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

TECHNICAL ASSISTANCE GUIDE

QUALITY ASSURANCE

ROUTINE MEDICAL SURVEY

OF

PLAN NAME

DATE OF SURVEY:

PLAN COPY

Issuance of this July 10, 2026 Technical Assistance Guide renders all other versions obsolete.

QUALITY ASSURANCE REQUIREMENTS

Table of Contents

This Technical Assistance Guide (TAG) serves as a guide for medical surveys which are conducted under the Health and Safety Code medical survey statutes and regulations. This TAG may be revised as appropriate, to incorporate new or updated relevant legal requirements as they impact the surveys, or for any other reason as determined by the Department. Health plans are responsible for complying with applicable statutes and regulations upon their effective dates and, therefore, are deemed to have prior notice of all statutes and regulations effective during the medical survey period. Health plans may be assessed for compliance with those requirements even when they have not yet been added to the TAG. The Department's medical survey authority is broad, and includes, but is not limited to, reviewing books and records, conducting interviews, making site visits, and making telephone calls to verify information as part of the survey assessment of any Key Element question in this TAG. The recipients of these telephone calls may include, but not be limited to, health plan and delegate physicians/medical directors, plan customer service representatives, triage nurses, and/or network/contracted providers.

FULL SERVICE TAG

Requirement QA-001: QA Program Intent and Regulatory Purpose, Structure & Requirements

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

Staff responsible for the activities described above, for example:

- CEO
- Board Members (if feasible)
- QA Director
- QA Committee members
- Designated physician/clinician that provides oversight of QA program
- Providers that participate in the QA program

DOCUMENTS TO BE REVIEWED

- QA program description and/or plan
- QA Work Plan or Action Plan
- Organization charts showing the relationship of the QA department and committees to the overall structure and the accountability of senior management for QA activities
- Annual QA Plan evaluation for the last two years
- Minutes of the QA Committee or its equivalent and its subcommittee meetings for the last 18–24 months
- Meeting minutes of governing body's review of QA monitoring results
- Job description and resume of physician or other clinician, as appropriate, who provides clinical direction to the QA program
- Review licensing filing of the Plan's QA program and confirm submission of appropriate policies and procedures

QA-001 - Key Element 1:

1. **The Plan has established and documented a QA program consistent with the intent and regulatory purpose of the Act.**
   CA Health and Safety Code section 1369; 28 CCR 1300.69(a) through (c), and (h); 28 CCR 1300.70(a); (b)(1)-(2), and (c).

Assessment Questions
1.1 Does the Plan have a written description of the QA program?
1.1 Comments

FULL SERVICE TAG

1.2	Does the QA program document that: 1) the quality of care provided is being reviewed; 2) problems are being identified; 3) effective action is taken to improve care where deficiencies are identified; and 4) follow-up is planned where indicated?
1.2 Comments	
1.3	Does the QA program address service elements, including accessibility, availability, and continuity of care?
1.3 Comments	
1.4	Does the QA program monitor whether the provision and utilization of services meet professionally recognized standards of practice?
1.4 Comments	
1.5	Is the written public policy participation procedure incorporated into the Plan's bylaws or other governing documents?
1.5 Comments	
1.6	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 Plan's governing board (corporation), the Plan's governing body or executive committee (partnership, trust, or unincorporated association), or the owner (sole proprietorship)? c) At least one member is a provider?
1.6 Comments	

QA-001 - Key Element 2:

2. The QA program is designed/structured to ensure effective quality oversight. 28 CCR 1300.70(b)(1)(A) through (C).

Assessment Questions	
2.1	Does the QA program ensure a level of care which meets professionally recognized standards of practice is delivered to all enrollees?
2.1 Comments	
2.2	Does the Plan have mechanisms to identify and correct quality of care problems for all provider entities?
2.2 Comments	

FULL SERVICE TAG

2.3	Are physicians (or in the case of specialized plans, dentists, optometrists, psychologists or other appropriate licensed professionals) who provide care to enrollees an integral part of the QA program?
2.3 Comments	

FULL SERVICE TAG

QA-001 - Key Element 3:

3. The written QA program meets defined requirements.
28 CCR 1300.70(b)(2)(A), (B), and (F).

Assessment Questions
3.1 Does the written QA plan describe the goals and objectives of the program and organization arrangements?
3.1 Comments
3.2 Is there 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?
3.2 Comments
3.3 Does the written QA plan include the methodology for ongoing monitoring and evaluation of health services?
3.3 Comments
3.4 Does the written QA plan include the scope of the program and required levels of activity?
3.4 Comments
3.5 Do the Plan's written documents delineate QA authority, function, and responsibility?
3.5 Comments
3.6 Do the Plan's written documents provide evidence that the Plan has established QA activities?
3.6 Comments
3.7 Was the QA program approved by the Plan's governing body?
3.7 Comments

QA-001 - Key Element 4:

4. The Plan's governing body provides adequate oversight of the QA program.
28 CCR 1300.70(b)(2)(C).

Assessment Questions
4.1 Does the Plan's governing body meet and review QA reports at least quarterly?
4.1 Comments

FULL SERVICE TAG

4.2	Are reports to the Plan's governing body sufficiently detailed to include findings and actions taken as a result of the QA program?
4.2 Comments	
4.3	Are reports to the Plan's governing body sufficiently detailed to identify those internal or contracting provider components which the QA program has identified as presenting significant or chronic quality of care issues?
4.3 Comments	

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

FULL SERVICE TAG

Requirement QA-002: QA Program Monitors the Full Scope of QA Activities

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

Staff responsible for the activities described above, for example:

- Medical Director responsible for supervising 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 QA
- Delegate Director of Quality Improvement, if Plan delegates QA

DOCUMENTS TO BE REVIEWED

- Reports on QA and analysis of the QA program/plan;
  - Utilization reports
  - Mortality/morbidity rates
  - Reports/analysis of complaints and grievances
  - HEDIS results for the last three years, if applicable
  - QA activity reports, documentation and studies
  - QA Committee or applicable subcommittee minutes
  - Enrollee/provider satisfaction surveys results
  - Access and availability studies including telephone access studies
  - Special ad hoc reports to the Board, if applicable
  - Files detailing the review access/ availability complaints, continuity of care, utilization of services
- List of established performance goals and associated tracking reports
- QA Committee and subcommittee reports and 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 reports and meeting minutes
- Section 805 reports
- PQI Log
- Sample of PQI files
- PQI track and trend reports by provider, issue, and severity levels of confirmed quality issues

FULL SERVICE TAG

QA-002 - Key Element 1:

1. The Plan monitors the provision and utilization of services and identifies and corrects quality of care problems for all provider entities.
28 CCR 1300.70(a)(3).

Assessment Questions
1.1 Does the Plan monitor service elements including accessibility, availability, and continuity of care?
1.1 Comments
1.2 Does the Plan's monitoring include all provider entities (e.g., physicians, hospitals, outpatient surgery centers, and ancillary services such as laboratories)?
1.2 Comments
1. 3 Does the Plan's monitoring include all service types (e.g., preventive care, primary care, specialty, emergency, inpatient, ancillary)?
1.3 Comments
1.4 Does the Plan monitor whether the provision and utilization of services meet professionally recognized standards of practice?
1.4 Comments
1.5 Do the Plan's files demonstrate the Plan identifies quality issues.
1.5 Comments

QA-002 - Key Element 2:

2. The Plan formulates and implements effective and timely corrective actions when it confirms problems or fails to meet performance goals.
28 CCR 1300.70(a)(1), (b)(1)(B) and (D).

Assessment Questions
2.1 Do the Plan's files demonstrate it implements effective corrective actions to address identified quality issues?
2.1 Comments
2.2 Do the Plan's files demonstrate it plans follow-up to assess the effectiveness of its corrective actions where indicated?
2.2 Comments

FULL SERVICE TAG

QA-002 - Key Element 3:

3. 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).

Assessment Questions	
3.1	Has the Plan established a process for investigating the quality of care for individual cases or providers (e.g. cases identifies through complaints or sentinel events involving the quality of care provided by providers)?
3.1 Comments	
3.2	For individual cases/providers (e.g., cases identified through complaints or sentinel events involving the quality of care provided by the provider), does the Plan either prescribe a corrective action plan or require that the offending provider submit a corrective action plan?
3.2 Comments	
3.3	For individual cases/providers (e.g., cases identified through complaints or sentinel events involving the quality of care provided by the provider), does the Plan follow through and request evidence that corrective actions have been implemented by the offending providers?
3.3 Comments	

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

FULL SERVICE TAG

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

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

Staff responsible for the activities described above, for example:

- Medical Director
- QA Director
- QA Coordinator

DOCUMENTS TO BE REVIEWED

- Organization chart depicting reporting relationships between QA and other departments
- Physician reviewer agreements with the Health Plan. Contract terms and conditions
- List of QA Committee members and titles, role and responsibility within the Committee, if any
- QA policies and procedures

QA-003 - Key Element 1:

1. **The QA program is designed to ensure appropriate care is not delayed or withheld for any reason.**
   28 CCR 1300.70(b)(1)(D) and (E).

Assessment Questions
1.1 Is the Plan's QA program designed to ensure there is no potential financial gain and/or incentive to the Plan providers and/or others to delay or withhold appropriate care consistent with professionally recognized standards of practice?
1.1 **Comments**
1.2 Is the Plan's QA program designed to ensure the Plan does not exert economic pressure to cause institutions to grant privileges to health care providers that would not otherwise be granted?
1.2 Comments
1.3 Is the Plan's QA program designed to ensure it does not pressure health care providers or institutions to render care beyond the scope of their training or experience?
1.3 Comments

FULL SERVICE TAG

1.4	Are all treatment decisions rendered by qualified clinical staff, unhindered by fiscal and administrative management?
1.4 Comments	
1.5	Does the Plan demonstrate that enrollee care is appropriate and consistent with professionally recognized standards of practice and is not withheld or delayed for any reason?
1.5 Comments	

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

FULL SERVICE TAG

Requirement QA-004: Credentialing

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, both individual and institutional, are licensed and/or certified; ensuring participating primary care physicians and specialists have admitting staff privileges with at least one participating hospital; ensuring all participating medical specialists are certified or Board eligible; defining standards for credentialing and re-credentialing of HIV/AIDS specialists; identifying providers whose licenses have been suspended or revoked; etc.
- Contracts with individual providers
- Contracts with contracted entities, including provider groups
- Complaint and grievance reports
- Delegation contracts as applicable
- Monitoring and tracking reports of credentialing and re-credentialing

QA-004 - Key Element 1:

1. **The Plan verifies that all Plan provider staff and all participating providers, including individual and institutional, are licensed and/or certified, as required by law.**
   CA Health and Safety Code section 1367(a) through (c); 28 CCR 1300.70 28 CCR 1300.74.16(e).

Assessment Questions	
1.1	Does the Plan have policies and procedures for verifying licensure/certification of its providers?
1.1 Comments	
1.2	Does the Plan ensure facilities utilized by the Plan, personnel employed by or under contract with the Plan, and equipment are licensed, registered, and certified as required by law?
1.2 Comments	
1.3	Does the Plan have criteria for identifying a provider as an HIV/AIDS specialist?
1.3 Comments	

FULL SERVICE TAG

1.4 Has the Plan established a corresponding mechanism for credentialing and re-credentialing HIV/AIDS providers in accordance with the regulation?
1.4 Comments

QA-004 - Key Element 2:

2. The Plan verifies that participating primary care physicians and specialists have admitting staff privileges with at least one participating hospital. 28 CCR 1300.51(d)(H)(iii).

Assessment Question
2.1 Does the Plan have established requirements for provider admitting staff privileges in participating hospitals?
2.1 Comments

End of Requirement QA-004: Credentialing

FULL SERVICE TAG

Requirement QA-005: QA Delegation Oversight

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

Staff responsible for the activities described above, for example:

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

DOCUMENTS TO BE REVIEWED

- Related policies and procedures, including those detailing the processes for delegation and continued oversight of delegated entities
- Pre-delegation assessments
- Delegation contracts, letters of agreements, and memoranda of understanding
- 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 QA program description and Work Plan
- Plan board or QA 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

QA-005 - Key Element 1:

1. The Plan has an oversight mechanism to ensure delegates are performing all delegated QA functions.
28 CCR 1300.70(b)(2)(B) and (C).

Assessment Questions
1.1 To the extent the Plan delegates QA functions, do the Plan's documents show the Plan has an oversight mechanism to ensure its delegates adequately perform their delegated QA functions?
1.1 Comments

FULL SERVICE TAG

End of Requirement QA-005: QA Delegation Oversight

FULL SERVICE TAG

Statutory/Regulatory Citations

CA Health and Safety Code section 1367(a) – (c)

QA-004 KE1

A health care service plan and, if applicable, a specialized health care service plan shall meet the following requirements:
(a) Facilities located in this state including, but not limited to, clinics, hospitals, and skilled nursing facilities to be utilized by the plan shall be licensed by the State Department of Public Health, where licensure is required by law. Facilities not located in this state shall conform to all licensing and other requirements of the jurisdiction in which they are located.
(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.
(c) Equipment required to be licensed or registered by law shall be so licensed or registered, and the operating personnel for that equipment shall be licensed or certified as required by law.

CA Health and Safety Code section 1369

QA-001 KE1

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

QA-002 KE3

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.

FULL SERVICE TAG

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.
an integral part of the QA program;

28 CCR 1300.51(d) H and J
QA-004 **KE2**
(d) Exhibits to Plan Application.
H. Geographical Area Served.
Note: The applicant is required to demonstrate that, throughout the geographic regions designated as the plan's Service Area, a comprehensive range of primary, specialty, institutional and ancillary services are readily available at reasonable times to all enrollees and, to the extent feasible, that all services are readily accessible to all enrollees.
For the purpose of evaluating the geographic aspects of availability and accessibility, consideration will be given to the actual and projected enrollment of the plan based on the residence and place of work of enrollees within and, if applicable, outside the service area, including the individual and group enrollment projections furnished in Items CC, DD and EE of this application.
An applicant for plan license must demonstrate compliance with the accessibility requirement in each of the areas specified in paragraphs (i) through (iv) below, either by demonstrating compliance with the standard specified in such paragraphs or, in the alternative, by presenting other information demonstrating compliance with reasonable accessibility pursuant to Rule 1300.67.2.1.
(i) Primary Care Providers. All enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider in such numbers and distribution as to accord to all enrollees a ratio of at least one primary care provider (on a full-time equivalent basis) to each 2,000 enrollees.
(ii) Hospitals. In the case of a full-service plan, all enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated hospital which has a capacity to serve the entire dependent enrollee population based on normal utilization, and, if separate from such hospital, a contracting or plan-operated provider of all emergency health care services.
(iii) Hospital Staff Privileges. In the case of a full-service plan, there is a complete network of contracting or plan-employed primary care physicians and specialists each of whom has admitting staff privileges with at least one contracting or plan-operated hospital equipped to provide the range of basic health care services the plan has contracted to provide.

FULL SERVICE TAG

(iv) Ancillary Services. Ancillary laboratory, pharmacy and similar services and goods dispensed by order or prescription by the primary care provider are available from contracting or plan-operated providers at locations (where enrollees are personally served) within a reasonable distance from the primary care provider.

J. Internal Quality of Care Review Systems.

Applicant is required to demonstrate that it has a system for the review of the quality of health care to identify, evaluate and remedy problems relating to access, continuity and quality of care, utilization and cost of services. The following exhibits require a description and explanation of the system including narrative, organization and process charts and review criteria. See Rule 1300.70.

1. Organization and Operation. As Exhibit J-1, furnish a description of this basic structure, organization and authority of the applicant's quality of care review system, including:

a. An organization chart showing the key persons, the committees and bodies responsible for the conduct of the review system, the provisions for support staff and the relationship of such persons, committees and bodies to the general organization of the plan. See Item J-4 below.

b. A narrative explanation of the review system covering the matters depicted in the organization chart and the following: the key persons involved, their titles and their qualification; the extent and type of support staff; the areas of authority and responsibility of the key persons and the committees, if divided among persons and committees; the frequency of meetings of the committees and the portion of their time devoted to the review system by key persons. See Item J-4 below.

2. Standards and Norms. Attach as Exhibit J-2 a description of the standards and norms of the system (including any measurement of deviation in their application), and indicate how these standards and norms will be communicated to providers.

3. Operation of System. Attach as Exhibit J-3 a description of the operation of the review system, including the frequency and scope of audits, the utilization of the audit results and the procedures and methods for the enforcement of the standard and norms of the system.

4. Administration of System by Providers. If portions of the review system are administered by contracting providers, by affiliates of the applicant or by other persons who are not officers or employees of the applicant, attach Exhibit J-4 identifying those portions of the system together with the providers, affiliates or persons administering them on behalf of the applicant, and describe and furnish copies of the contractual provisions which assure the maintenance of the system to the standards of the applicant and those of the Act and the rules thereunder.

5. Monitoring of Provider Administration. Attach as Exhibit J-5, a description of the contractual arrangements which will be employed to enable the plan to monitor, and require, compliance with the quality of care review system, to the extent such system is administered by such contracting providers.

FULL SERVICE TAG

28 CCR 1300.69(a) - (c) and (h)
QA-001 **KE1**
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 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.
(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.

FULL SERVICE TAG

28 CCR 1300.70
QA-001 KE1, KE2, KE3, KE4; QA-002 KE1, KE2, KE3; QA-003 KE1; QA-004 KE1; QA-005 KE1.

(a) Intent and Regulatory Purpose.
(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.
(2) This section is not intended to set forth a prescriptive approach to QA methodology. This section is intended to afford each plan flexibility in meeting Act quality of care requirements.
(3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.
(4) The Department's assessment of a plan's QA program will focus on:
(A) the scope of QA activities within the organization;
(B) the structure of the program itself and its relationship to the plan's administrative structure;
(C) the operation of the QA program; and
(D) the level of activity of the program and its effectiveness in identifying and correcting deficiencies in care.
(b) Quality Assurance Program Structure and Requirements.
(1) Program Structure.
To meet the requirements of the Act which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that:
(A) a level of care which meets professionally recognized standards of practice is being delivered to all enrollees;
(B) quality of care problems are identified and corrected for all provider entities;
(C) physicians (or in the case of specialized plans, dentists, optometrists, psychologists or other appropriate licensed professionals) who provide care to the plan's enrollees are an integral part of the QA program;
(D) appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason, including a potential financial gain and/or incentive to the plan providers, and/or others; and
(E) the plan does not exert economic pressure to cause institutions to grant privileges to health care providers that would not otherwise be granted, nor to pressure health care providers or institutions to render care beyond the scope of their training or experience.
(2) Program Requirements.
In order to meet these obligations each plan's QA program shall meet all of the following requirements:

FULL SERVICE TAG

(A) There must be a written QA plan describing the goals and objectives of the program and organization arrangements, including staffing, the methodology for on-going monitoring and evaluation of health services, the scope of the program, and required levels of activity.
(B) Written documents shall delineate QA authority, function and responsibility, and provide evidence that the plan has established quality assurance activities and that the plan's governing body has approved the QA Program. To the extent that a plan's QA responsibilities are delegated within the plan or to a contracting provider, the plan documents shall provide evidence of an oversight mechanism for ensuring that delegated QA functions are adequately performed.
(C) The plan's governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities. Any delegated entity must maintain records of its QA activities and actions, and report to the plan on an appropriate basis and to the plan's governing body on a regularly scheduled basis, at least quarterly, which reports shall include findings and actions taken as a result of the QA program. The plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. Reports to the plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components which the QA program has identified as presenting significant or chronic quality of care issues.
(D) Implementation of the QA program shall be supervised by a designated physician(s), or in the case of specialized plans, a designated dentist(s), optometrist(s), psychologist(s) or other licensed professional provider, as appropriate.
(E) Physician, dentist, optometrist, psychologist or other appropriate licensed professional participation in QA activity must be adequate to monitor the full scope of clinical services rendered, resolve problems and ensure that corrective action is taken when indicated. An appropriate range of specialist providers shall also be involved.
(F) There must be administrative and clinical staff support with sufficient knowledge and experience to assist in carrying out their assigned QA activities for the plan and delegated entities.
(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees.
If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:
(1) Inform each provider of the plan’s QA program, of the scope of that provider’s QA responsibilities, and how it will be monitored by the plan.
(2) Ascertain that each provider to which QA responsibilities have been delegated has an in-place mechanism to fulfill its responsibilities, including administrative capacity, technical expertise and budgetary resources.

FULL SERVICE TAG

(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.
(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 underutilization of specialist services and preventive health care services.
(I) Inpatient Care.
1. A plan must have a mechanism to oversee the quality of care provided in an inpatient setting to its enrollees which monitors that:
a. providers utilize equipment and facilities appropriate to the care; and
b. if hospital services are fully capitated that appropriate referral procedures are in place and utilized for services not customarily provided at that hospital.
2. The plan may delegate inpatient QA functions to hospitals, and may rely on the hospital's existing QA system to perform QA functions. If a plan does delegate QA responsibilities to a hospital, the plan must ascertain that the hospital's quality assurance procedure will specifically review hospital services provided to the plan's enrollees, and will review services provided by plan physicians within the hospital in the same manner as other physician services are reviewed.
(c) In addition to the internal quality of care review system, a plan shall design and implement reasonable procedures for continuously reviewing the performance of health care personnel, and the utilization of services and facilities, and cost. The reasonableness of the procedures and the adequacy of the implementation thereof shall be demonstrated to the to the Department.

28 CCR 1300.74.16(e)
QA-004 **KE1**
(e) For the purposes of this section an "HIV/AIDS specialist" means a physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following four criteria:
(1) Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; or

FULL SERVICE TAG

(2) Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; or
(3) Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:
(A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and
(B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; or
(4) Meets the following qualifications:
(A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and
(B) Has completed any of the following:
1. In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties; or
2. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or
3. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV medicine.