53860 Quality of Care

(a)

Each plan shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all practitioners providing services on its behalf in all types of settings, including, but not limited to, ambulatory, inpatient and home settings.

(b)

Each plan shall implement an effective quality improvement program in accordance with the standards in Title 10, section 1300.70.

(c)

In addition to subsection (b), each plan shall implement and maintain a quality improvement program including at a minimum the following elements: (1) A system of accountability which includes the participation of the plan's governing body, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the plan's medical director, and the inclusion of contracted physicians and other health care providers in the process of quality improvement program development and performance review. (2) Objective and systematic monitoring and evaluation of the quality and appropriateness of care and services rendered on an ongoing basis, including conducting quality of care studies that address the quality of clinical care as well as the quality of health services delivery. (3) A utilization management program,

including, but not limited to procedures for monitoring under and over-utilization of services, procedures to evaluate medical necessity, prior authorization policies and procedures, and criteria used for approval, referral and denial of services, pursuant to Health and Safety Code, section 1363.5.

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(2)

Objective and systematic monitoring and evaluation of the quality and appropriateness of care and services rendered on an ongoing basis, including conducting quality of care studies that address the quality of clinical care as well as the quality of health services delivery.

(3)

A utilization management program, including, but not limited to procedures for monitoring under and over-utilization of services, procedures to evaluate medical necessity, prior authorization policies and procedures, and criteria used for approval, referral and denial of services, pursuant to Health and Safety Code, section 1363.5.

(d)

The department shall arrange for, at least annually, an external quality of care review of each plan from an entity qualified to conduct such reviews in accordance with Title 42 USC, Section 1396a (30)(C). In addition, as a component of its contract compliance monitoring activities, the department shall conduct annual medical reviews which shall include but not be limited to an appraisal of plan

performance in areas such as access to care, continuity of care, quality of care, provision of health education and preventive services, and authorization and denial of services. The department's annual medical reviews shall not duplicate the external quality of care review, except to the extent that such duplication is necessary to verify the plan's compliance with any corrective actions arising out of the external quality of care review. Each plan shall cooperate with and assist both the external quality review organization and the department in the conduct of these reviews.

(e)

The department shall issue medical review reports to the plan detailing findings, recommendations, corrective actions and sanctions, as appropriate. Each plan shall comply in full with any corrective action plan issued by the department. Failure to comply may result in the imposition of sanctions as appropriate.