blue california
Promise Health Plan

Policy Title: Medical Services Committee Functions		POLICY #: 70.2.49 Line of business: ALL	
Department Name: Utilization Management	**Original Date** 1/02	**Effective Date** 5/19	**Revision Date** 12/18, 1/22
Department Head: Sr. Director, UM		**Date: 4/25/22**	
Medical Services/P&T Committee: (If Applicable) PHP CMO		**Date: 4/25/22**	

PURPOSE

To define the role and responsibilities of the Medical Services Committee.

POLICY

The Medical Services Committee is responsible for the oversight of the UM Program and reports to the Board of Directors.

PROCEDURE

The Medical Services Committee is composed of the Blue Shield of California Promise Chief Medical Officer (CMO) who chairs the committee along with membership assigned to include primary care physicians and a representative sample of specialty care providers. The term of membership is for one year with reappointment by the committee and approval by the Board of Directors. There is no limit on the number of terms a member may serve.

The committee operates by majority rule with only physician members of the committee having voting privileges. A quorum is established with a minimum of three (3) physician members in attendance.

All committee members and participants will maintain the standards of ethics and confidentiality regarding patient information and proprietary information.

Some of the UM Data reviewed by the (MSC) includes but it not limited to;
The following reports are reviewed at the MSC and QMC Meetings:

- Medical Utilization Management:
  - Hospital bed activity by admit, LOS, unit type and level of care
  - Specialty referrals
  - Referrals that are approved, deferred, modified, and denied
  - Turnaround time compliance
  - ER utilization patterns
- Care Management
- Pharmacy Utilization Management
- Appeals and Grievances

- Quality
- Regulatory Compliance
- CCS Program Performance Update
- Other reports as requested by the QMC

The Medical Services Committee meets on a quarterly basis and is responsible for the following:

- Reviewing UM data and process performance
- Reviewing all relevant related program data and performance, including care management, population health management, behavioral health, social programs, and health education.
- Approving clinical criteria used in making UM decisions annually
- Reviewing and approving the UM program Description, UM Work Plan, Policies, and Procedures annually and on an ongoing basis
- Reviewing member and provider satisfaction survey results, including identifying deficiencies related to UM and approving corrective action plans
- Reviewing, evaluating, and making recommendations regarding UM activities, including reports of provider utilization practice patterns
- Providing input and recommendations to update the UM program, in response to application of new and existing medical technologies
- Referring identified providers or practitioners needing remedial or corrective action to the QM or Peer Review Committees
- Making recommendations for educational information and programs for contracted practitioners and provider network
- Reviewing issues that may be considered detrimental to the delivery of cost-effective, quality outcomes, such as:
    - Over- and under-utilization analysis: identified through practitioner/provider profile reports,
    - monitoring medical services and readmission patterns
    - Monitoring and addressing patterns of unused authorizations

REFERENCES