PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

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I. RELATED POLICIES:

A. CMP10 – Confidentiality
B. MPQP1008 – Conflict of Interest Policy for QI Activities
C. MPQP1016 – Potential Quality Issue Investigation and Resolution
D. MPCR602 – Reporting Actions to Authorities
E. CMP36 – Delegation Oversight and Monitoring
F. MPQG1011 – Non-Physician Medical Practitioners & Medical Assistants Practice Guidelines

II. IMPACTED DEPTS:

Health Services

III. DEFINITIONS:

A. Non-Physician Medical Practitioners (NPMP): NPMP's are defined as nurse practitioners (NP), physician assistants (PA), certified nurse midwives (CNM) and licensed midwives (LM).
B. Partnership Advantage: Effective Jan. 1, 2028, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Enrollees will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook. Coverage criteria apply on implementation of D-SNP, effective Jan. 1, 2028 and subject to CMS and DHCS approval.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The Peer Review Committee (PRC) reviews concerns and complaints about the quality of clinical care and services provided to Partnership HealthPlan of California's (Partnership's) members and makes recommendations for actions to prevent reoccurrence of any issues. The PRC also reviews sentinel conditions identified as having quality concerns. PRC discussions and documents are protected by federal and state laws (Cal. Civ. Code §43.7.) governing confidentiality of health care peer review activities conducted in good faith.

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VI. POLICY / PROCEDURE:

A. Committee Structure

1. Membership
   a. The PRC is comprised of one or more licensed physicians in primary care (e.g., Family Medicine, Internal Medicine or Pediatrics), and one or more specialist physicians (e.g., OB/GYN, General Surgery) currently practicing in hospitals, medical groups, and practice sites contracted with Partnership or otherwise regularly seeing Medi-Cal members. Medi-Cal population experienced physicians who have retired from practice within the last two years are also eligible to serve on the PRC. There will be a minimum of three external physician members on the PRC. There is no upper limit to the number of standing members on the PRC.
   b. NPMPs as defined in MPQG1011 who are currently practicing within Partnership's service area may also serve as PRC members. There is no defined number of any type of NPMP who may serve on the PRC.
   c. The PRC's external clinicians are a subset of the voters of the Quality/Utilization Advisory Committee. As a confidential body, however, the PRC does not report case specifics to the Q/UAC, which is a Brown Act committee. PRC caseload numbers are reported in aggregate by quarter twice each year to both the Q/UAC and the Physician Advisory Committee (PAC).
   d. Partnership staff physicians are also voting members of the PRC and include, but are not limited to, the Chief Medical Officer, the Deputy Chief Medical Officer, the Medical Director for Quality, the Behavioral Health Clinical Director, the Medical Director for Medicare Services, and Regional and Associate Medical Directors, as assigned by the CMO.
   e. Additional Partnership non-voting staff attending and supporting the PRC include the Director of Pharmacy or designee; the Director of Health Equity; and members of the Member Safety Quality Inspection and Quality Investigation teams.
   f. Members serve open terms and may elect to resign at any time by formally advising the chair.
   g. Members with annual attendance of < 50% may be barred from future participation in the PRC.
2. Chair: The Chief Medical Officer (CMO) chairs the PRC. When the CMO is unavailable, the Medical Director for Quality is the designated chair. A Regional or Associate Medical Director acts as the temporary chair when needed. The role of the Chair is to assure that all quality matters and concerns are evaluated thoroughly, that there is adequate input to the discussion, that a reasonable effort is made to obtain the facts of the matter, and that matters are fully investigated and any required actions are completed. The Chair must ensure that the process follows protocol; is always fair and unbiased; and, that any providers under scrutiny are afforded due process, receiving adequate notifications and opportunities to respond to the concerns under investigation.
3. Meetings: The PRC meets at least quarterly and on an as-needed basis.
4. Dual Capacity: External physicians and NPMPs are also voting members of the Quality/Utilization Advisory Committee (Q/UAC).
5. Compensation: External members are eligible to receive a financial stipend for each Q/UAC **or** PRC meeting attended to compensate them for travel time and time away from work.
6. Voting: Internal and external physician and NPMP members constitute the voting membership, with the Chair serving in a tie breaking capacity as necessary. A quorum is not required for a meeting to occur, except where formal action needs to take place or in instances where the Chair determines that a quorum is necessary. In this case, the PRC's quorum is comprised of more than 50% of the voting membership. The Chair may not be counted for purposes of a quorum.
   a. NPMPs may vote to score providers and/or systems only in areas in which they possess subject matter expertise. For example, CNMs and LMs may vote only in cases involving obstetrics. Nurse Practitioners and PAs may vote only in cases involving their area(s) of practice, such as outpatient primary care, hospital care, pediatrics, internal or family medicine.
7. Confidentiality: To preserve an atmosphere promoting free and open discussion between and among

committee members, each external member signs an annual Confidentiality Statement prepared and retained by Partnership. This statement signifies the intent to protect individuals against misuse of information and to ensure that all information, medical or otherwise, regarding patients, practitioners and providers is handled in a confidential manner. Partnership staff are governed by similar confidentiality policies, as required elements of employment.

8. Conflict of Interest: The integrity of the Peer Review process requires prevention of input and decision making where a conflict of interest exists. All non-Partnership clinicians taking part in the peer review process, including those on the PRC, are required to adhere to Partnership's Conflict of Interest (MPQP1008) policy. Each external PRC member signs an annual Conflict of Interest Statement prepared and retained by Partnership. Partnership staff are governed by similar conflict of interest policies.

B. Committee Responsibilities
   1. The PRC will carefully review the clinical care in all situations in which a quality of care concern has been raised and forwarded for committee review. See MPQP1016 - Potential Quality Issue Investigation and Resolution for details of this process.
   2. The PRC will evaluate the quality concern related to clinical care and determine whether there is sufficient evidence that the involved practitioner failed to provide care within generally accepted standards.
   3. Minutes are maintained according to the Confidentiality policy CMP10.
   4. External Peer Review
      a. Circumstances that require external review:
         1) Referral for "medical specialist review" when the PRC membership does not include members with adequate expertise or training to fully evaluate the quality of care concern.
         2) The PRC cannot make a determination and requests external review.
         3) An individual whose case is under review requests external peer review.
         4) When dealing with potential litigation that might affect a provider's contracted status.
         5) When dealing with ambiguous or conflicting recommendations from internal reviewers, or when there does not appear to be a strong consensus for a particular recommendation.
   5. Subcommittees: Complex or specialized peer review issues may be reviewed by a PRC subcommittee. These subcommittees meet on an *ad hoc* basis when cases identified through the peer review process require specialized peer review. A minimum of three clinicians are assigned to any peer review subcommittee. A minimum of 50% of subcommittee members must participate to take action. The notes, findings, and recommendations of the peer review subcommittee are presented to the next regular peer review meeting for deliberation. The principles of evaluation, confidentiality and recommended rating are the same as for the PRC as a whole. *Ad hoc* subcommittees may be created at the discretion of the CMO or PRC. There are two standing subcommittees:
      a. Medication Safety Subcommittee: This subcommittee evaluates potential quality issues referred by the Quality department related to appropriate use of opioid medications in patients with a diagnosis of chronic pain. Members of this subcommittee will include at least one specialist board certified in pain management and one behavioral health provider.
      b. Substance Use Services Subcommittee: This subcommittee evaluates potential quality issues referred by the Quality department related to the provision of services related to the treatment of Substance Use Disorder (SUD). The subcommittee will be chaired by the Behavioral Health Clinical Director and include at least one outside specialist experienced in addiction treatment or in addiction medicine.

C. Confidentiality
   1. As specified in State statute (Cal. Civ. Code §43.7.), peer review activities are not subject to discovery. The members of the PRC and the records associated with its reviews and actions shall be

afforded all of the immunity, protection and privileges under California law. A practitioner under review shall be afforded all rights and protections under California law. The PRC and the CMO shall take all reasonable steps to protect the confidentiality of the committee's deliberations, reviews and actions, including all information obtained at all stages of the investigation, review and decision making process. Any confidential health information obtained during the course of peer review investigations shall be protected from loss, tampering, alteration and unauthorized or inadvertent disclosure of information.

D. Indemnification
   1. Partnership will indemnify, defend and hold harmless the members of the PRC from and against losses and expenses (including attorneys' fees, judgments, settlement and other costs, direct or indirect) incurred or suffered by reason or based upon any threatened, pending or completed action, suit, proceeding, investigation or other dispute relating or pertaining to any alleged act or failure to act within the scope or quality assessment activities as a member of the PRC. Partnership will retain the responsibility for the sole management and defense of any such claims, suits, investigations or other disputes against PRC members, including, but not limited to, selection of legal counsel to defend against any such actions. The indemnity set forth herein is expressly conditioned on the PRC member's good-faith belief that his or her actions and/or communications are reasonable and warranted and in furtherance of Partnership's peer review, quality assessment, or quality improvement responsibilities. In no event will Partnership indemnify a member for acts of omissions taken in bad faith or in pursuit of the member's private economic interests.

E. Oversight
   1. The PRC is accountable to Partnership's Board of Commissioners on Medical Care.

F. Delegation Oversight and Monitoring
   1. Partnership may delegate Potential Quality Issue (PQI) investigation, including PRC oversight.
   2. A formal agreement is maintained and inclusive of all delegated functions.
   3. Partnership will review related policies and procedures and annual summary reports of findings and actions taken as a result of the PQI review process and provide feedback as part of Partnership's annual oversight audit.
   4. Results from Oversight and Monitoring activities shall be presented to the Delegation Oversight Review Sub-Committee (DORS) for review and approval.

VII. REFERENCES:

A. Cal. Civ. Code §43.7 - Immunity from Liability; Mental Health Professional Quality Assurance Committees; Professional Societies, Members or Staff; Peer Review or Insurance Underwriting Committees; Hospital Governing Board

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=CIV&sectionNum=43.7.

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer or designee

X. REVISION DATES:

Medi-Cal

09/17/14; 11/19/14; 01/20/16; 3/16/16; 3/15/17,* 06/13/18; 05/08/19; 5/13/20; 5/12/21; 06/08/22; 06/14/23; 02/14/24; 02/12/25; 02/11/26; 10/14/26

Partnership Advantage (effective Jan. 1, 2028)
N/A

*Through 2017, Approval Date reflective of the Quality Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:
N/A