Capital Health PLAN℠

An Independent Licensee of the Blue Cross and Blue Shield Association

Medicare Medical Quality Improvement Program Description

2023

Approval by Board of Directors: 12/90, 12/92, 2/1/94, 2/27/96, 6/3/97, 2/18/98, 5/17/99, 8/22/00, 3/13/01, 11/20/01,12/17/02, 3/9/04, 3/15/05, 2/21/06, 3/13/07, 12/18/07, 12/16/08, 12/22/09, 11/30/10,11/22/11, 11/27/12, 11/19/13, 3/31/15, 3/29/2016, 3/28/2017, 3/20/2018, 3/20/2019, 03/03/2020, 03/2021,1/2022, 1/2023

CAPITAL HEALTH PLAN
MEDICARE QUALITY IMPROVEMENT PROGRAM DESCRIPTION

INTRODUCTION

The purpose of Capital Health Plan (CHP) is to provide people in Leon and surrounding counties (a nine-county area of northern Florida) with high quality, affordable health care that: 1) focuses on delivery of evidence-based medical care under the direction of primary care physicians in an effective, timely and cost-effective manner 2) emphasizes low administrative costs and ethical business practices 3) is proactive and innovative in its quest to continually improve the health of the community. CHP incorporates this Quality Improvement (QI) Program as an integral part of its operation.

The Health Plan, a not for profit corporation, was incorporated in 1978. The first members were enrolled in 1982. The plan serves the area of Leon and the surrounding counties of Jefferson, Wakulla, Gadsden, Calhoun, Liberty, Madison, Liberty and Franklin. The Medicare membership as of October 1, 2022, is 23,536. The most recent demographic information from the 2022 NCQA CAHPS Member Satisfaction Survey indicates that 85.78% of the CHP Medicare population is Caucasian, 13.49% is African American and <1% is of other ethnicities. Language translation services are available in the event the member does not speak English.

As a mixed model HMO, there are currently 705 practitioners in the CHP network; 180 are primary care physicians (PCPs) and 525 are physician specialists. The PCPs include 102 family physicians, 27 pediatricians, and 50 internal medicine physicians. CHP employs 25 PCPs, 1 radiologist, 5 Urgent Care physicians, and 8 optometrists. The remaining PCPs or specialists practice independently or in affiliated group practices. In accordance with the State of Florida law, patients have direct access to podiatrists, chiropractors, dermatologists, and gynecologists.

SCOPE

Capital Health Plan provides comprehensive Medicare Advantage Part C and D services through retiree and individual Medicare Advantage Part D (MAPD) plans and an integrated health care delivery system for Medicare beneficiaries. The following facilities are available to the membership:

- Six (6) primary hospitals provide inpatient hospital services; (Calhoun/Liberty, Weems, HCA, TMH, Madison and DMH)
- Seventeen (17) outpatient facilities provide home health and hospice services;
- Eleven (11) skilled nursing facilities provide extended care/rehabilitation services;
- Fourteen (14) outpatient facilities provide rehabilitation therapy and durable medical equipment services;
- Nine (9) outpatient surgical facilities; and
- Nine (9) dialysis centers

The following health plan activities are included in the scope of CHP's Medicare QI program:

- Clinical/service quality
- Patient safety/risk management
- Physician and hospital quality
- Pharmacy management and medication safety
- Credentialing and re-credentialing
- Utilization management
- Access and availability to healthcare services
- Culturally and linguistically appropriate services
- Continuity and coordination of care
- Chronic care improvement program
- Complex case management
- Population Health and disease management programs
- Wellness program and activities
- Member connections
- Delegation monitoring and oversight
- Member rights and responsibilities
- Privacy and confidentiality

QUALITY IMPROVEMENT PROGRAM OBJECTIVES

CHP strives to continually improve health care services by pursuing the Institute of Healthcare Improvement's 'Triple Aim' to improve the experience of care, the health of populations, and to reduce per capita costs of health care. These improvement activities are consistent with the National Strategy for Quality Improvement in Health Care in the report to the United States Congress in March 2011.

Quality improvement initiatives that support The Triple Aim and the National QI Strategy will include integration of health care systems of care, redesign of primary care services and structures, population health management, and improvements to financial management systems. CHP's staff practices continue to maintain a primary care 'medical home' model to ensure that health care services are safe, patient-centered, timely, effective, and efficient. Measurement systems and improvement initiatives are implemented to continually improve culturally and linguistically appropriate services, ensuring that the health care delivered is equitable for all members.

VISION OF QUALITY FOR CAPITAL HEALTH PLAN

CHP maintains a reputation as a local, state, and national leader in quality of care and service through:

- Medicare CMS star rating of 4.5
- Medicare NCQA rating of 4.5 stars
- Medicare NCQA Accreditation
- Industry-leading benchmark performance on clinical outcome measures
- Industry-leading member satisfaction
- Very low (<2%) voluntary disenrollment

QUALITY IMPROVEMENT PROGRAM STRATEGIC GOALS

NATIONAL AIMS[1]:

- Better Care
- Healthy People/ Healthy Communities
- Affordable Care

NATIONAL PRIORITIES[2]:

- Engage patients and families in managing their health and making decisions regarding their care;
- Improve the health of the population;
- Improve the safety and reliability of America's healthcare system;
- Ensure that patients receive well-coordinated care within and across healthcare organizations, settings and levels of care;
- Ensure appropriate and compassionate care for members with life-limiting illnesses; and
- Eliminate overuse while ensuring the delivery of appropriate care.

CLINICAL CARE

- Achieve scores on HEDIS clinical measures that demonstrate national leadership (Rating of 5.0);
- Evaluate and prioritize clinical measures based on the overall value to members;
- Maintain a dialogue with the best "delivery system" health plans in the country;
- Provide community leadership in access, satisfaction, clinical outcomes, the care of chronically ill, and efficiency through the "Medical Home" model provided by staff practices (PCPs, Urgent Care, and selected specialists);
- Promote evidence-based clinical practice within the network;
- Implement interventions to decrease rates of hospital readmissions within 30 days;
- Implement interventions to reports to decrease inappropriate ER usage;

[1] Source of National Aims: Report to the U.S. Congress, National Strategy for Quality Improvement in Health Care, November, 2016. Accessed from www.AHRQ.gov/workingforquality/about/agency-specific-quality-strategic-plans/nqs3.html on February 4, 2021

[2] Source of National Priorities: National Priorities Partnership convened by the National Quality Forum, November 2008

- Improve the health status of members through preventive/wellness activities, population health, disease management, case management, and a chronic care improvement program for members with complex conditions;
- Coordinate clinical care to ensure seamless delivery of healthcare services across the Network; and
- Create incentives that align goals of the health plan, practitioners, and health plan staff.

MEMBER/PRACTITIONER SATISFACTION

- Achieve and maintain scores for CAHPS Rating of Health Plan measure that exceeds the 90th national percentile;
- Achieve scores on CAHPS member satisfaction survey questions that demonstrate national leadership (rating of 5.0);
- Evaluate and prioritize survey measures based on the overall value to members; and
- Maintain optimal practitioner satisfaction by targeting issues identified through practitioner satisfaction surveys.

ACCESS AND AVAILABILITY TO CARE AND SERVICES

- Maintain affordability of CHP's products;
- Provide a superior level of access to urgent care, primary care, eye care, infusion services and other network services;
- Continually improve member access to health services, with particular emphasis on vulnerable populations (ex. Nancy Van Vessem M.D. Center for Healthy Aging); and
- Strive to meet member expectations by achieving access and availability targets.

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

- Evaluate cultural needs of members including race, ethnicity and language, implementing interventions to improve the availability of services when improvement opportunities are identified;
- Measure and analyze clinical quality measures in the Medicare population stratified by race/ethnicity to identify opportunities to reduce health care disparities, implementing interventions when appropriate; and
- Maintain compliance with the Affordable Care Act, Section 1557 (implemented in 2016)

.PATIENT SAFETY

- Monitor and implement interventions to improve performance on HEDIS and CMS star rating patient safety measures;
- Monitor and address adverse events, medication errors, adverse drug events and quality of care issues through incident reporting, analysis and interventions;
- Provide members with access to provider and practitioner-patient safety information;
- Conduct reporting of patient safety data according to applicable state and federal regulations; and
- Implement interventions to ensure safety at CHP facilities through the CHP Safety Committee.

QUALITY IMPROVEMENT/ ACCREDITATION

- Achieve a Medicare CMS 5.0 Star Rating;
- Maintain an NCQA Medicare Star Rating of 4.5;
- Maintain NCQA Medicare Accreditation;
- Maintain compliance with state and federal regulations related to quality improvement;
- Implement and maintain an annual QI project in compliance with CMS's Chronic Care Improvement Plan (CCIP) requirements;
- Implement interventions to improve 2023 priority measures identified in the 2023 Medicare QI Work plan and the Star Workplan as measures with scores less than 5 Stars. Maintain current ongoing interventions for measures scored at 5 stars;
- Integrate quality improvement processes throughout Capital Health Plan and its healthcare delivery system, striving to integrate quality improvement at every level of the organization;
- Integrate procedures for monitoring and ensuring compliance with NCQA standards in

departments that provide the specified services. Maintain overall oversight monitoring procedures to ensure that CHP achieves the highest accreditation scores possible which will contribute to optimal national rankings;
- Allocate and distribute resources necessary to support QI initiatives;
- Integrate enrollee feedback into the design of the QI program through analysis of member satisfaction and complaint data;
- Expand and standardize quality measurement and reporting capabilities through the network;
- Develop the capability to submit HEDIS data electronically (new ECDS measures); and
- Develop procedures to provide timely and accurate HEDIS member and physician level data necessary to develop interventions to improve results.

ACCOUNTABILITY OF THE GOVERNING BODY

The Capital Health Plan Board of Directors maintains the ultimate accountability for the QI program. The Healthcare Delivery Committee, a committee of the Board, provides direct oversight to the QI program through quarterly review of program activities. This committee reports directly to the Board of Directors on a quarterly basis.

ACCOUNTABILITY OF QUALITY COMMITTEES

The Board of Directors and Health Delivery Committee have delegated the direct responsibility and authority for QI Program oversight to the Plan's Quality Improvement Management Team (QIMT). The Quality Improvement Management Team consists of CHP senior managers, Medical Directors, Associate Medical Directors, department directors, and managers. QIMT relies on the following committees to oversee specific aspects of the QI program:

- Quality Improvement Committee (QIC): coordinates, provides oversight to clinical improvement activities;
- Medication Management Committee: monitors compliance with Medicare Part D requirements coordinates pharmacy QI activities and safe medication practices, and provides oversight for delegated procedures, including the formulary;
- The Pharmacy Quality Continuous Improvement Committee: reviews pharmacy data and information about medication quality-related events that occur within CHP health centers
- Credentials Committee: reviews practitioner/provider information during initial credentialing and re-credentialing, making approval decisions or recommendations for adverse decisions related to network participation*; and
- Compliance Committee, providing oversight for CHP's Compliance and HIPPA Privacy programs in conjunction with the Compliance officer and Compliance Director.

QUALITY COMMITTEES: MEETING/ DECISION-MAKING PROCEDURES

- Quality committees meet according to their planned schedule unless the chairperson cancels or reschedules a meeting, or the committee does not have a quorum for a specific meeting.
- A quorum for a meeting is met when a minimum of 50% of the committee members are present.
- Committees document meeting outcomes through meeting minutes. Committee members are offered the opportunity to review and suggest revisions to meeting minutes. The chairperson of each committee signs final meeting minutes to attest to committee acceptance of the minutes. All committee documentation is marked "confidential records for quality and/or peer review".
- Each committee member is entitled to one vote per decision. Decisions are made by majority vote.

Credentials Committee: Decision-making procedures:

- Each member reviews a checklist for practitioners and/or providers that have not been approved by a Medical Director, reviewing compliance with each credentialing or re-credentialing requirement;
- The committee reviews and evaluates information and discusses issues of concern;
- The committee makes approval decisions related to initial credentialing and/or recredentialing;
- Adverse decision recommendations are brought before the CHP Senior Management Team

for a final decision.

ACCOUNTABILITY OF KEY CHP MANAGERS

- The Chief Executive Officer (CEO) has the ultimate responsibility for the overall coordination and direction of the QI program. The CEO ensures that the Plan's service and clinical improvement initiatives receive appropriate integration and linkage to CHP's strategic planning and budgeting processes, including allocation of financial and human resources for QI initiatives.
- The CHP Board of Directors and CEO appoints a primary care physician from the Physician Group of Capital Health Plan as the physician responsible for the QI program. This physician works to integrate and implement QI activities collaboratively with network practitioners and providers.
- An appointed primary care physician from the Physician Group of Capital Health Plan chairs the Quality Improvement Committee and participates on the Medication Management Committee.
- An appointed primary care physician from the Physician Group of Capital Health Plan chair the Credentials Committee.
- The Senior Vice-President of Clinical Operations and Quality Improvement is an active member of QIMT and is responsible for assuring that quality outcomes support the strategic initiatives of the Plan. The Senior Vice-President is responsible for reporting QI activities to the Board of Directors and provides feedback to the QIMT and QIC committees.
- The Senior Vice-President of Marketing and Administrative Services participates as an ad-hoc member of QIMT. The Senior Vice-President is responsible for communicating quality improvement activities to CHP's members through newsletters, member handbooks and other informational program materials. This Senior Vice-President provides oversight over benefit development/maintenance procedures and develops member educational programs.
- The Director of Clinical Quality and Performance Improvement leads and coordinates the quality improvement program and is responsible for the day-to-day operation of the program. The Director develops data collection tools then collects, analyzes and presents quality data to internal and external audiences to identify and monitor improvement activities. The Director provides expertise in QI tools and methods to teach and facilitate a culture of quality improvement at CHP. The Director is accountable for the administration of the HEDIS and CAHPS national performance measurement programs and improving Medicare Star ratings. The Director is accountable to ensure that CHP maintains compliance with NCQA and regulatory standards including Medicare requirements for quality improvement.
- The Compliance Officer is accountable for CHP's Compliance program. The Compliance Officer also functions as CHP's HIPAA Privacy Officer and Risk Manager (meeting State of Florida Risk Management requirements related to clinical operations). The Vice-President of Information Systems is the designated HIPAA Security Officer. The two HIPAA officials work in partnership to provide leadership and coordination for CHP's HIPAA privacy and security programs.

CONFIDENTIALITY OF MEMBER INFORMATION

All quality improvement practices and activities fully comply with the requirements established by CHP's HIPAA compliance program. CHP safeguards confidential information. Disclosures are made in accordance with state and federal law, industry standards, and professional ethics. Therefore, all records, writings, data, reports, information, and any other material labeled as "quality improvement" are held in the strictest confidence. CHP staff members and committee members whose duties require knowledge of, and access to, information from clinical reviews and other functions of the QI Program appropriately safeguard the information.

QUALITY IMPROVEMENT PERFORMANCE INDICATORS/ ACTIVITIES

A number of performance indicators and activities exist to support the goals of the QI Program. They are evaluated and prioritized annually based on:

- Medicare Star Rating scores;
- Capital Health Plan's Strategic Plan;
- Recommendations from the previous year's QI Program Evaluation
- HEDIS data analyzed at the health plan level, and stratified by staff vs. affiliates, individual

physicians, and race/ethnicity;

- CAHPS member satisfaction data analyzed at the health plan level, stratified by staff vs. affiliates, and race/ethnicity;
- Medication therapy management measures;
- Individual physician level performance measures (National Quality Forum measures)
- Hospital clinical quality and safety measures;
- Practitioner satisfaction and quality review data;
- Customer complaint and grievance data;
- Analysis of clinical data, health risks, claims, demographic, race/ethnicity and language data
- Feedback from external customers;
- Analysis of HEDIS/CAHPS data;
- Performance data from quality indicators or accreditation/regulatory surveys;
- Clinical and service improvement activities, including Medicare Chronic Care Improvement Program (CCIP);
- Care coordination and hospital readmission data and indicators;
- Risk management and patient safety data;
- Population health and chronic care improvement program indicators;
- Wellness and health promotion indicators;
- Confidentiality/HIPAA indicators; and
- Performance levels established by NCQA and federal and state governmental agencies.

CARE FOR MEMBERS WITH COMPLEX HEALTH NEEDS

The CHP Case Management Program works with members with complex health needs to arrange and coordinate care and services. Members identified for the program include those with multiple chronic conditions, physical or developmental disabilities, and severe mental illnesses. Case managers assess their needs and provide interventions up to and including complex case management.
The Nancy Van Vessem, MD Center for Health Aging provides a comprehensive teamwork approach to the medical care of members with chronic and complex conditions. The Center's physicians and staff work with members to support the physical, social and emotional aspects of chronic illness to achieve optimal clinical outcomes.

CONTINUITY/COORDINATION OF CARE

CHP monitors and analyzes data on an ongoing basis to ensure that members receive seamless, continuous, and appropriate care. Specific indicators are routinely monitored that evaluate communication between medical services and between medical and behavioral health services. The use of pharmacological medications is also routinely evaluated. Opportunities for improvement in the continuity and coordination of care are identified and addressed on an ongoing basis.

ADVERSE INCIDENTS AND QUALITY OF CARE ISSUES

The review and trending of adverse incidents (including adverse drug events and medication errors) and quality of care issues provides information on potential problems that require further investigation. Investigations of individual events and trends in adverse incidents/quality of care issues are used to detect potential unsafe/ineffective treatments. Results from this activity may lead to interventions such as quality improvement activities, changes in policies, and/or clinical practice guidelines. Quality of care issues that are related to individual physicians are incorporated into recredentialing decisions.

USE OF EXTERNAL CONSULTANTS

CHP utilizes external board certified physician consultants to review and evaluate potential quality of care issues.

DELEGATION

Capital Health Plan delegates the following functions:

- Primary source verification for Credentialing is delegated to Med Advantage, Inc., an NCQA certified CVO (credentials verification organization);
- Credentialing of practitioners for telemedicine services is delegated to Online Care Network II P.C. an NCQA certified CVO;
- Web-based pharmacy claims and benefits information, Medicare formulary

development/maintenance and pharmacy utilization management criteria are delegated to Prime Therapeutics, a pharmacy benefit management organization;
- Utilization management decision-making procedures related to radiation oncology is delegated to AIM Specialty Health. AIM is certified by NCQA in Utilization Management.
- CHP provides member experience and/or clinical performance data as part of delegation agreements if requested by the delegate. CHP provides reports with trended data results that are specific to the performance of the delegate.

REGULATORY AND ACCREDITING BODIES

Capital Health Plan maintains compliance with all regulatory and accrediting bodies overseeing managed care organizations. These regulatory/accrediting bodies include the following:

- Centers for Medicare and Medicaid Services (CMS)
- Florida Department of Health/ Agency for Healthcare Administration (AHCA)
- Office of Insurance Regulation
- National Committee for Quality Assurance (NCQA) – accreditation organization

Compliance with these agencies includes, but is not limited to the following:

- Participating and coordinating quality/clinical site visits and inquiries by government regulatory agencies
- Partnering with CHP's Compliance Program to implement and monitor compliance with new and existing HIPAA regulations
- Preparing and submitting required regulatory reports and filings in a timely manner
- Achieving minimum performance levels or above as required
- Preparing, implementing and monitoring improvement plans as necessary

ANNUAL QI PLAN EVALUATION

The effectiveness of CHP's Quality Improvement Program is evaluated by annual evaluation for Commercial and Medicare clinical and service performance measures for topics that include access, availability, continuity, and utilization measures. The summary of effectiveness includes adequacy of QI Program resources, QI Committee structure, practitioner participation, and leadership involvement in the program. The health plan's achievements are identified through this process. The need to restructure or change the QI Program for the following year is addressed. The Quality Improvement Management Team and the CHP Board of Directors approve these evaluations on an annual basis.

CHP Quality Committees

Committee	Objectives	Membership
Quality Improvement Management Team (QIMT) Meets minimum of 4 times per year, more often as needed.	• Review and approve the QI and Utilization Management program documents on an annual basis (program descriptions, work plans and program evaluations); • Assess and ensure progress toward annual QI, and Utilization Management goals; • Integrate the QI Program with strategic initiatives and budgeting processes; • Incorporate quality at all levels of the organization • Monitor and promote continual improvement in member and practitioner satisfaction surveys; • Monitor and promote continual improvement in practitioner access and availability of services; • Monitor and ensure compliance with accreditation and regulatory bodies; • Prioritize, select, and provide oversight to service quality initiatives, including risk management, patient safety and language/diversity activities; • Provide guidance and feedback to committees reporting to QIMT. • Report Quality related concerns to the Health Delivery Committee of the Board of Directors; and • Address and respond to Quality of Care issues.	• SR. Vice-President of Clinical Operations and Quality Improvement • Medical Directors • Associate Medical Directors • Director, CQPI • Director of Nursing • Director of Nursing NVV Center • Director of Care Coordination • Claims Operations Director • Accreditation Manager • Network Services Manager • Decision Support Systems Manager • Ad-Hoc Corporate Compliance Officer/ Compliance Director • CEO
Quality Improvement Committee (QIC) Meets minimum of 4 times per year.	• Reviews and recommends revisions to Medicare QI program documents (program descriptions, work plans, program evaluations and quarterly reports) on an annual basis; • Oversees and assesses results for Medicare QI evaluation activities; • Review and approve Disease Management, Chronic Care Improvement and Case Management Program Descriptions and reports on at least an annual basis; • Review and evaluate quality of care issues related to individual practitioners/providers. The committee identifies and monitors corrective action plans. They may refer cases to CHP's Senior Management Team for a potential adverse event related to network participation; • Prioritize, select and monitor clinical quality initiatives, including patient safety; • Provide clinical expertise, feedback and analysis for clinical performance indicators and quality activities; • Provide oversight to wellness and preventive health activities; and • Review and approve clinical practice guidelines and preventive health guidelines at least every other year (according to established schedules).	• PGCHP Staff Physicians Medical Director • Practicing Network Physicians • Network Psychiatrist • Senior VP, Clinical Operations, QI • Director, CQPI • Director, Care Coordination • Compliance Officer • CHP Staff • Director of Pharmacy Services

Medicare Star Rating Committee Meets minimum of 6 times per year.	• Review and distribute to the organization CMS updates and information related to the Star Rating Program; • Coordinate with designated accountable managers to plan and track progress of QI initiatives; • Monitor and promote continual improvement in the areas of clinical quality, member satisfaction, customer service, drug pricing and patient safety included in CMS's Star Rating program; • Review and track internal performance on potential star rating measures on an ongoing basis as data becomes available; • Communicate star rating priorities to staff and departments responsible for star ratings; and • Meet routinely to discuss issues related to existing star measures, track measure performance as data becomes available, and review regulatory updates.	• CQPI Director • Medicare Sales Manager • Financial Analyst/Medical Admin • Director of Nursing • Director CQPI • Manager Medication Management Services • SR. Vice-President of Clinical Operations and Quality Improvement • Director Care Coordination • CQPI Staff
Committee	**Objectives**	**Membership**
Compliance Committee Meets minimum of 4 times per year, more often as needed.	• Review and approve policies, procedures and practices related to compliance and HIPAA regulations; and • Provide oversight for CHP's compliance and HIPAA programs.	• Compliance Officer • Chief Executive Officer • Senior Vice Presidents • Controller • Directors
CHP Safety Committee Meets minimum of 4 times per year, more often as needed.	♦ Review and approve policies, procedures and practices related to the safety within CHP facilities; ♦ Provide oversight for the implementation of safety procedures; and ♦ Review incident reports regarding safety issues and recommend/approve solutions.	♦ IT Security Administrator ♦ Director of Facilities ♦ Sr. VP of Operations ♦ Director of Nursing ♦ Telecommunications Administrator ♦ Directors, Supervisors and Managers representing all CHP locations
Medication Management Committee Meets minimum of 6 times per year, more often as needed.	• Monitor compliance with NCQA accreditation and Medicare Advantage/Part D requirements; • Monitor Part D Star Rating performance measures; identifies and provides oversight over improvement interventions; • Review and approve pharmacy policies and procedures on an annual basis; • Review and approve delegate policies, procedures and formulary on an annual basis; • Review and adopt utilization and clinical criteria pertaining to medication use; • Monitor and promote continual improvement in safe medication practices; • Develop interventions to improve performance measures related to medication use; • Collaborate with the pharmacy benefit management company (PBM) to resolve benefit and quality issues; and • Review and analyze routine reports from the PBM; review and provide oversight over delegated functions.	• Medical Directors • Associate Medical Director • Director Pharmacy Services • Practicing Network Physicians • Network Psychiatrist • CHP Staff
Pharmacy Continuous Quality Improvement Committee Meets 4 times per year.	• Review pharmacy data and information about medication errors and quality-related events that occur within CHP medical centers; and • Recommend improvement interventions as appropriate.	• Chair-Appointed PGCHP Physician • Medical Director • Practicing Physicians • Director of Pharmacy Services • Sr. VP of Operations • Director of Nursing

		• CSR Representative • Director of Urgent Care • Eye Care Representative
Credentials Committee Meets minimum of 4 times during each calendar year, more often as needed.	• Review and approve practitioners and providers into the CHP network based on specific credentialing/recredentialing criteria; • Review and make recommendations for adverse decisions to the Senior Management Team; • Review and approve credentialing criteria, policies and procedures on at least an annual basis; • Review and approve delegate policies and procedures on an annual basis; and • Review and analyze quarterly and annual credentialing reports; provide oversight over delegated functions in credentialing.	• Medical Director • Practicing Network Physicians • Manager, Network Services