TECHNICAL ASSISTANCE GUIDE FOR MEDICAL AUDITS

Category 5:

Quality Improvement and Health Equity Transformation Program

June 2026

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

TABLE OF CONTENTS

INTRODUCTION

In accordance with California Welfare and Institutions Code Section 14456, the Department of Health Care Services (DHCS) conducts medical audits of Medi-Cal Managed Care Plans (MCPs) on an annual basis. Medical audits evaluate MCPs' compliance with the DHCS contractual requirements and applicable laws and regulations. The Contract and Enrollment Review Division (CERD) of DHCS' Audits and Investigations (A&I) is responsible for performing the mandated audits. The audit scope encompasses the following six categories of review:

- Category 1 – Utilization Management
- Category 2 – Population Health Management and Coordination of Care
- Category 3 – Network and Access to Care
- Category 4 – Grievances, Appeals, and Member's Rights
- Category 5 – Quality Improvement and Health Equity Transformation Program
- Category 6 – Plan Organization and Administration

USING THE TECHNICAL ASSISTANCE GUIDE (TAG)

The TAGs are designed to identify key elements commonly evaluated by A&I's audit process to promote transparency. The TAG is grouped by subcategories and includes the following components, as applicable:

Requirement: This column identifies "key" statutory, regulatory, and contractual requirements related to core managed care organization systems and processes that may be included in scope and additional areas identified based on risk. While this narrows the audit scope, the audit team may investigate the MCP's compliance with other requirements.

- MCPs are ultimately responsible for ensuring compliance with all provisions of the DHCS contract as well as any applicable All Plan Letters (APLs), Plan Letters (PLs) and Dual Policy Letters.
- The contract requirements can be supplemented with applicable laws, regulations, APLs, etc.
- This TAG cites language from the DHCS Boilerplate Contract and related Federal and State laws and regulations.
- "Contractor" means "MCP" or "Plan" in this document.

Documentation Reviewed: The items in this column reflect a hierarchy of documents.

- Initially listed items (√) indicated will most likely confirm contractual compliance or not.
- Lower listed alternate/optional documents (△) may contain information that will help determine the status of the MCP's compliance with a particular requirement.
- Documents are not only reviewed for individual compliance, but as reference in the review of all other evidence and interviews to determine actual implementation in practice, effectiveness and MCP actions taken.
- The Documents include, but are not limited to:
    - Policies and Procedures
    - Organizational Charts
    - Committee Meeting Minutes
    - Monitoring Reports

- Data Logs

» Verification Studies (▲) are listed in this section where applicable.

Examples of Best Practices: This column details strategies implemented by some MCPs to either demonstrate compliance with a contract requirement or correct an identified deficiency. MCPs and individual audits can present distinct characteristics, and best practices may not transfer seamlessly. The audit team does not audit to best practices but may use them to evaluate compliance. It remains the responsibility of the MCP to demonstrate that it is meeting its contractual obligations.

CATEGORY 5: QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM

Introduction/Overview

The Quality Improvement and Health Equity Transformation Audit Program includes a systematic examination of the Managed Care Plan's (MCP) process for monitoring, evaluating, and taking timely action to address necessary improvements in the quality of care delivered by its providers. In addition, the audit now includes review of the measures the MCP takes to ensure equitable access to care for all members while also addressing Social Drivers of Health and reducing health disparities.

The Category 5 Audit Program includes the following subcategories:

- 5.1: Quality Improvement and Health Equity Transformation Program and Overview
- 5.2: Governing Board
- 5.3: Quality Improvement and Health Equity Committee
- 5.4: Provider Participation
- 5.5: Subcontractor and Downstream Subcontractor Quality Improvement Activities
- 5.6: Quality Improvement and Health Equity Transformation Program Policies and Procedures
- 5.7: Quality Improvement and Health Equity Annual Plan
- 5.8: National Committee for Quality Assurance Accreditation
- 5.9: External Quality Review Requirements
- 5.10: Quality Care for Children
- 5.11: Skilled Nursing Facilities – Long Term Care
- 5.12: Disease Surveillance

» 5.13: Credentialing and Recredentialing (includes provider training requirements)

CATEGORY 5.1: QIHET PROGRAM AND OVERVIEW

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2 **General Requirements** Contractor must implement a Quality Improvement and Health Equity Transformation Program (QIHETP) that includes, at a minimum, the standards set forth in 42 Code of Federal Regulations (CFR) sections 438.330 and 438.340, and 28 California Code of Regulations (CCR) section 1300.70, and be consistent with the principles outlined in the DHCS Comprehensive Quality Strategy and a forthcoming All Plan Letter (APL). Contractor must monitor, evaluate, and take timely action to address necessary improvements in the Quality of Care delivered by all its Providers in any setting, and take appropriate action to improve upon Health Equity. Contractor is responsible for the quality and Health Equity of all Covered Services regardless of whether or not those services have been delegated to a Subcontractor, Downstream Subcontractor, or Network Provider.	✓ Policies and Procedures ✓ QIHETP Program Description ✓ QIHETP Work Plan ✓ QIHETP Peer Review and Credentialing Committee Meeting Minutes ✓ QIHETP Evaluation ✓ Verification Study of Potential Quality Issues (PQI) ensures an effective QIS ✓ Governing Board Meeting Minutes ✓ NE Review: Reports on Lead Testing USPSTF, IHAs, EPSDT, Tobacco, SBIRT ✓ Review a flow chart and/or organization chart identifying all components of the	The Plan provides documented evidence to demonstrate adherence to its own internal Policies and Procedures (e.g., PQI (Potential Quality Issue) cases consistently document review by appropriate clinical staff with appropriate follow-up action taken), QIHEC (Quality Improvement and Health Equity Committee) meeting minutes document discussion and review of quality improvement activities as described in QIHETP (program) and policies; under the joint supervision of the Chief Quality Officer and the Chief Health Equity Officer. QIHETP (program) is reviewed and updated annually. If departmental reports reveal notable trends, the QIHEC conducts barrier analysis and follow-up action to address issues identified. The meeting minutes consistently document discussion of these activities and subsequent minutes document progress on achieving goals and re-measurement activities as necessary.

Requirement	Documentation to Review	Examples of Best Practices
	QIHETP, including who is involved and responsible for each activity ✓ Review policies that specify the responsibility of the Governing Board in the QIHETP.	

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.1 **Overview (Accountability)** Contractor must maintain a QIHETP which includes the following, at a minimum: A. Oversight and participation of Contractor's Governing Board; B. Creation and designation of a Quality Improvement and Health Equity Committee (QIHEC) whose activities are supervised by Contractor's medical director or the medical director's designee, in collaboration with Contractor's Chief Health Equity Officer; C. Supervision of QIHETP activities by Contractor's medical director and the Chief Health Equity Officer; and D. The participation of a broad range of Network Providers, including but not limited to hospitals, clinics, county partners, physicians, Community Health Workers (CHWs), and other non-clinical Providers in the process of QIHETP development and performance review.	Review policies and procedures to address how Plan will meet each of the following requirements: 1) Quality and Health Equity Performance Measure annual reporting requirements 2) Exceed DHCS Quality and Health Equity Performance measure benchmarks 3) Ensure all Fully Delegated Subcontractors exceed DHCS Quality and Health Equity Performance measure benchmarks 4) Performance Improvement Projects (PIPs)	The Plan produces organizational charts that are current, updated, and include the designation of a QIC with a direct reporting relationship to the Board and the QI Program Description, Policies and Procedures, organization charts, and duty statements all delineate clear roles and responsibilities of key QI staff, including reporting and supervisory relationships. QI staff are comprised of qualified clinical staff under the supervision of the Medical Director. The Plan should ensure the QIHETP integrates continuous quality improvement (CQI) principles across all physical and behavioral health services under the supervision of the Medical Director and Chief Health Equity Officer. Interventions must address identified disparities, support family-centered design, and include region-specific PHM strategies. Use of member experience, appeals, grievances, utilization data, and PNA findings is essential for tailored QIHE activities.

Requirement	Documentation to Review	Examples of Best Practices
	5) Consumer Satisfaction Survey 6) Network Adequacy Validation 7) Encounter Data Validation 8) Focused Studies 9) Technical Assistance Recommendations Review procedures on how Providers, Plan Subcontractors / Downstream Subcontractors will participate in the QIHETP and Population Needs Assessment (PNA) and how findings from both will be shared with Providers, Plan Subcontractors and Downstream Subcontractors.	

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2 **Quality of Care** A. Contractor must deliver quality care that enables all its Members to maintain health and improve or manage a chronic illness or disability. Contractor must ensure quality care in each of the following areas: 1) Clinical quality of physical health care; 2) Clinical quality of Behavioral Health care focusing on prevention, recovery, resiliency, and rehabilitation; 3) Access to primary and specialty health care Providers and services; 4) Availability and regular engagement with Primary Care Providers (PCP); 5) Continuity of care and Care Coordination across settings and at all levels of care, including transitions in care, with the goal of establishing consistent Provider-patient relationships; and 6) Member experience with respect to clinical quality, access and availability, culturally and linguistically competent health care and services, continuity of care, and Care Coordination.	✓ Review the Quality Improvement and Health Equity Plan to ensure it Integrates UM activities into the Quality Improvement System (QIS), including a process to integrate reports on the number and types of service requests, denials, deferrals, modifications, Appeals, and Grievances to the medical director or their designee. ✓ QIHET Program Description ✓ Internal Monitoring Reports ✓ QI Meeting Minutes ✓ Policies and Procedures	In addition to above: The Plan's QIHET Program Description includes processes and standards to ensure the quality of clinical care provided in all settings, including but not limited to: preventive services (children and adults), perinatal care, primary care, specialty care, emergency services, inpatient services, and ancillary care services. The plan should be able to provide evidence of MCP mechanisms such as processes and cadence of regular engagement with PCPs - tools and resources provided and monitoring/evaluation mechanisms to ensure that quality of care is provided to members.

Requirement	Documentation to Review	Examples of Best Practices
	✓ Review Quality Performance Measures and Health Equity performance measures related to health care services for Members less than 21 years of age.	
Exhibit A, Attachment III, Section 2.2 **Continuous Quality Improvement** B. Contractor must apply the principles of continuous quality improvement (CQI) to all aspects of Contractor's service delivery system through analysis, evaluation, and systematic enhancements of the following: 1) Quantitative and qualitative data collection and data-driven decision-making; 2) Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field; 3) Feedback provided by Members, community partners, and Network Providers in the design, planning, and implementation of its CQI activities; and	✓ Review quantitative and qualitative data collection and data-driven decision-making ✓ Review Up-to-date, evidence-based practice guidelines and explicit criteria developed by recognized sources or certified professionals, or, where evidence-based practice guidelines do not exist, consensus of	In addition to above: The Plan reviews evidence of a summary of performance findings - may include MCAS results and actions/strategies/QI methods such as PIPs/PDSAs taken to improve performance, taking into consideration member and provider input including community partners.

Requirement	Documentation to Review	Examples of Best Practices
4) Other issues identified by Contractor or DHCS.	professionals in the field ✓ Feedback provided by Members, Community Partners, and Network Providers in the design, planning, and implementation of its CQI activities	
Exhibit A, Attachment III, Section 2.2 **Population Health Management Interventions** C. Contractor must develop Population Health Management interventions designed to address Social Drivers of Health (SDOH), reduce disparities in health outcomes experienced by different subpopulations of Members, and work towards achieving Health Equity by: 1) Developing equity-focused interventions intended to address disparities in the utilization and outcomes of physical and Behavioral Health care services; and 2) Engaging in a Member and family-centric approach in the development of interventions and strategies, and in the delivery of all health care services.	✓ Review documents to see if Plan has developed equity-focused interventions intended to address disparities in the utilization and outcomes of physical and behavioral health care services ✓ Review documents to see if Plan has been engaging in a Member and family-centric approach in the	In addition to above: The Plan reviews examples of interventions that it has implemented and how it has showed progress to address improvements. In designing QI and HE focused strategies, the Plan includes in the review application use of focused groups, CAC engagement, etc.; with input from the Chief Health Equity Officer.

Requirement	Documentation to Review	Examples of Best Practices
	development of interventions and strategies, and in the delivery of all health care services	
Exhibit A, Attachment III, Section 2.2 **QIHET Requirements for Both Physical and Behavioral Health Services** D. Contractor must ensure that the QIHETP requirements of this Contract are applied to the delivery of both physical and Behavioral Health Services.	✓ See Pages 7 – 8 ✓ Documents should include discussion of behavioral health services	See Pages 7 – 8

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 4.4.16 **Enhanced Care Management Quality and Performance Incentive Program** A. Contractor must meet all quality management and Quality Improvement requirements in Exhibit A, Attachment III, Section 2.2 (Quality Improvement and Health Equity Transformation Program (QIHETP)) and any additional quality requirements set forth in associated guidance from DHCS for ECM. B. Contractor may participate in a performance incentive program related to building Provider capacity for ECM, related health care quality and outcomes, and other performance milestones and measures, in accordance with APL 23-003 or other technical guidance. *Note: ECM is covered more extensively in Audit Category 2: Population Health Management and Coordination of Care*	✓ Review Contractor's Enhanced Care Management Quality and Performance Incentive Program	See pages 7 – 11

CATEGORY 5.2: GOVERNING BOARD

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.2 **Governing Board** Contractor must implement and maintain written policies and procedures that specify the responsibilities of its Governing Board, which include the following, at a minimum: A. Approving the overall QIHETP and the annual plan of the QIHETP. B. Appointing an accountable entity or entities within Contractor's organization responsible for the oversight of the QIHETP.	✓ Policies and Procedures ✓ QIHETP Description documenting board approval ✓ QIHETP Work Plan and Evaluation ✓ Board Meeting Minutes that document QIHETP Description, QIHETP Work Plan, and QIHETP Evaluation approvals if the Quality documents not "stamped" with Board approval. ✓ Written QIHEC Progress Reports that describe actions taken, progress in meeting QIHETP objectives,	The Board meeting minutes and Plan's written materials clearly document annual review, discussion, and approval of the QIHETP Program Description and Work Plan. The QIHET Program Description, Policies and Procedures, organization charts, and duty statements all delineate clear roles and responsibilities of key QI staff, including reporting and supervisory relationships. The Board must receive regular reports from QIHEC and direct adjustments based on performance gaps. Oversight should include QIHETP plan approval, delegation monitoring, and guidance to meet health equity goals.

Requirement	Documentation to Review	Examples of Best Practices
	improvements made. ✓ QIHETP Org Chart including key individuals, titles, and credentials	
Exhibit A, Attachment III, Section 2.2.2 **Governing Board** Contractor must implement and maintain written policies and procedures that specify the responsibilities of its Governing Board, which include the following, at a minimum: C. Receiving written QIHEC progress reports that describe actions taken, progress in meeting QIHETP objectives, and improvements made. **CCR §1300.70(b)(2)(C)** **Quality Assurance Program** (b) Quality Assurance (QA) 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	✓ Policies and Procedures ✓ Grievance Logs, including subcontractor ✓ Meeting Minutes: Quality Improvement, Governing Board, Member Advisory Committee	Grievance logs demonstrate all elements required and show the inclusion of exempt grievances. The plan documents review of the grievance log as contractually required. The QIHEC committee meets regularly and takes action on QIHETP activities

Requirement	Documentation to Review	Examples of Best Practices
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.		
Exhibit A, Attachment III, Section 2.2.2 **Governing Board** Contractor must implement and maintain written policies and procedures that specify the responsibilities of its Governing Board, which include the following, at a minimum: D. Directing necessary modifications to QIHETP policies and procedures to ensure compliance with the Quality Improvement (QI) and Health Equity standards in this Contract and the DHCS Comprehensive Quality Strategy.	✓ Board Meeting Minutes ✓ QIHEC Committee Meeting Minutes	The Plan's Board meeting minutes consistently document review, discussion, and feedback provided on reports and minutes received from the QIHEC on no less than on a quarterly basis. Subsequent minutes document continued status on progress on achieving goals and re-measurement activities as necessary.

CATEGORY 5.3: QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.3 **QIHE Committee: General Summary** A. Contractor must implement and maintain a Quality Improvement and Health Equity Committee (QIHEC) designated and overseen by its Governing Board. Contractor's medical director or the medical director's designee must head QIHEC in collaboration with Contractor's Chief Health Equity Officer. Contractor must ensure that a broad range of Network Providers, including but not limited to hospitals, clinics, county partners, physicians, Subcontractors, Downstream Subcontractors, Network Providers, and Members, actively participate in the QIHEC or in any sub-committee that reports to the QIHEC. The Subcontractors, Downstream Subcontractors, and Network Providers that are part of QIHEC must be representative of the composition of Contractor's Network and include, at a minimum, Network Providers who provide health care services to Members affected by Health Disparities, Limited English Proficiency (LEP) Members, Children with Special Health Care Needs (CSHCN), Seniors and Persons with Disabilities (SPDs), and persons with chronic conditions.	✓ Policies and Procedures ✓ QIHET Program Description ✓ QIHET Organizational Chart, including key individuals, titles, and credentials ✓ QIHEC Meeting Minutes ✓ QIHEC Committee Roster and Charter showing network provider participation	The Plan provides documented evidence to substantiate that the QIHEC reports to the board and includes active participation by the Contractor's medical director or the medical director's designee, the Contractor's Chief Health Equity Officer, and network physicians and providers, including those that serve SPDs (e.g., QIHEC meeting rosters, meeting minutes, charter, etc.). The QIHEC must evaluate member-level data, performance metrics, and social risk indicators. Membership should reflect provider diversity, including those serving LEP, SPD, and CSHCN populations.

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.3 **QIHE Committee: Responsibilities** A. The QIHEC's responsibilities include the following: 1) Analyze and evaluate the results of QI and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other Contractor committees such as the Community Advisory Committee (CAC); 2) Institute actions to address performance deficiencies, including policy recommendations; and 3) Ensure appropriate follow-up of identified performance deficiencies.	✓ Review the written summary of QIHEC activities, as well as QIHEC activities of its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors ✓ Findings, recommendations, and actions must be prepared after each meeting and submitted to Contractor's Governing Board. ✓ Contractor must also submit the written summary to DHCS upon request. ✓ Board Meeting Minutes ✓ QIHEC Committee Meeting Minutes	The QIHEC receives reports and meeting minutes from various departments and their respective committees (e.g., UM, Access, G&A, etc.) on no less than on a quarterly basis. If departmental reports reveal notable trends, the QIHEC conducts barrier analysis and follow-up action to address issues identified. The QIHEC meeting minutes consistently document discussion of these activities and subsequent minutes document progress on achieving goals and re- measurement activities as necessary. The Board receives reports and meeting minutes from the QIHEC on no less than on a quarterly basis. The Board meeting minutes consistently document review, discussion, and feedback provided on reports and minutes received from the QIHEC as necessary.

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.3 **QIHE Committee: Member Confidentiality** B. Contractor must ensure Member confidentiality is maintained in QI discussions and ensure avoidance of conflict of interest among the QIHEC members.	✓ Verify Plan compliance with this requirement during MCQMD pre-entrance conference	MCQMD confirms Plan complies with requirement.
Exhibit A, Attachment III, Section 2.2.3 **QIHE Committee: Meeting Frequency, Written Summary of Plan Activities on Website** C. Contractor must ensure that the QIHEC meets at least quarterly, and more frequently if needed. A written summary of QIHEC activities, as well as QIHEC activities of its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, findings, recommendations, and actions must be prepared after each meeting and submitted to Contractor's Governing Board. Contractor must also submit the written summary to DHCS upon request. D. Contractor must make the written summary of the QIHEC activities publicly available on Contractor's website at least on a quarterly basis	✓ Board Meeting Minutes ✓ QIHEC Committee Meeting Minutes ✓ Written Summary of QIHEC activities (Plan and Subcontractor) ✓ Findings, recommendations, and actions must be prepared after each meeting and submitted to contractor's Governing Board. ✓ Contractor must also submit the written summary to DHCS upon request.	The QIHEC receives reports and meeting minutes from various departments and their respective committees (UM, Access, G&A) on no less than on a quarterly basis. If departmental reports reveal notable trends, the QIHEC conducts barrier analysis and follow-up action to address issues identified. The QIHEC meeting minutes consistently document discussion of these activities and subsequent minutes document progress on achieving goals and re-measurement activities. The Board receives reports and meeting minutes from the QIHEC on no less than on a quarterly basis. The Board meeting minutes consistently document review, discussion, and feedback provided on reports and minutes received from the QIHEC as necessary.

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.3 **QIHE Committee: Subcontractor Requirements** E. Contractor must ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors maintain a QIHEC that meets the requirements set forth in this Section. Contractor must also ensure that they report to Contractor's QIHEC quarterly, at a minimum.	✓ See Pages 15 – 17 ✓ Review Delegation Agreements	See Pages 15 – 17. In addition, Plan ensures delegates are compliant with DHCS contractual requirements.

CATEGORY 5.4: PROVIDER PARTICIPATION

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.4 **Provider Participation in QIHETP and PNA** Contractor must ensure that its Network Providers, Fully Delegated Subcontractors, and Downstream Fully Delegated Subcontractors participate in the QIHETP and Population Needs Assessment (PNA) as described in Exhibit A, Attachment III, Subsection 4.3.2 (Population Needs Assessment). Contractor must incorporate its Fully Delegated Subcontractor and Downstream Fully Delegated Subcontractor data and results into the development of its PNA, as described in Exhibit A, Attachment III, Subsection 4.3.2 (Population Needs Assessment). Contractor must regularly update its Network Providers, Fully Delegated Subcontractors, and Downstream Fully Delegated Subcontractors on activities, findings, and recommendations of the QIHEC's QIHETP and PNA results. **Exhibit A, Attachment III, 3.2.4** **Contractor's Provider Manual** Contractor must solicit feedback from Contractor committees including but not limited to the Community Advisory Committee (CAC) and Quality Improvement Committee (QIC), to	✓ Policies and Procedures ✓ QIHET Program Description ✓ QIHEC Committee Meeting Minutes ✓ Provider Manual ✓ Provider Newsletters ✓ Plan Website ✓ Population Needs Assessment ✓ Review to see evidence of: ○ Contractor ensures QIHEC meets at least quarterly and more frequently if needed ○ Written summary of QIHEC activities (Plan and Subcontractors) ○ QIHEC recommendations, including actions prepared after each meeting and submitted to the	The Plan provides documented evidence to substantiate that the QIHEC includes active participation by contracted physicians and providers (e.g., QIHEC meeting rosters, meeting minutes, etc.). The Plan provides documentation to substantiate that providers are informed of the activities and outcomes of the QIHEC at a set frequency on a continuous basis (e.g., Provider Manual, Provider newsletters, provider portal, fax blasts, etc.).

inform the development of Contractor Provider manual and clarify new and revised policies and procedures contained therein.	Contractor's Governing Board ○ Contractor has submitted the written summary to DHCS upon request	

CATEGORY 5.5: SUBCONTRACTOR QUALITY IMPROVEMENT ACTIVITIES (DELEGATION)

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.5 MCP Accountability and Subcontractor's QI and Health Equity Responsibilities and Specific Functions A. Contractor is accountable for all QI and Health Equity functions and responsibilities that are delegated to Subcontractors and any Downstream Subcontractors, in accordance with Exhibit A, Attachment III, Subsection 3.1.1 (Overview of Contractor's Duties and Obligations). Contractor must, at a minimum, specify the following requirements in its Subcontractor Agreements and Downstream Subcontractor Agreements, as applicable: 1) QI or Health Equity responsibilities, and specific subcontracted functions and activities of Subcontractor and Downstream Subcontractor.	✓ Delegation Agreements ✓ Annual Audits ✓ Quarterly Reports – Monitoring and Oversight ✓ Quality Improvement and Health Equity Program Annual Plan ✓ Quality Improvement Projects ✓ Verification Study ▲ PQI, if applicable	Delegation agreements delineate specific delegated functions and activities of both the Plan and subcontractor (e.g., UM, credentialing, G&A, etc.), clearly distinguishing Plan responsibilities from subcontractor responsibilities and evaluation processes. Delegation agreements must mandate quarterly QI reports, annual audits, and corrective actions where deficiencies exist. Oversight should verify compliance with DHCS health equity and QI standards and ensure timely CAP follow-ups. QIHE Annual Plan Subcontractor plan aligns with Plan priorities, including measurable goals, specific populations, and tracks improvement over time. Quality Improvement Projects include clear aims, targeted populations, and provide a root cause analysis for target interventions. These projects demonstrate measurable and reportable improvements over time.

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.5 **Schedule, Quarterly Reporting and Annual Review of MCP's Oversight, Monitoring and Evaluation of Subcontractors** A. Contractor is accountable for all QI and Health Equity functions and responsibilities that are delegated to Subcontractors and any Downstream Subcontractors, in accordance with Exhibit A, Attachment III, Subsection 3.1.1 (Overview of Contractor's Duties and Obligations). Contractor must, at a minimum, specify the following requirements in its Subcontractor Agreements and Downstream Subcontractor Agreements, as applicable: 2) The schedule for Contractor's ongoing oversight, monitoring, and evaluation of Subcontractor and Downstream Subcontractor, including quarterly reporting and an annual review of Subcontractor's and Downstream Subcontractor's performance.	✓ Delegation Agreements ✓ Annual Audits ✓ Quarterly Reports – Monitoring and Oversight ✓ Subcontractor Oversight Schedule: ✓ Subcontractor Performance Scorecards/Dashboard	Delegation agreements delineate specific delegated functions and activities of both the Plan and subcontractor (UM, credentialing, G&A, etc.), clearly distinguishing Plan responsibilities from subcontractor responsibilities. Aside from annual onsite audits and reviews, delegation agreements describe more robust monitoring activities on a more frequent basis (biannual, quarterly, monthly, etc.) to ensure continuous oversight of subcontractors (and affiliated MSOs). Monitoring activities include but are not limited to the required submission of various reports at a set frequency (utilization, referral patterns, turnaround times, dashboards, etc.), joint meetings between the subcontractor and Plan, validation audits to ensure the accuracy of reports submitted, etc. Subcontractor Oversight Schedule establishes regular monitoring cadence and defines expectations for performance review. Subcontractor Performance Scorecard/Dashboard tracks key quality and health equity metrics over time and are utilized to identify gaps to drive improvement over time.

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.5 **Subcontractor's Reporting Requirements and Plan Approval Procedures** **A.** Contractor is accountable for all QI and Health Equity functions and responsibilities that are delegated to Subcontractors and any Downstream Subcontractors, in accordance with Exhibit A, Attachment III, Subsection 3.1.1 (Overview of Contractor's Duties and Obligations). Contractor must, at a minimum, specify the following requirements in its Subcontractor Agreements and Downstream Subcontractor Agreements, as applicable: 3) Subcontractor's and Downstream Subcontractor's reporting requirements and Contractor's approval procedure of Subcontractor's and Downstream Subcontractor's reports. 4) Subcontractor's and Downstream Subcontractor's obligation to report findings and actions of QI or Health Equity activities at least quarterly to Contractor.	✓ Delegation Agreements ✓ Delegate's Policies and Procedures ✓ Annual Audits ✓ Quarterly Reports – Monitoring and Oversight ✓ Subcontractor Reporting Requirements and Submission Templates/Guidelines ✓ Contractor Review and Approval Process Quarterly QIHE Reports	Delegation agreements require subcontractor to submit quarterly reports which describe all findings and actions taken as a result of the subcontractor's internal quality improvement activities. These quarterly reports are specific to quality improvement activities and are separate and distinct from other data or quarterly roll-up reports. Quarterly reports are sufficiently detailed and document all follow-up action taken by the subcontractor to address any needed improvements in quality of care to prevent the recurrence of issues (e.g., barrier analysis, CAPs, enhanced monitoring, re-measurement activities). Subcontractor reporting requirements can assist to clearly define what must be reported, the cadence, and provides standards for consistency. Contractor Review and Approval process provides a formal review with feedback and approval of activities. Quarterly QI & HE Reports include key findings with actions taken to demonstrate progress over time.

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.5 **MCP Actions and Remedies for Subcontractor Poor Performance** A. Contractor is accountable for all QI and Health Equity functions and responsibilities that are delegated to Subcontractors and any Downstream Subcontractors, in accordance with Exhibit A, Attachment III, Subsection 3.1.1 (Overview of Contractor's Duties and Obligations). Contractor must, at a minimum, specify the following requirements in its Subcontractor Agreements and Downstream Subcontractor Agreements, as applicable: 5) Contractor's actions and remedies if Subcontractor's and Downstream Subcontractor's obligations are not satisfactorily performed.	✓ Delegation Agreements ✓ Plan and Delegate's Policies and Procedures ✓ Corrective Actions ✓ Follow-Up Monitoring of Corrective Action Plans ✓ Subcontractor Performance Scorecards/Dashboard	Delegation agreements delineate specific actions/remedies taken by the Plan if the subcontractor's obligations are not met (e.g., de-delegation, CAPs, re-measurement activities, enhanced reporting, more frequent audits). Follow-Up monitoring of Corrective Action Plans demonstrate follow through when gaps and issues are identified.

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.5 **MCP Oversight Procedures and Evaluation of Subcontractor Ability and Capacity** B. Contractor must maintain an adequate oversight procedure to ensure Subcontractor's and Downstream Subcontractor's compliance with all QI or Health Equity delegated activities that, at a minimum: 1) Evaluates Subcontractor's and Downstream Subcontractor's ability to perform the delegated activities, including an initial determination that Subcontractor and Downstream Subcontractor have the administrative capacity, experience, and budgetary resources to fulfill their contractual obligations.	✓ Policies and Procedures (Plan and Subcontractor) ✓ Delegation Oversight Committee Meeting Minutes ✓ Pre-Delegation Audits ✓ Subcontractor Reports ✓ Pre-Delegation Readiness Assessment	The Plan's policies and procedures ensure that a comprehensive pre-delegation review is completed prior to entering into contracts with each subcontractor (and its affiliated MSO, if applicable), with input by the Chief Quality Improvement Officer and Chief Health Equity Officer. The Plan's comprehensive pre- delegation review assesses whether each subcontractor (and its affiliated MSO, if applicable) has the administrative capacity, task experience, and budgetary resources to fulfill all delegated responsibilities The Plan correspondingly provides documented evidence to demonstrate adherence to its own internal policies and procedures (e.g. pre-delegation audits for all subcontractors, documentation that substantiates that each subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities, Delegation Oversight Committee meeting minutes which document discussion of pre-delegation reviews and approval of each subcontractor). Pre-delegation readiness assessment evaluates the administrative capacity and resources before delegation.

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.5 **MCP Oversight and Ensuring Subcontractor Meets QI and Health Equity Standards** B. Contractor must maintain an adequate oversight procedure to ensure Subcontractor's and Downstream Subcontractor's compliance with all QI or Health Equity delegated activities that, at a minimum: 2) Ensures Subcontractor and Downstream Subcontractor meet QI and Health Equity standards set forth in this Contract.	✓ Policies and Procedures (Plan and Subcontractor) ✓ Delegation Oversight Committee Meeting Minutes ✓ Delegation Audits ✓ Subcontractor Reports ✓ Compliance Tracking Reports	The Plan produces documentation to substantiate (with input from the Chief Quality Improvement Officer and Chief Health Equity Officer) that a comprehensive assessment of each subcontractor's policies and procedures has been completed to ensure alignment with all regulatory, statutory, and contractual standards. Compliance Tracking Reports demonstrate ongoing monitoring and follow-up on identified issues.
Exhibit A, Attachment III, Section 2.2.5 **MCP Continuous Monitoring, Evaluation, and Approval of Subcontractor and DHCS Reporting** B. Contractor must maintain an adequate oversight procedure to ensure Subcontractor's and Downstream Subcontractor's compliance with all QI or Health Equity delegated activities that, at a minimum: 3) Includes Contractor's continuous monitoring, evaluation and approval of its delegated functions to Subcontractor and Downstream Subcontractor. Contractor must make the findings of its continuous monitoring and evaluation of the Subcontractor and Downstream Subcontractor available to	✓ Policies and Procedures (Plan and Subcontractor) ✓ Delegation Oversight Committee Meeting Minutes ✓ Delegation Audits ✓ Subcontractor Reports ✓ Subcontractor Performance Scorecards/Dashboard	The Plan's policies and procedures delineate specific oversight and monitoring activities designed to ensure subcontractors (and affiliated MSOs, if applicable) meet all delegated responsibilities. Aside from annual onsite audits and reviews, the Plan's policies and procedures describe more robust monitoring activities on a more frequent basis (e.g., biannual, quarterly, monthly) to ensure continuous oversight of subcontractors (and affiliated MSOs, if applicable). The Plan provides documented evidence subcontractors submit all reports (utilization, referral patterns, turnaround times, dashboards) at the frequencies specified in delegation

Requirement	Documentation to Review	Examples of Best Practices
DHCS at least annually, but more frequently when directed by DHCS. **CCR Tit. 28 § 1300.70(b)(2)(B)** **Quality Assurance Program Structure and Requirements: QA Authority and Oversight** 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.		agreements. The Plan is readily able to produce all reports. Documentation in Delegation Oversight Committee meeting minutes substantiate the consistent review, analysis, and discussion of all reports submitted by subcontractors (and affiliated MSO, if applicable), including follow-up action taken when areas of concern are noted. The Plan conducts re- measurement activities as necessary to ensure continual compliance. The Plan provides documented evidence to substantiate that onsite audits of subcontractors are performed at the frequencies specified in delegation agreements. Documentation in Delegation Oversight Committee meeting minutes support the consistent review, analysis, and discussion of all audit findings, including follow-up action taken when areas of concern are noted. The Plan conducts re- measurement activities as necessary to ensure continual compliance The Plan conducts joint meetings between the subcontractor and Plan as evidenced by documented meeting minutes.

Requirement	Documentation to Review	Examples of Best Practices
CCR Tit. 28 § 1300.70(b)(2)(G) **Quality Assurance Program Structure and Requirements: Informing Providers** 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.	✓ QI Program Description (Plan and Subcontractor) ✓ Delegation Agreements ✓ Policies and Procedures (Plan and Subcontractor) ✓ Delegation Oversight Committee Meeting Minutes ✓ Delegation Audits ✓ Subcontractor Reports ✓ Subcontractor Performance Scorecards/Dashboard	Delegation agreements delineate specific delegated functions and activities of the Plan and Subcontractor (UM, credentialing, G&A), clearly distinguishing Plan responsibilities from subcontractor responsibilities. The Plan performs a documented assessment of the subcontractor's QI Program Description to ascertain how the subcontractor continuously reviews the quality of care delivered to members to identify opportunities for improvement. The Plan informs the subcontractor of its own QI Program Description and how the Plan continuously reviews the quality of care delivered to members to identify opportunities for quality improvement The Plan retains overall responsibility for reviewing the quality of care delivered to members and informs the subcontractor through delegation agreements how delegated functions will be monitored by the Plan (robust monitoring activities on a frequent basis other than just annually to ensure continuous oversight, required submission of reports at a specified frequency, periodic audits, corresponding CAPs, follow-up action, re-measurement activities).

Requirement	Documentation to Review	Examples of Best Practices
CCR Tit. 28 § 1300.70(b)(2)(G) **Quality Assurance Program Structure and Requirements: Provider Capacity** 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: 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.	✓ Policies and Procedures (Plan and Subcontractor) ✓ Delegation Oversight Committee Meeting Minutes ✓ Pre-Delegation Audits ✓ Subcontractor Reports ✓ Subcontractor Performance Scorecards/Dashboard	The Plan's policies and procedures ensure that a comprehensive pre- delegation review is completed prior to entering into contracts with each subcontractor (and its affiliated MSO, if applicable). The Plan's comprehensive pre- delegation review assesses whether each subcontractor (and its affiliated MSO, if applicable) has the administrative capacity, task experience, and budgetary resources to fulfill all delegated responsibilities. The Plan correspondingly provides documented evidence to demonstrate adherence to its own internal policies and procedures (e.g. pre-delegation audits for all subcontractors, documentation that substantiates that each subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities, Delegation Oversight Committee meeting minutes which document discussion of pre-delegation reviews and approval of each subcontractor

Requirement	Documentation to Review	Examples of Best Practices
CCR Tit. 28 § 1300.70(b)(2)(G) **Quality Assurance Program Structure and Requirements: Ongoing Oversight** 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: 3) Have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated QA responsibilities.	✓ Policies and Procedures (Plan and Subcontractor) ✓ Delegation Oversight Committee Meeting Minutes ✓ Delegation Audits ✓ Subcontractor Reports	The Plan's policies and procedures delineate specific oversight and monitoring activities designed to ensure subcontractors (and affiliated MSOs, if applicable) meet all delegated responsibilities. Aside from annual onsite audits and reviews, the Plan's policies and procedures describe more robust monitoring activities on a more frequent basis (e.g., biannual, quarterly, monthly, etc.) to ensure continuous oversight of subcontractors (and affiliated MSOs, if applicable). The Plan provides evidence that subcontractors submit all reports (e.g., utilization, referral patterns, turnaround times, dashboards, etc.) at the frequencies specified in delegation agreements. The Plan is readily able to produce all reports. The Plan provides documented evidence to substantiate that it validates the accuracy of all reports submitted by subcontractors (and affiliated MSOs, if applicable) to ensure that data has not been manipulated (e.g., unannounced onsite audits, random sampling, verification studies). Documentation in Delegation Oversight Committee meeting minutes substantiate the consistent review, analysis, and discussion of all reports submitted by subcontractors (and affiliated MSOs, if applicable), including follow-

Requirement	Documentation to Review	Examples of Best Practices
		up action taken when areas of concern are noted. The Plan conducts re- measurement activities as necessary to ensure continual compliance. The Plan provides documented evidence to substantiate that onsite audits of subcontractors are performed at the frequencies specified in delegation agreements. Documentation in Delegation Oversight Committee meeting minutes support the consistent review, analysis, and discussion of all audit findings, including follow-up action taken when areas of concern are noted. The Plan conducts re- measurement activities as necessary to ensure continual compliance The Plan conducts joint meetings between the subcontractor and Plan as evidenced by documented meeting minutes.

Requirement	Documentation to Review	Examples of Best Practices
CCR Tit. 28 § 1300.70(b)(2)(G) **Quality Assurance Program Structure and Requirements: Professional Standards** 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: 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.	✓ Policies and Procedures (Plan and Subcontractor) ✓ QI Program Description (Subcontractor)	The Plan performs a documented assessment of the subcontractor's QI Program Description to ensure the inclusion of standards used to evaluate whether members receive health care that is consistent with professionally recognized standards of practice. The Plan provides documentation to substantiate the subcontractor's adherence to its QI Program Description and use of standards to evaluate whether members receive health care consistent with professional recognized standards of practice (e.g., quarterly subcontractor reports which describe all findings and actions taken as a result of the subcontractor's internal quality improvement activities.

Requirement	Documentation to Review	Examples of Best Practices
CCR Tit. 28 § 1300.70(b)(2)(G) **Quality Assurance Program Structure and Requirements: Provider Referral Patterns** 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: 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.	✓ Committee Meeting Minutes ✓ Delegation Audits ✓ Subcontractor Reports ✓ Verification Study: Included in Category 1 – Utilization Management	The Plan produces documentation to substantiate the continuous evaluation of each subcontractor's (and MSO's, if applicable) referral and specialist care patterns of practice (submission of utilization reports at a set frequency, validation of data submitted, discussion and analysis of reports in Delegation Oversight Committee meeting minutes, follow-up action taken, re-measurement activities). The Plan produces documentation to substantiate the continuous evaluation of each subcontractor's (and MSO's, if applicable) ability to provide timely access to specialists, ancillary support services, and preventive health services (e.g., submission of utilization reports at a set frequency, validation of data submitted, discussion and analysis of reports in Delegation Oversight Committee meeting minutes, follow-up action taken, re-measurement activities.

Requirement	Documentation to Review	Examples of Best Practices
CCR Tit. 28 § 1300.70(b)(2)(G) **Quality Assurance Program Structure and Requirements: Preventative Health Care** 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: 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.	✓ Delegation Agreements ✓ Delegation Oversight Committee Meeting Minutes Delegation Audits ✓ Subcontractor Reports	The Plan produces documentation to substantiate that each subcontractor (and its affiliated MSO, if applicable) provides health care services which include preventive health care measures consistent with professionally recognized standards of practice (e.g., submission of utilization reports at a set frequency, validation of data submitted, discussion and analysis of reports in Delegation Oversight Committee meeting minutes, follow-up action taken, re-measurement activities.

Requirement	Documentation to Review	Examples of Best Practices
CCR Tit. 28 § 1300.70(b)(2)(H) **Quality Assurance Program Structure and Requirements: Administrative Capacity** 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.	✓ Policies and Procedures (Plan and Subcontractor) ✓ Delegation Oversight Committee Meeting Minutes ✓ Pre-Delegation Audits ✓ Subcontractor Reports	The Plan's policies and procedures ensure that a comprehensive pre- delegation review is completed prior to entering into contracts with each subcontractor (and its affiliated MSO, if applicable). The Plan's comprehensive pre- delegation review assesses whether each subcontractor (and its affiliated MSO, if applicable) has the administrative capacity, task experience, and budgetary resources to fulfill all delegated responsibilities. The Plan correspondingly provides documented evidence to demonstrate adherence to its own internal policies and procedures (pre-delegation audits for all subcontractors, documentation that substantiates that each subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities, Delegation Oversight Committee meeting minutes which document discussion of pre-delegation reviews and approval of each subcontractor).

Requirement	Documentation to Review	Examples of Best Practices
CCR Tit. 28 § 1300.70(b)(2)(H) **Quality Assurance Program Structure and Requirements: Detecting Underutilization** A plan that has capitation or risk-sharing contracts must: 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.	✓ Policies and Procedures (Plan and Subcontractor) ✓ Delegation Oversight Committee Meeting Minutes ✓ Delegation Audits ✓ Subcontractor Reports	The Plan's policies and procedures delineate robust oversight and monitoring activities designed to specifically detect and correct under-service by subcontractors (and affiliated MSOs, if applicable), including possible under-utilization of specialist and preventive health care services (e.g., submission of utilization reports at a set frequency, validation of data submitted, discussion and analysis of reports in Delegation Oversight Committee meeting minutes, follow-up action take, re-measurement activities.

Requirement	Documentation to Review	Examples of Best Practices
CCR Tit. 28 § 1300.70(b)(2)(I) **Quality Assurance Program Structure and Requirements: Inpatient Care** 1) A plan must have a mechanism in place 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 procedures 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.	✓ Policies and Procedures (Plan and Subcontractor) ✓ Delegation Oversight Committee Meeting Minutes ✓ Delegation Audits ✓ Subcontractor Reports	The Plan's policies and procedures delineate robust oversight and monitoring activities for ensuring quality of care to members and appropriate referral processes are followed.

CATEGORY 5.6: QIHETP POLICIES AND PROCEDURES

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.6 **Policies and Procedures: Org Charts, Structure, and Sharing QIHETP Findings** Contractor must develop, implement, maintain, and periodically update its QIHETP policies and procedures that include, at a minimum, the following: A. Contractor's commitment to the delivery of quality and equitable health care services B. Contractor's, Fully Delegated Subcontractor's, and Downstream Fully Delegated Subcontractor's organizational chart, listing the key staff and the committees responsible for QI and Health Equity activities, including reporting relationships of QIHEC to executive staff C. Qualification and identification of staff who are responsible for QI and Health Equity activities D. A process for sharing QIHETP findings with its Subcontractors, Downstream Subcontractors, and Network Providers E. The role, structure, and function of the QIHEC **Exhibit A, Attachment III, Section 2.2.6** **Policies and Procedures: Covered Services for Members and Non-Discrimination** Contractor must develop, implement, maintain, and periodically update its QIHETP policies and	✓ QIHET Program Description ✓ QIHETP Policies and Procedures ✓ QIHEC Meeting Minutes ✓ UM Meeting Minutes ✓ Org Charts ✓ Plan Staff Resumes and Licenses ✓ Population Needs Assessment Policies and Procedures ✓ Policies and Procedures for ensuring the delivery of medically necessary NSMHS and SMHS	The QIHET Program Description delineates processes to ensure that medically necessary services are accessible to all members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, and that all covered services are provided in a culturally and linguistically appropriate manner. The QIHET Program Description delineates processes to ensure that medical decisions are based on clinical practice guidelines that are adopted from nationally recognized organizations. Policies must codify processes for clinical practice guideline use, disparity analysis, culturally/ linguistically appropriate services, and health equity intervention deployment. Mechanisms must exist to monitor over/under-utilization and ensure access across all service domains.

Requirement	Documentation to Review	Examples of Best Practices
procedures that include, at a minimum, the following: F. The policies and procedures to ensure that all Covered Services are available and accessible to all Members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, health status, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate manner. **Exhibit A, Attachment III, Section 2.2.6** **Policies and Procedures: Identifying and Reducing Health Disparities** Contractor must develop, implement, maintain, and periodically update its QIHETP policies and procedures that include, at a minimum, the following: G. The policies and procedures designed to identify, evaluate, and reduce Health Disparities, by performing the following: 1) Analyzing data to identify differences in Quality of Care and utilization, as well as the underlying reasons for variations in the provision of care to its Members;		

Requirement	Documentation to Review	Examples of Best Practices
2) Developing equity-focused interventions to address the underlying factors of identified Health Disparities, including SDOH; and 3) Meeting disparity reduction targets for specific populations and/or measures as identified by DHCS and as directed under Exhibit A, Attachment III, Subsection 2.2.9.A (Quality Performance Measures).		
Exhibit A, Attachment III, Section 2.2.6 **Policies and Procedures: Integration of UM into the QIHET** Contractor must develop, implement, maintain, and periodically update its QIHETP policies and procedures that include, at a minimum, the following: H. Description of the integration of Utilization Management (UM) activities into the QIHETP as specified in Exhibit A, Attachment III, Section 2.3 (Utilization Management Program), including a process to integrate reports on the number and types of service requests, denials, deferrals, modifications, Appeals, and Grievances to the medical director or the medical director's designee.	✓ See Above ✓ In addition, a list of UM reports sent to the QIHEC	The Plan's QIHEC routinely monitors reports on member and types of service requests, denials, deferrals, modifications, appeals and grievances and implements appropriate follow-up measures

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.6 **Policies and Procedures: Clinical Practice and Evidence-Based Guidelines** Contractor must develop, implement, maintain, and periodically update its QIHETP policies and procedures that include, at a minimum, the following: I. Policies and procedures to adopt, disseminate, and monitor the use of clinical practice guidelines that: 1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the relevant field; 2) Consider the needs of Members; 3) Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines, or are developed with involvement of board-certified Providers from appropriate specialties; 4) Have been reviewed by Contractor's medical director, as well as Subcontractors, Downstream Subcontractors, and Network Providers, as appropriate; and 5) Are reviewed and updated at least every two years;	See Above	See Above In addition, The QIHET Program Description delineates processes to ensure that medical decisions are based on clinical practice guidelines that are adopted from nationally recognized organizations.

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.6 **Policies and Procedures: Inclusion of PHM** Contractor must develop, implement, maintain, and periodically update its QIHETP policies and procedures that include, at a minimum, the following: J. The inclusion of Population Health Management (PHM) activities, including the findings of the annual PNA, as required in Exhibit A, Attachment III, Subsection 4.3.2 (Population Needs Assessment)	See Above	See Above
Exhibit A, Attachment III, Section 2.2.6 **Policies and Procedures: SMHS and NSMH and Mental Health Parity** K. Policies and procedures that ensure the delivery of Medically Necessary non-specialty and Specialty Mental Health Services as outlined in Exhibit A, Attachment III, Section 5.5 (Mental Health and Substance Use Disorder Benefits). L. Policies and procedures that ensure that Contractor and its Subcontractors, Downstream Subcontractors, Network Providers, and other entities with which Contractor contracts for the delivery of health care services comply with all mental health parity requirements in 42 CFR section 438.900 et seq.	See Above	See Above

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.6 **Policies and Procedures: Monitoring** M. Mechanisms to detect both over-and under-utilization of services including, but not limited to, outpatient Prescription Drugs. N. Mechanisms to continuously monitor, review, evaluate, and improve access to and availability of all Covered Services. The mechanisms must include oversight processes that ensure Members are able to obtain Medically Necessary appointments within established standards for time or distance, timely access, and alternative access in accordance with APL 23-001, and Welfare and Institutions Code (W&I) sections 14197 and 14197.04. O. Mechanisms to continuously monitor, review, evaluate, and improve quality and Health Equity of clinical care services provided, including, but not limited to, preventive services for Children and adults, perinatal care, Primary Care, specialty, emergency, inpatient, Behavioral Health and ancillary care services; and P. Mechanisms to continuously monitor, review, evaluate, and improve coordination and continuity of care services to all Members, including SPDs, CSHCNs, Members with chronic conditions, including Behavioral Health, Members experiencing homelessness, Members recently released from incarceration, Members	See Above	See Above In addition, the QIHET Program Description delineates monitoring activities to specifically ensure that SPDs or those members with chronic conditions receive case management, coordination and continuity of care, and access and availability to care as appropriate.

Requirement	Documentation to Review	Examples of Best Practices
who use Long-Term Services & Supports, and Children receiving Child welfare services.		

CATEGORY 5.7: QUALITY IMPROVEMENT AND HEALTH EQUITY ANNUAL PLAN

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.7 Through regional quality and health equity teams, Contractor must develop and submit an annual QI and Health Equity plan to DHCS, as directed below and in and a forthcoming APL. A. Develop QI and Health Equity plan annually for submission to DHCS that includes the following, at a minimum: **QIHE Annual Plan: Assessment/Evaluation** 1) A comprehensive assessment of the QI and Health Equity activities undertaken, including an evaluation of the effectiveness of QI interventions; **QIHE Annual Plan: Performance Analysis** 2) A written analysis of required Quality Performance Measure results, and a plan of action to address performance deficiencies, including analyses of each Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's performance measure results and actions to address any deficiencies; **QIHE Annual Plan: Actions Taken**	✓ QIHET Program Description ✓ Quality Improvement and Health Equity Program Annual Plan ✓ Prior Year QIHE Evaluation and Actions Taken	The QIHET Program Description delineates ongoing monitoring activities to continuously review, evaluate, and improve access to and availability of services, under the supervision of the Chief Medical Officer and the Chief Health Equity Officer.

Requirement	Documentation to Review	Examples of Best Practices
3) An analysis of actions taken to address any Contractor-specific recommendations in the annual External Quality Review (EQR) technical report and Contractor's specific evaluation reports;		
Exhibit A, Attachment III, Section 2.2.7 **QIHE Annual Plan: Analysis of Service Delivery and Quality of Care** 4) An analysis of the delivery of services and Quality of Care of Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, based on data from multiple sources, including quality performance results, Encounter Data, Grievances and Appeals, Utilization Review and the results of consumer satisfaction surveys; **QIHE Annual Plan: Equity-Focused Interventions** 5) Planned equity-focused interventions to address identified patterns of over- or under-utilization of physical and Behavioral Health care services; **QIHE Annual Plan: Member and Community Engagement** 6) A description of Contractor's commitment to Member and/or family focused care through Member and community engagement such as review of CAC findings, Member listening sessions, focus groups or surveys, and	See Above	See Above

Requirement	Documentation to Review	Examples of Best Practices
collaboration with local community organizations; and how Contractor utilizes the information from this engagement to inform Contractor policies and decision-making;		
Exhibit A, Attachment III, Section 2.2.7 **PHM Findings** 7) PHM activities and findings as outlined in Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*); and **Performance Improvement Projects** 8) Outcomes/findings from Performance Improvement Projects (PIPs), consumer satisfaction surveys and collaborative initiatives. To the extent that Contractor delegates its QI and Health Equity activities to its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, Contractor's QI and Health Equity annual plan must include evaluation and findings specific to the Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's performance. **APL References:** • APL 25-009 (CAC) • APL 23-001 (PNA and PHM Strategy) • APL 24-004 (QIHE Requirements)	See Above	See Above

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.7 **QIHE Annual Plan: Accreditation Reports** Through regional quality and health equity teams, Contractor must develop and submit an annual QI and Health Equity plan to DHCS, as directed below and in and a forthcoming APL. B. Provide annual copies of all final reports of independent private accrediting agencies (e.g. the National Committee for Quality Assurance (NCQA)) relevant to Contractor's, Fully Delegated Subcontractor's, and Downstream Fully Delegated Subcontractor's Medi-Cal line of business, including: 1) Accreditation status, survey type, and level, as applicable; 2) Accreditation agency results, including recommended actions or improvements, Corrective Action plans, and summaries of findings; and 3) Expiration date of the accreditation. In addition, pursuant to 42 CFR section 438.332, Contractor must authorize independent private accrediting agencies to provide DHCS a copy of Contractor's most recent accreditation review annually.	In addition to above: ✓ Plan's website	The Plan posts NCQA accreditation on its website. Per Section 2.2.8 of the Contract, the Plan submits NCQA Health Plan Accreditation and Health Equity Accreditation results to DHCS. The plans provide a summary of NCQA recommendations and results of the accreditation including areas that need improvement including how the MCPs will be addressing the identified areas.

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.7 **QIHE Annual Plan: Annual Report to DHCS** Through regional quality and health equity teams, Contractor must develop and submit an annual QI and Health Equity plan to DHCS, as directed below and in and a forthcoming APL. C. Provide an annual report to DHCS that includes an assessment of all Subcontractors' and Downstream Subcontractors' performance of its delegated QI or Health Equity activities.	✓ QI or Health Equity Assessment Report ✓ QIHE Evaluation (and actions taken)	Of note, there are MCPs that do not delegate QI and HE activities; Plans should state if they delegate or do not delegate. Delegated QI and HE activities should be specified. The Plan may be able to provide a summary of subcontractor performance and if below standards, what the MCPs mechanisms are to correct the performance deficiency either through CAPs or TA. Also, MCPs may be able to include how subcontractors are involved in QI activities to improve HE and QI performance. The Plan is able to provide an annual assessment report of all subcontractors' performance of its delegated QI or Health Equity activities.
Exhibit A, Attachment III, Section 2.2.7 **QIHE Annual Plan: Publication on Website** Through regional quality and health equity teams, Contractor must develop and submit an annual QI and Health Equity plan to DHCS, as directed below and in and a forthcoming APL. D. Contractor must make the QI and Health Equity plan publicly available on its website on an annual basis.	✓ Review Website	Plan's QIHE Annual Plan is posted on the Plan's website.

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.7 **QIHE Annual Plan: Regional Partner Meetings** Through regional quality and health equity teams, Contractor must develop and submit an annual QI and Health Equity plan to DHCS, as directed below and in and a forthcoming APL. E. Contractor must attend regional collaborative meetings which may include additional regional partners including but not limited to county Mental Health Plans (MHPs), Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS), Local Government Agencies, public hospitals, and community-based organizations (CBOs).	✓ Meeting agendas ✓ Meeting minutes, if available	Plan is able to show evidence that demonstrates attendance and participation by regional partners in developing the Annual Plan, under the supervision of the Chief Quality Improvement Officer and Chief Health Equity Officer.

CATEGORY 5.8: NCQA ACCREDITATION

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.8 **NCQAA: General Requirements** Contractor must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by no later than January 1, 2026. Contractor must maintain full NCQA HPA and Health Equity Accreditation throughout the term of this Contract and submit every 3 years NCQA Health Plan Accreditation and Health Equity Accreditation results. Contractor must also complete additional NCQA accreditation programs as directed by DHCS. In accordance with W&I section 14184.203, Contractor must also ensure that all its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors have full NCQA HPA and Health Equity Accreditation by no later than January 1, 2026. Contractor must also ensure all its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors maintain full NCQA HPA and Health Equity Accreditation throughout the term of this Contract. Contractor must ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors also complete additional NCQA accreditation programs as directed by DHCS.	✓ QIHET Program Description ✓ Internal Monitoring Reports ✓ Annual copies of all final reports of independent private accrediting agencies (NCQA) relevant to Contractor's fully delegated subcontractor's Medi-Cal line of business, including: ○ Accreditation status, survey type, and level ○ Accreditation agency results, including recommended actions or improvements, Corrective Action Plans, and summaries of findings	Plan and its fully delegated subcontractors have NCQA Accreditation by January 1, 2026 Plan maintains accreditation and submits results to DHCS every three years. The Plan ensures it and all delegated entities achieve and maintain NCQA HPA by 1/1/2026. The Plan submits all NCQA reports to DHCS and includes accreditation oversight in the annual QI report.

Requirement	Documentation to Review	Examples of Best Practices
	○ Expiration date of the accreditation	
Exhibit A, Attachment III, Section 2.2.8 **NCQAA: General Requirements**	See Above	See Above
Exhibit A, Attachment III, Section 2.2.8 **NCQAA: Accreditation Components** Contractor must provide DHCS with the following components of Contractor's, Fully Delegated Subcontractor's, and Downstream Fully Delegated Subcontractor's NCQA HPA and Health Equity Accreditation status and reviews within 30 calendar days of the receipt of the completed report from NCQA: A. Accreditation status; B. Survey type; C. Results of the review D. Healthcare Effectiveness Data and Information Set (HEDIS ®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS ®) summary level data E. Recommended actions or improvements; F. Corrective Action Plans and summaries of findings; and G. Expiration date of the accreditation.	See Above	See Above

Requirement	Documentation to Review	Examples of Best Practices
Contractor must notify DHCS of the date of its NCQA site visit within 15 calendar days of confirmation of the site visit by NCQA. Contractor must make available all written materials submitted to NCQA available to DHCS and allow DHCS representative(s) to participate in the NCQA audit activities, including but not limited to, the NCQA site visit.		
Exhibit A, Attachment III, Section 2.2.8 **NCQAA: Reporting Changes to DHCS and Corrective Actions** Contractor must notify DHCS of any change in NCQA HPA and Health Equity Accreditation status within 30 calendar days of receipt of the final NCQA report. In addition to complying with the Corrective Actions imposed by NCQA, Contractor must also comply with any additional Corrective Actions imposed by DHCS to address a change in Contractor's accreditation status. If Contractor fails to obtain or maintain its HPA or Health Equity Accreditation status within the timeframe described above and anytime thereafter, Contractor will be subject to Corrective Actions by DHCS, including but not limited to, the actions set forth in Exhibit E, Sections 1.16 (*Termination*), 1.19 (*Sanctions*), and 1.20 (*Liquidated Damages*).	See Above	See Above

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.8 **NCQAA: MCP Policies and Procedures for Subcontractor Accreditation Status** Contractor must have policies and procedures in place to oversee the HPA and Health Equity Accreditation status of its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors throughout the term of this Contract. Contractor must have policies and procedures in place to subject its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors to Corrective Actions if Contractor's Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor fails to maintain its HPA and Health Equity Accreditation status, including, but not limited to, termination of Subcontractor Agreements or Downstream Subcontractor Agreements with Fully Delegated Subcontractors or Downstream Fully Delegated Subcontractors, sanctions, and damages.	See Above	See Above

Requirement	Documentation to Review	Examples of Best Practices
42 CFR Section 438.332 **Review of Accreditation Status of MCOs** Contractor must: 1) Authorize independent private accrediting agencies to provide DHCS a copy of Contractor's most recent accreditation review annually. 2) Provide an annual report to DHCS that includes an assessment of all Subcontractors' and Downstream Subcontractors' performance of its delegated QI or Health Equity activities. 3) Make the QI and Health Equity plan publicly available on its website on an annual basis.	See Above	See Above

CATEGORY 5.9: EXTERNAL QUALITY REVIEW REQUIREMENTS

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.9 **EQRR: General Requirement** At least annually or more frequently as directed by DHCS, Contractor must cooperate with and assist the External Quality Review Organization (EQRO) designated by DHCS in conducting its EQR reviews of Contractor in accordance with 42 USC section 1396u-2(c)(2), 42 CFR section 438.310 et seq., and 22 CCR section 53860(d). Contractor must comply with all requirements set forth in 42 CFR section 438.310 et seq., the forthcoming APL, and the Centers for Medicare & Medicaid Services (CMS) EQR protocols, which provide detailed instructions on how to complete the EQR activities.	✓ Review on an annual basis that Contractor has tracked and reported on a set of Quality Performance Measures and Health Equity Measures identified by DHCS	Plan cooperates with external reviews as required.

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.9 **EQRR: Quality Performance Measures** In addition, Contractor must also comply with the following requirements: A. Quality Performance Measures On an annual basis, Contractor must track and report on a set of Quality Performance Measures and Health Equity measures identified by DHCS in accordance with all of the following requirements: 1) Contractor must work with the EQRO to conduct an onsite assessment of the Quality Measure Compliance Audit and DHCS-required Quality Performance Measures; 2) Contractor must calculate and report all required Quality Performance Measures and Health Equity measures at the county or regional reporting unit level and possibly Skilled Nursing Facility (SNF) level as directed by DHCS. Contractor must separately report to DHCS all required performance measure results at the county or reporting unit level and SNF level for certain measures for its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors a) Contractor must calculate performance measure rates, to be verified by the EQRO;	See Above	See note above regarding EQR. In addition:

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.9 **EQRR: Quality Performance Measures** In addition, Contractor must also comply with the following requirements: A. Quality Performance Measures b) Contractor must report audited results on the required performance measures to DHCS no later than June 15 of each year or on another date as established by DHCS. Contractor must initiate reporting on required Quality Performance Measures for the reporting cycle following the first year of this Contract operation; 3) Contractor must meet or exceed the DHCS-established Minimum Performance Level (MPL) for each required Quality Performance Measure and Health Equity measure selected by DHCS. Contractor must ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors whose rates Contractor separately reports to DHCS also meet or exceed the DHCS-established MPL for each required Quality Performance Measure. and Health Equity measure selected by DHCS. 4) Contractor must meet Health Disparity reduction targets for specific populations and measures as identified by DHCS.	See Pages 58 - 59	See Pages 58 - 59

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.9 **EQRR: Quality Performance Measures** In addition, Contractor must also comply with the following requirements: A. Quality Performance Measures 5) In accordance with 42 CFR section 438.700 et seq., W&I section 14197.7, and Exhibit E, DHCS may impose financial sanctions, administrative sanctions, and/or Corrective Actions on Contractor for failure to meet or exceed required MPLs as detailed in APL 23-012. DHCS may require Contractor to make changes to its executive personnel if a Contractor has persistent and pervasive poor performance as evidenced by multiple performance measures consistently below the MPL over multiple years. DHCS may also limit Contractor's Service Area expansion or suspend Member Enrollment based on Contractor's persistent and pervasive poor performance on Quality Performance Measures.	See Pages 58 - 59	See Pages 58 - 59

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.9 **EQRR: Quality Performance Measures** In addition, Contractor must also comply with the following requirements: A. Quality Performance Measures In addition to sanctions and Corrective Actions, DHCS reserves the right, subject to actuarial judgment and generally accepted actuarial principles and practices, to consider Contractor's performance on specified quality and equity benchmarks, as determined by DHCS and communicated to Contractors in advance of each applicable Rating Period, within the determination of Capitation Payment rates for that Rating Period. Contractor is responsible for ensuring that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors also meet or exceed the DHCS-established MPL. If its Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor fails to meet or exceed the DHCS-established MPL, Contractor must have policies and procedures in place to subject its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors to appropriate enforcement actions, which may include, but are not limited to, financial sanctions, corrective action plans, and a requirement to change its executive personnel.	See Pages 58 - 59	See Pages 58 – 59

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.9 **EQRR: Performance Improvement Projects** In addition, Contractor must also comply with the following requirements: B. PIPs 1) Contractor must conduct or participate in PIPs, including any PIP required by CMS, in accordance with 42 CFR section 438.330. Contractor must conduct or participate in, at a minimum, two (2) PIPs per year, as directed by DHCS. At its sole discretion, DHCS may require Contractor to conduct or participate in additional PIPs, including statewide PIPs. DHCS may also require Contractor to participate in statewide collaborative PIP workgroups. 2) Contractor must have policies and procedures in place to ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors also conduct and participate in PIPs and any collaborative PIP workgroups as directed by CMS or DHCS. 3) Contractor must comply with the PIP requirements outlined in a forthcoming APL and must use the PIP reporting format as designated therein to request DHCS' approval of proposed PIPs. 4) Each PIP must include the following: a) Measurement of performance using objective quality indicators;	See Pages 58 - 59	See Pages 58 - 59

Requirement	Documentation to Review	Examples of Best Practices
b) Implementation of equity-focused interventions to achieve improvement in the access to and Quality of Care; c) Evaluation of the effectiveness of the interventions based on the performance measures; and d) Planning and initiation of activities for increasing or sustaining improvement. 5) Contractor must report the status of each PIP at least annually to DHCS.		
Exhibit A, Attachment III, Section 2.2.9 **EQRR: Consumer Satisfaction Survey** In addition, Contractor must also comply with the following requirements: Consumer Satisfaction Survey 1) On an annual basis until January 1, 2026, Contractor must timely provide all data requested by the EQRO in a format designated by the EQRO in conducting a consumer satisfaction survey. 2) Beginning January 1, 2026, concurrent with the requirement for HPA by the NCQA, Contractor must publicly post the annual results of its, and its Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's, CAHPS survey on Contractor's website, including	See Pages 58 - 59	See Pages 58 - 59

Requirement	Documentation to Review	Examples of Best Practices
results of any supplemental questions as directed by DHCS. 3) If Contractor has HPA prior to January 1, 2026 and reports its CAHPS data to the NCQA, Contractor must publicly post the annual results of its, and its Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's, CAHPS survey on Contractor's website, including results of any supplemental questions as directed by DHCS. 4) Contractor must incorporate results from the CAHPS survey in the design of QI and Health Equity activities.		
Exhibit A, Attachment III, Section 2.2.9 **EQRR: Network Adequacy Validation** In addition, Contractor must also comply with the following requirements: D. Network Adequacy Validation Contractor must participate in the EQRO's validation of Contractor's Network adequacy representations from the preceding 12 months to comply with requirements set forth in 42 CFR sections 438.14(b), 438.68, and 438.358.	See Pages 58 - 59	See Pages 58 - 59

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.9 **EQRR: Encounter Data Validation** In addition, Contractor must also comply with the following requirements: E. Encounter Data Validation As directed by DHCS, Contractor must participate in EQRO's validation of Encounter Data from the preceding 12 months to comply with requirements set forth in 42 CFR sections 438.242(d) and 438.818.	See Pages 58 - 59	See Pages 58 - 59
Exhibit A, Attachment III, Section 2.2.9 **EQRR: Focused Studies** In addition, Contractor must also comply with the following requirements: F. Focused Studies As directed by DHCS, Contractor must participate in an external review of focused clinical and/or non-clinical topic(s) as part of DHCS' review of quality outcomes and timeliness of, and access to, services provided by Contractor.	See Pages 58 - 59	See Pages 58 - 59

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.9 **EQRR: Technical Assistance** In addition, Contractor must also comply with the following requirements: G. Technical Assistance In accordance with 42 CFR section 438.358(d) and at the direction of DHCS, Contractor must implement EQRO's technical guidance provided to Contractor in conducting mandatory and optional activities described in 42 CFR section 438.358 and this Contract.	See Pages 58 - 59	See Pages 58 - 59

CATEGORY 5.10: QUALITY OF CARE FOR CHILDREN

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.10 **Quality Care for Children: Health Equity** Contractor must maintain a robust program to ensure the provision of all physical, behavioral, and oral health services to Members less than 21 years of age. Contractor must also maintain mechanisms to identify and improve on gaps in the quality of and access to care in each of the following areas: E. Quality and Health Equity 1) Contractor must identify and address underutilization of Children's preventive services including but not limited to EPSDT services such as well Child visits, developmental screenings and immunizations; 2) Contractor must report on DHCS-identified Quality Performance Measures and Health Equity performance measures related to health care services for Members less than 21 years of age, and must exceed any DHCS-specified MPL, in accordance with Exhibit A, Attachment III, Subsection 2.2.9.A (Quality Performance Measures); 3) Contractor must engage with local entities when developing interventions and strategies to address deficiencies in performance measures related to health care services for Members less than 21 years of age;	✓ QIHET Program Description ✓ Internal Monitoring Reports ✓ Quality Performance Measures and Health Equity Performance Measures related to health care services for members less than 21 years of age ✓ Meeting Minutes from CAC and focused groups (to ensure that community partnerships are fostered) ***Note:*** *The remaining areas under Contract Section 2.2.10 (A. Scope of Services, B. Utilization Management, C. Population Health Management and Coordination of Care, D. Network and Access to Care, F. Mental Health*	The Plan's QIHET Program Description must be developed with input from the Chief Quality Improvement Officer and the Chief Health Equity Officer and must include processes and standards to ensure the quality of clinical care provided in all settings, including but not limited to preventive services (children and adults), perinatal care, primary care, specialty care, emergency services, inpatient services, and ancillary care services. The Plan emphasizes a focus on EPSDT, immunizations, and well-child visits with outreach to under-utilizing populations. Equity interventions should be tailored by age group and incorporate family engagement strategies and CAC feedback. Plans provide progressive strategies on performance deficiencies and how they are monitoring provider and subcontractor performance, including leveraging community partnerships to uplift best practices and use of QI methods/models to impact results.

	and Substance Use Disorder Services, and G. School-Based Services) are included in Audit Category 2.	
Exhibit A, Attachment III, Section 2.2.10 **Quality Care for Children: Health Equity** 4) Contractor must meet any Health Disparity reduction targets for specific populations and measures for Members less than 21 years of age, as identified by DHCS and in accordance with Exhibit A Attachment III, Subsection 2.2.9.A.2 (Quality Performance Measures); 5) Contractor must participate in any value-based payment programs for services provided to Members less than 21 years of age, as directed by DHCS; 6) Contractor must engage in planned Health Equity-focused interventions to address identified gaps in the quality of and access to care for Members less than 21 years of age, including preventive and screening services; and 7) Contractor must engage in a Member and family-oriented engagement strategy to QI and Health Equity, including Children and caregiver representation on the Community Advisory Committee (CAC), and using CAC findings and recommendations, and the results of Member listening sessions, focus groups and surveys, to inform QI and Health Equity interventions, as outlined in Exhibit A, Attachment III, Subsection	See Above	In addition to above: The Plan is able to provide evidence of meetings with partners, fostering relationships, having common goals for progress evaluations and pivots – working with provider sites and implementing CAPs are examples.

5.2.11.D. (Cultural and Linguistic Programs and Committees).		

CATEGORY 5.11: SKILLED NURSING FACILITIES – LONG-TERM CARE

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.11 **SNFs – Long-Term Care** Contractor must implement and maintain policies and procedures for providing applicable Long-Term Care (LTC) services for Members as detailed in Exhibit A Attachment III, Subsection 5.3.7.G (Services for All Members). Contractors must maintain a comprehensive Quality Assurance Performance Improvement (QAPI) program for LTC services provided. Contractors must have a system in place to collect quality assurance and improvement findings from CDPH to include, but not be limited to, survey deficiency results, site visit findings, and complaint findings. Contractor's comprehensive QAPI program must incorporate all requirements in APL 23-004.* *Note: LTC is covered more extensively in Audit Category 2: Population Health Management and Coordination of Care.*	✓ Review that the Long-Term Care Contractor has implemented and maintained policies and procedures for providing applicable LTC services for Members as detailed in Exhibit A Attachment III, Subsection 5.3.7 G (Services for All Members) ✓ Review Plan's PASRR Policy (Preadmission, Screening, and Resident Review)	Effective January 2024, LTC services transitioned from FFS to managed care. The audit scope currently includes a review of policies and procedures. The Plan's LTC QAPI programs must be developed with input from the Chief Quality Improvement Officer and the Chief Health Equity Officer, and must include the five key elements (see reference on next page) identified by CMS and should put systems in place to monitor long-term care and services across the network of providers, drawing data from multiple sources. The Plan is able to provide on annual basis evidence of oversight of LTC services providers, action taken, and ongoing QA. The Plan is able to produce list of contracted SNFs for the area serviced (when requested).

References
APL 24-009 (Supersedes APL 23-004) **Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care** Please note APL 23-004 has been replaced with APL 24-009 that was published on September 16, 2024. Depending on the audit review period, staff may need to refer to APL 24-009.
Boilerplate Contract Page 31 **SNFs – Definition** Per 2024 DHCS contract, page 31: "Skilled Nursing Facility (SNF) means any facility, place, building, agency, skilled nursing home, convalescent hospital, nursing home, or nursing facility as defined in 22 CCR section 51121, which is licensed as a SNF by California Department of Public Health (CDPH) or is a distinct part or unit of a hospital, meets the standard specified in 22 CCR section 51215 of these regulations, except that the distinct part of a hospital does not need to be licensed as a SNF, and has been certified and enrolled for participation as a SNF in the Medi-Cal program."
Quality Assurance Performance Improvement (QAPI) Program **QAPI Five Key Elements** The CMS website lists five elements that make up a general framework for Plan's to implement a QAPI program in nursing homes: Element 1: Design and Scope Element 2: Governance and Leadership Element 3: Feedback, Data Systems and Monitoring Element 4: Performance Improvement Projects Element 5: Systematic Analysis and Systemic Action

CATEGORY 5.12: DISEASE SURVEILLANCE

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.12 **Disease Surveillance** Contractor must implement and maintain procedures for reporting any serious diseases or conditions to both local and State public health authorities and to implement directives from the public health authorities as required by law, including but not limited to, 17 CCR section 2500 *et seq*.	✓ Review procedures for reporting any serious diseases or conditions to both local and State public health authorities and to implement directives from the public health authorities as required by law.	Plan has procedures and tracking mechanisms to ensure serious diseases and conditions are reported as required. The plan is able to validate real-time procedures for reporting to public health authorities and updating internal logs in compliance with 17 CCR § 2500. Includes internal audit trails and training documentation for timely disease notification processes.

CATEGORY 5.13: CREDENTIALING AND RECREDENTIALING

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.13 **Standards** Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must implement and maintain written policies and procedures regarding the initial Credentialing, recredentialing, recertification, and reappointment of Network Providers in accordance with 42 CFR section 438.214 and APL 22-013. Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure its policies and procedures are reviewed and approved by its Governing Board. Contractor must ensure that the responsibility for recommendations regarding Credentialing decisions rests with a Credentialing committee or other peer review body. A. Standards Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure that all their Network Providers who deliver Covered Services and have executed Network Provider Agreements with Contractor are qualified in accordance with current applicable legal, professional, and technical standards, and are appropriately licensed, certified, or registered.	✓ Policies and Procedures ✓ Credentialing Committee Meeting Minutes ✓ ▲ Verification Study ✓ A verification study of physician credentialing files may be conducted to confirm that all providers are appropriately licensed, certified, and/or registered, have good standing in the Medicare and Medicaid/Medi-Cal programs, and possess a valid NPI number.	▲ Verification Study Results show compliance with all contract requirements and that all providers are appropriately licensed, certified, and/or registered, have good standing in the Medicare and Medicaid and Medi-Cal programs, and possess a valid NPI number. The Plan maintains documentation in credentialing files to substantiate that primary sources (State licensing agencies) are consistently used to verify providers' credentials (license and/or board certification, education, residency and/or specialty training, continuing education) at initial credentialing and recredentialing. The Plan maintains documentation in credentialing files to substantiate that the following additional information is consistently verified (not necessarily through primary sources): work history, hospital and clinic privileges, DEA certificate, NPI, malpractice insurance, sanctions or limitations on licensure) at initial credentialing and recredentialing.

Requirement	Documentation to Review	Examples of Best Practices
Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure that all their Network Providers have good standing in the Medicare and Medicaid/Medi-Cal programs and have a valid National Provider Identifier (NPI) number. Contractor must ensure that Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's Network. Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure that all contracted Laboratory Testing Sites have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number. **All Plan Letter 19-004** **Provider Credentialing and Screening** MCPs that receive a rating of "excellent," "commendable," or "accredited" from the NCQA will be deemed to have met DHCS' requirements for credentialing. Such MCPs will be exempt from DHCS' medical review audit of credentialing practices. However, MCPs retain overall responsibility for ensuring that credentialing requirements are met.	See Above	In addition to above: The Plan ensures credentialing includes checks for Medicare/Medi-Cal exclusions, licensure, and disciplinary actions. Require timely 805 reporting and ensure new providers receive Medi-Cal-specific training within 30 days. The Plan maintains documentation in credentialing files to substantiate that providers consistently submit signed and dated applications at initial credentialing and recredentialing attesting to the following: any limitations or inabilities that affect the provider's ability to perform any essential functions, a history of loss of license or felony conviction, a history or loss or limitation of privileges or disciplinary activity, a lack of present illegal drug use, the application's accuracy and completeness.

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.13 **Subcontractor Delegation** B. Subcontractor and Downstream Subcontractor Credentialing Contractor may delegate Credentialing and recredentialing activities, but Contractor remains ultimately responsible for the completeness and accuracy of these activities, as outlined in Exhibit A, Attachment III, Subsection 3.1.1 (*Overview of Contractor's Duties and Obligations*).	See Pages 74 – 75 ✓ Delegation Agreements	See Pages 74 – 75 Plan ensures delegates are compliant with DHCS contractual requirements.
Exhibit A, Attachment III, Section 2.2.13 **Provider Organization Certification** C. Credentialing Provider Organization Certification Contractor may obtain Credentialing provider organization certification (POC) from the NCQA. Contractor may accept evidence of NCQA POC certification in lieu of a monitoring visit at Network Provider's facilities.	See Pages 74 – 75 ✓ Delegation Agreements	See Pages 74 – 75 Plan ensures delegates are compliant with DHCS contractual requirements.

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.13 **Disciplinary Actions** Contractor must implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner, including dentists, to the appropriate authorities. Contractor must implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating the privileges of practitioners, including dentists. Contractor must implement and maintain a Provider appeal process.	✓ Policies and Procedures ✓ Credentialing Committee Meeting Minutes ✓ 805 Reporting ▲ Verification Study A verification study of providers terminated during the audit review period may be reviewed to confirm timely 805 reporting to appropriate authorities.	▲ Verification Study results show compliance with Contract requirements that providers terminated during the audit review period may be reviewed to confirm timely 805 reporting to appropriate authorities. The Plan's Policies and Procedures delineate monitoring activities to ensure the timely reporting of serious quality deficiencies resulting in the suspension or termination of a provider to the appropriate authorities. The Plan's Policies and Procedures delineate processes for enacting disciplinary actions such as reducing, suspending, or terminating a provider's privileges. The Plan's Policies and Procedures describe the process for which providers may appeal disciplinary actions. The Plan correspondingly provides documented evidence to demonstrate adherence to its own internal Policies and Procedures (e.g., timely 805 reporting, Credentialing Committee meeting minutes, provider appeals).

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.13 **Medi-Cal and Medicare Provider Status** Contractor must verify that its Subcontractors, Downstream Subcontractors, and Network Providers have not been terminated as Medi-Cal or Medicare Providers or have not been placed under a restriction (payment or temporary suspension) resulting in placement on the Suspended and Ineligible Provider List, List of Excluded Entities, or Restricted Provider Database. Contractor cannot maintain contracts with Network Providers, Subcontractors, or Downstream Subcontractors who have been terminated by either Medicare or Medi-Cal or placed on the Suspended and Ineligible Provider List.	✓ Policies and Procedures ✓ Credentialing Committee Meeting Minutes ✓ 805 Reporting ✓ Provider Directory ▲ Verification Study A verification study of providers terminated during the audit review period may be reviewed to confirm timely removal of providers from the network and the Prover Directory.	▲ Verification Study results show compliance with Contract requirements that providers terminated during the audit review period may be reviewed to confirm timely removal of providers from the network and Provider Directory. The Plan conducts continuous monitoring of the Suspended and Ineligible Provider List to promptly identify providers who have been terminated from participation in the Medi-Cal and/or Medicare program(s). The Plan correspondingly provides documented evidence to demonstrate that timely follow-up action is taken when providers have been placed on the Suspended and Ineligible Provider List (e.g., discussion in Credential Committee meeting minutes, prompt removal of provider from the network and Provider Directory).

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 2.2.13 **Contractor's NCQA Accreditation** If Contractor has received an accredited status from NCQA, Contractor will be deemed to meet the DHCS requirements for Credentialing and may be exempt from the DHCS medical review audit for Credentialing.	✓ Validate Plan's accreditation certificate	Plan has obtained NCQA accreditation
Exhibit A, Attachment III, Section 2.2.13 **Credentialing of Other Non-Physician Providers** Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must develop and maintain policies and procedures that ensure that the credentials of Nurse Practitioners, Certified Nurse Midwives (CNMs), clinical nurse Specialists, Physician Assistants, mental health Providers, and substance use treatment Providers have been verified in accordance with State requirements applicable to the Provider category.	See Pages 74 – 75	See Pages 74 – 75

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 3.2.5 **New Provider Training** Contractor must ensure that all Network Providers receive training regarding the Medi-Cal Managed Care program to ensure they operate in full compliance with the Contract and all applicable federal and State statutes, regulations, All Plan Letters (APLs), and Policy Letters (PLs). Contractor must conduct training for all Network Providers. Contractor must start training within ten Working Days and complete training within 30 Working Days after Contractor places a newly contracted Network Provider on active status. Contractor may conduct Network Provider training online or in-person. Contractor must maintain records of attendance to validate that Network Providers received training on a bi-annual basis. A. Contractor must ensure that Network Provider training includes education on Covered Services, policies and procedures for clinical protocols governing Prior Authorization and UM, and carved out services including, how to refer to and coordinate care with agencies, programs and third parties with which Contractor has a Memorandum of Understanding (MOU) as required under this Contract.	✓ Policies and Procedures ✓ Training Materials ✓ Internal Tracking and Monitoring Reports ✓ Provider Manual ✓ Provider Newsletters ▲ Verification Study A verification study of all new providers during the audit review period to confirm that training is completed within 30 working days after the provider is placed on active status.	▲ Verification Study results show compliance with Contract requirements that all new providers during the audit review period may be reviewed may be reviewed to confirm that training is completed within 30 working days after the provider is placed on active status. The Plan's Policies and Procedures delineate monitoring activities to ensure that all new providers (i.e., physicians and non-physicians) complete initial Medi-Cal Managed Care training within 30 working days after being placed on active status. The Plan correspondingly provides documented evidence to demonstrate adherence to its internal Policies and Procedures (e.g., maintenance of all provider attestations, tracking system/grid which clearly identifies the dates of training completion and active status). The Plan's produces initial provider training materials that specifically address each of the following components: Medi-Cal Managed Care services, policies, and procedures; methods for sharing information between the Plan, provider, member, and/or other healthcare providers; and information on member rights (e.g. grievance and appeal procedures, full

Requirement	Documentation to Review	Examples of Best Practices
		disclosure of health care information to members). The Plan's Policies and Procedures address the provision of *ongoing* provider training when deemed necessary (e.g., implementation of new regulations, changes to departmental-specific internal processes, audit/internal findings prompting re-training, etc.). The Plan correspondingly provides documented evidence of ongoing provider training or outreach to substantiate dissemination of new information (e.g., training materials, sign-in sheets, Provider Services outreach, updated Provider Manual, provider newsletters, provider portal, fax blasts).

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 3.2.5 **Network Provider Training: Frequency** B. Contractor must conduct ongoing training, at least once every two years, for Network Providers on required preventive healthcare services, including Early Periodic Screening, Diagnosis and Testing (EPSDT) services for Members less than 21 years of age; appropriate medical record documentation; and coding requirements. This must include training on existing Contractor data collection and reporting requirements and Quality Improvement programs to ensure required preventive services are offered and provided. This training also must include, but is not limited to, training on Population Health Management (PHM) program requirements (i.e., care management services) including referrals, health education resources, and Provider and Member incentive programs. **Exhibit A, Attachment III, Section 3.2.5** **Network Provider Training: Notifying Providers of P&P Changes** C. Contractor must immediately notify Network Providers when changes to its existing policies and procedures impact Network Providers' provision of Medi-Cal Covered Services to Members and not wait until the next biennial mandatory training	✓ Policies and Procedures ✓ Training Materials ✓ Internal Tracking and Monitoring Reports ✓ Provider Manual ✓ Provider Newsletters ▲ Verification Study A verification study of all providers during the audit review period is reviewed to confirm training is conducted at least every two years.	▲ Verification Study results show compliance with Contract requirements that all providers during the audit review have completed ongoing training at least every two years. The Plan's Policies and Procedures delineate monitoring activities to ensure that all providers receive training at least every two years. The Plan correspondingly provides documented evidence to demonstrate adherence to its internal Policies and Procedures (e.g., maintenance of all provider attestations, tracking system/grid which clearly identifies the dates of training completion and active status). The Plan correspondingly provides documented evidence of ongoing provider training or outreach to substantiate dissemination of new information (e.g., training materials, sign-in sheets, Provider Services outreach, updated Provider Manual, provider newsletters, provider portal, fax blasts).

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 3.2.5 **Network Provider Training: Member Access** D. Contractor's training must educate Network Providers on Member access, including compliance with appointment waiting time standards and ensuring telephone, translation, and language access is available for Members during hours of operation. Training must also include education on secure methods for sharing information between Contractor, Network Providers, Subcontractors, Downstream Subcontractors, Members, and other healthcare professionals. This must include training on ensuring Providers have accurate contact information for the Member and all Network Providers involved in the Member's care. Contractor must also provide training on how to refer and coordinate care for Members who need access to Excluded Services.	See Pages 79 – 81 ✓ Review of documents should show training on specific topics such as: appointment wait times; language assistance, sharing of information; procedures for referrals and coordination of care ▲ Verification Study A verification study of all providers during the audit review period may be reviewed to confirm training includes the specified areas above.	See Pages 79 – 81 ▲ Verification Study results show compliance with Contract requirements that all providers during the audit review have completed training in the required areas. The Plan's Policies and Procedures delineate monitoring activities to ensure that all providers receive training on the specified areas. The Plan correspondingly provides documented evidence to demonstrate adherence to its internal Policies and Procedures (e.g., maintenance of all provider attestations, tracking system/grid which clearly identifies the dates of training completion and active status).

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 3.2.5 **Network Provider Training: Member Rights** E. Contractor must ensure that Network Provider biennial mandatory training includes information on all Member rights specified in Exhibit A, Attachment III, Section 5.1 (Member Services), and diversity, equity and inclusion training (sensitivity, diversity, communication skills, and cultural competency/humility training) as specified in Exhibit A, Attachment III, Subsection 5.2.11.C. (Cultural and Linguistic Programs and Committees). This process must also include an educational program for Network Providers regarding health needs to include but not be limited to, the Seniors and Persons with Disabilities (SPD) population, Members with chronic conditions, Members with Specialty Mental Health Service (SMHS) needs, Members with Substance Use Disorder (SUD) needs, Members with intellectual and Developmental Disabilities (DDs), and Children with Special Health Care Needs (CSHCN). Trainings must include Social Drivers of Health (SDOH) and disparity impacts on Members' health care. Attendance records must be reviewed and maintained by Contractor's Health Equity officer.	See Pages 79 – 81 ✓ Review of documents should show training on specific topics such as: member services; diversity, equity, and inclusion training that includes sensitivity, diversity, communication skills, and cultural competency topics; targeted training for specified populations listed ▲ Verification Study A verification study of all providers during the audit review period may be reviewed to confirm training includes the specified areas above.	See Pages 79 – 81 ▲ Verification Study results show compliance with Contract requirements that all providers during the audit review have completed training in the required areas. The Plan's Policies and Procedures delineate monitoring activities to ensure that all providers receive training on the specified areas. The Plan correspondingly provides documented evidence to demonstrate education attendance records management by the Chief Health Equity Officer and adherence to its internal Policies and Procedures (e.g., maintenance of all provider attestations, tracking system/grid which clearly identifies the dates of training completion and active status).

Requirement	Documentation to Review	Examples of Best Practices
Exhibit A, Attachment III, Section 3.2.5 **Network Provider Training: Committee and Board of Director Review** F. Trainings must be reviewed by the appropriate Contractor committees, including Contractor's board of director's compliance and oversight committee and QIC, routinely, but not less than biennially, to ensure consistency and accuracy with current requirements and Contractor's policies and procedures.	✓ Policies and Procedures ✓ Compliance Meeting Minutes ✓ QIHEC Meeting Minutes ✓ Training Materials	The Plan ensures committees and board of directors review and approve training materials that are consistent with requirements, policies and procedures at least biennially.
Exhibit A, Attachment III, Section 3.2.5 **Network Provider Training: Practice Guidelines** G. In compliance with 42 Code of Regulations (CFR) section 438.236(b), Contractor must ensure that practice guidelines are based on valid and reliable clinical evidence or a consensus of Providers in that particular field, consider the needs of Contractor's Members, are adopted in consultation with Network Providers, and are reviewed and updated periodically as appropriate. In addition to Network Provider training, Contractor must disseminate their practice guidelines to all affected Providers.	✓ QIHET Program Description ✓ QIHETP Policies and Procedures ✓ QIHEC Meeting Minutes ✓ Clinical Practice GuidelinesProvider Manual ✓ Provider Newsletters ✓ Website Review	The QIHET Program Description delineates processes to ensure that medical decisions are based on clinical practice guidelines that are adopted from nationally recognized organizations.