

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

TECHNICAL ASSISTANCE GUIDE

**QUALITY MANAGEMENT
ROUTINE DENTAL SURVEY
OF
PLAN NAME**

(A Medi-Cal Dental Managed Care Plan)

DATE OF SURVEY:

PLAN COPY

Issuance of this January 15, 2016 Technical Assistance Guide renders all other versions obsolete.

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QUALITY MANAGEMENT REQUIREMENTS
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Requirement QM-001: QM Program Intent and Regulatory Purpose, Structure and Requirements

STATUTORY/REGULATORY CITATIONS

CA Health and Safety code section 1367.01(j)

(j) A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

CA Health and Safety Code section 1369

Every plan shall establish procedures to permit subscribers and enrollees to participate in establishing the public policy of the plan. For purposes of this section, public policy means acts performed by a plan or its employees and staff to assure the comfort, dignity, and convenience of patients who rely on the plan's facilities to provide health care services to them, their families, and the public.

CA Health and Safety code section 1370

Every plan shall establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs. Notwithstanding any other provision of law, there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person who participates in plan or provider quality of care or utilization reviews by peer review committees which are composed chiefly of physicians and surgeons or dentists, psychologists, or optometrists, or any of the above, for any act performed during the reviews if the person acts without malice, has made a reasonable effort to obtain the facts of the matter, and believes that the action taken is warranted by the facts, and neither the proceedings nor the records of the reviews shall be subject to discovery, nor shall any person in attendance at the reviews be required to testify as to what transpired thereat. Disclosure of the proceedings or records to the governing body of a plan or to any person or entity designated by the plan to review activities of the plan or provider committees shall not alter the status of the records or of the proceedings as privileged communications.

The above prohibition relating to discovery or testimony shall not apply to the statements made by any person in attendance at a review who is a party to an action or proceeding the subject matter of which was reviewed, or to any person requesting hospital staff privileges, or in any action against an insurance carrier alleging bad faith by the carrier in refusing to accept a settlement offer within the policy limits, or to the director in conducting surveys pursuant to Section 1380.

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This section shall not be construed to confer immunity from liability on any health care service plan. In any case in which, but for the enactment of the preceding provisions of this section, a cause of action would arise against a health care service plan, the cause of action shall exist notwithstanding the provisions of this section.

28 CCR 1300.67.2.2(d)(1)

(d) Quality Assurance Processes. Each plan shall have written quality assurance systems, policies and procedures designed to ensure that the plan's provider network is sufficient to provide accessibility, availability and continuity of covered health care services as required by the Act and this section. In addition to the requirements established by Section 1300.70 of Title 28, a plan's quality assurance program shall address:

(1) Standards for the provision of covered services in a timely manner consistent with the requirements of this section.

28 CCR 1300.69

Unless a plan complies with the requirements of the Health Maintenance Organization Act of 1973 in affording subscribers and enrollees' procedures to participate in establishing the public policy of the plan, as defined in Section 1369 of the Act, it shall comply with each of the following requirements:

(a) If the plan is a corporation, either:

(1) At least one-third of its governing board shall be subscribers and/or enrollees, or

(2) There shall be established a standing committee which shall be responsible for participating in establishing public policy of the plan as defined in Section 1369 of the Act, and whose recommendations and reports are regularly and timely reported to the governing board. The governing board shall act upon such recommendations and such action shall be recorded in the board's minutes. The membership of the standing committee shall comply with each of the following:

(A) At least 51% of the members shall be subscribers and/or enrollees,

(B) At least one member shall be a member of the governing board of the plan, and

(C) At least one member shall be a provider.

(b) If the plan is a partnership, trust or unincorporated association, there shall be established a standing committee of the governing body or executive committee of the plan, which committee shall be responsible for participation in establishing public policy of the plan as defined in Section 1369 of the Act and whose recommendations and reports are regularly and timely reported to the governing body or executive committee of the plan. The governing body or executive committee of the plan shall act upon such recommendations and such action shall be recorded in its minutes. The membership of the standing committee shall comply with each of the following:

(1) At least 51% of the members shall be subscribers and/or enrollees,

(2) At least one member shall also be a member of the governing body or executive committee of the plan, and

(3) At least one member shall be a provider.

(c) If the plan is a sole proprietorship, it shall establish a standing committee which shall be responsible for participation in establishing public policy of the plan as defined in Section 1369 of the Act and whose recommendations are reported regularly and timely

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to the sole proprietor. The sole proprietor shall act upon such recommendations and such action shall be recorded. The membership of the standing committee shall comply with each of the following:

- (1) At least 51% of the members shall be subscribers and/or enrollees,
- (2) The sole proprietor shall be a member, and
- (3) At least one provider shall be a member.
- (d) Those individuals who fulfill the requirements stated in this section for subscriber and/or enrollee membership upon the governing body or standing committee shall be persons who are not employees of the plan, providers of health care services, subcontractors to the plan or group contract brokers, or persons financially interested in the plan.
- (e) Advisory committees do not meet the requirements of subsections (a), (b) or (c).
- (f) Enrollees and subscribers participating in establishing public policy shall have access to information available from the plan regarding public policy, including financial information and information about the specific nature and volume of complaints received by the plan and their disposition.
- (g) In connection with the selection of enrollee and subscriber members of any governing board or standing committee, the plan shall generally consider the makeup of its enrollee and subscriber population, including but not limited to factors such as ethnic extraction, demography, occupation and geography as well as identifiable and individual group participation. Any such selection or election of enrollee or subscriber members shall be conducted on a fair and reasonable basis. This subsection does not require the plan to maintain supporting statistical data.
- (h) The public policy participation procedure shall be incorporated into the bylaws or other governing documents of the plan. The terms of subscriber and enrollee members of the public policy making body shall be of reasonable length and overlap so as to provide continuity and experience in representation. A standing committee shall meet at least quarterly.
- (i) The plan shall
 - (1) in each evidence of coverage or combined evidence of coverage and disclosure form, or at least annually by other means, furnish to its subscribers and enrollees a description of its system for their participation in establishing public policy, and
 - (2) communicate material changes affecting public policy to subscribers and enrollees.

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

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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.

28 CCR 1300.70(a)(4)(B)

(a) Intent and Regulatory Purpose.

(4) The Department's assessment of a plan's QA program will focus on:

- (B) the structure of the program itself and its relationship to the plan's administrative structure;

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(b)(1) and (2)

(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;

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(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.

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(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.

28 CCR 1300.70(b)(2)(A)

(b)(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.

28 CCR 1300.70(b)(2)(A), (B) and (F)

(b)(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

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documents shall provide evidence of an oversight mechanism for ensuring that delegated QA functions are adequately performed.

(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.

28 CCR 1300.70(b)(2)(C)

(b)(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.

(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.

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

Staff responsible for the activities described above, for example:

- CEO
- Board Member (if feasible)
- QA Director
- QA Committee members
- Designated dentist/clinician that provides oversight of QA Program
- Providers that participate in the QA Program

DOCUMENTS TO BE REVIEWED

- QM Program description and/or plan
- QM Work Plan or action plan
- Organizational charts showing the relationship of the QA department and committees to the overall structure and the accountability of senior management for QA activities
- Annual QM Plan evaluation for the last two years

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- Minutes of the QM Committee or its equivalent and its subcommittee meetings for the last 18–24 months
- Meeting Minutes of Governing Body review of QM monitoring results.
- Job description and resume of dentist or other clinician, as appropriate, who provides clinical direction to the QA program
- Review licensing filing of the Plan’s QM program and confirm submission of appropriate policies and procedures.

QM-001 - Key Element 1:

- 1. The Plan has established and documented a QM Program consistent with regulatory purpose and intent. (Pre-Onsite)**
CA Health and Safety code section 1367.01(j); CA Health and Safety Code section 1369; CA Health and Safety code section 1370; 28 CCR 1300.67.2.2(d)(1); 28 CCR 1300.69; 28 CCR 1300.70(a); 28 CCR 1300.70(b)(1) and (2)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have a written description of the QM Program?			
1.2 Has the Plan designated a dentist or other licensed professional, as appropriate, to provide clinical direction to the QM Program?			
1.3 Is there evidence that participation of the dentist in QA activity is adequate to monitor the full scope of services, resolve problems, and ensure corrective action is taken when indicated?			
1.4 Does the QA Plan confirm: 1) problems are identified, 2) effective action is taken to improve care when deficiencies are identified, and 3) follow-up is planned where indicated?			
1.5 Does the scope of the QA Program address service elements, including accessibility, availability, and continuity of care?			
1.6 Does the scope of the QA Program monitor whether the provision and utilization of services meets professionally recognized standards of practice?			
1.7 Does the Plan have a written Public Policy?			
1.8 Does the Public Policy Committee include the following participants; a) At least 51% of members are subscribers/enrollees? b) At least one member is from the Board of Directors? c) At least one member is from the provider (contracted) community?			

QM-001 - Key Element 2:

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- 2. The QM Program is designed/structured to ensure a level of care is provided that meets professional standards, that problems are identified and corrected, and dentists who provide care to Plan enrollees are an integral part of the QA Program. (Pre-Onsite)
28 CCR 1300.70(b)(1)**

Assessment Questions	Yes	No	N/A
2.1 Is the Plan's QM Program designed/ structured to ensure that the level of care being delivered to all enrollees meets professionally recognized standards of practice?			
2.2 Is the Plan's QM Program designed/ structured to identify and correct quality of care problems for all provider entities?			
2.3 Is the Plan's QM Program designed/ structured to have dentists who provide care to enrollees as an integral part of the QA Program?			
2.4 Does the Plan track and trend quality of care provided by individual providers/provider groups against professionally recognized standards of practice (e.g., provider-specific rates, investigation of complaints regarding specific cases, site visits)?			

QM-001 - Key Element 3:

- 3. The written QM Program includes all required elements. (Pre-Onsite)
28 CCR 1300.70(b)(2)(A), (B) and (F)**

Assessment Questions	Yes	No	N/A
3.1 The Plan's QM Program includes goals and objectives?			
3.2 The Plan's QM Program includes organization arrangements including staffing, clinical, and administrative staff?			
3.3 The Plan's QM Program includes methodology for ongoing monitoring and evaluation of health services?			
3.4 The Plan's QM Program defines the scope of the Program and required levels of activity? (See Key Element 1)			
3.5 The Plan's QM Program delineates the QA authority, function, and responsibility?			
3.6 The Plan's QM Program includes established quality assurance activities? (See Key Element 1)			
3.7 Was the QM Program approved by the governing body?			

QM-001 - Key Element 4:

- 4. The Plan's Governing Body, its quality committees if any, and any internal or contracting providers to whom QA responsibilities have been delegated oversee their QA Program responsibilities
28 CCR 1300.70(b)(2)(C); 28 CCR 1300.70(a)(4)(B)**

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Assessment Questions	Yes	No	N/A
Do the Plan's Governing Body, QA Committees, if any, and any internal or contracting providers to whom QA responsibilities have been delegated do the following:			
4.1 Meet on a quarterly basis or more frequently if problems were identified?			
4.2 Maintain records of QA activities and actions, and report to the Plan and to the Plan's governing body on a regularly scheduled basis, at least quarterly?			
4.3 Provide reports that include findings and actions taken as a result of the QA Program?			
4.4 Establish a program to monitor and evaluate the care provided by each contracting provider group to ensure care provided meets professionally recognized standards of practice?			
4.5 Provide reports to the Plan's governing body with sufficient detail to include findings and actions taken as a result of the QA Program?			
4.6 Provide reports to the Plan's governing body with sufficient detail to identify those internal or contracting provider components which the QA Program has identified as presenting significant or chronic quality of care issues?			

End of Requirement QM-001: QM Program Intent and Regulatory Purpose, Structure and Requirements

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Requirement QM-002: QM Program Monitors the Full Scope of QM Activities (Pre- Onsite Review)

STATUTORY/REGULATORY CITATIONS

CA Health and Safety Code section 1367.01(j)

(j) A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

CA Health and Safety Code section 1370

Every plan shall establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs. Notwithstanding any other provision of law, there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person who participates in plan or provider quality of care or utilization reviews by peer review committees which are composed chiefly of physicians and surgeons or dentists, psychologists, or optometrists, or any of the above, for any act performed during the reviews if the person acts without malice, has made a reasonable effort to obtain the facts of the matter, and believes that the action taken is warranted by the facts, and neither the proceedings nor the records of the reviews shall be subject to discovery, nor shall any person in attendance at the reviews be required to testify as to what transpired thereat. Disclosure of the proceedings or records to the governing body of a plan or to any person or entity designated by the plan to review activities of the plan or provider committees shall not alter the status of the records or of the proceedings as privileged communications.

The above prohibition relating to discovery or testimony shall not apply to the statements made by any person in attendance at a review who is a party to an action or proceeding the subject matter of which was reviewed, or to any person requesting hospital staff privileges, or in any action against an insurance carrier alleging bad faith by the carrier in refusing to accept a settlement offer within the policy limits, or to the director in conducting surveys pursuant to Section 1380.

This section shall not be construed to confer immunity from liability on any health care service plan. In any case in which, but for the enactment of the preceding provisions of this section, a cause of action would arise against a health care service plan, the cause of action shall exist notwithstanding the provisions of this section.

28 CCR 1300.67.2.2.(d)(1)

(d) Quality Assurance Processes. Each plan shall have written quality assurance systems, policies and procedures designed to ensure that the plan's provider network is

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sufficient to provide accessibility, availability and continuity of covered health care services as required by the Act and this section. In addition to the requirements established by Section 1300.70 of Title 28, a plan's quality assurance program shall address:

(1) Standards for the provision of covered services in a timely manner consistent with the requirements of this section.

28 CCR 1300.67.04(e)(2)

(e) Implementation.

(2) By July 1, 2008, every plan shall file, in accordance with Section 1352 of the Act, an amendment to its quality assurance program providing its written language assistance program policies and procedures, together with information and documents sufficient to demonstrate compliance with the requirements and standards of Section 1367.04 of the Act and this section. The filing shall include the plan's Section 1367.04(b)(1)(B)(v) notices. All materials filed with the Department that contain documents in non-English languages shall include the following minimum supporting documentation:

(i) The English version of each non-English document.

(ii) An attestation by the translator or, if applicable, by an authorized officer of the organization providing translator services, outlining the qualifications of the translator making the translation and affirming that the non-English translation is an accurate translation of the English version.

28 CCR 1300.67.2.2.(d)(1)

(d) Quality Assurance Processes. Each plan shall have written quality assurance systems, policies and procedures designed to ensure that the plan's provider network is sufficient to provide accessibility, availability and continuity of covered health care services as required by the Act and this section. In addition to the requirements established by Section 1300.70 of Title 28, a plan's quality assurance program shall address:

(1) Standards for the provision of covered services in a timely manner consistent with the requirements of this section.

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.

(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.

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28 CCR 1300.70(a)(3)

(a) Intent and Regulatory Purpose.

(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.

28 CCR 1300.70(b)(1)(A)

(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;

28 CCR 1300.70(b)(1)(B) and (C)

(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:

(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;

(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;

28 CCR 1300.70(b)(1)(B) and (D)

(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:

(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

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28 CCR 1300.70(b)(2)(C)

(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:

(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.

28 CCR 1300.70 (b)(2)(C) through (E)

(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:

(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) 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.

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28 CCR 1300.70(2)(H)

(2) Program Requirements.

(H) A plan that has capitation or risk-sharing contracts must:

1. Ensure that each contracting provider has the administrative and financial capacity to meet its contractual obligations; the plan shall have systems in place to monitor QA functions.
2. Have a mechanism to detect and correct under-service by an at-risk provider (as determined by its patient mix), including possible under utilization of specialist services and preventive health care services.

California Business and Professions Code Section 805

a) As used in this section, the following terms have the following definitions:

(1) (A) "Peer review" means both of the following:

(i) A process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of licentiates to make recommendations for quality improvement and education, if necessary, in order to do

either or both of the following:

(I) Determine whether a licentiate may practice or continue to practice in a health care facility, clinic, or other setting providing medical services, and, if so, to determine the parameters of that practice.

(II) Assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services.

(ii) Any other activities of a peer review body as specified in subparagraph (B).

(B) "Peer review body" includes:

(i) A medical or professional staff of any health care facility or clinic licensed under Division 2 (commencing with Section 1200) of the Health and Safety Code or of a facility certified to participate in the federal Medicare Program as an ambulatory surgical center.

(ii) A health care service plan licensed under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or a disability insurer that contracts with licentiates to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code.

(iii) Any medical, psychological, marriage and family therapy, social work, professional clinical counselor, dental, or podiatric professional society having as members at least 25 percent of the eligible licentiates in the area in which it functions (which must include at least one county), which is not organized for profit and which has been determined to be exempt from taxes pursuant to Section 23701 of the Revenue and Taxation Code.

(iv) A committee organized by any entity consisting of or employing more than 25 licentiates of the same class that functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity.

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(2) "Licentiate" means a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, or dentist. "Licentiate" also includes a person authorized to practice medicine pursuant to Section 2113 or 2168.

(3) "Agency" means the relevant state licensing agency having regulatory jurisdiction over the licentiates listed in paragraph (2).

(4) "Staff privileges" means any arrangement under which a licentiate is allowed to practice in or provide care for patients in a health facility. Those arrangements shall include, but are not limited to, full staff privileges, active staff privileges, limited staff privileges, auxiliary staff privileges, provisional staff privileges, temporary staff privileges, courtesy staff privileges, locum tenens arrangements, and contractual arrangements to provide professional services, including, but not limited to, arrangements to provide outpatient services.

(5) "Denial or termination of staff privileges, membership, or employment" includes failure or refusal to renew a contract or to renew, extend, or reestablish any staff privileges, if the action is based on medical disciplinary cause or reason.

(6) "Medical disciplinary cause or reason" means that aspect of a licentiate's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

(7) "805 report" means the written report required under subdivision (b).

(b) The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805 report with the relevant agency within 15 days after the effective date of any of the following that occur as a result of an action of a peer review body:

(1) A licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason.

(2) A licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.

(3) Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.

(c) The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805 report with the relevant agency within 15 days after any of the following occur after notice of either an impending investigation or the denial or rejection of the application for a medical disciplinary cause or reason:

(1) Resignation or leave of absence from membership, staff, or employment.

(2) The withdrawal or abandonment of a licentiate's application for staff privileges or membership.

(3) The request for renewal of those privileges or membership is withdrawn or abandoned.

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(d) For purposes of filing an 805 report, the signature of at least one of the individuals indicated in subdivision (b) or (c) on the completed form shall constitute compliance with the requirement to file the report.

(e) An 805 report shall also be filed within 15 days following the imposition of summary suspension of staff privileges, membership, or employment, if the summary suspension remains in effect for a period in excess of 14 days.

(f) A copy of the 805 report, and a notice advising the licentiate of his or her right to submit additional statements or other information pursuant to Section 800, shall be sent by the peer review body to the licentiate named in the report. The information to be reported in an 805 report shall include the name and license number of the licentiate involved, a description of the facts and circumstances of the medical disciplinary cause or reason, and any other relevant information deemed appropriate by the reporter. A supplemental report shall also be made within 30 days following the date the licentiate is deemed to have satisfied any terms, conditions, or sanctions imposed as disciplinary action by the reporting peer review body. In performing its dissemination functions required by Section 805.5, the agency shall include a copy of a supplemental report, if any, whenever it furnishes a copy of the original 805 report. If another peer review body is required to file an 805 report, a health care service plan is not required to file a separate report with respect to action attributable to the same medical disciplinary cause or reason. If the Medical Board of California or a licensing agency of another state revokes or suspends, without a stay, the license of a physician and surgeon, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.

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

Staff responsible for the activities described above, for example:

- Dental Director responsible to supervise the implementation of the QA Program.
- QA Director or equivalent
- Member Services Director
- UM Director/ Medical Director involved in UM Review
- QA Committee members
- Participating providers
- Staff responsible for developing and analyzing reports
- Delegate Clinical Director, if Plan delegates QM
- Delegate Director of Quality Improvement, if Plan delegates QM

DOCUMENTS TO BE REVIEWED

- QM Reporting and Analysis Plan;
 - Utilization reports
 - Reports/analysis of complaints and grievances
 - QM activity reports, documentation and studies
 - QM Committee or applicable subcommittee minutes

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- Enrollee/provider satisfaction surveys results
- Access and availability studies including telephone access studies
- Special ad hoc reports to the Board, if applicable
- Files detailing the review access/ availability complaints, continuity of care, utilization of services
- List of established performance goals and associated tracking reports
- QM 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 and follow-up monitoring.
- Policy and procedure for peer review and section 805 reporting
- Peer Review Committee minutes
- Section 805 Reports
- PQI Log
- Sample of PQI Files to be reviewed on site
- PQI track and trend reports by provider, by issue and by level of severity of confirmed problems

QM-002 - Key Element 1:

1. **The Plan monitors required service elements and utilization of services and identifies and corrects quality of care problems for all provider entities. CA Health and Safety Code section 1367.01(j); 28 CCR 1300.70(a)(3); 28 CCR 1300.67.04(e)(2); 28 CCR 1300.67.2.2.(d)(1); 28 CCR 1300.70(2)(H)**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan's QA monitoring include accessibility, availability, and continuity of care?			
1.2 Does the Plan's QA monitoring include provider entities (e.g., dentists, specialists, dental groups)?			
1.3 Does the Plan's QA monitoring include whether utilization of services meets professionally recognized standards of practice?			
1.4 Does the scope of the QA Program include a process by which the Plan monitors compliance with section 1367.01?			
1.5 Does the scope of the QA process for monitoring section 1367.01 include provisions for evaluation of complaints ?			
1.6 Does the scope of the QA process for monitoring section 1367.01 include assessment of trends ?			
1.7 Does the scope of the QA process for monitoring section 1367.01 include implementation of actions to correct identified problems?			
1.8 Does the scope of the QA process for monitoring section 1367.01 include mechanisms to communicate actions and			

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Assessment Questions	Yes	No	N/A
results to appropriate health plan employees and contracting providers?			
1.9 Does the scope of the QA process for monitoring section 1367.01 include provisions for evaluation of any corrective action plan and measurements of performance ?			
1.10 Does the scope of the QA Program include Language Assistance Program policies and procedures, together with information and documents sufficient to demonstrate compliance with the requirements and standards of section 1367.04			
1.11 Does the scope of the QA Program include metrics for measuring and monitoring the adequacy of the Plan's contracted provider network to provide enrollees with timely access to needed health care services?			
1.12 Does the Plan have written quality assurance systems, policies and procedures designed to ensure that the Plan's provider network is sufficient to provide accessibility, availability and continuity of covered health care services as required by the Act and this section?			

QM-002 - Key Element 2:

- 2. The QA Program must document that problems are being identified. CA Health and Safety code section 1370; 28 CCR 1300.70(a)(1); 28 CCR 1300.70(b)(1)(B) and (C); 28 CCR 1300.70(b)(2)(C)**

Assessment Questions	Yes	No	N/A
2.1 Does the Plan have a variety of monitoring activities used to identify problems in the quality of care and the Plan's delivery to identify problems in service and care?			
2.2 Where the Plan has failed to meet performance goals or targets, does the Plan conduct gap analysis and investigate barriers to better isolate the problems for both clinical and non-clinical aspects of its health service delivery?			

QM-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. 28 CCR 1300.70(a)(1); 28 CCR 1300.70(b)(1)(B) and (D); 28 CCR 1300.70(b)(2)(C)**

DENTAL TAG

Assessment Questions	Yes	No	N/A
3.1 Does the Plan implement corrective actions or QM Programs to address identified quality issues?			
3.2 Does the Plan incorporate input from appropriate professionals into the design of its corrective action plans or QM Programs?			
3.3 Does the Plan assess the effectiveness of its corrective actions or QM Programs?			
3.4 Does the Plan critically evaluate the outcome of its corrective actions or QM Programs and take steps to rectify continued deficiencies?			

QM-002 - Key Element 4:

- 4. The QA Program must be directed by providers and must document that the quality of care provided is being reviewed.
CA Health and Safety Code section 1370; 28 CCR 1300.70(a)(1); 28 CCR 1300.70 (b)(2)(C) through (E); CA Business and Professions Code section 805.**

Assessment Questions	Yes	No	N/A
For individual cases/providers (e.g., cases identified through complaints or sentinel events involving the quality of care provided by the provider):			
4.1 Does the Plan have an established process for investigating quality of care cases?			
4.2 Does the Plan involve clinicians with the appropriate knowledge or specialty (e.g., DDS, MD's) in the review process?			
4.3 Does the Plan complete investigations involving quality of care issues within the timeframes established by the Quality Management and Peer Review Programs? (Within reasonable time frame.)			
4.4 Does the Plan have a peer review mechanism in place?			
4.5 Does the Plan have a system to judge the severity of issues and the care involved that relies on professionally accepted standards of practice?			
4.6 Is the peer review case scoring system standardized, defined and communicated to all dentists involved in peer review?			
4.7 Does the Plan refer cases to a Peer Review Committee or other appropriate body of clinicians when appropriate?			

DENTAL TAG

Assessment Questions	Yes	No	N/A
4.8 Does the Plan have policies and procedures that establish a method for reporting determinations of the peer review body in accordance with Section 805?			
4.9 If the Plan has denied a licentiate's application for membership, terminated membership, imposed a summary suspension of membership or imposed restrictions, or if a licentiate has resigned following notice of an impending investigation, has the Plan filed an 805 Report?			
4.10 Does the Plan either prescribe a corrective action plan or require that the offending provider submit a corrective action plan?			
4.11 Is the corrective action plan commensurate or equal to the seriousness of the quality of care problem?			
4.12 Does the Plan follow through and request evidence that corrective actions have been implemented by the offending providers?			

End of Requirement QM-002: QM Program Monitors the Full Scope of QM Activities

DENTAL TAG

Requirement QM-003: Precautions to Ensure Appropriate Care is Not Withheld or Delayed for Any Reason

STATUTORY/REGULATORY CITATIONS

CA Health and Safety Code section 1367(g)

(g) The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management.

28 CCR 1300.70(b)(1)(D) and (E)

(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:

(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(2)(H)

(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.

(H) A plan that has capitation or risk-sharing contracts must:

1. Ensure that each contracting provider has the administrative and financial capacity to meet its contractual obligations; the plan shall have systems in place to monitor QA functions.
2. Have a mechanism to detect and correct under-service by an at-risk provider (as determined by its patient mix), including possible under utilization of specialist services and preventive health care services.

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

Staff responsible for the activities described above, for example:

- Dental Director;
- QA Director
- QA Coordinator

DENTAL TAG

DOCUMENTS TO BE REVIEWED

- Organizational chart depicting reporting relationships between QM and other departments.
- Dental Reviewer agreements with the Health Plan. Descriptions in the Provider Manual regarding prior authorization requirements, benefit coverage. Contract terms and conditions.
- List of QM Committee members and titles, role and responsibility within the Committee, if any.
- Quality Assurance policies and procedures

QM-003 - Key Element 1:

1. **The QM Program is designed to ensure appropriate care is not delayed or withheld for any reason.**
CA Health and Safety Code section 1367(g); 28 CCR 1300.70(b)(1)(D) and (E); 28 CCR 1300.70(2)(H)

Assessment Questions	Yes	No	N/A
1.1 Can the Plan demonstrate there is no financial incentive or gain to the Plan providers and/or others to delay or withhold appropriate care?			
1.2 Can the Plan demonstrate that it does not exert economic pressure on institutions to grant privileges to health care providers that would not otherwise be granted?			
1.3 Can the Plan demonstrate that it does not pressure health care providers or institutions to render care beyond the scope of their training or experience?			
1.4 Are all treatment decisions rendered by appropriate clinical staff, void of any influence or oversight by the Finance Department?			
1.5 Does the Dental Director's responsibility to supervise medical management of the Plan's benefits occur without financial influence by the Finance Department?			
If the Plan has capitation or risk-sharing contracts, answer the following:			
1.6 Does the QA Program include an assessment of the administrative capacity of contracting provider's abilities to meet their obligations and monitors the contracting provider's QA functions?			
1.7 Does the QA Program have a mechanism to detect and correct under-service by an at-risk provider (as determined by patient mix) including possible under-utilization of specialist services and preventive health care services?			

DENTAL TAG

End of Requirement QM-003: Precautions to Ensure Appropriate Care is Not Withheld or Delayed for Any Reason

DENTAL TAG

Requirement QM-004: Credentialing

STATUTORY/REGULATORY CITATIONS

CA Health and Safety Code section 1367(b)

Personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where licensure or certification is required by law.

28 CCR 1300.67.2(e)

(e) A plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral;

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

Staff interviews are not required or recommended unless a specific concern is identified.

DOCUMENTS TO BE REVIEWED

- Related policies and procedures, including: credentialing and re-credentialing; ensuring all Plan providers and all participating providers are licensed and/or certified; ensuring all participating medical specialists are certified or board eligible; identifying providers whose licenses have been suspended or revoked; etc.
- Monitoring and tracking reports of credentialing and re-credentialing
- Delegation contracts as applicable

QM-004 - Key Element 1:

1. The Plan ensures that all Plan provider staff and all participating providers, both individual and institutional, are licensed and/or certified, as required by law.

CA Health and Safety Code section 1367(b)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan verify licensure/certification of its providers at the time of acceptance into the Plan network and prior to licensure/certification expirations?			
1.2 Does the Plan have a mechanism to identify on a periodic basis providers whose license has been suspended or revoked?			
1.3 Does the Plan takes steps to ensure the suspended provider does not continue to examine and treat patients until licensure is restored?			

DENTAL TAG

QM-004 - Key Element 2:

- 2. The Plan provides access to required specialists who are certified or eligible for certification by the appropriate specialty board.
28 CCR 1300.67.2(e)**

Assessment Question	Yes	No	N/A
2.1 Does the Plan provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral?			

End of Requirement QM-004: Credentialing

DENTAL TAG

Requirement QM-005: QM Delegation Oversight

STATUTORY/REGULATORY CITATIONS

CA Health and Safety code Section 1370

Every plan shall establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs. Notwithstanding any other provision of law, there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person who participates in plan or provider quality of care or utilization reviews by peer review committees which are composed chiefly of physicians and surgeons or dentists, psychologists, or optometrists, or any of the above, for any act performed during the reviews if the person acts without malice, has made a reasonable effort to obtain the facts of the matter, and believes that the action taken is warranted by the facts, and neither the proceedings nor the records of the reviews shall be subject to discovery, nor shall any person in attendance at the reviews be required to testify as to what transpired thereat. Disclosure of the proceedings or records to the governing body of a plan or to any person or entity designated by the plan to review activities of the plan or provider committees shall not alter the status of the records or of the proceedings as privileged communications.

The above prohibition relating to discovery or testimony shall not apply to the statements made by any person in attendance at a review who is a party to an action or proceeding the subject matter of which was reviewed, or to any person requesting hospital staff privileges, or in any action against an insurance carrier alleging bad faith by the carrier in refusing to accept a settlement offer within the policy limits, or to the director in conducting surveys pursuant to Section 1380.

This section shall not be construed to confer immunity from liability on any health care service plan. In any case in which, but for the enactment of the preceding provisions of this section, a cause of action would arise against a health care service plan, the cause of action shall exist notwithstanding the provisions of this section.

28 CCR 1300.70(b)(2)(G)(1) through (3)

(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.

DENTAL TAG

(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.

28 CCR 1300.70(b)(2)(G)(1) through (6)

(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.

28 CCR 1300.70(b)(2)(G)(3)

(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.

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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:

(3) Have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated QA responsibilities.

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

Staff responsible for the activities described above, for example:

- Delegate Dental Director
- Plan QA Manager
- Delegate QA Manager
- Plan QA coordinators that conduct audits of the delegates
- QA representatives from one or more provider delegates
- Plan staff person responsible for the delegation
- Delegate staff person responsible for the delegation

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
- 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 QM Program Description and Work Plan
- Plan board or QM committee or subcommittee minutes which 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

QM-005 - Key Element 1:

If a Plan delegates any QM responsibilities to affiliates and vendors including but not limited to contracting provider groups and/or credentialing verification organizations:

- 1. The Plan assesses the capability of each delegated entity by performing a capability assessment prior to delegation.
CA Health and Safety code Section 1370; 28 CCR 1300.70(b)(2)(G)(1) through (3)**

DENTAL TAG

Assessment Questions	Yes	No	N/A
1.1 Does the Plan assess the delegate's policies and procedures for conducting the delegated responsibilities?			
1.2 Does the Plan assess the delegate's administrative capabilities?			
1.3 Does the Plan assess the delegate's technical expertise?			
1.4 Does the Plan assess the delegate's budgetary resources?			

QM-005 - Key Element 2:

- 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.
CA Health and Safety code Section 1370; 28 CCR 1300.70(b)(2)(G)(1) through (6)**

Assessment Questions	Yes	No	N/A
2.1 Does the Plan have an agreement with each delegate that defines the scope of responsibilities and how the delegate will be monitored by the Plan?			
2.2 Does the contract/agreement include a description of the delegated services?			
2.3 Does the contract/agreement include a description of The administrative responsibilities of the delegate (e.g., for handling of grievances and appeals, customer service)?			
2.4 Does the contract/agreement include a description of how the Plan will monitor the delegated entity?			
2.5 Does the Plan require the delegate to have standards for evaluating that enrollees receive health care consistent with professionally recognized standards of practice?			
2.6 Are these standards included in the delegate's QA Program?			
2.7 Are there evaluation methods to assure the delegate's continued adherence to these standards?			
2.8 Does the Plan require that the delegate's quality and utilization review mechanisms encompass provider referral and specialist care patterns of practice?			
2.9 Does the Plan require that the delegate's quality and utilization review mechanisms encompass			

DENTAL TAG

Assessment Questions	Yes	No	N/A
<u>assessment of timely access</u> to specialists, and ancillary support services?			
2.10 Does the Plan require that the delegate’s quality and utilization review mechanisms encompass access to appropriate <u>preventive health services</u> based on <u>reasonable standards</u> established by the Plan and/or delegated providers?			
2.11 Does the Plan require that the delegate’s quality and utilization review mechanisms encompass appropriate <u>preventive health care measures</u> consistent with professionally recognized standards of practice, <u>indicating</u> when <u>screening for conditions</u> should be done?			

QM-005 - Key Element 3:

- 3. The Plan has put in place ongoing oversight procedures to ensure that delegates are fulfilling all delegated QM responsibilities.
CA Health and Safety code Section 1370; 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 providers are fulfilling all delegated QA responsibilities?			
3.2 Do appropriate minutes of committee meetings indicate regular review of delegate reports and activities?			
3.3 Does the Plan conduct periodic site visits to the delegate?			
3.4 Does the Plan periodically review the delegate’s QM Program Description?			
3.5 Does the Plan periodically review the delegate’s QM Work Plan?			
3.6 Does the Plan implement corrective action and conduct follow-up reviews to address any deficiencies?			

End of Requirement QM-005: QM Delegation Oversight

DENTAL TAG

DHCS REQUIREMENTS FOR GMC PROGRAMS

Requirement QM-006: Quality Improvement System

CONTRACT CITATIONS

Medi-Cal Dental GMC Program Exhibit A, Attachment 5, Provision D

D. 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 dental director or a dentist 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 or chronic conditions (such as asthma, diabetes, congestive heart failure), actively participate on 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.

Medi-Cal Dental GMC Program Exhibit A, Attachment 5, Provision F

F. Delegation of Quality Improvement Activities

1. 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:

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

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

c. 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.

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

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

a. 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.

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- b. Ensures subcontractor meets standards set forth by the Contractor and DHCS.
- c. Includes the continuous monitoring, evaluation and approval of the delegated functions.

Medi-Cal Dental GMC Program Exhibit A, Attachment 5, Provision I

I. Quality Improvement Annual Report

Contractor shall develop an annual quality improvement report for submission to DHCS on an annual basis due no later than thirty (30) calendar days after the beginning of the calendar year.

The annual report shall include:

1. A comprehensive assessment of the quality improvement activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the quality improvement program, including but not limited to, the collection of aggregate data on utilization; the review of quality of services rendered; the results of the Performance Measures; and, outcomes/findings from Quality Improvement Projects (QIPs), consumer satisfaction surveys and collaborative initiatives.
2. Copies of all final reports of any non-governmental accrediting agencies 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.
3. An assessment of subcontractor's performance of delegated quality improvement activities.

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

Staff responsible for the activities described above, for example:

- Dental Director
- QA Director
- QA coordinators that conduct provider site audits
- Plan staff person(s) responsible for conducting monitoring activities and Quality Improvement Studies
- Director Network Management
- Plan staff person responsible for credentialing

DOCUMENTS TO BE REVIEWED

- Quality Improvement Committee Minutes
- Annual Quality Improvement Report
- Provider Network and Provider Manual
- Policies and procedures that describe dental record requirements
- Credentialing policies and procedures
- Site Audit Tools
- Monitoring logs and tracking tools
- Delegation Agreements if applicable

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QM-006 - Key Element 1:

- 1. Quality Improvement Committee and Annual Report: The Plan’s Quality Improvement Committee meets quarterly and complies with the contractual reporting requirements.
 Medi-Cal Dental GMC Program Exhibit A, Attachment 5, Provision D and I**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan maintain a Quality Improvement Committee designated by and accountable to the governing body of the Plan? Is the QIC facilitated by the Dental Director or a dentist designee?			
1.2 Does the Plan’s QIC meet at least quarterly? Does the Plan submit copies of the meeting minutes that reflect activities, findings, recommendations, and actions to the governing body on a scheduled basis?			
1.3 Does the Plan submit committee meeting minutes to DHCS on quarterly basis?			
1.4 Does membership on the Quality Committee include contracting dentists and other providers who are representative of the provider network?			
1.5 Does the Plan have processes in place to ensure submission of an annual quality improvement report to DHCS no later than thirty (30) calendar days after the beginning of the calendar year?			
1.6 Does the annual report include a comprehensive assessment of the quality improvement activities, evaluation of areas of success and needed improvements, including but not limited to, the collection of aggregate data on utilization; the review of quality of services rendered; the results of the performance measures; and consumer satisfaction surveys and collaborative initiatives?			
1.7 Does the annual report include any reports from any non-governmental accrediting agencies 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?			
1.8 Does the report include, if applicable, an assessment of the Plan’s delegated quality activities?			

QM-006 - Key Element 2:

- 2. Delegation of Quality Improvement Activities: The Plan provides proper oversight of the subcontractor for all delegated quality improvement functions**

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and responsibilities. The Plan includes the specified minimum elements in their subcontract.

Medi-Cal Dental GMC Program Exhibit A, Attachment 5, Provision F

Assessment Questions	Yes	No	N/A
2.1 Does the Plan delegate any quality improvement functions or responsibilities, such as utilization management, credentialing, or site review?			
2.2 Does the subcontract include the quality improvement responsibilities, and specific delegated functions and activities of the Contractor and subcontractor?			
2.3 Does the subcontract include provisions stating the Plan's oversight, monitoring, and evaluation processes and subcontractor's agreement to such processes?			
2.4 Does the subcontract contain the reporting requirements and approval processes, including subcontractor's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly?			
2.5 Does the subcontract include the Plan's actions/remedies if subcontractor's obligations are not met?			
2.6 Does the Plan maintain a system to ensure accountability for delegated quality improvement actions that meet the minimum requirements? Including:			
a. Does the Plan's system evaluate 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?			
b. Does the Plan's system ensure the subcontractor meets standards set forth by the Contractor and DHCS?			
c. Does the Plan's system include continuous monitoring, evaluation and approval of the delegated functions?			

End of Requirement QM-006: Quality Improvement System

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Requirement QM-007: Provider Relations

CONTRACT CITATIONS

Medi-Cal Dental GMC Program Exhibit A, Attachment 9, Provision D

D. Provider Manual

Contractor shall issue a provider manual and updates to the providers of Medi-Cal dental services. The manual and updates shall serve as a source of information to dental providers regarding Medi-Cal dental services, policies and procedures, statutes, regulations, telephone access and special requirements regarding the Medi-Cal Dental Managed Care program.

Provider manuals shall include information about grievance and State Fair Hearing processes, procedures and timeframes, in accordance with 42 CFR 438.414.

1. Member's right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing;
2. Member's right to file grievances and appeals and their requirements and timeframes for filing;
3. Availability of assistance in filing;
4. Toll-free numbers to file oral grievances and appeals; and
5. Member's right to request continuation of benefits during an appeal or State Fair Hearing.

Medi-Cal Dental GMC Program Exhibit A, Attachment 9, Provision E

E. Provider Training

Contractor shall ensure that all providers receive training regarding the Medi-Cal Dental Managed Care program in order to operate in full compliance with the contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi-Cal Dental Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, provider, Member and/or other healthcare professionals. Contractor shall conduct training for all providers within ten (10) business days after the Contractor places a newly contracted provider on active status. Contractor shall ensure that provider training includes, but is not limited to, information on all Member rights specified in Exhibit A, Attachment 14, Member Services, including the right to full disclosure of dental care information and the right to actively participate in dental care decisions. Contractor shall ensure that ongoing training is conducted when deemed necessary by either the Contractor or DHCS.

Medi-Cal Dental GMC Program Exhibit A, Attachment 14, Provision A(1)(a)(1)-(16).

A. Members Rights and Responsibilities

1. Member Rights and Responsibilities

Contractor shall develop, implement and maintain written policies that address the Member's rights and responsibilities and shall communicate these to its Members and providers.

- a. Contractor's written policies regarding Member rights shall include the following:

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- 1) to be treated with respect, giving due consideration to the Member's right to privacy and the need to maintain confidentiality of the Member's medical and dental information.
 - 2) to be provided with information about the plan and its services, including covered services, as identified in the Medi-Cal Dental Manual of Criteria.
 - 3) to be able to choose a Primary Care Dentist within the Contractor's network.
 - 4) to participate in decision making regarding their own dental care, including the right to refuse treatment.
 - 5) to voice grievances, either verbally or in writing, about the organization or the care received.
 - 6) to receive interpretation services for their language.
 - 7) to have access to all medically necessary dental service provided in Federally Qualified Health Centers, Rural Health Clinics or Indian Health Service Facilities, and access to emergency dental services outside the Contractor's network pursuant to federal law.
 - 8) to request a State Medi-Cal fair hearing, including information on the circumstances under which an expedited fair hearing is possible.
 - 9) to have access to, and where legally appropriate, receive copies of, amend or correct their dental record.
 - 10) to disenroll upon request.
 - 11) to receive written Member informing materials in alternative formats (including Braille, large size print, and audio format) upon request and in a timely fashion appropriate for the format being requested.
 - 12) to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
 - 13) to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.
 - 14) freedom to exercise these rights without adversely affecting how they are treated by the Contractor, providers, or the State.
 - 15) to have access to Contractor's health education programs and outreach services in order to improve dental health.
 - 16) To request a second opinion, including from a specialist at no cost.
- b. Contractor's written policy regarding Member responsibilities shall include providing accurate information to the professional staff, following instructions, and cooperating with the providers.

42 CFR Title 42, Chapter IV, Subchapter C, Part 438, Subpart F, Section 438.414

438.414 Information about the grievance system to providers and subcontractors. The MCO or PHP must provide the information specified at § 438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.

42 CFR Title 42, Chapter IV, Subchapter C, Part 438, Subpart A, Section 438.10

438.10 Information requirements.

(g) Specific information requirements for enrollees of MCOs and PIHPs. In addition to the requirements in § 438.10(f), the State, its contracted representative, or the MCO and PIHP must provide the following information to their enrollees:

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(1) Grievance, appeal, and fair hearing procedures and timeframes, as provided in §§ 438.400 through 438.424, in a State-developed or State-approved description, that must include the following:

- (i) For State fair hearing—
 - (A) The right to hearing;
 - (B) The method for obtaining a hearing; and
 - (C) The rules that govern representation at the hearing.
 - (ii) The right to file grievances and appeals.
 - (iii) The requirements and timeframes for filing a grievance or appeal.
 - (iv) The availability of assistance in the filing process.
 - (v) The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone.
 - (vi) The fact that, when requested by the enrollee—
 - (A) Benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing; and
 - (B) The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.
 - (vii) Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.
- (2) Advance directives, as set forth in § 438.6(i)(2).
- (3) Additional information that is available upon request, including the following:
- (i) Information on the structure and operation of the MCO or PIHP.
 - (ii) Physician incentive plans as set forth in § 438.6(h) of this chapter.

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

Staff responsible for the activities described above, for example:

- Dental Director
- QA Director
- Plan person responsible for provider education
- Director Network Management

DOCUMENTS TO BE REVIEWED

- Provider Manual
- Policies and procedures that describe member rights, including those that describe the member's right to a State fair hearing, a grievance, and how to file a grievance.
- Provider and Member Newsletters
- Evidence of Coverage documents
- Provider training manual
- Policies and procedures that describe the requirements for provider training, and the content of the training.
- Monitoring and tracking documents used in provider training.

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QM-007 - Key Element 1:

- 1. Provider Manual: Plan issues a Provider Manual and updates to the providers of Medi-Cal dental services which contain information outlined in the Medi-Cal Dental Managed Care contract.
Medi-Cal Dental GMC Program Exhibit A, Attachment 9, Provision D**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have policies and procedures in place for distribution of the Provider Manual and updates to all of its contracted providers to provide information regarding Medi-Cal dental services, policies and procedures, statutes, regulations, telephone access and special requirements regarding Medi-Cal Dental Managed Care Program?			
1.2 Does the Plan's Provider Manual include information regarding Members' rights to State Fair Hearings, including the process, procedures, timeline, how to obtain a hearing, and representation rules at a hearing?			
1.3 Does the Plan's Provider Manual include information regarding Members' rights to file grievances and appeals and their requirements and timeframes for filing? And the availability of assistance in filing?			
1.4 Does the Plan's Provider Manual include toll-free numbers for filing oral grievances and appeals?			
1.5 Does the Plan's Provider Manual include information regarding Members' rights to request a continuation of benefits during an appeal or State Fair Hearing?			

QM-007 - Key Element 2:

- 2. Provider Training: The Plan ensures that all providers receive training regarding the Medi-Cal Dental Managed Care Program.
Medi-Cal Dental GMC Program Exhibit A, Attachment 9, Provision E**

Assessment Questions	Yes	No	N/A
2.1 Does the Plan's provider training relate to Medi-Cal Dental Managed Care services, policies, procedures and any modifications to existing services, policies or procedures?			
2.2 Does the Plan's provider training include methods for sharing information between Contractor, provider, Member and/or other healthcare professionals?			
2.3 Does the Plan conduct training for all providers within 10 business days after the Plan places a newly contracted provider on active status?			
2.4 Does the Plan's provider training include information on all			

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Member rights specified in Exhibit A, Attachment 14, Member Services, including the right to full disclosure of dental care information and the right to actively participate in dental care decisions?			
2.5 Does the Plan provide ongoing training when deemed necessary by either the Plan or DHCS?			

QM-007 - Key Element 3:

**3. Prohibited Punitive Action against the Provider: The Plan ensures that punitive action is not taken against the provider who either requests an expedited resolution or supports a Member’s appeal.
 Medi-Cal Dental GMC Program Exhibit A, Attachment 9, Provision F**

Assessment Questions	Yes	No	N/A
3.1 Does the Plan ensure that punitive action is not taken against providers who either request an expedited resolution or support a Member’s appeal?			
3.2 Does the Plan ensure that it does not prohibit or restrict dental professionals acting within the lawful scope of practice from advising or advocating on behalf of a Member who is his or her patient for the Member’s health status, medical care, or treatment options?			

End of Requirement QM-007: Provider Relations