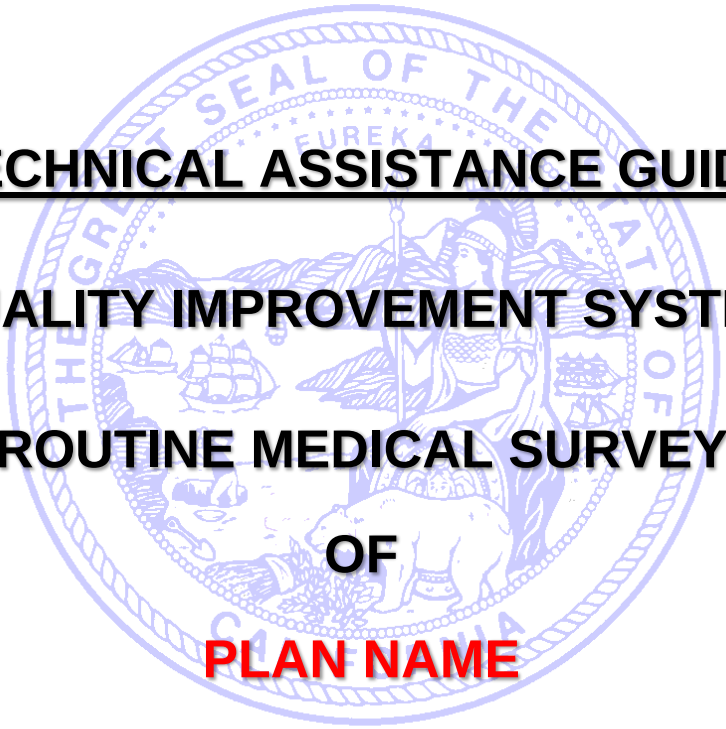
DEPARTMENT OF MANAGED HEALTH CARE
OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

1115 WAIVER SURVEY



TECHNICAL ASSISTANCE GUIDE

QUALITY IMPROVEMENT SYSTEM

ROUTINE MEDICAL SURVEY

OF

PLAN NAME

DATE OF SURVEY:

PLAN COPY

Issuance of this February 11, 2015 Technical Assistance Guide renders all other versions obsolete.

Technical Assistance Guide (TAG)

1115 WAIVER QUALITY IMPROVEMENT (QI) SYSTEM TAG

QUALITY IMPROVEMENT (QI) SYSTEM REQUIREMENTS

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1115 WAIVER QUALITY IMPROVEMENT (QI) SYSTEM TAG

Requirement QI-001: Verify that the Health Plan maintains a system of accountability for quality improvement within the organization.

CONTRACT/STATUTORY/REGULATORY CITATIONS

DHCS Two-Plan Contract, Exhibit A, Attachment 1 – Organization and Administration of the Plan
6. Medical Director
Contractor shall maintain a full time physician as medical director pursuant to Title 22 CCR Section 53857 whose responsibilities shall include, but not be limited to, the following:
F. Direct involvement in the implementation of Quality Improvement activities.

9. Member Representation
Contractor shall ensure that Medi-Cal Members, including Seniors and Persons with Disabilities (SPD), and persons with chronic conditions (such as asthma, diabetes, congestive heart failure), are represented and participate in establishing public policy within the Contractor's advisory committee or other similar committee or group.

DHCS GMC Contract, Exhibit A, Attachment 1 – Organization and Administration of the Plan
6. Medical Director
Contractor shall maintain a full time Physician as Medical Director, pursuant to 22 CCR 53913.5, whose responsibilities shall include, but not be limited to, the following:
F. Direct involvement in the implementation of Quality Improvement activities.

9. Member Representation Contractor shall ensure that Medi-Cal Members, including Seniors and Persons with Disabilities (SPD) and persons with chronic conditions (such as asthma, diabetes, congestive heart failure), are represented and participate in establishing public policy within the Contractor's advisory committee or other similar committee or group.

DHCS COHS Contract, Exhibit A, Attachment 1 – Organization and Administration of the Plan
6. Medical Director
Contractor shall maintain a full time Physician as Medical Director whose responsibilities shall include, but not be limited to, the following:
F. Have a role in the implementation of Quality Improvement activities.

9. Member Representation
Contractor shall ensure that Medi-Cal Members, including Seniors and Persons with Disabilities (SPD) or persons with chronic conditions (such as asthma, diabetes,

congestive heart failure), are represented and participate in establishing public policy within the Contractor's advisory committee or other similar committee or group.

DHCS Two-Plan Contract, Exhibit A, Attachment 4 – Quality Improvement System

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor.

2. Accountability

Contractor shall maintain a system of accountability which includes the participation of the governing body of the Contractor's organization, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the medical director, and the inclusion of contracted physicians and contracted providers in the process of QIS development and performance review. Participation of non-contracting providers is discretionary.

3. Governing Body

Contractor shall implement and maintain policies that specify the responsibilities of the governing body including at a minimum the following:

A. Approves the overall QIS and the annual report of the QIS.

B. Appoints an accountable entity or entities within Contractor's organization to provide oversight of the QIS.

C. Routinely receives written progress reports from the quality improvement committee describing actions taken, progress in meeting QIS objectives, and improvements made.

D. Directs the operational QIS to be modified on an ongoing basis, and tracks all review findings for follow-up.

4. Quality Improvement Committee

A. Contractor shall implement and maintain a Quality Improvement Committee (QIC) designated by, and accountable to, the governing body; the committee shall be facilitated by the medical director or a physician designee. Contractor must ensure that subcontractors, who are representative of the composition of the contracted provider network including but not limited to subcontractors who provide health care services to Seniors and Persons with Disabilities and chronic conditions (such as asthma, diabetes, congestive heart failure), actively participate on the committee or medical sub-committee that reports to the QIC.

B. The committee shall meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The activities, findings, recommendations, and actions of the committee shall be reported to the governing body in writing on a scheduled basis.

C. Contractor shall maintain minutes of committee meetings and minutes shall be submitted to DHCS quarterly. Contractor shall maintain a process to ensure rules of confidentiality are maintained in quality improvement discussions as well as avoidance of conflict of interest on the part of committee members.

7. Written Description
Contractor shall implement and maintain a written description of its QIS that shall include the following:
B. Organizational chart showing the key staff and the committees and bodies responsible for quality improvement activities including reporting relationships of QIS committee(s) and staff within the Contractor's organization.
E. The role, structure, and function of the quality improvement committee.
G. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that Members are able to obtain appointments within established standards.
I. Description of the activities, including activities used by Members that are Seniors and Persons with Disabilities or persons with chronic conditions, designed to assure the provision of case management, coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services and care management.

DHCS GMC Contract, Exhibit A, Attachment 4 – Quality Improvement System
1. General Requirement
Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in 28 CCR 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider. This Provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor.

2. Accountability
Contractor shall maintain a system of accountability which includes the participation of the governing body of the Contractor’s organization, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the medical director, and the inclusion of contracting Physicians and contracting Providers in the process of QIS development and performance review. Participation of non-contracting providers is at the Contractor’s discretion.

3. Governing Body
Contractor shall implement and maintain policies that specify the responsibilities of the governing body including at a minimum the following:

A. Approves the overall QIS and the annual report of the QIS. B. Appoints an accountable entity or entities within Contractor's organization to provide oversight of the QIS. C. Routinely receives written progress reports from the quality improvement committee describing actions taken, progress in meeting QIS objectives, and improvements made. D. Directs the operational QIS to be modified on an ongoing basis, and tracks all review findings for follow-up.

4. Quality Improvement Committee
Contractor shall implement and maintain a Quality Improvement Committee designated by, and accountable to, the governing body; the committee shall be facilitated by the medical director or a physician designee. Contractor must ensure that subcontractors, who are representative of the composition of the contracted provider network including but not limited to subcontractors who provide health care services to Seniors and Persons with Disabilities and chronic conditions (such as asthma, diabetes, congestive heart failure), actively participate on the committee or medical subcommittee that reports to the committee. The committee shall meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The activities, findings, recommendations, and actions of the committee shall be reported to the governing body in writing on a scheduled basis. Contractor shall maintain minutes of committee meetings and minutes shall be submitted to DHCS quarterly. Contractor shall maintain a process to ensure rules of confidentiality are maintained in quality improvement discussions as well as avoidance of conflict of interest on the part of committee members.

7. Written Description
Contractor shall implement and maintain a written description of its QIS that shall include the following:
B. Organizational chart showing the key staff and the committees and bodies responsible for quality improvement activities including reporting relationships of QIS committee(s) and staff within the Contractor's organization.
E. The role, structure, and function of the quality improvement committee.
G. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that members are able to obtain appointments within established standards.
I. Description of the activities, including activities used by members that are Seniors and Persons with Disabilities and chronic conditions, designed to assure the provision of case management, coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services and care management.

DHCS COHS Contract, Exhibit A, Attachment 4 – Quality Improvement System
1. General Requirement
Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28 CCR Section 1300.70. Contractor shall

monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor.

2. Accountability
Contractor shall maintain a system of accountability which includes the participation of the governing body of the Contractor's organization, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the Medical Director, and the inclusion of contracting Physicians and Contracted Providers in the process of QIS development and performance review. Participation of non-contracting providers is at the Contractor’s discretion.

3. Governing Body
Contractor shall implement and maintain policies that specify the responsibilities of the governing body including at a minimum the following:
A. Approves the overall QIS and the annual report of the QIS.
B. Appoints an accountable entity or entities within Contractor's organization to provide oversight of the QIS.
C. Routinely receives written progress reports from the quality improvement committee describing actions taken, progress in meeting QIS objectives, and improvements made.
D. Directs the operational QIS to be modified on an ongoing basis, and tracks all review findings for follow-up.

4. Quality Improvement Committee
Contractor shall implement and maintain a Quality Improvement Committee (QIC) designated by, and accountable to, the governing body; the Medical Director or a physician designee shall actively participate on the committee. Contractor must ensure that subcontractors, who are representative of the composition of the contracted provider network including but not limited to subcontractors who provide health care services to Seniors and Persons with Disabilities or chronic conditions (such as asthma, diabetes, congestive heart failure), actively participate on the committee or medical sub-committee that reports to the QIC.
The committee shall meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The activities, findings, recommendations, and actions of the committee shall be reported to the governing body in writing on a scheduled basis.
Contractor shall maintain minutes of committee meetings and minutes shall be submitted to DHCS quarterly. Contractor shall maintain a process to ensure rules of confidentiality are maintained in quality improvement discussions as well as avoidance of conflict of interest on the part of committee members.

7. Written Description
Contractor shall implement and maintain a written description of its QIS that shall include the following:
B. Organizational chart showing the key staff and the committees and bodies responsible for Quality Improvement activities including reporting relationships of QIS committee(s) and staff within the Contractor's organization.
E. The role, structure, and function of the quality improvement committee.
G. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that members are able to obtain appointments within established standards.
I. Description of the activities, including activities used by Members that are Seniors and Persons with Disabilities or persons with chronic conditions, designed to assure the provision of case management, coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services and care management.

28 CCR 1300.70(a)(1)
(a) Intent and Regulatory Purpose.
(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

28 CCR 1300.70(b)(2)
(b) Quality Assurance Program Structure and Requirements.
(2) Program Requirements.
In order to meet these obligations each plan's QA program shall meet all of the following requirements:
(A) There must be a written QA plan describing the goals and objectives of the program and organization arrangements, including staffing, the methodology for on-going monitoring and evaluation of health services, the scope of the program, and required levels of activity.
(B) Written documents shall delineate QA authority, function and responsibility, and provide evidence that the plan has established quality assurance activities and that the plan's governing body has approved the QA Program. To the extent that a plan's QA responsibilities are delegated within the plan or to a contracting provider, the plan documents shall provide evidence of an oversight mechanism for ensuring that delegated QA functions are adequately performed.
(C) The plan's governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities. Any delegated entity must maintain records of its QA activities and actions, and report to the plan on an appropriate basis and to the plan's governing body on a regularly scheduled basis, at least quarterly, which reports

shall include findings and actions taken as a result of the QA program. The plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. Reports to the plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components which the QA program has identified as presenting significant or chronic quality of care issues.
(D) Implementation of the QA program shall be supervised by a designated physician(s), or in the case of specialized plans, a designated dentist(s), optometrist(s), psychologist(s) or other licensed professional provider, as appropriate.
(E) Physician, dentist, optometrist, psychologist or other appropriate licensed professional participation in QA activity must be adequate to monitor the full scope of clinical services rendered, resolve problems and ensure that corrective action is taken when indicated. An appropriate range of specialist providers shall also be involved.
(F) There must be administrative and clinical staff support with sufficient knowledge and experience to assist in carrying out their assigned QA activities for the plan and delegated entities.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- CEO
- Board Member (if feasible)
- Quality Improvement (QI) Director
- QI Committee members
- Designated Medical Director that provides oversight of QI Program
- Providers that participate in the QI Program (optional)

DOCUMENTS TO BE REVIEWED

- QI Program description and/or Plan
- QI Work Plan or Action Plan
- Organizational charts showing the relationship of the QI department and committees to the overall structure and the accountability of senior management for QI activities
- QI Plan evaluation for the last two years
- Minutes of the QI Committee or its equivalent and its subcommittee meetings for the last 18–24 months
- Meeting Minutes of Governing Body review of QI monitoring results
- Job description and resume of Physician who provides clinical direction to the QI Program

1115 WAIVER QUALITY IMPROVEMENT (QI) SYSTEM TAG

QI-001 - Key Element 1:

1. The Plan's QI Program defines and maintains a system of accountability for quality throughout the organization.
DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4 – Quality Improvement System, Provisions 1, 2, and 7(B), 7(E), and 7(I); 28 CCR 1300.70(a)(1); 28 CCR 1300.70(b)(2)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have a written description of the QI Program that delineates the QI authority, function, and responsibility? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provisions 1 and 7; 28 CCR 1300.70(b)(2)			
1.2 Does the QI Program describe the goals, objectives, and organizational arrangements? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provisions 1 and 7; 28 CCR 1300.70(b)(2)			
1.3 Does the QI Program include a description of the scope of the Program's monitoring activities? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 1; 28 CCR 1300.70(b)(2)			
1.4 Does the QI Program include the methodology for on-going monitoring and evaluation of care provided by each contracted provider entity to ensure the care provided meets professionally recognized standards of practice? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 1; 28 CCR 1300.70(b)(2)			
1.5 Is the QI Program supported by sufficient and experienced staffing (clinical and administrative) to assist in carrying out assigned QI activities? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 1; 28 CCR 1300.70(b)(2)			
1.6 Does the QI Program ensure that effective action is taken to address any needed improvements in quality of care delivered by all providers? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 1; 28 CCR 1300.70(a)(1); 28 CCR 1300.70(b)(2)			
1.7 Does the QI Program include contracting physicians and providers in QI Program development and evaluation? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 1; 28 CCR 1300.70(b)(2)			

1115 WAIVER QUALITY IMPROVEMENT (QI) SYSTEM TAG

QI-001 - Key Element 2:

2. The Plan's Governing Body and its Quality Improvement Committee shall meet oversight, direction, and accountability requirements and regularly review the QI Program and associated activities.
DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 1 – Organization and Administration of the Plan, Provision 9; Attachment 4 – Quality Improvement System, Provisions 3 and 4; 28 CCR 1300.70(b)(2)(C)

Assessment Questions	**Yes**	**No**	**N/A**
2.1 Does the Plan's Governing Body meet at least quarterly? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 4; 28 CCR 1300.70(b)(2)(C)			
2.2 Does the Plan's QI Committee meet at least quarterly? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 4; 28 CCR 1300.70(b)(2)(C)			
2.3 Are reports to the Plan's Governing Body and QI Committee sufficiently detailed to include findings and actions taken resulting from SPD enrollee QI monitoring activities (e.g. focusing on case management, continuity, and coordination of care, etc.)? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 4			
2.4 Does the Plan's Governing Body act upon the reports and information provided (e.g. provide feedback to QI staff, provide instructions to providers, update UM policies and procedures, etc.)? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provisions 3(C) and 4			
2.5 Does the Plan's QI Committee act upon the reports and information provided (e.g. provide feedback to QI staff, provide instructions to providers, update UM policies and procedures, etc.)? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provisions 3(C) and 4			
2.6 Has the Plan's Governing Body approved the QI Program? DHCS COHS Contract, Exhibit A, Attachment 4, Provision 3(A)			
2.7 Do subcontractors who provide health care services to SPDs actively participate on the QI Committee or a medical sub-committee that reports to the QI Committee? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 4			

Assessment Questions	Yes	No	N/A
2.8 Do QI Committees include SPDs? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 1, Provision 9			
2.9 Are SPDs involved in plan advisory groups and committees? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 1, Provision 9			

QI-001 - Key Element 3:

3. The QI Program is directed by a designated Medical Director.
DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 1 – Organization and Administration of the Plan, Provision 6(F); 28 CCR 1300.70(b)(2)(D)

Assessment Questions	Yes	No	N/A
3.1 Are QI activities supervised by a Medical Director? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 1, Provision 6(F); 28 CCR 1300.70(b)(2)(D)			
3.2 Does the QI Program define how the Medical Director is directly involved in the implementation of QI activities?			
3.3 Is the designated Medical Director involved in the QI Program operations (evidenced by time commitment, clinical oversight, and guidance to QI staff)?			

End of Requirement QI-001: Verify that the Health Plan maintains a system of accountability for quality improvement within the organization.

1115 WAIVER QUALITY IMPROVEMENT (QI) SYSTEM TAG

Requirement QI-002: The Health Plan monitors, evaluates, and takes effective action to maintain quality of care and to address needed improvements in quality.

CONTRACT/STATUTORY/REGULATORY CITATIONS

DHCS Two-Plan Contract, Exhibit A, Attachment 4 – Quality Improvement System

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor.

4. Quality Improvement Committee

A. Contractor shall implement and maintain a Quality Improvement Committee (QIC) designated by, and accountable to, the governing body; the committee shall be facilitated by the medical director or a physician designee. Contractor must ensure that subcontractors, who are representative of the composition of the contracted provider network including but not limited to subcontractors who provide health care services to Seniors and Persons with Disabilities and chronic conditions (such as asthma, diabetes, congestive heart failure), actively participate on the committee or medical sub-committee that reports to the QIC.

B. The committee shall meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The activities, findings, recommendations, and actions of the committee shall be reported to the governing body in writing on a scheduled basis.

C. Contractor shall maintain minutes of committee meetings and minutes shall be submitted to DHCS quarterly. Contractor shall maintain a process to ensure rules of confidentiality are maintained in quality improvement discussions as well as avoidance of conflict of interest on the part of committee members.

7. Written Description

Contractor shall implement and maintain a written description of its QIS that shall include the following:

A. Organizational commitment to the delivery of quality health care services as evidenced by goals and objectives which are approved by Contractor's governing body and periodically evaluated and updated.

C. Qualifications of staff responsible for quality improvement studies and activities, including education, experience and training.

D. A description of the system for provider review of QIS findings, which at a minimum, demonstrates physician and other appropriate professional involvement and includes provisions for providing feedback to staff and providers, regarding QIS study outcomes.

G. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that Members are able to obtain appointments within established standards.
I. Description of the activities, including activities used by Members that are Seniors and Persons with Disabilities or persons with chronic conditions, designed to assure the provision of case management, coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services and care management.

9(B) Under/Over-Utilization Monitoring
In addition to the EAS performance measures, Contractor shall submit to an audit of, and report rates for, an Under/Over-Utilization Monitoring Measure Set based upon selected HEDIS Use of Service measures or any other standardized or DHCS-developed utilization measures selected by DHCS. These measures may be audited as part of the EAS/HEDIS Compliance Audit, and these rates shall be submitted with the EAS audited rates or separately as directed by DHCS. DHCS will bear the costs associated with the Compliance Audit as performed by the contracted EQRO.
The measures selected for inclusion in the set will be chosen by DHCS on an annual basis. By August 1 of each year, DHCS will notify Contractors of the HEDIS and other EAS performance measures selected for inclusion in the following year's Utilization Monitoring measure set.

DHCS-COHS Contract, Exhibit A, Attachment 4 – Quality Improvement System
1. General Requirement
Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28 CCR Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor.

4. Quality Improvement Committee
Contractor shall implement and maintain a Quality Improvement Committee (QIC) designated by, and accountable to, the governing body; the Medical Director or a physician designee shall actively participate on the committee. Contractor must ensure that subcontractors, who are representative of the composition of the contracted provider network including but not limited to subcontractors who provide health care services to Seniors and Persons with Disabilities or chronic conditions (such as asthma,

diabetes, congestive heart failure), actively participate on the committee or medical sub-committee that reports to QIC.

The committee shall meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The activities, findings, recommendations, and actions of the committee shall be reported to the governing body in writing on a scheduled basis.

Contractor shall maintain minutes of committee meetings and minutes shall be submitted to DHCS quarterly. Contractor shall maintain a process to ensure rules of confidentiality are maintained in quality improvement discussions as well as avoidance of conflict of interest on the part of committee members.

7. Written Description
Contractor shall implement and maintain a written description of its QIS that shall include the following:
A. Organizational commitment to the delivery of quality health care services as evidenced by goals and objectives which are approved by Contractor's governing body and periodically evaluated and updated.
C. Qualifications of staff responsible for quality improvement studies and activities, including education, experience and training.
D. A description of the system for provider review of QIS findings, which at a minimum, demonstrates physician and other appropriate professional involvement and includes provisions for providing feedback to staff and providers, regarding QIS study outcomes.
G. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that members are able to obtain appointments within established standards.
I. Description of the activities, including activities used by Members that are Seniors and Persons with Disabilities or persons with chronic conditions, designed to assure the provision of case management, coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services and care management.

9(B). Under/Over-Utilization Monitoring
In addition to the EAS performance measures, Contractor shall submit to an audit of, and report rates for, an Under/Over-Utilization Monitoring Measure Set based upon selected HEDIS Use of Service measures or any other standardized or DHCS-developed utilization measures selected by DHCS. These measures may be audited as part of the EAS/HEDIS Compliance Audit and these rates shall be submitted with the EAS audited rates or separately as directed by DHCS. DHCS will bear the costs associated with the Compliance Audit as performed by the contracted EQRO. The measures selected for inclusion in the set will be chosen by DHCS on an annual basis. By August 1 of each year, DHCS will notify Contractors of the HEDIS and other EAS

performance measures selected for inclusion in the following year's Utilization Monitoring measure set.

DHCS Two Plan Contract, Exhibit A, Attachment 5 – Utilization Management
4. Review of Utilization Data
Contractor shall include within the UM program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member utilization patterns shall be reported to DHCS upon request.

DHCS GMC Contract, Exhibit A, Attachment 5 – Utilization Management
4. Review of Utilization Data
Contractor shall include within the UM program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member utilization patterns shall be reported to DHCS upon request.

DHCS COHS Contract, Exhibit A, Attachment 5 – Utilization Management
4. Review of Utilization Data
Contractor shall include within the UM program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member utilization patterns shall be reported to DHCS upon request.

28 CCR 1300.70(a)
(a) Intent and Regulatory Purpose.
(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.
(2) This section is not intended to set forth a prescriptive approach to QA methodology. This section is intended to afford each plan flexibility in meeting Act quality of care requirements.
(3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.
(4) The Department's assessment of a plan's QA program will focus on:
(A) the scope of QA activities within the organization;
(B) the structure of the program itself and its relationship to the plan's administrative structure;
(C) the operation of the QA program; and
(D) the level of activity of the program and its effectiveness in identifying and correcting deficiencies in care.

1115 WAIVER QUALITY IMPROVEMENT (QI) SYSTEM TAG

28 CCR 1300.70(b)(1)
(b) Quality Assurance Program Structure and Requirements.
(1) Program Structure.
To meet the requirements of the Act which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that:
(A) a level of care which meets professionally recognized standards of practice is being delivered to all enrollees;
(B) quality of care problems are identified and corrected for all provider entities;
(C) physicians (or in the case of specialized plans, dentists, optometrists, psychologists or other appropriate licensed professionals) who provide care to the plan's enrollees are an integral part of the QA program;
(D) appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason, including a potential financial gain and/or incentive to the plan providers, and/or others; and
(E) the plan does not exert economic pressure to cause institutions to grant privileges to health care providers that would not otherwise be granted, nor to pressure health care providers or institutions to render care beyond the scope of their training or experience.

28 CCR 1300.70(c)
(c) In addition to the internal quality of care review system, a plan shall design and implement reasonable procedures for continuously reviewing the performance of health care personnel, and the utilization of services and facilities, and cost. The reasonableness of the procedures and the adequacy of the implementation thereof shall be demonstrated to the Department.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director responsible to supervise the implementation of the QI Program.
- QI Director or equivalent
- Other Directors / Officers responsible for service elements:
  - Member Services Director (Grievances and Appeals)
  - Utilization Management Director (Utilization Management)
  - Provider Relations Director (Provider Access)
- Staff responsible for monitoring and developing and analyzing audit reports

DOCUMENTS TO BE REVIEWED

- QI Reporting and Analysis Plan
  - Utilization reports
  - Mortality/morbidity rates

  - Reports/analysis of complaints and grievances
  - HEDIS results for the last three years, if applicable
  - QI activity reports, documentation, and studies
  - QI Committee or applicable Subcommittee minutes
  - Enrollee/provider satisfaction surveys results
  - Access and availability studies including telephone access studies
  - Special ad hoc reports to the Board, if applicable
  - Reports and/or analysis detailing the review access/ availability complaints, continuity of care, utilization of services
  - Enrollee complaints
- List of established performance goals and associated tracking reports for serving the SPD population (e.g. case management assignment, updates to the health risk assessments, etc.)
- QI Committee and Subcommittee meeting minutes
- Related policies and procedures, including: the process for investigating quality of care, system issues, and/or administrative problems; monitoring procedures including problem identification, evaluation, corrective action; follow-up monitoring activities
- Potential quality issue tracking log
- Potential quality issue track and trend reports by provider, by issue and by level of severity of confirmed problems

QI-002 - Key Element 1:

1. The QI Program monitors required service elements, types, and utilization for all provider entities.
DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4 – Quality Improvement System, Provisions 1, 7(G), and 7(I); 28 CCR 1300.70(a)(1); 28 CCR 1300.70(a)(3); 28 CCR 1300.70(b)(1)

Assessment Questions	Yes	No	N/A
1.1 Does the scope of the QI Program incorporate monitoring and analysis to identify quality of care problems for all service elements, including accessibility, availability, continuity, and coordination of care, and access to case management for the SPD populations? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 1; 28 CCR 1300.70(a)(1); 28 CCR 1300.70(a)(3)			
1.2 Does the scope of the QI Program incorporate monitoring and analysis to identify quality of care problems for all service types (e.g., preventive care, primary care, specialty care, emergency care, inpatient care, ancillary services)? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 1; 28 CCR 1300.70(b)(1)(B)			

Assessment Questions	Yes	No	N/A
1.3 Does the scope of the QI Program include monitoring and analysis to identify quality of care problems for all provider entities, including those serving the SPD populations (e.g., Physicians, medical groups, hospitals, out-patient surgery centers)? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 1			
1.4 Does the scope of the QI Program include monitoring and analysis to determine whether the provision and utilization of services meets professionally recognized standards of practice? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 1; CCR 1300.70(a)(1)			
1.5 Does the QI Program confirm a quality of care monitoring cycle: 1) identify problems; 2) take effective action to improve care where deficiencies are identified; and 3) follow up is planned and implemented where indicated? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 1			
1.6 Are the Plan's data collection and reporting systems adequate to produce reliable and timely data and reports from various business units?			
1.7 Does the Plan utilize a variety of monitoring approaches (e.g. standardized performance measures; provider site visits, satisfaction surveys; investigating, tracking and trending enrollee complaints/grievances; investigating provider complaints, etc.) to identify problems in service and care?			
1.8 Does the Plan use appropriate study designs and sound statistical techniques when monitoring, conducting studies and developing reports?			

QI-002 - Key Element 2:

2. The QI Program must document that problems are being identified. DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4 – Quality Improvement Services, Provisions 1 and 7(D); 28 CCR 1300.70(a)(1); 28 CCR 1300.70 (b)(1)(B)

Assessment Questions	Yes	No	N/A
2.1 Where the Plan has failed to meet performance goals or targets, does the Plan effectively identify or isolate specific problems in its health service delivery system (including both clinical and non-clinical aspects of care)? 28 CCR 1300.70(b)(1)(B)			
2.2 Does the Plan have a system for tracking potential quality issues to ensure that all issues are investigated?			
2.3 Does the Plan ensure that all potential quality issues are investigated in a timely manner?			
2.4 Does the Plan refer identified potential quality issues to the QI Committee or other appropriate body for input? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 1			
2.5 Does the Plan's QI system include provider review of QIS findings? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 7(D)			
2.6 Does the Plan's QI system include provisions for providing feedback to staff and providers regarding quality improvement outcomes? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 1			

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QI-002 - Key Element 3:

3. When problems are confirmed or performance goals are not met, the Plan formulates and implements effective corrective actions in a timely manner. DHCS Two-Plan, GMC, and COHS Contract Exhibit A, Attachment 4 – Quality Improvement System, Provision 7(G); 28 CCR 1300.70(a)(1); 28 CCR 1300.70(b)(1)(B)

Assessment Questions	Yes	No	N/A
3.1 Does the Plan implement corrective actions or QI Programs to address identified quality issues? DHCS Two-Plan, GMC, and COHS Contract Exhibit A, Attachment 4, Provision 1			
3.2 Does the Plan incorporate input from appropriate professionals into the design of its corrective action plans or QI Programs? DHCS- Two Plan, GMC, and COHS Contract Exhibit A, Attachment 4, Provision 7(E)			

Assessment Questions	Yes	No	N/A
3.3 Does the Plan evaluate the outcome of its corrective actions or QI Programs? DHCS- Two Plan, GMC, and COHS Contract Exhibit A, Attachment 4, Provision 1; 28 CCR 1300.70(a)			
3.4 Does the Plan take effective action to address any needed improvements in the quality of care delivered by its providers? DHCS- Two Plan, GMC, and COHS Contract Exhibit A, Attachment 4, Provision 1; 28 CCR 1300.70(a)			

QI-002 - Key Element 4:

4. The QI Program defines the processes to continuously review the quality of care and performance of medical personnel and the utilization of services and facilities.

DHCS- Two Plan, GMC, and COHS Contract, Exhibit A, Attachment 4 – Quality Improvement System, Provisions 4 and 7(G); DHCS- Two Plan, GMC, and COHS Contract, Exhibit A, Attachment 5 – Utilization Management, Provision 4; 28 CCR 1300.70(a)(1); 28 CCR 1300.70(b)(1)

Assessment Questions	Yes	No	N/A
4.1 Does the Plan have an established process for investigating quality of care cases? DHCS- Two Plan, GMC and COHS Contract Exhibit A, Attachment 4, Provision 4			
4.2 Does the Plan have an established process for investigating over- or under-utilization cases? DHCS- Two Plan, GMC and COHS Contract Exhibit A, Attachment 5, Provision 4			
4.3 Is the Plan's QI program designed to ensure that physicians (or other appropriately licensed professionals) who provide care to the Plan's enrollees are an integral part of the Plan's QI program? DHCS- Two Plan, GMC and COHS Contract Exhibit A, Attachment 4, Provision 1; 28 CCR 1300.70(b)(1)(C)			
4.4 Does the Plan complete investigations involving quality of care issues within the timeframes established by the Quality Improvement programs?			
4.5 Does the Plan either prescribe a corrective action plan or require that the offending provider submit a corrective action plan?			

Assessment Questions	Yes	No	N/A
4.6 Does the Plan follow through and request evidence that corrective actions have been implemented by the offending providers?			

End of Requirement QI-002: The Health Plan monitors, evaluates, and takes effective action to maintain quality of care and to address needed improvements in quality.

1115 WAIVER QUALITY IMPROVEMENT (QI) SYSTEM TAG

Requirement QI-003: The Health Plan remains ultimately accountable even when Quality Improvement activities have been delegated.

CONTRACT/STATUTORY/REGULATORY CITATIONS

DHCS Two Plan Contract, Exhibit A, Attachment 4 – Quality Improvement System

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor.

6. Delegation of Quality Improvement Activities

A. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to subcontractors. If Contractor delegates quality improvement functions, Contractor and delegated entity (subcontractor) shall include in their Subcontract, at minimum:

1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and subcontractor.

2) Contractor's oversight, monitoring, and evaluation processes and subcontractor's agreement to such processes.

3) Contractor's reporting requirements and approval processes. The agreement shall include subcontractor's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly.

4) Contractor's actions/remedies if subcontractor's obligations are not met.

B. Contractor shall maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum:

1) Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.

2) Ensures subcontractor meets standards set forth by the Contractor and DHCS.

3) Includes the continuous monitoring, evaluation and approval of the delegated functions.

DHCS GMC Contract, Exhibit A, Attachment 4 – Quality Improvement System

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in 28 CCR 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor

shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider. This Provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor.

6. Delegation of Quality Improvement Activities
A. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to subcontractors. If Contractor delegates quality improvement functions, Contractor and delegated entity (subcontractor) shall include in their subcontract, at minimum:
1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and subcontractor.
2) Contractor's oversight, monitoring, and evaluation processes and subcontractor's agreement to such processes.
3) Contractor's reporting requirements and approval processes. The agreement shall include subcontractor's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly.
4) Contractor's actions/remedies if subcontractor's obligations are not met.
B. Contractor shall maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum:
1) Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.
2) Ensures subcontractor meets standards set forth by the Contractor and DHCS.
3) Includes the continuous monitoring, evaluation and approval of the delegated functions.

DHCS COHS Contract, Exhibit A, Attachment 4 – Quality Improvement System
1. General Requirement
Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28 CCR Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor.

6. Delegation of Quality Improvement Activities
A. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to subcontractors. If Contractor delegates quality improvement functions, Contractor and delegated entity (subcontractor) shall include in their Subcontract, at minimum:

1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and subcontractor.
2) Contractor's oversight, monitoring, and evaluation processes and subcontractor's agreement to such processes.
3) Contractor's reporting requirements and approval processes. The agreement shall include subcontractor's responsibility to report findings and actions taken as a result of the Quality Improvement activities at least quarterly.
4) Contractor's actions/remedies if subcontractor's obligations are not met.
B. Contractor shall maintain a system to ensure accountability for delegated Quality Improvement activities, that at a minimum:
1) Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.
2) Ensures subcontractor meets standards set forth by the Contractor and DHCS.
3) Includes the continuous monitoring, evaluation and approval of the delegated functions.

28 CCR 1300.70(b)(2)(G)
(b) Quality Assurance Program Structure and Requirements.
(2) Program Requirements.
In order to meet these obligations each plan's QA program shall meet all of the following requirements:
(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees.
If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:
(1) Inform each provider of the plan's QA program, of the scope of that provider's QA responsibilities, and how it will be monitored by the plan.
(2) Ascertain that each provider to which QA responsibilities have been delegated has an in-place mechanism to fulfill its responsibilities, including administrative capacity, technical expertise, and budgetary resources.
(3) Have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated QA responsibilities.
(4) Require that standards for evaluating that enrollees receive health care consistent with professionally recognized standards of practice are included in the provider's QA program, and be assured of the entity's continued adherence to these standards.
(5) Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers.

(6) Ensure that health services include appropriate preventive health care measures consistent with professionally recognized standards of practice. There should be screening for conditions when professionally recognized standards of practice indicate that screening should be done.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Plan Medical Director or designated QI Physician
- Plan staff person responsible for delegation
- Delegate staff person responsible for delegation
- Delegate Medical Director
- Plan QI Manager
- Delegate QI Manager
- Plan QI coordinators that conduct audits of the delegates
- QI representatives from one or more provider delegates

DOCUMENTS TO BE REVIEWED

- Related policies and procedures, including those detailing the processes for delegation and continued oversight of delegated entities
- Pre-delegation assessments
- Delegation contracts, letters of agreements, and memoranda of understanding
- Delegation audit tools, forms, and reports/results
- Documentation that the Plan conducts a periodic audit of delegated activities and requires a corrective action plan for deficiencies identified with documentation of appropriate follow-up
- Documentation that the Plan periodically reviews and approves delegate's QI Program Description and Work Plan
- Plan Board or QI Committee or Sub-Committee minutes demonstrating document review and oversight of delegated providers and organizations
- Corrective action plans for delegated providers as appropriate
- Routine and ad hoc reports from the delegated entities
- Minutes of governance committee in which delegate reports were discussed

QI-003 - Key Element 1:

If the Plan delegates <u>any</u> QI responsibilities to affiliates and vendors including but not limited to contracting provider groups, hospitals, etc.:

1. The Plan assesses the capability of each delegated entity by performing a capability assessment prior to delegation.

DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4 – Quality Improvement System, Provisions 1, 6(A), and 6(B); 28 CCR 1300.70(b)(2)(G)(1)-(3)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan delegate any QI responsibilities? If yes, then identify who the delegates are and complete the assessment questions in this section.			
1.2 Does the Plan assess the delegate's policies and procedures for conducting the delegated responsibilities? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 6(B)			
1.3 Does the Plan assess the delegate's administrative capacities? DHCS- Two Plan, GMC, and COHS Contract, Exhibit A, Attachment 4, Provisions 1 and 6(B)(1); 28 CCR 1300.70(b)(2)(G)			
1.4 Does the Plan assess the delegate's task experience? DHCS- Two Plan, GMC, and COHS Contract, Exhibit A, Attachment 4, Provisions 1 and 6(B)(1)			
1.5 Does the Plan assess the delegate's budgetary resources? DHCS- Two Plan, GMC, and COHS Contract, Exhibit A, Attachment 4, Provisions 1 and 6(B)(1)			

QI-003 - Key Element 2:

If the Plan delegates <u>any</u> QI responsibilities to affiliates and vendors including but not limited to contracting provider groups, hospitals, etc.:

2. The Plan and each delegate have a delegation agreement that details the delegated services, the administrative responsibilities, the procedures for exchanging information/coordinating care, and the reporting/monitoring responsibilities of both the Plan and the delegate.
DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4 – Quality Improvement System, Provisions 1, 6(A), and 6(B); 28 CCR 1300.70(b)(2)(G)(1)-(6)

Assessment Questions	Yes	No	N/A
2.1 Does the Plan have an agreement with each delegate that defines the scope of the Plan's and the delegate's responsibilities? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 1			
2.2 Does the contract/agreement include a description of the			

Assessment Questions	Yes	No	N/A
delegated services? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 6(A)			
2.3 Does the contract/agreement include a description of the delegate's administrative responsibilities (e.g. the handling of grievances and appeals, customer service)? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 6(A)(1)			
2.4 Does the contract/agreement include a description of how the Plan will monitor the delegated entity? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 6(A)(2)			
2.5 Does the scope of the delegate's responsibilities include access and availability? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 6(A)(2)			
2.6 If yes to Assessment Question 2.5, then has the Plan adequately defined monitoring, problem identification, and corrective action requirements? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 6(A)(2)			
2.7 Does the scope of the delegate's responsibilities include coordination of care? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 6(A)(2)			
2.8 If yes to Assessment Question 2.7, then has the Plan adequately defined monitoring, problem identification, and corrective action requirements? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 6(A)(2)			
2.9 Does the scope of the delegate's responsibilities include access to case management? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 6(A)(2)			
2.10 If yes to Assessment Question 2.6, then has the Plan adequately defined monitoring, problem identification, and corrective action requirements? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 6(A)(2)			

1115 WAIVER QUALITY IMPROVEMENT (QI) SYSTEM TAG

QI-003 - Key Element 3:

If the Plan delegates <u>any</u> QI responsibilities to affiliates and vendors including but not limited to contracting provider groups, hospitals, etc.:

3. The Plan has put in place ongoing oversight procedures to ensure that delegates are fulfilling all delegated QI responsibilities.
DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4 – Quality Improvement System, Provisions 1, 6(A), and 6(B); 28 CCR 1300.70(b)(2)(G)(3)

Assessment Questions	Yes	No	N/A
3.1 Does the Plan have ongoing oversight procedures in place to ensure that delegates are fulfilling all delegated QI responsibilities? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision (6)(B)(3)			
3.2 Does the Plan ensure that the delegate's QI Program includes standards for evaluating whether enrollees receive health care consistent with professionally recognized standards of practice? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provisions 1 and 6(A)(2)			
3.3 Does the Plan demonstrate compliance with oversight procedures (e.g., analysis of delegate reports and data, review of delegate QI Committee minutes, review of QI Work Plan, etc.)? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provisions 1 and 6(A)(2)			
3.4 Does the Plan conduct periodic site visits to the delegate? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 6(A)(2)			
3.5 Does the Plan implement corrective action and conduct follow-up reviews to address any deficiencies? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provisions 6(A)(4) and 6(B)(3)			
3.6 Does the Plan periodically review the delegate's QI Work Plan? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 6(A)(3)			
3.7 Does the delegate provide the Plan with reports of the delegate's findings and actions taken as a result of its delegated QI activities? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A,			

Attachment 4, Provision 6(A)(3)			
3.8 If yes to Assessment Question 3.7, then does the Plan receive these reports on a quarterly basis? DHCS Two-Plan, GMC, and COHS Contracts, Exhibit A, Attachment 4, Provision 6(A)(3)			

End of Requirement QI-003: The Health Plan remains ultimately accountable even when Quality Improvement activities have been delegated.