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

CAL MEDICONNECT SURVEY

TECHNICAL ASSISTANCE GUIDE

QUALITY MANAGEMENT SYSTEM

ROUTINE MEDICAL SURVEY

OF

PLAN NAME

DATE OF SURVEY:

PLAN COPY

Issuance of this October 27, 2015 Technical Assistance Guide renders all other versions obsolete.

Technical Assistance Guide (TAG)

CAL MEDICONNECT QUALITY IMPROVEMENT (QI) SYSTEM TAG

QUALITY IMPROVEMENT (QI) SYSTEM REQUIREMENTS

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CAL MEDICONNECT QUALITY IMPROVEMENT (QI) SYSTEM TAG

Requirement QI-001: The Health Plan utilizes a system or process to maintain and improve quality of care with respect to Medicaid-based services under Cal MediConnect.

STATUTORY /REGULATORY CITATIONS

Cal MediConnect Prime Contract

2.10. Network Management

2.10.1.2. The Contractor will work in collaboration with Network Providers to actively improve the quality of care provided to Enrollees, consistent with the quality improvement goals and all other requirements of this Contract.

2.16. Quality Improvement Program

2.16.1. Quality Improvement (QI) Program. The Contractor shall:

2.16.1.1. Deliver quality care that enables Enrollees to stay healthy, get better, manage chronic illnesses and/or disabilities, and maintain/improve their quality of life. Quality care refers to:

2.16.1.2. Quality of physical health care, including primary and specialty care;

2.16.1.3. Quality of Behavioral Health services focused on recovery, resiliency and rehabilitation;

2.16.1.4. Quality of LTSS;

2.16.1.5. Adequate access and availability to primary, Behavioral Health services, specialty health care, and LTSS providers and services;

2.16.1.6. Continuity and coordination of care across all care and services settings, and for transitions in care; and

2.16.1.7. Enrollee experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum.

2.16.2. Apply the principles of Continuous Quality Improvement (CQI) to all aspects of the Contractor's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:

2.16.2.1. Quantitative and qualitative data collection and data-driven decision-making;

2.16.2.2. Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

2.16.2.3. Feedback provided by Enrollees and providers in the design, planning, and implementation of its CQI activities;

2.16.2.4. Rapid Cycle Quality Improvement, when appropriate, as determined by DHCS;

2.16.2.5. Issues identified by the Contractor, DHCS and/or CMS; and

2.16.2.6. Ensure that the QI requirements of this Contract are applied to the delivery of primary and specialty health care services, Behavioral Health services and LTSS.

2.16.3. QI Program Structure

2.16.3.1. The Contractor shall maintain a well-defined QI organizational and program structure that supports the application of the principles of CQI to all aspects of the Contractor's service delivery system. The QI program must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. The Contractor's QI organizational and program structure shall comply with all applicable provisions of 42 C.F.R. § 438,, including Subpart D, Quality Assessment and Performance Improvement, 42 C.F.R. § 422, Subpart D Quality Improvement, and shall meet the quality management and improvement criteria described in the most current NCQA health plan accreditation requirements in 28 CCR Section 1300.70.

2.16.3.2. The Contractor shall:

2.16.3.2.1. Establish a mechanism to detect both underutilization and overutilization of services and assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

2.16.3.2.2. Establish a set of QI functions and responsibilities that are clearly defined and that are proportionate to, and adequate for, the planned number and types of QI initiatives and for the completion of QI initiatives in a competent and timely manner;

2.16.3.2.3. Ensure that such QI functions and responsibilities are assigned to individuals with the appropriate skill set to oversee and implement an organization-wide, cross-functional commitment to, and application of, CQI to all clinical and non-clinical aspects of the Contractor's service delivery system;

2.16.3.2.4. Establish internal processes to ensure that the quality management activities for primary, specialty, Behavioral Health services, and LTSS reflect utilization across the Provider Network and include all of the activities in this Section 2.16 of this Contract and, in addition, the following elements:

2.16.3.2.4.1. A process to utilize Healthcare Plan Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Services (CAHPS), the Health Outcomes Survey (HOS) and other measurement results in designing QI activities;

2.16.3.2.4.2. A medical record review process for monitoring Provider Network compliance with policies and procedures, specifications and appropriateness of care. Such process shall include the sampling method used which shall be proportionate to utilization by service type. The Contractor shall submit its process for medical record reviews and the results of its medical record reviews to DHCS;

2.16.3.2.4.3. A process to measure Provider Network and Enrollees, at least annually, regarding their satisfaction with the Contractor's plan. The Contractor shall submit a survey plan to DHCS for approval and shall submit the results of the survey to DHCS and CMS;

2.16.3.2.4.4. A process to measure clinical reviewer consistency in applying clinical criteria to utilization management activities, using inter-rater reliability measures;
2.16.3.2.4.5. A process for including Enrollees and their families in quality management activities, as evidenced by participation in consumer advisory boards; and
2.16.3.2.4.6. In collaboration with and as further directed by DHCS, develop a customized medical record review process to monitor the assessment for and provision of LTSS.

2.16.3.2.5. Have in place a written description of the QI Program that delineates the structure, goals, and objectives of the Contractor's QI initiatives. Such description shall include the following:
2.16.3.2.5.1. 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.
2.16.3.2.5.2. Organizational chart showing the key staff and the committees and bodies responsible for quality improvement activities including reporting relationships of QI committee(s) and staff within the Contractor's organization.
2.16.3.2.5.3. Qualifications of staff responsible for quality improvement studies and activities, including education, experience and training.
2.16.3.2.5.4. The role, structure, and function of the Quality Improvement Committee.
2.16.3.2.5.5. The processes and procedures designed to ensure that all Covered Services that are Medically Necessary are available and accessible to all Enrollees regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, and that all Covered Services that are Medically Necessary are provided in a culturally and linguistically appropriate manner.
2.16.3.2.5.6. 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 Enrollees are able to obtain appointments within established standards.
2.16.3.2.5.7. Description of the quality of clinical care services provided, including, but not limited to, preventive services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services.
2.16.3.2.5.8. Description of the activities, including activities used by 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.

2.16.3.2.6. Address all aspects of health care, including specific reference to Behavioral Health services and to LTSS, with respect to monitoring and improvement efforts, and integration with physical health care. Behavioral Health

and LTSS aspects of the QI program may be included in the QI description, or in a separate QI Plan referenced in the QI description as follows:

2.16.3.2.6.1. Address the roles of the designated physician(s), Behavioral Health clinician(s), and LTSS providers with respect to QI program;

2.16.3.2.6.2. Identify the resources dedicated to the QI program, including staff, or data sources, and analytic programs or IT systems; and

2.16.3.2.6.3. Include organization-wide policies and procedures that document processes through which the Contractor ensures clinical quality, access and availability of health care and services, and continuity and coordination of care. Such processes shall include, but not be limited to, Appeals and grievances and utilization management.

2.16.3.3.3. Submit to DHCS and CMS an annual QI Work Plan that shall include the following components or other components as directed by DHCS and CMS:

2.16.3.3.3.1. Planned clinical and non-clinical initiatives;

2.16.3.3.3.2. The objectives for planned clinical and non-clinical initiatives;

2.16.3.3.3.3. The short and long term time frames within which each clinical and non-clinical initiative's objectives are to be achieved;

2.16.3.3.3.4. The individual(s) responsible for each clinical and non-clinical initiative;

2.16.3.3.3.5. Any issues identified by the Contractor, DHCS, Enrollees, and providers, and how those issues are tracked and resolved over time;

2.16.3.3.3.6. Program review process for formal evaluations that address the impact and effectiveness of clinical and non-clinical initiatives at least annually; and

2.16.3.3.3.7. Process for correcting deficiencies.

2.16.3.3.4. Evaluate the results of QI initiatives at least annually, and submit the results of the evaluation to the DHCS and CMT. The evaluation of the QI program initiatives shall include, but not be limited to, the results of activities that demonstrate the Contractor's assessment of the quality of physical and Behavioral Health services rendered, the effectiveness of LTSS, and accomplishments and compliance and/or deficiencies in meeting the previous year's QI Strategic Work Plan; and

2.16.3.3.5. Contractor shall develop an QI report for submission to DHCS and CMS on an annual basis. The annual report shall include:

2.16.3.3.5.1. An Assessment of the QI activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the QI program, including but not limited to:

2.16.3.3.5.1.1. The collection of aggregate data on utilization;

2.16.3.3.5.1.2. The review of quality of services rendered; and

2.16.3.3.5.1.3. Outcomes/findings from Quality Improvement Projects (QIPs), consumer satisfaction surveys and collaborative initiatives.

2.16.3.3.5.2. Copies of all final reports of non-governmental accrediting agencies (e.g. JCAHO, NCQA) relevant to the Contractor's Medi-Cal line of business,

including accreditation status and any deficiencies noted. Include the corrective action plan developed to address noted deficiencies.

2.16.3.3.5.3. An assessment of First Tier, Downstream and Related Entity's performance of delegated QI activities.

2.16.3.3.6. Maintain sufficient and qualified staff employed by the Contractor to manage the QI activities required under the Contract, and establish minimum employment standards and requirements (e.g. education, training, and experience) for employees who will be responsible for quality management. QI staff shall include:

2.16.3.3.6.1. At least one designated physician, who shall be a medical director or associate medical director, at least one designated Behavioral Health provider, and a professional with expertise in the assessment and delivery of LTSS with substantial involvement in the QI program; and

2.16.3.3.6.2. A qualified individual to serve as the Cal MediConnect QI Director.

2.16.7. Quality Improvement Committee: 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 Enrollees and Network Providers, who are representative of the composition of the contracted Provider Network, actively participate on the committee or medical sub-committee that reports to the QIC.

2.16.7.1. 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.

2.16.7.2. 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.

28 CCR 1300.70

(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.
(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.
(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.
(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.

NCQA health plan accreditation requirements (most current version)
Located at https://www.ncqa.org/Programs/Accreditation.aspx

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
- Analysis, evaluation, and data collection tools and information used to meet the Plan's CQI and QI goals
- Policies and procedures to ensure that QI activities for all Medicaid based services demonstrate utilization across the Provider Network.
- QI annual report (for submission to DHCS and CMS)
- 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.
- Reports to the Plan's governing body and QI committee and any subsequent feedback provided by the governing body or committee
- Job description and resume of Physician who provides clinical direction to the QI Program
- List of Plan Advisory Board Members

QI-001 - Key Element 1:

1. **The Plan's QI Program defines and maintains a process to improve quality in Medicaid-based services.**

CAL MEDICONNECT QUALITY IMPROVEMENT (QI) SYSTEM TAG

Assessment Questions	Yes	No	N/A
1.1 Does the QI Program utilize CQI principles to deliver high quality, coordinated, and culturally competent clinical care with respect to all Medicaid based services? (§2.16, § 2.16.1.1; §2.16.1.2; §2.16.1.3; §2.16.1.4; §2.16.1.5; §2.16.1.6; §2.16.1.7; §2.16.2.6; §2.16.3.1.)			
1.2 Does the Plan meet current NCQA health plan accreditation requirements? (§2.16.3.1.)			
1.3 Does the Plan maintain, review and revise a written State quality strategy that it submits to CMS? (§2.16.3; § 438.200.)			
1.4 Does the QI program seek CQI for Medicaid based services through analysis, evaluation and improvement, using the following: a. Data collection and data driven decision making; b. Current evidence based practice guidelines; c. Feedback from Enrollees and Providers; d. Rapid Cycle Quality Improvement (if appropriate); and e. Any identified issues? (§2.16.2, § 2.16.2.1; §2.16.2.2; §2.16.2.3; §2.16.2.4; §2.16.2.5)			
1.5 Is the QI program accessible and understandable to both external and internal individuals and entities? (§2.16.3.1.)			
1.6 Does the Plan have a tool to detect when health services are being underutilized or over-utilized? (§2.16.3.2.1.)			
1.7 Does the Plan have a tool to assess the quality and appropriateness of care furnished to Enrollees with special health care needs? (§2.16.3.2.1.)			

CAL MEDICONNECT QUALITY IMPROVEMENT (QI) SYSTEM TAG

Assessment Questions	Yes	No	N/A
1.8 Has the Plan clearly identified its Quality Improvement functions and responsibilities, and are they adequate to complete the Quality Improvement initiatives in a competent and timely manner? (§2.16.3.2.2.)			
1.9 Are the QI responsibilities assigned to individuals with the appropriate skill set? (§2.16.3.2.3.)			
1.10 Does the Plan establish the appropriate internal processes to ensure that QI activities for all Medicaid based services demonstrate utilization across the Provider Network, including: (§2.16.3.2.4; §2.16.3.2.4.1)			
A. A medical review process for monitoring Provider Network compliance with Medicaid based services, which includes a compliant sampling method (with results submitted to DHCS)? (§2.16.3.2.4.2.)			
B. An annual process to measure Enrollees' satisfaction with Medicaid based services with survey questions and results submitted to the DHCS? (Verify process only, not outcome.) (§2.16.3.2.4.3.)			
C. A process to measure clinical reviewer consistency in applying clinical criteria to utilization management activities, using inter-rater reliability measures? (§2.16.3.2.4.4)			
D. A process to include Enrollees and their families in QI activities, through involvement in consumer advisory boards? (§2.16.3.2.4.5)			
E. A customized medical record review process to monitor the assessment for and provision of LTSS? (§2.16.3.2.4.6.)			

CAL MEDICONNECT QUALITY IMPROVEMENT (QI) SYSTEM TAG

Assessment Questions	Yes	No	N/A
1.11 Does the Plan have a written description of the QI Program that delineates the structure, goals, and objectives of the Plan's QI initiatives? (§2.16.3.2.5)			
A. Are the goals and objectives approved by the Governing Body? (§2.16.3.2.5.1.)			
B. Are the goals and objectives periodically evaluated and updated? (§2.16.3.2.5.1.)			
C. Does the QI Program description include an Organizational chart showing key staff and committees responsible for QI activities, including reporting relationships? (§2.16.3.2.5.2.)			
D. Does the QI Program description include qualifications of staff responsible for QI studies and activities? (§2.16.3.2.5.3.)			
E. Does the QI Program description include the role, structure, and function of the QI Committee? (§2.16.3.2.5.4.)			
F. Does the QI Program description include processes and procedures to ensure that all Medicaid Covered Services that are Medically Necessary are available and accessible to all Enrollees (regardless of background) and are provided in a culturally and linguistically appropriate manner? (§2.16.3.2.5.5.)			
G. Does the QI Program include a description of tools used to review, evaluate, and improve access and availability of services? (§2.16.3.2.5.6.)			

CAL MEDICONNECT QUALITY IMPROVEMENT (QI) SYSTEM TAG

Assessment Questions	Yes	No	N/A
H. Does the QI Program include a description of the quality of Medicaid clinical care services provided? (§2.16.3.2.5.7.)			
I. Does the QI Program describe activities designed to ensure that case management, coordination, and continuity of care services are provided? (This includes availability and access to care, clinical services, and care management for persons with or without chronic conditions.) (§2.16.3.2.5.8.)			
1.12 Does the QI Program make specific reference to Behavioral Health services, Non-Emergency Medical Transportation, Non-Medical Transportation and LTSS, with respect to monitoring and improvement efforts, and integration with physical health care? (§2.16.3.2.6.)			
A. Do the descriptions of the Behavioral Health and LTSS aspects of the QI program address the roles of the designated physician(s), Behavioral Health clinician(s), and LTSS providers? (§2.16.3.2.6.1.)			
B. Do the descriptions of the Behavioral Health and LTSS aspects of the QI program identify the resources dedicated to the QI program, including staff, data sources, analytic programs or IT systems? (§2.16.3.2.6.2.)			
C. Do the descriptions of the Behavioral Health and LTSS aspects of the QI program include policies and procedures that document clinical quality, access and availability, and continuity and coordination of care (such as Appeals and grievances and utilization management)? (§2.16.3.2.6.3.)			
1.13 Does the Plan prepare a QI work plan that includes all required Medicaid based components, including: (§2.16.3.3.3.)			

CAL MEDICONNECT QUALITY IMPROVEMENT (QI) SYSTEM TAG

Assessment Questions	Yes	No	N/A
A. Planned clinical and non-clinical initiatives? (§2.16.3.3.3.1.)			
B. Objectives for planned clinical and non-clinical initiatives? (§2.16.3.3.3.2.)			
C. Short and long-term time frames for each clinical and non-clinical initiative? (§2.16.3.3.3.3.)			
D. Individuals responsible for each clinical and non-clinical initiative? (§2.16.3.3.3.4.)			
E. Any issues identified by the Plan, DHCS, Enrollees, and Providers, and how those issues are tracked and resolved over time? (§2.16.3.3.3.5.)			
F. The process for formal evaluations that address the impact and effectiveness of clinical and non-clinical initiatives? (§2.16.3.3.3.6.)			
G. The process for correcting deficiencies? (§2.16.3.3.3.7.)			
1.14 Does the Plan evaluate the results of QI initiatives at least annually, and submit the results to DHCS and CMS? (§2.16. 3.3.4.)			
A. Does the annual evaluation include the Plan's assessment of the quality of physical and Behavioral Health services rendered? (§2.16.3.3.4.)			
B. Does the annual evaluation include the effectiveness of LTSS? (§2.16.3.3.4.)			

Assessment Questions	Yes	No	N/A
C. Does the annual evaluation include accomplishments and compliance and/or deficiencies in meeting the previous year's QI Strategic Work Plan? (§2.16. 3.3.4.)			
1.15 Has the Plan developed a report on an annual basis that includes an assessment of QI activities and an evaluation of successes and needed improvements in QI services rendered? (§2.16. 3.3.5; §2.16. 3.3.5.1.)			
A. Does the report assess and evaluate the following: 1. Collection of aggregate data on utilization? 2. Review of quality of services rendered? 3. Outcomes/findings from Quality Improvement Projects (QIPs), consumer satisfaction surveys and collaborative initiatives? (§2.16.3.3.5.1; §2.16.3.3.5.1.1; §2.16. 3.3.5.1.2; §2.16. 3.3.5.1.3.)			
B. Does the report provide copies of all final reports of non-governmental accrediting agencies (e.g. JCAHO, NCQA) relevant to the Plan's Medi-Cal line of business, including accreditation status any deficiencies noted, and the corrective action plan to address any deficiencies? (§2.16.3.3.5.2.)			
C. Does the report include an assessment of First Tier, Downstream and Related Entity's performance of delegated QI activities? (§2.16. 3.3.5.3.)			

QI-001 - Key Element 2:

2. The Plan's Governing Body and its Quality Improvement Committee meets oversight, direction, and accountability requirements.

Assessment Questions	Yes	No	N/A
2.1 Do the Plan's Governing Body and QI Committee meet at least quarterly? (§2.16.7.1.; 28 CCR Section 1300.70 (b)(1)(C).)			
2.2 Does the Plan maintain and submit its QIC meeting minutes to DHCS quarterly? (§2.16.7.2.)			
2.3 Does the Plan ensure rules of confidentiality are followed, and committee members avoid conflicts of interest? (§2.16.7.2.)			
2.4 Do reports to the Plan's Governing Body and QI Committee include findings and actions taken as a result QI monitoring activities? (§2.16.7.1; 28 CCR Section 1300.70 (b)(1)(C).)			
2.5 Does the Plan's Governing Body and 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.)? (§2.16.7.1; 28 CCR Section 1300.70 (b)(1)(C).)			
2.6 Does the Plan ensure that a substantial number of Cal MediConnect Enrollees actively participate on the Quality Improvement Committee or medical sub-committee that reports to the QIC? (§2.16.7.)			
2.7 Does the Plan ensure that Network Providers, who are representative of the composition of the contracted Provider Network, actively participate on the Quality Improvement Committee or medical sub-committee that reports to the QIC? (§2.16.7.)			

QI-001 - Key Element 3:

3. The QI Program is directed by a designated Medical Director and supported by qualified staff.

CAL MEDICONNECT QUALITY IMPROVEMENT (QI) SYSTEM TAG

Assessment Questions	Yes	No	N/A
3.1 Is the QI Program supported by a sufficient number of qualified staff to assist in carrying out assigned QI activities? (§2.16.3.2.3.; §2.16.3.2.5.3.; §2.16.3.3.6.)			
3.2 Does the QI staff the following individuals, that each have substantial involvement in the QI Program: (§2.16.3.3.6; §2.16.3.3.6.1; §2.16.3.3.6.2.)			
A. Designated physician (Medical director or associate director)?			
B. Designated Behavioral Health provider?			
C. LTSS assessment and delivery expert?			
D. A qualified Cal MediConnect QI director?			
3.2 Does the QI Program have minimum employment requirements for employees who will be responsible for quality management (i.e. education, training, experience)? (§2.16.3.3.6.)			
3.1 Are QI activities supervised by a Medical Director? (§2.16.3.3.6.1.; 28 CCR Section 1300.70 (b)(1)(D).)			
3.2 Does the QI Program define how the Medical Director is directly involved in the implementation of QI activities? (28 CCR Section 1300.70 (b)(1)(E))			
3.3 Is there evidence that the designated Medical Director is substantially involved in the QI Program operations (evidenced by time commitment, clinical oversight, and guidance to QI staff)? (28 CCR Section 1300.70 (b)(1)(E).)			

End of Requirement QI-001: The Health Plan utilizes a system or process to maintain and improve quality of care with respect to Medicaid-based services under Cal MediConnect.

CAL MEDICONNECT QUALITY IMPROVEMENT (QI) SYSTEM TAG

Requirement QI-002: The Health Plan monitors, evaluates, and employs a system of corrective action to maintain and improve quality of care with respect to Medicaid-based services.

STATUTORY /REGULATORY CITATIONS

Cal MediConnect Prime Contract

2.5. Care Delivery Model

2.5.1.14. Annual Evaluation of Care Management Program. Contractor will conduct annual review, analysis, and evaluation of the effectiveness of the care management program processes and identify actions to be implemented to improve the quality of care and delivery of services.

2.5.1.14.1. Contractor will have a process for developing a corrective action plan, with specified timelines, for any out of compliance findings.

2.11.7. Review of Utilization Data

2.11.7.1. Contractor shall include within the utilization management program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Enrollee utilization patterns shall be reported to DHCS upon request.

2.16. Quality Improvement Program

2.16.4. QI Activities

2.16.4.1. Performance Measurement

2.16.4.1.1. The Contractor shall engage in performance measurement and performance improvement projects, designed to achieve, through ongoing measurement and intervention, significant improvements, sustained over time, in clinical care and non-clinical care processes, outcomes and Enrollee experience. The Contractor's QI program must include a health information system to collect, analyze, and report quality performance data as described in 42 C.F.R. §§ 422.516(a), 422.152, and 423.514 for Parts C and D, respectively.

2.16.4.1.2. Performance improvement projects must involve:

2.16.4.1.2.1. Measurement of performance using objective quality indicators

2.16.4.1.2.2. Implementation of systems interventions to achieve improvement in quality

2.16.4.1.2.3. Evaluation of the effectiveness of the interventions

2.16.4.1.2.4. Planning and initiation of activities for increasing and sustaining improvement

2.16.4.1.3. Measurement and improvement projects shall be conducted in accordance with requirements in the CFAM-MOU, Figure 7-1 core quality measures, and as specified in this Contract, and shall include, but are not limited to:

2.16.4.1.3.2. The Contractor shall collect annual data and contribute to all Demonstration QI-related processes, as directed by DHCS and CMS, as follows:

2.16.4.1.3.2.1. Collect and submit to DHCS, CMS and/or CMS' contractors, in a timely manner, data for the measures;

2.16.4.1.3.2.2. Contribute to all applicable DHCS and CMS data quality assurance processes, which shall include, but not be limited to, responding, in a timely manner, to data quality inadequacies identified by DHCS and rectifying those inadequacies, as directed by DHCS

2.16.4.1.3.2.3. The Contractor shall demonstrate how to utilize results of the measures specified in any CMS and DHCS reporting requirements documents in designing QI initiatives.

2.16.4.2. Consumer Satisfaction Survey:

2.16.4.2.1. At intervals as determined by DHCS, DHCS' contracted EQRO will conduct a consumer satisfaction survey of a representative sample of Enrollees in each county, as determined by the technical specifications of the survey instrument chosen by DHCS. If requested, Contractor shall provide appropriate data to the EQRO to facilitate this survey.

2.16.4.3. Quality Improvement Project (QIP) Requirements

2.16.4.3.1. The Contractor shall implement and adhere to all processes relating to the QIP requirements, as directed by DHCS and CMS, and as follows:

2.16.4.3.1.1. In accordance with 42 C.F.R. § 438.240 (d) and 42 C.F.R. § 422.152 (d), collect information and data in accordance with QIP requirement specifications for its Enrollees; using the format and submission guidelines specified by DHCS and CMS in annual guidance provided for the upcoming Contract year;2.16.4.3.1.2. The Contractor is required to conduct or participate in two (2) QIPS approved by DHCS. If Contractor holds multiple managed care contracts with DHCS, Contractor is required to conduct or participate in two (2) QIPS for each Contract.

2.16.4.3.1.2.1. One (1) QIP must be an internal quality improvement project (IQIP).

2.16.4.3.1.2.2. One (1) QIP must be a DHCS facilitated statewide collaborative.

2.16.4.4. Implement the QIP requirements, in a culturally competent manner;

2.16.4.5. Evaluate the effectiveness of QIP interventions, completed in a reasonable time period as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year;

2.16.4.6. Plan and initiate processes to sustain achievements and continue improvements;

2.16.4.7. Submit to DHCS and CMS, comprehensive written reports, using the format, submission guidelines and frequency specified by DHCS and CMS. Such reports shall include information regarding progress on QIP requirements, barriers encountered and new knowledge gained. As directed by DHCS and CMS, the Contractor shall present this information to DHCS and CMS at the end of the QI requirement project cycle as determined by DHCS and CMS; and

2.16.5. CMS-Specified Performance Measurement and Performance Improvement Projects

2.16.5.1. The Contractor shall conduct additional performance measurement or performance improvement projects if mandated by CMS pursuant to 42 C.F.R. § 438.240(a)(2).

CFAM-MOU, Figure 7-1 (pg. 108)
This figure outlines the required Core Quality Measures under the Demonstration.
https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CAMOU.pdf

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
  - 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 Cal MediConnect 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
- Agreements for data sharing between the Plan and providers of Medicaid-based services
- Any copies of reports relating to the review of LTSS programs from other agencies (e.g. MSSP Utilization Review Reports)

QI-002 - Key Element 1:

1. The QI Program monitors required service elements, types, and utilization for all Medicaid based provider entities.

Assessment Questions	Yes	No	N/A
1.1 Does the QI Program monitor and identify quality of care problems for provider entities providing Medicaid-based services to the Cal MediConnect population (e.g., MSSP sites and individual CBAS centers)? (s 1300.70(a)(1))			
1.2 Does the QI Program monitor and analyze data to determine whether the provision and utilization of services is in compliance with current regulations? (§2.16.3.; 28 CCR Section 1300.70 (b)(2)(G)(5).)			
1.3 Does the QI program include a health information system to collect, analyze, and report quality performance data? (§2.16.4.1.1.)			
A. Do performance improvement projects use objective quality indicators? (§2.16.4.1.2.1.)			
B. Do performance improvement projects implement systems to achieve quality improvement? (§2.16.4.1.2.2.)			
C. Do performance improvement projects evaluate the effectiveness of interventions? (§2.16.4.1.2.3.)			

CAL MEDICONNECT QUALITY IMPROVEMENT (QI) SYSTEM TAG

Assessment Questions	Yes	No	N/A
D. Do performance improvement projects plan and initiate activities for increasing and sustaining improvement? (§2.16.4.1.2.4.)			
1.5 Does the Plan conduct measurement and improvement projects in accordance with requirements in the CFAM-MOU, Figure 7-1 as required in the CFAM-MOU? (§ 2.16.4.1.3.)			
1.6 Does the Plan collect annual data and submit it to DHCS, CMS, or CMS' contractors in a timely manner? (§2.16.4.1.3.2; §2.16.4.1.3.2.1.)			
1.7 Does the Plan contribute to applicable quality assurance processes, including timely responding to and rectifying data quality inadequacies identified? (§2.16.4.1.3.2.2.)			
1.8 Does the Plan demonstrate how to utilize the results in its reports to design QI initiatives? (§2.16.4.1.3.2.3.)			
1.9 Does the Plan collect information and data in accordance with QIP requirements for its Enrollees per the annual guidance provided by DHCS and CMS? (§2.16.4.3.1.1)			
1.10 Does the Plan conduct or participate in an internal quality improvement project (IQIPS) approved by DHCS? (A separate IQIPS is needed for each contract if the Plan has multiple managed care contracts.) (§2.16.4.1.3.1.2; §2.16.4.1.3.1.2.1.)			
1.11 Does the Plan conduct or participate in a DHCS facilitated statewide collaborative? (A separate QIP is needed for each contract if Plan has multiple managed care contracts.) (§2.16.4.1.3.1.2; §2.16.4.1.3.1.2.2.)			

Assessment Questions	Yes	No	N/A
1.12 Does the Plan implement the QIP requirements in a culturally competent manner? (§2.16.4.4.)			
1.13 Does the Plan conduct a consumer satisfaction survey of a representative sample of Enrollees in each county, as determined by the technical specifications of the survey instrument chosen by DHCS? (§2.16.4.2.1.)			
1.14 Does the Plan evaluate the effectiveness of QIP interventions, with enough time to produce new information on quality of care each year? (§2.16.4.5.)			
1.15 Does the Plan have a process for continuing to improve and for sustaining its achievements? (§2.16.4.6.)			
1.16 Does the Plan submit comprehensive written reports to the DHCS and CMS concerning progress on QIP requirements, barriers encountered and new knowledge gained? (§2.16.4.7.)			

QI-002 - Key Element 2:

2. The QI Program identifies problems with the provision of Medicaid-based services, and implements effective corrective actions in a timely manner when problems are confirmed or performance goals are not met.

Assessment Questions	Yes	No	N/A
2.1 Does the Plan effectively identify or isolate specific problems in its delivery system of Medicaid-based services when they are identified? (§2.16.2.5; 28 CCR Section 1300.70(b)(1)(B).).			
2.2 Does the Plan have an effective system for tracking potential quality issues to ensure that all issues are investigated? (28 CCR Section 1300.70(b)(2)(C).)			

Assessment Questions	Yes	No	N/A
2.3 Does the Plan ensure that all potential quality issues are investigated in a timely manner? (28 CCR Section 1300.70(b)(2)(C).)			
2.4 Does the Plan refer identified issues to the QI Committee or other appropriate body for input when appropriate? 28 CCR Section 1300.70(b)(2)(C)			
2.5 Does the plan conduct an annual evaluation of the Care Management Program and identify actions to be implemented to improve the quality of care and delivery of services? (§2.5.1.14.)			
2.6 Does the Plan implement timely corrective actions to address identified quality issues in the Plan's Care Management Program? (§2.5.1.14.1.)			
2.7 Does the Plan critically evaluate the outcome of its corrective actions or QI Programs and take steps to rectify continued deficiencies? (§2.16.3.3.3.7.)			

QI-002 - Key Element 4:

4. The Plan continuously reviews the quality of care and performance of Medicaid-based services and the utilization of services and facilities.

Assessment Questions	Yes	No	N/A
4.1 For cases identified through complaints or sentinel events involving quality of care, does the Plan involve clinicians with the appropriate knowledge in the review process? (§2.16.3.3.6.)			
4.2 For cases identified through complaints or sentinel events involving the quality of care, does the Plan either prescribe a corrective action plan or require that the offending provider submit a corrective action plan? (§1300.70 (a)(1) and (b)(1)(B))			

Assessment Questions	Yes	No	N/A
4.3 For individual cases identified through complaints or sentinel events involving the quality of care, does the Plan follow through and request evidence that corrective actions have been implemented by the offending providers? (§1300.70 (b)(2)(B))			

End of Requirement QI-002: The Health Plan monitors, evaluates, and employs a system of corrective action to maintain and improve quality of care with respect to Medicaid-based services.

CAL MEDICONNECT QUALITY IMPROVEMENT (QI) SYSTEM TAG

Requirement QI-003: The Health Plan provides oversight when delegating responsibilities or processes related to quality management.

STATUTORY /REGULATORY CITATIONS

Cal MediConnect Prime Contract

1.44. First Tier, Downstream and Related Entity — An individual or entity that enters into a written arrangement that is acceptable to CMS and DHCS with the Contractor, to provide administrative or health care services to the Contractor under this Contract.

2.16.3.3. Delegation of Quality Improvement Activities

2.16.3.3.1. Contractor is accountable for all QI functions and responsibilities (e.g. utilization management, credentialing and site review) that are delegated to First Tier, Downstream, and Related Entities.

2.16.3.3.2. Contractor shall maintain a system to ensure accountability for delegated QI activities, that at a minimum:

2.16.3.3.2.1. Evaluates First Tier, Downstream and Related Entity's ability to perform the delegated activities including an initial review to assure that the First Tier, Downstream, and Related Entity has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities;

2.16.3.3.2.2. Ensures First Tier, Downstream, and Related Entity meets standards set forth by the Contractor and DHCS; and

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

2.16.3.3.3. Submit to DHCS and CMS an annual QI Work Plan that shall include the following components or other components as directed by DHCS and CMS:

2.16.3.3.3.1. Planned clinical and non-clinical initiatives;

2.16.3.3.3.2. The objectives for planned clinical and non-clinical initiatives;

2.16.3.3.3.3. The short and long term time frames within which each clinical and non-clinical initiative's objectives are to be achieved;

2.16.3.3.3.4. The individual(s) responsible for each clinical and non-clinical initiative;

2.16.3.3.3.5. Any issues identified by the Contractor, DHCS, Enrollees, and providers, and how those issues are tracked and resolved over time;

2.16.3.3.3.6. Program review process for formal evaluations that address the impact and effectiveness of clinical and non-clinical initiatives at least annually; and

2.16.3.3.3.7. Process for correcting deficiencies.

Cal MediConnect Prime Contract; Appendix C

A. Contractor shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on Contractor's behalf related to the operation

of the Medicare-Medicaid plan are in compliance with 42 C.F.R. §§422.504, 423.505, and 438.6(l).

C. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities contain the following:
3. Language that specifies the delegated activities and reporting requirements;
4. Language that provides for revocation of the delegation activities and reporting requirements or specifies other remedies in instances where CMS, DHCS or the Contractor determine that such parties have not performed satisfactorily;
5. Language that specifies the performance of the parties is monitored by the Contractor on an ongoing basis and the Contractor may impose corrective action as necessary;
G. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for medical providers include additional provisions. Such contracts or arrangements must contain the following:
21. To participate and cooperate in the Contractor's Quality Improvement System.
22. If Contractor delegates Quality Improvement activities, Subcontract shall include provisions as specified by DHCS.

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

Staff responsible for the activities described above, for example:

- Plan Medical Director or Physician designated to facilitate QI committee
- Plan staff person responsible for delegation of delivery of Medicaid-based services
- Delegated Entities staff responsible for delegated QI activities
- Medical Director(s) of Delegated Entities
- Plan QI Manager
- QI Manager of Delegated Entities
- Plan QI coordinators that conduct audits of the Delegated Entities
- QI representatives from one or more Delegated Entities

DOCUMENTS TO BE REVIEWED

- Related policies and procedures, including those detailing the processes for delegation of QI activities analyzing provision of Medicaid-based services and continued oversight of Delegated Entities with responsibility for QI activities analyzing provision of Medicaid-based services
- Pre-delegation assessments or initial reviews
- 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 QI activities and requires a corrective action plan for deficiencies identified with documentation of appropriate follow-up
- Plan Board or QI Committee or Sub-Committee minutes demonstrating review and oversight of QI activities conducted by Delegated Entities
- Corrective action plans developed by Delegated Entities if related to quality of Medicaid-based services delivery
- Routine and ad hoc reports about the QI activities of Delegated Entities
- Minutes of governance committee in which the QI activities of Delegated Entities were discussed

QI-003 - Key Element 1:

1. The Plan assesses, prior to delegation, the capability of each Delegated Entity that has been delegated responsibility to perform QI activities that analyze the quality of Medicaid-based services delivery.

Assessment Questions	Yes	No	N/A
1.1 Does the Plan assess each Delegated Entity's policies and procedures for conducting delegated QI functions and responsibilities? (§2.16.3.3.2.1)			
1.2 Does the Plan assess whether each Delegated Entity has administrative capacity to fulfill delegated QI functions and responsibilities? (§2.16.3.3.2.1)			
1.3 Does the Plan assess whether each Delegated Entity has technical expertise to fulfill delegated QI functions and responsibilities? (§2.16.3.3.2.1)			
1.4 Does the Plan assess whether each Delegated Entity has budgetary resources to fulfill delegated QI functions and responsibilities? (§2.16.3.3.2.1)			

QI-003 - Key Element 2:

2. The Plan's agreements with Delegated Entities that perform QI activities related to the provision of Medicaid-based services detail the required QI activities and reporting requirements as stated in the three-way contract.

Assessment Questions	Yes	No	N/A
2.1 If the scope of a Delegated Entity's responsibilities includes access, availability, continuity and coordination of care, and/or access to case management of Medicaid-based services, does the Plan's agreement with the Delegated Entity also delegate responsibility to perform QI activities and reports analyzing the quality of these responsibilities as they relate to the provision of Medicaid-based services? (§2.16.3.3.2.2)			
2.2 Does the Plan's agreement with each Delegated Entity with responsibility to perform that performs QI activities related to Medicaid-based services adequately describe the QI activities and reports required to be performed by the Delegated Entity? (Section C.3 of Appendix C)			
2.3 Does the Plan's agreement with each Delegated Entity that performs QI activities related to Medicaid-based services include language that provides for revocation or other remedies where CMS, DHCS or Plan determine the Delegated Entity has not performed satisfactorily? (Section C.4 of Appendix C)			
2.4 Does the Plan's agreement with each Delegated Entity that performs QI activities related to Medicaid-based service delivery include language that states that the performance of the party will be continuously monitored by Plan and the Plan may impose corrective action as necessary? (Section C.5 of Appendix C)			

Assessment Questions	Yes	No	N/A
2.5 Does the contract/agreement include a description of how the Plan will monitor the delegated entity? (Section C.5 of Appendix C)			
2.6 If the Delegated Entity is a medical provider delivering Medicaid-based services, does the Plan's agreement state that such Delegated Entity must participate and cooperate in the Plan's QI Program? (Section G.21 of Appendix C)			
2.7 If the Delegated Entity is a medical provider delivering Medicaid-based services, does the Plan's agreement include provisions specified by DHCS? (Section G.22 of Appendix C)			

QI-003 - Key Element 3:

3. The Plan utilizes oversight procedures to ensure that Delegated Entities are fulfilling all delegated QI activities related to the quality of Medicaid-based service delivery.

Assessment Questions	Yes	No	N/A
3.1 Does the Plan maintain oversight procedures to ensure that Delegated Entities that perform QI activities which analyze the quality of Medicaid-based service delivery are fulfilling all delegated QI responsibilities? (§2.106.3.3.2.3)			
3.2 Does the Plan ensure that the Delegated Entity's QI Program includes standards for evaluating whether enrollees receive Medicaid-based services that are consistent with professionally recognized standards of practice? (§2.16.3.3.2.3)			
3.3 Does the Plan demonstrate compliance with oversight procedures? (analysis of Delegated Entity reports and data, review of Delegated Entity QI Committee minutes, review of QI Work Plans, etc.) (§2.16.3.3.2.3)			

3.4 Does the Plan conduct periodic site visits of Delegated Entities with responsibility to perform QI activities and reports analyzing the quality of Medicaid-based service delivery? (§2.16.3.3.2.3)			
3.5 Does the Plan implement corrective action and conduct follow-up reviews to address any deficiencies? (§2.16.3.3.2.3)			
3.6 If QA activities are delegated to a participating provider does the Plan:			
A. 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? (§2.11.5.2; 28 CCR Section 1300.70(b)(2)(G).)			
B. Ascertain that each provider to which QA responsibilities have been delegated has an in-place a mechanism to fulfill its responsibilities, including administrative capacity, technical expertise and budgetary resources? (§2.11.5.2; 28 CCR Section 1300.70(b)(2)(G).)			
C. Have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated QA responsibilities? (§2.11.5.2; 28 CCR Section 1300.70(b)(2)(G).)			
D. 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? (§2.11.5.2; 28 CCR Section 1300.70(b)(2)(G).)			
(E) 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? (§2.11.5.2; 28 CCR Section 1300.70(b)(2)(G).)			

(F) 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? (§2.11.5.2; 28 CCR Section 1300.70(b)(2)(G).)			
3.7 If the Plan has capitation or risk-sharing contracts, does it ensure that each contracting provider has the administrative and financial capacity to meet its contractual obligations? (§2.11.5.2; 28 CCR Section 1300.70 (b)(2)(H).)			
3.8 If the Plan has capitation or risk -sharing contracts, does it have systems in place to monitor QA functions? (§2.11.5.2; 28 CCR Section 1300.70 (b)(2)(H).)			

End of Requirement QI-003: The Health Plan provides oversight when delegating responsibilities or processes related to quality management.