facility (inpatient/emergency/post-acute care) and provides timely education and assistance with access to care and services, with the goal of preventing unnecessary readmissions. The Case Manager will complete a transitions of care assessment.

Telephonic Disease Management (TDM)/Advance Care Planning is a system of coordinated heath care interventions and communications for defined patient populations with conditions where self-care efforts can be implemented to manage the conditions and to prevent complications and advance care planning needs

Complex Case Management (CCM) is provided to Members who have experienced a critical event or diagnosis that requires extensive use of resources and requires oversight to navigate the needed delivery of care and services. Case management becomes complex when the illness and/or conditions and

complexity are severe and require an intense level of management beyond that of General Case Management.

Case Management (CM) in collaboration with Good Medicine/Home Based care provided to members who are homebound and require assistance with coordination of care, eliminating barriers to care, and care planning. The assigned Case Manager works directly with the physicians of Good Medicine/Home Based Care to provide coordination as needed and refers to other programs if criteria are met such as CHF/COPD, Complex Case Management, or end of life planning.

Program is the focused arrangement of the sequence of services and resources necessary to respond to a member's overall care requirements in catastrophic or complicated cases. Assures that the member is provided with quality care in the most cost-effective manner through appropriate utilization of all available health care resources.

Aa multi-disciplinary team approach to develop a treatment plan which may include the primary care physician, specialist, home health agencies, discharge planners, physical therapists, social workers, hospital UM nurses, SHP UM staff, the member, the member's family, and others as appropriate.

Members eligible for case management may vary depending on the population and the trends being reported which will be determined when assessing the case management needs of the member. The CCM team will improve access to primary and specialty care, coordinate care for members who receive multiple services and identify and reduce barriers to services for members with complex conditions.

Overall care management goal is to help members regain optimum health and/or improved functional capability, in the right setting and in a cost-effective manner. It involves a comprehensive assessment of the member's condition, social determinants of health, determination of available benefits and resources and development and implementation of care management plan with performance goals, monitoring, and follow-up. Outcome goals for case management will include:

1. Decrease in readmission rates.
2. Improve member satisfaction with the CCM process.
3. Decreased use of ER/Urgent Care.
4. Decreased member cancellation of appointments.
5. Improved member/family understanding of disease and treatment.
6. Improve care coordination needs.
7. Analysis of refusal rates.
8. Analysis of re-admit reasons in cohort discharged as clinically stable.

Care Management outcome data combined with member satisfaction survey data will be analyzed annually and process improvements implemented. Each process improvement will be evaluated quarterly to determine outcome improvement. Resources for member education will be evaluated annually.

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 and 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:

1. Mental health and substance use disorder services, including all inpatient and partial hospital care.

2. Mental health evaluations and treatment as well as treatment for substance use disorders, including all outpatient services.

SHP shall monitor the continuity and coordination of care that members receive, and take action, 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:

1. Exchange of information between medical (e.g. PCPs, medical/surgical specialists, organization providers) and mental health providers, in accordance with a member's right to confidentiality of protected health information.

2. Appropriate diagnosis, treatment and referral of mental health and substance use disorders.

3. Appropriate use of psychotropic medications.

    a. Pharmacy data is analyzed and reviewed to ensure appropriate use and adherence to prescribing guidelines for psychotropic medications (e.g. anti-depressants, ADHD medications, etc.) with respect to acute and continuation of therapy.

4. Management of coexisting medical and mental health conditions.

    a. 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.

    b. Appropriate screening and management of member with co-occurring medical and mental health disorders.

5. Prevention programs for mental healthcare.

    a. Collaborative development and implementation of primary or secondary prevention programs (i.e. autism or depression screening) for mental healthcare which are based on professionally recognized standards of care.

6. Severe and persistent mental illness.

a. Continuity and coordination of services for members with severe and persistent mental illness is monitored.

SHP shall retain full responsibility for assuring 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.

A psychiatrist or qualified mental health representative will be a member of the MMC for coordination of medical and mental health care. Utilization of mental health and substance use disorder services are reviewed through the MMC and any sub-committees that are formed to address any quality or access to care issues. Members that require medically necessary treatment of mental health and substance use disorders, including those mental health or substance use disorders identified in the International Classification of Diseases or the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, are identified as special needs members by SHP and are provided direct access to services. Members have the right to access any provider in the network in the case of any exacerbations directly without authorization or referrals that may act as barriers to care. If services for the medically necessary treatment of a mental health or substance use disorder are not available in the network within the geographic and timely access standards set by law or regulation, SHP shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services that, to the maximum extent possible, meet those geographic and timely access standards.

CCM will annually, at a minimum, review claims for case finding of special needs members. During the year, referrals, reporting of utilization and ongoing monitoring may be used to identify members meeting the definition of special needs and outreach conducted. SHP sites have implemented a depression screening into the member visit record for early identification and intervention of at-risk members.

Referral Management and Prospective Review

Referral management involves an assessment of the medical necessity (evaluation of the proposed treatment plan, appropriateness of practitioner type/setting/level of care and benefit coverage) prior to the delivery of care by a medical practitioner. This process is initiated by the member's PCP or other treating physician prior to delivery of the care. SHP will use established criteria based on nationally recognized evidence based medical and practice standards used in the review of referral requests and, if considered medically necessary, the referrals will be approved.

1. SHP retains the right to exempt certain providers (e.g. place a physician on authorization auto-approval) or diagnoses from referral management. Decisions to exempt services from the need for prior authorization are made through the prior authorization operations committee which reviews the risk and data based upon previous decision-making history to determine if a service or provider meets internal guidelines to be exempt. The physician leadership make up the membership of this committee which meets at least quarterly and reports to the MMC. The purpose of this group is to decrease barriers to care and allow direct access to services for members.

2. Selected referral categories and referral types may not require authorization when requested by a PCP for a group contracted physician and services directed to a specific group of providers.

3. For referrals to contracted or non-contracted specialty physicians outside of a member's medical group, PCPs or other treating physicians are required to request prior authorization from the SHP UM Department.

4. Services must be provided by participating (in-network) providers except when those services are not available within SHP's contracted network. The Medical Director or Physician Reviewer must review all referral requests to non-participating providers.

    a. These out-of-network referrals may be authorized if the service requested by the member's PCP or other treating physician is not available from a participating network provider. The services must be medically necessary and a covered benefit to be considered.

    b. Cases that require specialized medical expertise before making a decision for out-of-network referral may be sent by the Medical Director to the MMC or SHP's independent panel of board-certified specialist physician consultants for review and recommendation. Physician consultants from the appropriate specialty areas of medicine and surgery who are certified by the ABMS will be utilized as appropriate in the review process.

5. Medical necessity will be determined by review of the member's condition, diagnosis and the proposed treatment plan against the adopted nationally recognized criteria approved by the MMC.

6. SHP UM staff verifies eligibility, benefits as described in policy *SHPS 852 Benefit Verification* and coordinates referral management requirements.

7. Providers may request authorizations telephonically (orally) at **844-337-3700**, via fax at **858-260-5877**, directly via EPIC (the Scripps electronic health care record) interface with the UM Department or electronically via a provider's Scripps-Link (Plan Link) account portal. SHP shall maintain telephone access for providers and members to verbally request authorization for health care services.

8. The Physician Reviewers review all referral requests that do not meet medical criteria and make all final medical necessity denial determinations. All denials are made by qualified health care professionals.

9. SHP complies with all referral decision making timeframe standards for turnaround times as outlined by the state of California.

10. The PCP or other treating physician should submit a request for authorization approval to SHP before scheduling a service requiring prior authorization. Non-contracted providers who wish to request authorization for services must contact the prior authorization before scheduling the service. Refer to policy *SHPS 878 Communication Services for Providers and Practitioners* for details on accessing authorization services through telephone or the portal.

11. If authorized, the notification to the requesting provider and specialist will be made within twenty-four (24) hours of the decision, specifying the specific services approved. Services shall be authorized as medically necessary for proposed treatment, of a duration not to exceed one (1) year at a time,

utilizing established criteria and consistent with benefit coverage.

12. The PCP retains the responsibility for coordination of the member's care, unless a specific arrangement is made to transfer care to the specialist for a specified period of time, in accordance with the PCP contract with SHP.

Standing Referrals

Members who require specialized care over a prolonged period for a life-threatening, degenerative or disabling condition, including human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS), and active treatment for cancer may be allowed a standing referral to a specialist who has expertise in treating the condition or disease, or for the purpose of having the specialist coordinate the member's healthcare.

1. Specialists and specialty care centers are validated to assure the provider holds appropriate accreditation or designation as having special expertise in treating the condition or disease *(refer to credentialing policy SHPS 400 Credentialing & Re-Credentialing)*.

2. A list of HIV/AIDS specialists, as defined by Title 28 CCR § 1300.74.16, are reviewed and updated annually, emailed to the UM, Case Management and Provider Relations staff and kept in easily accessible shared files.

3. A listing of specialists and specialty care centers, including HIV/AIDS specialists are available to providers and members via the plan website to assist in the referral process.

4. The PCP can request authorization for an out-of-network specialist if one is not available within SHP's network, who can provide appropriate specialty care to the member as determined by the PCP in consultation with SHP's Medical Director and as documented in the treatment plan.

5. The PCP and specialist determine the need for continuing care from the specialist and request authorization based on an agreed upon treatment plan, if any. Treatment plans may limit the number of specialist visits or the length of time the visits are authorized and may require the specialist to make regular reports to the PCP.

6. The PCP retains the responsibility for coordination of care unless a specific arrangement is made to transfer care to the specialist for a specified period of time, in accordance with the PCP agreement with SHP. In certain cases, for members with special health care needs or members seeking care by an obstetrician, the specialist may act as the primary care provider.

7. The determination shall be made within the regulatory timeframes for turnaround times when the request for determination of the requested service is made by the member or the member's PCP and all appropriate medical records and other items of information necessary to make the determination are provided.

8. After receiving the standing referral approval, the specialist is authorized to provide healthcare services that are within the specialist's area of expertise and training to the member in the same

manner as the PCP.

9. When authorizing a standing referral to a specialist for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV/AIDS medicine, SHP will refer the member to an HIV/AIDS specialist who meets California Health and Safety Code criteria.

10. Member denial letters for standing referrals will include:

    a. Health literate description of the service being requested.

    b. Clear and concise explanation of the reasons for the denial or modification of the originally requested service.

    c. Clinical reasons for the decision to deny, delay or modify health care services.

    d. The rationale or criteria the decision was based upon; and

    e. The member's rights to appeal the decision and how to do initiate an appeal.

11. Written communications to any member of a denial, delay or modification of a request shall include information as to how the member may:

    a. File a grievance with SHP; and

    b. Request an independent medical review in cases where the member believes that health care services have been improperly denied, modified or delayed by SHP, or by one of its contracting providers.

12. Written communications to a physician or other health care provider of a denial, delay or modification of a request shall include the following information:

    a. The name of the health care professional responsible for the denial, delay or modification; and

    b. The direct telephone number or an extension of the healthcare professional responsible for the denial, delay or modification to allow the requesting physician or health care provider to easily contact them.

Second Opinions

A member or their treating provider may request a second opinion if:

1. The member questions the reasonableness or necessity of a recommended surgical procedure.

2. The member questions the diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily functions or substantial impairment including a serious chronic condition.

3. The clinical conditions are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating provider is unable to diagnosis the condition.

4. The treatment plan in progress is not improving the medical condition within an appropriate period of time given the diagnosis and plan of care; or

5. The member has attempted to follow the plan of care or consulted with the initial provider regarding serious concerns about the diagnosis or plan of care.

The member will be responsible only for the cost of applicable co-pays in accordance with the Combined Evidence of Coverage and Disclosure Form (EOC). Requests by a member, their PCP or another treating physician for a second opinion will be considered by the Medical Director or a Physician Reviewer and the member will be directed to a participating provider or a provider selected by the member when a provider is not available in network.

Emergent Care

Emergent care does not require prior authorization. All emergency room care will be covered without prior authorization.

In the case of an emergent admission, the UM Department shall be notified following stabilization of an emergent medical condition. The concurrent review process is begun at that time.

All pre-service requests for urgent services (expedited referrals) will be reviewed and decision will be made no later than within twenty-four (24) hours of receipt for medical necessity.

Denial of Experimental Treatment for Terminally Ill Members

A terminal illness is defined as an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Life threatening diseases or conditions is defined as the likelihood of death is high unless the course of the disease is interrupted and diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival. Seriously debilitating diseases or conditions are defined as causing major irreversible morbidity. If an authorization or referral is being requested for coverage of investigational/experimental treatment, services or supplies, the case will be immediately forwarded to the Physician Reviewer for consideration.

When SHP denies coverage of a request for treatment, services, or supplies deemed experimental as recommended by a participating plan provider to member with a terminal illness, all of the following information will be provided to the member within five (5) business days of receiving the request:

1. A statement setting forth the specific medical and scientific reasons for denying coverage.

2. A description of alternative treatment, services, or supplies covered by SHP, if any.

3. Copies of the grievance procedures and Terminal Illness Complaint Form. SHP Terminal Illness Complaint Form provides an opportunity for the member to request a conference as part of SHP grievance system.

a. Upon receiving a Terminal Illness Complaint Form requesting a conference, the member is provided an opportunity to attend a conference, to review the reason for the denial, within thirty (30) calendar days. The Medical Director or designee representative attending the conference will have authority to determine the disposition of the appeal.

b. SHP allows attendance, in person, at the conference, by a member, a designee of the member, or both, or, if the member is a minor or incompetent, the parent, guardian, or conservator of the member, as appropriate.

c. The conference may be scheduled within five (5) business days if the treating physician determines, that based on standard medical practice, the effectiveness of either the proposed treatment, services, or supplies or any alternative treatment, services, or supplies covered by SHP, would be materially reduced if not provided at the earliest possible date.

Retrospective Review

Retrospective review may be performed in the following circumstances:

1. Emergent care will be retrospectively reviewed for medical necessity appropriateness, initiation of further UM activity and for identification of educational opportunities.

2. Identified potential quality of care concerns.

3. Identify and analyze trends requiring potential further study.

4. Service has been provided and a claim submitted without prior review and approval.

5. As part of a claims review in order to match the authorization of services to charges received.

6. For high dollar cases that exceed usual and customary charges.

UM Key Service and Administrative Performance Indicators

SHP will monitor indicators measuring performance in key areas of the UM Department. Results will be assessed and reported to the MMC and MAC on a quarterly basis. Data will be analyzed to identify trends related to overutilization or underutilization of services and develop interventions to correct adverse trends, evaluate the interventions and make changes as needed to optimize outcomes and achieve goals. UM will review the demographics related to health care and social determinants of health for the health plan population, processes, resources as needed to meet members' needs and improvement opportunities. The indicators will be objective, measurable, reviewed by the MMC and MAC annually and revised as needed.

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 action plans. Monitoring results for these indicators will be reported to the MAC on a semi-annual basis and included in the semi-annual program evaluation.

1. Bed days per 1,000 (acute, long term acute care (LTAC) and skilled nursing facility (SNF)).

2. Admissions per 1,000 (acute, LTAC and SNF).
3. Average Length of Stay (acute, LTAC and SNF).
4. Acute, LTAC and SNF readmission rates.
5. Authorization and referral decision meeting turnaround times.
6. Number and trends of service denials and appeals.
7. Staff and physician consistency of criteria application audit results (inter-rater reliability report).
8. Delegation oversight activity.
9. CCM outcomes.

New Medical Technology or New Applications of Existing Technologies or Medications

SHP will monitor the use of new medical technologies including, but not limited to, medical and surgical treatments and procedures, pharmaceuticals and medical equipment, as described in SHP's policies and procedures using appropriate nationally recognized criteria or literature. SHP reviews requests of new technologies using Hayes Technology Experimental & Investigational, which are national guidelines that are reviewed and updated annually.

Consistency of Criteria Application Process

In order to assure that review decisions are consistent among UM Nurses and Physician Reviewers and that criteria is applied in a consistent manner (using inter-rater reliability testing) in accordance with adopted criteria. SHP may conduct quarterly audits of completed referral and authorization requests for the UM Nurses and the Physician Reviewers on process and decision-making compliance with regulations. The scope of such audits may include prospective, concurrent and retrospective review decisions.

Feedback and opportunities for improvement on audit results will be given to each UM nurse, non-clinical staff, or Physician Reviewer. Summaries of audit outcomes and trends will be provided to the MMC. The Medical Director and the Director of Utilization Management will collaborate to develop and monitor corrective action plans as needed. Refer to policy *SHPS 816 Interrater Reliability Audits* for additional details on this process.

IX. Authorization and Referral Responsibilities

Turnaround Time

Authorization and referral activities within the scope of the UM program turnaround time will be monitored on at least a quarterly basis and reported to MMC. SHP will comply with the most current Health Industry Collaboration Effort (HICE) commercial turnaround time standards. The MMC will evaluate results on a

quarterly basis to identify opportunities for improvement to ensure authorization processes do not impede SHP's or providers' ability to schedule appointments within timeframes established in the Timely Access and Network Reporting Statutes and Regulations.

The following actions and responsibilities are part of the authorization and referral process:

A. SHP Responsibility:

1. Verify eligibility and benefit coverage.

2. Ensure that requested facilities, physicians and other providers are participating SHP providers whenever possible.

3. Evaluate medical necessity, proposed place of treatment and treatment plan.

4. Coordinate with UM staff on the admission of a member to a non-participating hospital, if applicable.

B. SHP Medical Director Responsibilities:

1. Monitor compliance with the UM program authorization and referral criteria.

2. Ensure that internal and external corrective actions are taken when problems are identified.

3. Oversee the review of authorization and referral requests along with clinical documentation prior to issuance of a denial based on lack of medical necessity.

4. Oversee the review of medical necessity denials and obtain specialist physician review for questionable or difficult cases. Physician consultants from the appropriate specialty areas of medicine and surgery who are certified by the ABMS will be utilized as appropriate in the review process.

5. Coordinate and communicate information and decisions to network physicians.

C. Physician Responsibilities:

The PCP is responsible for submitting referrals to the UM Department and obtaining approval prior to rendering services for members assigned to him or her in accordance with SHP policies. Contracted providers involved in treating the member are also responsible for obtaining authorization approval in accordance with SHP policy. Failure to obtain required authorization may result in denial of claims for these services.

D. Hospital Responsibilities (may vary based on specific contractual arrangements with each facility):

1. Ensure that authorization approval is obtained for all planned admissions for SHP members. Authorization approval is evidenced by a notice issued by the UM Department.

2. If the hospital contacts the UM Department to verify authorization approval for a service and finds that one has not been obtained, the UM staff will contact the PCP or other treating physician and coordinate the review process for the hospital.

3. Hospitals shall notify SHP of all emergent admissions upon stabilization of the member's emergent condition so that SHP can begin the concurrent review and discharge planning process. SHP will accept notification that is greater than one business day when the facility had a delay is determining the member's eligibility. The burden of proof that the facility could not determine the member's eligibility falls on the facility.

X.Clinical Guidelines/Review Criteria

In making referral and authorization decisions, SHP utilizes MCG™ and other professionally recognized clinical care guidelines. SHP may also refer to guidelines published by Up-to-Date and Hayes or those developed internally and adopted by the MMC. Practice guidelines are adopted from the Agency for Healthcare Research and Quality (AHRQ) National Guideline Clearinghouse for evidence based clinical practice guidelines and preventive care. The clinical guidelines are:

1. Evaluated and updated, if necessary, at least annually in accordance with generally accepted standards of medical practice.

2. Consistent with sound clinical principles and processes.

3. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the covered individual's illness, injury or disease.

4. Developed with involvement from actively practicing health care providers and not primarily for the convenience of the covered individual, physician or other health care provider.

5. Not more costly than an alternative service or sequence of services that is equally efficacious for the diagnosis or treatment of that covered individual's illness, injury or disease.

6. Are disclosed by SHP to providers, members and the public upon request.

SHP uses MCG™ which are national guidelines that are reviewed and updated at least annually or when there is a change in guidelines that are nationally adopted.

The clinical care guidelines are based upon established national guidelines, where available, scientific literature and prudent practice. Guidelines are peer reviewed and developed by consensus. Clinical guidelines will be reviewed and adopted by SHP's MMC for use as appropriate within SHP's health care delivery system.

Based on the guidelines produced, the MMC will develop medical criteria and performance measures for the monitoring and evaluation of care provided to members. The MMC may appoint multi-disciplinary sub-committees to develop guidelines and criteria when available clinical guidelines do not have specific criteria. These sub-committees will have representation consistent with services provided and provider panel

membership.

In selecting topics for guideline development when clinical guidelines are not in place, SHP will consider:

1. High volume and/or high-risk services.
2. Procedures with unexplained variations in services.
3. Procedures used in the prevention, diagnosis, treatment, management, or outcomes related to the clinical condition; and
4. The cost of the condition to SHP and members.

Information regarding criteria for appropriateness of medical services is available upon request from participating providers. Information regarding criteria for appropriateness of mental health criteria is also available from the Mental Health Services Administrator.

Guidelines will be provided to providers as they are developed and revised through educational sessions, mailings, newsletters and/or updates to provider manuals. When applicable, newly developed or revised guidelines may also be provided to members through special mailings.

SHP will inform contracted providers, members and the public of the criteria or guidelines used to make UM decisions to authorize, modify or deny services upon request. Criteria used as the basis of a decision to authorize, modify, or deny services in a specific case under review will be disclosed to the provider, member or public upon request. Dissemination of criteria or guidelines will include the following disclosure notice:

> *"The materials provided to you are guidelines used by this Provider Group to authorize, modify or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."*

The SHP Provider Manual will include instructions for providers to utilize in requesting this information or assisting members to obtain this information. Where appropriate member communications and educational materials will include instructions on requesting this information.

XI. Utilization Review Decisions Timeframes

SHP ensures that UM program processes for review and approval, modification, delay or denial of medical and mental health care services and medical necessity denials are consistently applied and will not interfere with or cause delay in service or preclude delivery of services.

SHP ensures all medical necessity requests prior to or concurrent with the provision of health care services shall be made in a timely fashion appropriate for the nature of the member's condition, not to exceed five (5) business days from the receipt of the information reasonably necessary and requested by the utilization review process to make the determination. Pharmacy determinations are made within twenty-four (24) hours

for urgent/ expedited requests and seventy-two (72) hours for standard requests. A detailed explanation of utilization review decision timeframes are further described in policies *SHPS 875 UM Turn Around Time Standards.*

When the member's condition is such that the member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, requiring expedited review SHP's decision to approve, modify, or deny requests prior to, or concurrent with, the provision of health care services shall be made in a timely fashion appropriate for the nature of the member's condition, not to exceed seventy-two (72) hours after the receipt of the information reasonably necessary and requested to make the determination.

The Medical Director supervises the review of UM decisions and a qualified Physician Reviewer will review all denials.

For mental health services, SHP requires the involvement of a psychiatrist or other licensed mental health professional in decisions to deny or modify mental health services.

SHP ensures that upon receipt of the information, all decisions to approve, modify or deny requests will be communicated to the provider(s) within twenty-four (24) hours and members within one (1) calendar day of making the determination

SHP ensures that communications to providers regarding decisions to approve a request will specify the health care service approved, name of provider or facility approved, number to call to coordinate care and volume of services approved (if applicable).

SHP ensures care is not unduly delayed for medical conditions requiring time sensitive services and complies with regulatory required timeframes that are reasonably necessary to make the determination.

SHP will abide by the timeliness standards for medical determinations and notification of members and providers as referenced in the HICE UM Timeliness Standards for commercial members at (https://www.iceforhealth.org/library/documents/ICE_UM_TAT_Commercial_Standards_070116.doc)

SHP will send communication to the member and physician if a decision to approve, modify or deny the request for authorization will not be made within five (5) business days due to:

1. SHP not being in receipt of all of the information reasonably necessary and requested.

2. SHP requires a consultation by an expert reviewer, or

3. SHP has asked that an additional examination or test, provided the test is reasonable and consistent with professionally recognized standards of medical practice, be performed upon the member.

SHP shall immediately upon the expiration of the timeframe, or as soon as the utilization reviewer becomes aware, they will miss the timeframe, whichever comes first, notify the provider and the member in writing of the following:

1. That SHP cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe.

2. The anticipated date on which a decision may be rendered and include the following information:

    a. Specify the information requested but not received.

    b. The expert reviewer to be consulted, or

    c. The additional examinations or tests required.

XII. Benefit Determinations

UM staff checks benefit coverage of requests using the member enrollment data benefit coverage. When a benefit is not covered, a denial can be issued by the UM staff. Benefit determinations include the following.

A. Services in the member's benefit plan that are limited by number, duration or frequency in the member's benefit plan.

B. Extension of treatments beyond the specific limitations and restrictions imposed in the member's benefit plan.

C. Care or services that do not depend on any circumstances, such as the member's medical need or a practitioner's order.

D. Requests for personal care services, such as cooking, grooming, transportation, cleaning and assistance with other activity of daily living (ADL).

E. Services or procedure are excluded from coverage from the benefit plan.

Exceptions can be made to the benefit plan for coverage by the medical group. All benefit coverage denials based on a diagnosis are referred to the Physician Reviewer for determination. The existence of pre-existing conditions is not a consideration in benefit coverage determinations.

XIII. Medical Necessity Determination Process

UM staff obtain and review necessary clinical information and use clinical guidelines and criteria approved by the MMC and based on professionally recognized standards of practice in addition to their clinical expertise to determine the medical necessity of proposed care. The UM staff will consider the following factors when applying criteria to a given individual including age, co-morbidities, complications, progress of treatment, psychosocial situation and home environment (when applicable). Only information needed to make determinations will be collected. The UM decision-making process will not be overly burdensome for the member, the practitioner, or the health delivery staff. Characteristics of the local delivery system available to members such as skilled nursing or subacute care facilities and home care to support the member following hospital discharge and the ability of local hospitals to provide all recommended services within the estimated

length of stay must be considered.

Decisions about the following require medical necessity review:

1. Covered medical benefits defined by the Evidence of Coverage (EOC) or Summary of Benefit Description (SBD).

2. Preexisting conditions, when the member has creditable coverage and the EOC, SBD, or HCSP has a policy to deny preexisting care or services.

3. Care or services whose coverage depends on specific circumstances.

4. Dental surgical procedures that occur within or adjacent to the oral cavity or sinuses and are covered under the member's medical benefits.

5. Out-of-network services that are only covered in clinically appropriate situations, including but not limited to when the member has a specific need that requestor believes cannot be met in-network, a service or procedure not provided in network or delivery of services are closer or sooner than provided or allowed within the access and availability standards.

6. Prior authorizations for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program.

7. "Experimental" or "investigational" requests.

If the UM staff is not able to approve the proposed care based on the available information, he/she refers the case to the Physician Reviewer for review and determination of medical necessity. This includes modifications to requests.

XIV.Denial and Modification Determinations

A. When the UM staff is unable to approve proposed care or needs to modify proposed care, a physician (or pharmacist for denial or modification of a prescription drug) must review the request and any available clinical information, prior to issuance of any denial or modification based on lack of medical necessity. As a part of the review, the Physician Reviewer may discuss the case with the attending physician. Refer to policies *SHPS 809 Denials and Modifications* and *SHPS 875 UM Turnaround Times* for additional information.

B. Written notification to deny, delay or modify a request to a physician or other health care provider include:

1. A clear and concise written explanation for the decision to deny, delay or modify health care services.

2. A description of the criteria and/or guidelines used to make the final denial determination to deny, delay or modify health care services.

3. The clinical reason(s) for the decision to deny, delay, or modify health care services regarding medical necessity in easily understandable language.

4. The name and the direct telephone number of the provider/practitioner responsible for the denial, delay, or modification.

5. Information on how to request an IMR in cases where the member believes that health care services have been improperly denied, modified, or delayed.

6. Information as to how the member may file an appeal or grievance with SHP:

    a. Submit an appeal within one hundred eighty (180) days to appeal the decision through SHP's grievance/appeal process.

    b. Appeal to the DMHC Help Center to answer questions or help in appealing the decision through IMR if not satisfied with the decision made by SHP.

    c. A written copy of the criteria or benefit provision used in the decision upon request.

    d. Notification that the member may be represented by anyone the member chooses, including legal counsel, a friend, or other spokesperson, and have that representative act on their behalf at all levels of appeal.

    e. Submit written comments, documents or other information relevant to the appeal.

    f. Have benefits continue pending the resolution of the appeal and how to request continued benefits.

    g. Method of obtaining, a fair hearing to contest the denial, deferral, or modification action and the decision that SHP or the delegate has made.

C. Administrative denials that occur during the utilization review process for reasons other than medical necessity do not require review by a physician. Administrative denials may be made for:

1. The member lacks eligibility with SHP.

2. The requested service is a non-covered benefit.

D. On a retrospective review of claims for non-authorized (i.e. not previously submitted for authorization or referral review) care, a denial may be issued for the following reasons:

1. The services were non-covered benefits.

2. The member was not eligible for SHP benefits at the time care was provided.

3. The care was not medically necessary (as reviewed by a Physician Reviewer).

4. For lack of prior authorization in circumstances, where the provider has demonstrated a pattern of failing to obtain authorization prior to rendering the service. The provider will be instructed that the member will not be held financially responsible for the services in these cases.

E. On a retrospective review of claims for approved care, payment for services may be denied if it is found that information previously given in support of the approval was erroneous or the actual care provided was inconsistent with the care requested and approved and not medically necessary as determined by medical review.

F. A written denial notice of the decision for standard and emergent requests is provided to the ordering provider and the member, which includes, but is not limited to, the following:

1. The member or member's legal guardian, if the member is a minor or an incompetent adult.

2. The facility, if applicable.

3. The requesting physician or specialist, as applicable.

4. The member's PCP.

G. Denial determinations for emergent service requests will be communicated to requesting provider(s) initially by telephone, facsimile or electronic mail, and then in writing within twenty-four (24) hours of making the decision.

H. All determinations to deny, delay or modify a request will be sent to the member in writing, via regular mail or MyScripps patient portal. This written notice shall include:

1. A clear and concise written explanation for the decision to deny, delay or modify health care services.

2. A description of the criteria and/or guidelines used to make the final denial determination to deny, delay or modify health care services.

3. The clinical reason(s) for the decision to deny, delay, or modify health care services regarding medical necessity in easily understandable language.

4. Information on how to request an IMR in cases where the member believes that health care services have been improperly denied, modified, or delayed.

5. Notice of availability of translation and interpreter services.

6. Information as to how the member may file a grievance or appeal with SHP, including:

a. How to appeal within one hundred eighty (180) days to appeal the decision through SHP grievance/appeal process.

b. How to appeal to the DMHC Help Center for answering questions or help in appealing the decision through IMR if not satisfied with the decision made by the Plan.

c. A written copy of the criteria or benefit provision used in the decision upon request.

d. Notification that the member may be represented by anyone the member chooses including legal counsel, friend, or other spokesperson and have that representative act on their behalf at all levels of appeal.

e. Submit written comments, documents, or other information relevant to the appeal.

f. Have benefits continue pending the resolution of the appeal and how to request continued services.

g. Method of obtaining, a fair hearing to contest the denial, deferral, or modification action and the decision that SHP or the delegate has made.

I. Notifications of initial determinations:

1. Utilization review decisions will be communicated to requesting providers initially by telephone, facsimile or electronic portal, in writing within twenty-four (24) hours of making the determination.

2. Notification for emergent utilization review requests will be made immediately following the determination, by telephone and then in writing within twenty-four (24) hours of making the decision.

3. Notification for standard utilization review request notification will be made by telephone, facsimile or electronically through in-basket messaging/ portal or electronic mail within twenty-four (24) hours of making the decision and then in writing within two (2) business days.

4. Providers with direct view access to the electronic referral management system are expected to monitor the authorization request status online and arrange for services to be rendered immediately upon update of the request to an approved status in the system. It is the responsibility of the provider to notify the member telephonically and establish an appointment for the approved service.

5. For initial determinations on retrospective authorization requests, SHP will provide written notification of denials to practitioners and members within thirty (30) calendar days of making the decision.

6. In order to inform practitioners of how they may contact a Physician Reviewer to discuss a denial determination, all written denial notifications to the practitioner will include the name and phone number of the Physician Reviewer. If a denial has been issued due to lack of necessary information, and the requesting provider calls and submits the information, the practitioner who issued the initial denial may review the case with the new information and reverse the decision. This is not considered an appeal case by NCQA.

XV.Language Assistance Program

A. SHP provides qualified medical interpreters at no cost to members whenever a language or communication barrier exists. Interpretive services are or accessible by phone twenty-four (24) hours a day, seven (7) days a week.

B. Written materials will be available for each eligible limited English proficient (LEP) language group that constitutes 5% of the member population served (based upon the annual member language assessment). Written vital documents include:

1. Applications.
2. Consent forms, including any form by which a member authorizes or consents to any action by SHP.
3. Letters containing important information regarding eligibility and participation criteria.
4. Notices pertaining to the denial, reduction, modification or termination of services and benefits and the right to file a grievance or appeal.
5. Notices advising LEP members of the availability of free language assistance and other outreach materials that are provided to members.
6. SHP's Explanation of Benefits or similar claim processing information that is sent to a member if the document requires a response from the member.
7. All member disclosures.

C. The member's preferred language for medical communication will be documented in the member's record for communication to staff. Staff will utilize interpretive services when providing critical medical communications. Providers are encouraged to access interpretive services at any time to support member communication. Communications considered "critical", or medical in nature, generally include, but may not be limited to:

1. Consent and/or acknowledgement of information discussion.
2. Advance directive discussion.
3. Resuscitation or do not resuscitate discussion.
4. Explaining any diagnosis and plan for medical treatment.
5. Explaining any medical procedures, tests, or surgeries.
6. Initial and discharge medication education.
7. Member complaints, appeals and grievances.
8. Discharge instructions.

D. Members may, after being informed of the availability of interpreters who are qualified to interpret medical information at no charge, select an individual of their choice to assist with their communication needs. Member refusal of SHP interpretive service should be documented in the member's record in addition to the name of the individual that the member had selected to perform interpretation. Staff members may

access a SHP medical information interpreter if at any time they feel there is a communication barrier with the interpreter selected by the member.

E. Notices advising members and families of the availability of translation and interpreter services at no cost, procedures for obtaining assistance and lodging complaints are included in service determination letters sent to members to deny or modify a requested service. Procedures for obtaining assistance and lodging complaints are displayed in public areas on the patient rights posters and Member Rights and Responsibilities handouts.

F. Education on interpretive services is provided during new employee orientation, annually through the Learning Management System (LMS) and in department meetings.

G. Member complaints and concerns must be directed to the appeals and grievances team.

H. Responding to a member requesting translation of any non-standard vital document by customer service representative (CSR):

1. CSR enters a customer relations module ticket (CRM) in Epic for interpreter or translation request.

2. If the member cannot communicate effectively in English, the CSR will attempt to verify the member's preferred spoken language. While member is holding, CSR contacts the interpreter services line and will put member back on the line once connected to an interpreter.

3. The CSR retrieves the letter or document requested and submits to customer service leads to be translated by Cyracom.

4. The CSR notifies caller that the letter will be sent to the vendor for translation. Customer service leads are responsible for sending the document to the vendor within the timeframes below:

    a. Urgent request or service: **One (1) business day.**

    b. Non-urgent or post-service request: **Two (2) business days.**

5. The CSR documents in the CRM when it was sent, the number and names it was faxed to.

6. The CSR also documents if the member refuses the translation service.

XVI. Appeals

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 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 appeal process

provides a written acknowledgment of a member's routine grievance or appeal within five (5) days of receipt. SHP's appeal process shall provide for the receipt, handling, and resolution of appeals within thirty (30) days of receipt. SHP's grievance system allows members to file appeals for at least one hundred eighty (180) calendar days following any event or action that is subject to the member's dissatisfaction.

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

Procedures are in place to escalate appeals for all urgent care needs 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 appeals, SHP will acknowledge the appeal within twenty-four (24) hours of receipt. All levels of urgent appeals will be resolved and responded to within three (3) calendar days or less, upon receipt of the appeal. An urgent 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 his/her enrollment has been or will be improperly canceled, rescinded or not renewed.

SHP's appeal process is designed to document and resolve member issues expeditiously and equitably in accordance with regulatory guidelines. To meet the required thirty (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 (as applicable), 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 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.

SHP has Appeal and Grievance system controls in place to manage Appeal and Grievance decisions including but not limited to denial upholds based on medical necessity decisions, receipt date, written notification, recording date, modified dates, timeliness of Appeal and Grievances decisions, and notification history. These controls protect Appeals and Grievance data from unauthorized modification or being altered outside of prescribed protocols. Audit procedures are in place to monitor the effectiveness of system controls as needed (at least annually). Any noncompliance is documented with oversight performed by SHPS Compliance department.

XVII.Delegation of UM Responsibilities

SHP may delegate responsibility for performing UM functions to contracted entities that meet SHP's standards for delegation. SHP will perform annual on-site and desktop audits of delegated entities to assure compliance with standards and to assure that the care provided by the delegated entity is based on professionally recognized standards of practice. Delegation oversight will be performed by the Delegation

Oversight Department under the direction of the Regulatory Oversight Committee. Although oversight of all UM activity is the responsibility of SHP MMC, medical groups with whom UM responsibilities have been delegated will maintain a quarterly UM Committee meeting to share SHP standards and MMC information. Delegation oversight activities include:

A. A pre-delegation assessment to verify the delegation candidate has the appropriate mechanisms and processes in place to fulfill the UM 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, system controls, and the clinical criteria/guidelines used in providing care to members and will be completed prior to delegated activities are performed.

B. Annual on-site or desktop review and approval of the delegate's UM program, policies and procedures, and documents used within the medical group. The annual audit will include a file review using NCQA methodology.

C. Execution of a delegation agreement which describes functions delegated, areas of responsibility, oversight procedures and reporting requirements, as needed.

D. At least semi-annual reports of delegation activity, including findings and actions taken as a result of UM activities, to the ROC and MAC. Delegated activities will also be addressed in the semi-annual report provided to the MAC.

E. SHP ensures that the following requirements are met by each delegate:

    1. Provides documents necessary for SHP to conduct oversight such as:

        a. UM Program Description.

        b. UM and other relevant policies and procedures.

    2. Has a designated Medical Director who holds an unrestricted license to practice medicine in California.

    3. The Medical Director's position description shall include substantial responsibility for providing clinical direction and oversight of the UM program.

    4. Has written criteria or clinical guidelines for UM decisions that meet the requirements and are clearly documented for each UM function along with the procedures for use and application of the criteria in making medical necessity determinations consistent with Section 1363.5 which must be:

        a. Developed with involvement from actively practicing health care providers.

        b. Consistent with sound clinical principles and processes.

        c. Evaluated and updated, if necessary, at least annually.

d. Disclosed by the delegate to providers, members, and the public upon request.

5. Submission of a UM Program Description and CCM Program Description (if applicable).

6. Quarterly submission of UM statistics and CCM statistics (if applicable).

7. Annual submission of UM Information Integrity (System Controls) report.

8. UM statistics may include:

   a. The number of UM cases handled by type (pre-service, urgent concurrent, or post-service) and by service (inpatient or outpatient).

   b. Denials made and reasons for denial.

   c. The number of cases appealed; and

   d. Turnaround times.

9. Annual audit of UM files such as reports on UM medical necessity denials, medical necessity and benefit appeals, hospital admissions, length of stay, referrals, denials and inpatient days per 1,000 members.

10. Evidence of performance of an annual evaluation and update of the delegate's UM program and evidence of review by the appropriate committee/s such as through committee meeting minutes and records of communication with the delegate.

11. Delegate's UM program has clear policies and procedures including utilization review processes such as pre-service, concurrent and retrospective review.

12. Delegate's UM program has a clearly stated policy that denials of coverage for reasons of medical necessity are made by a qualified licensed physician or health care professional.

13. Delegate provides telephone access for providers to request authorization for health care services.

14. Delegate's timeframes for UM decisions are within commercial regulatory standards and regulations complying with all applicable access standards and accessibility turnaround times.

15. Delegate provides timely responses in accordance to mandated timeframes for decisions and communication to both requesting provider and members.

16. Delegate's written notification for denials includes:

   a. Name and direct contact number for the professional responsible for a denial, delay, or modification of an authorization request.

   b. Clear and concise explanation of the reasons for the delegate's decision, a description of the

criteria used and clinical reasons for the decision regarding medical necessity.

c. Information on how to file a grievance with SHP and the DMHC and information on how to request an IMR.

17. Delegate assesses the quality of its UM program and processes and takes appropriate action when problems are identified.

18. Delegate has emergency health care services available and accessible within the service area twenty-four (24) hours a day, seven (7) days a week.

19. Delegate reimburses for emergency services provided to its members until the care results in stabilization of the member and the delegate shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the member's emergency medical condition.Delegate denies reimbursement to a provider for a medical screening examination only in cases where the services and care requested were not an emergency.Delegate's monitoring of their UM and Appeals (if applicable) system controls at least annually to protect data from unauthorized modification and/or deletion.

F. SHP oversees the delegate to ensure that the delegate is properly performing the functions. Corrective actions will be given for any element that does not meet SHP's threshold. SHP may de-delegate delegated functions at any time.

G. SHP retains ultimate accountabilities for all functions delegated to another party. SHP has policies and procedures for monitoring its delegated entities including methodology and conducts regular oversight of the UM program for each of its delegated entities for compliance with its established UM standards.

H. Refer to compliance policy ***SHPS 1210 Delegation of Plan Responsibilities*** for details of oversight activities and delegation agreement template.

XVIII. Confidentiality and Conflict of Interest

All aspects of UM 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.

UM records and member files are maintained within SHP's electronic health record (EHR). Any records not maintained within the EHR shall be maintained in SHP administrative offices and/or on a secure cloud-based repository. Correspondences to the member will be kept in the member's file.

Conflicts of interest include any nature of relationship with the beneficiary or the provider under review, including familial relationships, treating relationships, or other such close personal associations; currently having, or previously having had, a fiduciary relationship with a provider under review or the manufacturer or

distributor of a drug, device, or other product under review; or having any other involvement in a case under review which has the capacity to impair the judgement of the reviewer in making or informing a determination. 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.

Included in the Conflict of Interest, Nondisclosure, and Nondiscriminatory Statement, that is signed annually, is an attestation that individual reviewers are not financially incentivized, motivated, or otherwise rewarded for issuing modifications and/or denials of requested health care services and have not been offered any financial incentives that would encourage a decision that would result in underutilization or reduce or limit medically necessary care. This information is available to both members and providers via the SHP website. In addition, SHP distributes the affirmative statement about incentives annually to members and providers by mail, fax, or email.

XIX. Experience with the UM Processes [Member and Provider]

The MMC evaluates member and provider satisfaction with the UM program on an annual basis through member and provider satisfaction surveys. Assessing satisfaction allows the MMC to identify potential unfavorable effects of the UM program. It also allows identification of aspects of the UM program that are serving members well. As opportunities for improvement are identified, the MMC will recommend actions to improve performance and meet member/provider expectations.

A. Gather and use the information that specifically addresses member and provider satisfaction.

B. The survey includes:

1. The member and provider satisfaction with the process of getting a service approved, obtaining a referral, and managing a case for the provider.

2. UM questions specific to the overall process.

3. Soliciting feedback from members and providers who have appealed a UM determination or have been involved in appeals related UM determinations.

4. Tracking member and provider complaints specifically related to UM by category and research trends further when SHP has three (3) same/similar complaints or more in a six (6) month period.

C. SHP uses Press Ganey/CAHPS survey results.

D. Benchmarks outlined in workplan.

E. Present opportunities identified for improvement at MMC so recommended action plan can be made to improve the member and provider experience.

XX. Program Evaluation

The UM Program Description and UM Work Plan are subject to an annual review with revision, if appropriate. The UM Program Description and the UM Work Plan will be reviewed and approved by the MMC and MAC. The HICE tool and process will be utilized for the UM Work Plan.

XXI. System Controls

SHP has UM system controls in place to manage UM decisions including but not limited to denials based on medical necessity decisions, receipt date, written notification, recording date, modified dates, timeliness of UM decisions and notification history. These controls protect UM data from unauthorized modification or being altered outside of prescribed protocols. Audit procedures are in place to monitor effectiveness of system controls. Any noncompliance is documented with oversight performed by the SHPS Compliance department.

SHP has policies describing its system controls specific in place for UM denial and appeal notification dates. Refer to policy *SHPS 889 UM System Control* for additional details.

XXII. UM Trend Analysis for Quality Improvement

SHP UM program is committed to our mission of providing superior health services in a caring environment and making a positive measurable difference in the health of individuals in the communities we serve. Our UM program has been developed to work collaboratively with SHP QI program to provide a framework for analyzing the utilization of services provided to members and evaluating SHP data against national and regional benchmarks with the goal of continuous quality improvement. This framework includes, but it not limited to, reporting identified in policy *SHPS 827 Monitoring of Over/Under Utilization, Avoidable Days and Bed Days.*

APPROVAL SIGNATURES

DocuSigned by:
Deborah Bennett
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2/11/2025

Director, Utilization Management — Date

APPROVED BY:

Signed by:
Russell Zane, MD
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Chairperson, MMC — Date

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2/11/2025

Chairperson, MAC — Date