Policy:	GG.1629
Title:	**Quality Improvement and Health Equity Transformation Program (QIHETP)**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/ Michael Hunn 08/22/2024*
Effective Date:	04/01/2007
Revised Date:	06/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes CalOptima Health's commitment to the delivery of quality and equitable health care service and the process by which CalOptima Health shall develop, implement, and evaluate its Quality Improvement and Health Equity Transformation Program (QIHETP), a program that describes the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity (HE) and health care delivered to Members in accordance with the standards set forth in applicable laws, regulations, and contracts.

II. POLICY

A. CalOptima Health shall annually develop, implement and report a written Quality Improvement and Health Equity Transformation Program (QIHETP) and Work Plan, in compliance with the Department of Health Care Services (DHCS) contract. The QIHETP and Work Plan establishes methods for objectively and systematically evaluating and improving the Quality and Safety of Clinical Care to members and Quality of Service for physical, Behavioral Health Services, access and engagement of providers, continuity and coordination across settings and all levels of care, and Member experience. The QIHETP quality and health equity goals are aligned with DHCS' Health Equity Framework with the Comprehensive Quality Strategy. The QIHETP and Work Plan include but are not limited to the following:

1. Methods to continuously monitor, review, evaluate, and improve quality and HE 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.

2. Quality performance measure results with a plan.

3. CalOptima Health's organizational chart, listing the key staff and the committees responsible for Quality Improvement (QI) and Health Equity (HE) activities, including reporting relationships of QIHEC to executive staff.

4. Qualification and identification of staff who are responsible for QI and HE activities.

5. Methods to address External Quality Review (EQR) technical report and evaluation report recommendations.

6. Data from various sources include performance results, encounter data, Grievances and Appeals, utilization review, and member satisfaction surveys to analyze delivery of services and quality of care.

7. Community engagement with commitment to Member and family focused care.

8. Equity and Community Health activities and findings including but not limited to the findings of the annual Population Needs Assessment (PNA), and Population Health Management (PHM) Strategy designed to address Social Drivers of Health (SDOH), reduce disparities in health outcomes experienced by different subpopulations of Members, and work toward achieving HE by:

    a. Developing equity-focused interventions intended to address disparities in the utilization and outcomes of physical and behavioral health care services; and

    b. Engaging in a Member and family-centric approach in the development of interventions and strategies, and in the delivery of all health care services.

9. Methods to identify, evaluate, and reduce health disparities by performing the following:

    a. 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 the Members;

    b. Develop equity-focused interventions to address the underlying factors of identified health disparities, including SDOH; and

    c. Meeting disparity reduction targets for specific populations and/or measures as identified by DHCS.

10. Methods to evaluate Culturally and Linguistically Appropriate Services (CLAS) by reviewing and assessing the CLAS program

11. Integration of Utilization Management activities into the QIHETP including integrating reports on the number and types of service requests, denials, deferrals, modifications, Appeals and Grievances to the medical director or designee.

    a. Methods to detect both over-and under-utilization of services including, but not limited to, outpatient prescription drugs.

    b. Methods for equity focused interventions to identify patterns for over or under utilization of physical and behavioral health care services.

12. Adoption, dissemination, and monitoring the use of clinical practice guidelines that:

    a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the relevant field.

    b. Consider the needs of the Member.

c. 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.

d. Have been reviewed by CalOptima Health's medical director as well as Health Networks and Downstream Entities and Network Providers, as appropriate; and
e. Are reviewed and updated every two (2) years.

13. Methods to deliver Medically Necessary non-specialty and Specialty Mental Health Service.

    a. Methods to ensure CalOptima Health's Health Networks, Downstream Entities, Network Providers, and other entities contracted comply with all mental health parity requirements, in accordance with 42 CFR section 438.900.

14. Methods to continuously monitor, review, evaluate, and improve access to and availability of all Covered Services which include oversight ensuring Members are able to obtain Medically Necessary appointments within established standards for time or distance, timely access, and alternative access in accordance with DHCS APL 23-001: Network Certification Requirements and W&I Code sections 14197 and 14197.04.

15. Methods to continuously monitor, review, evaluate, and improve coordination and continuity of care services to all Members, including Seniors and Persons with Disabilities (SPDs), Children with Special Health Care Needs (CSHCN), Members with chronic conditions, including behavioral health, Members experiences homelessness, Members recently released from incarceration, Members who use Long-Term Services & Supports (LTSS), and Children in child welfare.

16. Methods to deliver quality care that enables all its Members to maintain health and improve or manage a chronic illness or disability. CalOptima Health shall ensure quality of care in each of the following areas:

    a. Clinical quality of physical health care.

    b. Clinical quality of behavioral health care focusing on prevention, recovery, resiliency, and rehabilitation.

    c. Access to primary and specialty health care Providers and services.

    d. Availability and regular engagement with Primary Care Providers (PCP).

    e. Continuity and care coordination across settings and at all levels of care, including transitions in care, with the goal of establishing consistent Provider-patient relationships.

    f. Member experience with respect to clinical quality, access, and availability, and culturally and linguistically competent health care and services, and continuity and Care Coordination.

17. Application of continuous quality improvement (CQI) to all aspects of CalOptima Health's service delivery system through analysis, evaluation, and systematic enhancements of the following:

a. Quantitative and qualitative data collection and data-driven-decision-making.

b. 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.

c. Feedback provided by Members and Network Providers in the design, planning, and implementation of its CQI activities.

d. Other issues identified by CalOptima Health or DHCS.

B. The QI and HE plan, which is a part of the QIHETP, includes the following, at minimum:

1. A comprehensive assessment of the QI and HE activities undertaken, including an evaluation of the effectiveness of QI interventions;

2. A written analysis of required quality performance measure results, and a plan of action to address performance deficiencies;

3. An analysis of actions taken to address any CalOptima Health-specific recommendations in the annual External Quality Review (EQR) technical report and CalOptima Health's specific evaluation reports;

4. An analysis of the delivery of services and quality of care based on data from multiple sources, including quality performance results, encounter data, Grievances and Appeals, utilization review and the results of consumer satisfaction surveys;

5. Planned equity-focused interventions to address identified patterns of over- or under-utilization of physical and behavioral health care services;

6. A description of CalOptima Health's commitment to Member and/or family focused care through Member and community engagement such as review of Clinical Advisory Committee findings, Member listening sessions, focus groups or surveys, and collaboration with local community organizations; and how CalOptima Health utilizes the information from this engagement to inform policies and decision-making;

7. Equity and Community Health activities and findings; and

8. Outcomes/findings from Performance Improvement Projects (PIPs), consumer satisfaction surveys and collaborative initiatives.

C. The QI Department shall develop the QIHETP in accordance with applicable National Committee for Quality Assurance (NCQA), state and federal regulations.

D. CalOptima Health's Chief Medical Officer, or Designee, and the Chief Health Equity Officer shall supervise QIHETP activities.

E. CalOptima Health shall share the QIHETP findings with its Health Networks, Downstream Entities, and Network Providers.

F. The QIHEC shall be responsible for the quality and HE of all Covered Services regardless of whether or not those services have been delegated to a Health Network, Downstream Entities, or Network Provider, in accordance with CalOptima Health Policy GG.1620: Quality Improvement Health Equity Committee (QIHEC).

1. CalOptima Health shall identify the role, structure, and function of the QIHEC, in accordance with CalOptima Health Policy GG.1620: Quality Improvement Health Equity Committee (QIHEC).

2. The QIHEC shall monitor, evaluate, and take timely action to address necessary improvements in the quality of care delivered by all its Network Providers in any setting, and take appropriate action to improve upon HE.

3. CalOptima Health through the QIHEC shall ensure that Health Networks and Downstream Entities meet QI and HE Standards.

4. The QIHEC shall oversee and ensure the execution of the QIHETP, in accordance with CalOptima Health Policy GG.1620: Quality Improvement Health Equity Committee (QIHEC).

5. CalOptima Health through the QIHEC shall 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, 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 all Covered Services are provided in a culturally and linguistic appropriate manner.

III. PROCEDURE

A. The QI Department shall modify the QIHETP, which includes the QI and HE annual plan, as necessary, to identify and implement new activities in order to continuously improve the structure, processes, and outcomes of the health care delivery system.

B. The QI Department staff shall review the QIHETP annually to evaluate the scope, organization, and effectiveness of the program.

C. The QI Department shall submit the reviewed or revised QIHETP to the QIHEC for approval on an annual basis.

D. Upon approval by the QIHEC, CalOptima shall submit the QIHETP to the CalOptima Board of Directors Quality Assurance Committee (QAC) for an annual review and approval as part of the oversight and governance process.

E. The QIHETP shall ensure the provision and utilization of services are in compliance with applicable state and federal regulations.

1. On an annual basis, the QI Department shall submit the QIHETP to RAC for submission to the DHCS and the CMS for review.

2. CalOptima Health shall make the findings of its continuous monitoring and evaluation of the Health Network and Downstream Entities available to:

a. DHCS at least annually or upon request from DHCS, and

b. Providers, Heath Networks, and downstream Subcontractors at least annually.

3. On an annual basis, CalOptima Health shall provide:

a. Annual copies of all final reports of independent private accrediting agencies (e.g., NCQA) to DHCS, including:

i. Accreditation status, survey type, and level, as applicable;

ii. Accreditation agency results, including recommended actions or improvements, Corrective Action plans, and summaries of findings; and

iii. Expiration date of the accreditation.

b. CalOptima Health shall authorize independent private accrediting agencies to provide DHCS with a copy of Contractor's most recent accreditation review annually.

F. On an annual basis, CalOptima Health shall make the QIHETP publicly available via the CalOptima Health website.

G. On a quarterly basis, the QIHEC shall provide progress reports to QAC that describe actions taken, progress in meeting QIHETP objectives, and improvements made.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS)
B. CalOptima Health Policy GG.1620: Quality Improvement Health Equity Committee (QIHEC)
C. National Committee for Quality Assurance (NCQA) Standards for Quality Improvement
D. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-001: Network Certification Requirements (Supersedes APL 21-006)
E. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-004: Quality Improvement and Health Equity Transformation Requirements (Supersedes APL 19-017)
F. QI HE Transformation Program
G. Title 42, Code of Federal Regulations (CFR), §422.152, 438.330(a)(1) and 438.330(b)
H. Title 28 California Code of Regulations (CCR), §1300.70

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
02/01/2016	Department of Health Care Services (DHCS)	Approved as Submitted
01/30/2023	Department of Health Care Services (DHCS)	Approved as Submitted
04/27/2023	Department of Health Care Services (DHCS)	Approved as Submitted
07/21/2023	Department of Health Care Services (DHCS)	Approved as Submitted
03/22/2024	Department of Health Care Services (DHCS)	File and Use
08/15/2024	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2007	GG.1629	Quality Improvement Program	Medi-Cal
Revised	11/01/2015	GG.1629	Quality Improvement Program	Medi-Cal OneCare OneCare Connect
Revised	08/01/2016	GG.1629	Quality Improvement Program	Medi-Cal OneCare OneCare Connect
Revised	11/01/2017	GG.1629	Quality Improvement Program	Medi-Cal OneCare OneCare Connect
Revised	01/01/2019	GG.1629	Quality Improvement Program	Medi-Cal OneCare OneCare Connect
Revised	03/01/2020	GG.1629	Quality Improvement Program	Medi-Cal OneCare OneCare Connect
Revised	12/31/2022	GG.1629	Quality Improvement Program	Medi-Cal OneCare
Revised	01/01/2023	GG.1629	Quality Improvement Program	Medi-Cal OneCare
Revised	04/01/2023	GG.1629	Quality Improvement and Health Equity Transformation Program (QIHETP)	Medi-Cal OneCare
Revised	07/01/2023	GG.1629	Quality Improvement and Health Equity Transformation Program (QIHETP)	Medi-Cal OneCare
Revised	03/01/2024	GG.1629	Quality Improvement and Health Equity Transformation Program (QIHETP)	Medi-Cal OneCare
Revised	06/01/2024	GG.1629	Quality Improvement and Health Equity Transformation Program (QIHETP)	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.
Behavioral Health Services	Specialty Mental Health Services (SMHS), Non-specialty Mental Health Services (NSMHS), and Substance Use Disorder (SUD) treatment.
Covered Services	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, this Contract, and APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under this Contract, as specified in Exhibit A,

	Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than 21 years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for CalOptima Health providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for CalOptima Health providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than 21 years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with APL 23-005; 14. Childhood lead poisoning case management provided by county health departments;

	15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Grievance	Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.
Health Equity	The reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

	OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services include Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Network Provider	A Provider that subcontracts with CalOptima Health for the delivery of Medi-Cal Covered Services.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B.
Quality Improvement	Systematic and continuous actions that lead to measurable improvements in the way health care is delivered and outcomes for Members.
Quality Improvement Health Equity Committee (QIHEC)	A committee facilitated by CalOptima Health's medical director, or the medical director's designee, in collaboration with the Health Equity officer, that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.
Quality and Safety of Clinical Care	Defined as, Quality of physical health care, including primary and specialty care; Quality of Behavioral Health Services; and Quality of LTSS.
Quality of Service	Defined as, adequate access and availability to primary, Behavioral Health Services, specialty health care, and LTSS providers and services; Continuity and coordination of care across all care and services settings, and for transitions in care; and member experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum.
Social Drivers of Health (SDOH)	The environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk. Also known as Health-Related Social Needs.
Subcontractor	An individual or entity that has a Subcontractor Agreement with CalOptima Health or CalOptima Health's Subcontractor that relates directly or indirectly to the performance of CalOptima Health's obligations under its contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.