Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th Street, Suite 500
Sacramento, CA 95814
Phone: 916-324-8176 | Fax: 916-255-5241
www.DMHC.ca.gov

ALL PLAN LETTER

DATE: June 28, 2024
Updated October 1, 2025

TO: All Health Care Service Plans[1]

FROM: Nathan Nau
Deputy Director, Office of Plan Monitoring

SUBJECT: REVISED APL 24-013 – Health Equity and Quality Program Policies and Requirements

The Department of Managed Health Care (DMHC) issues this All-Plan Letter (APL) to inform all health care service plans (health plans) of the DMHC Health Equity and Quality (HEQ) program policies and requirements.[2] The instructions provided herein supersede those previously published in APL 22-028 and REVISED APL 23-029.

I. Background

Assembly Bill (AB) 133 (Committee on Budget, 2021) (Health and Safety Code (HSC) section 1399.870 et seq.) required the DMHC to establish and convene a Health Equity and Quality Committee (Committee). The purpose of the Committee was to recommend a health equity and quality measure set (HEQMS) and benchmark standards for health plans, with the goal of addressing long-standing health inequities and ensuring the equitable delivery of high-quality health care services across all market segments, including the individual, small and large group markets, and the Medi-Cal Managed Care program.

Based on the Committee's recommendations, the DMHC established the HEQMS, including requirements for stratification by race and ethnicity, and a benchmark standard for the evaluation of health plan performance. The HEQMS will be effective for data collected for measurement year (MY) 2023 through at least MY 2027. The DMHC may reconvene the Committee to reevaluate the effectiveness of the HEQMS prior to the MY 2027 measure sunset date, pursuant to HSC section 1399.871.

[1] This APL does not apply to health plans that only offer Medicare Advantage products or other specialized health care service plan products, including specialized dental, vision, chiropractic, acupuncture plans, or Employee Assistance Programs (EAPs).
[2] Pursuant to HSC section 1399.874(b), the DMHC has authority to implement AB 133 using all-plan letters, methodologies, rules, policies, forms, or similar instructions, without taking regulatory action, until January 1, 2027.

II. DMHC HEQMS

The DMHC established 13 HEQ measures that consist of 12 Healthcare Effectiveness Data and Information Set (HEDIS®) measures and one Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measure (see Table 1).[3, 4] Each of the 13 HEQMS measures may be comprised of additional measure indicators established by the NCQA. Any reference to the 13 HEQMS measures in this APL, and in any referenced documents, is to be understood to be inclusive of the measure indicators listed in Table 1.

Table 1. HEQMS, Abbreviation, and Measure Steward

DMHC HEQ Measure Name	Abbreviation[5]	Measure Steward
1. Colorectal Cancer Screening[6]	COL / COL-E	NCQA
2. Breast Cancer Screening	BCS-E	NCQA
3. Glycemic Status Assessment for Patients with Diabetes[7] – 3.1 Glycemic Status <8.0% 3.2 Glycemic Status >9.0%	GSD	NCQA
4. Controlling High Blood Pressure	CBP	NCQA
5. Asthma Medication Ratio (Total age range)[8]	AMR	NCQA
6. Depression Screening and Follow-Up for Adolescents and Adults – 6.1 Depression Screening 6.2 Follow-Up on Positive Screen	DSF-E	NCQA
7. Prenatal and Postpartum Care – 7.1 Timeliness of Prenatal Care 7.2 Postpartum Care	PPC	NCQA
8. Childhood Immunization Status (Combo 10)[9]	CIS / CIS-E	NCQA
9. Well-Child Visits in the First 30 Months of Life – 9.1 First 15 Months 9.2 Age 15 Months - 30 Months	W30	NCQA

[3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). Technical specifications for measure indicators are in the most recent version of HEDIS® Volumes 1, 2, and 3.
[4] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[5] Measure abbreviations in Table 1 correspond to abbreviations used by the NCQA. Measure abbreviations that include "-E" refer to electronic data collection methodology. Consequently, the DMHC will continue to update abbreviations as the NCQA transitions additional measures to ECDS-only reporting.
[6] The NCQA transitioned the Colorectal Cancer Screening measure to ECDS-only beginning MY 2024.
[7] This measure was previously called Hemoglobin A1c Control for Patients with Diabetes.
[8] The NCQA plans to retire this measure after MY 2025.
[9] The NCQA transitioned the Childhood Immunization Status measure to ECDS-only beginning MY 2025.

DMHC HEQ Measure Name	Abbreviation[5]	Measure Steward
10. Child and Adolescent Well-Care Visits (Total age range)	WCV	NCQA
11. Plan All-Cause Readmissions (18-64 years of age)	PCR	NCQA
12. Immunizations for Adolescents (Combo 2)[10]	IMA / IMA-E	NCQA
13. CAHPS Health Plan Survey[11] (Medicaid and Commercial): Getting Needed Care – 13.1 Adult Survey 13.2 Child Survey	CPA / CPC	AHRQ

Additional information on the HEQMS can be found in the Health Equity and Quality Measure Set Tables attached to this APL.

III. HEQ Reporting and Accreditation Requirements

A. Health Plans Subject to HEQ Reporting

All health plans that deliver hospital, medical, or surgical services, or behavioral health services, or both, are required to report on all 13 HEQMS measures by line of business (i.e., Commercial, Medicaid, and Exchange), starting with MY 2023 data submitted in reporting year (RY) 2024.[12, 13, 14] HEQMS reporting by a health plan must be inclusive of the health plan's direct enrollment and all enrollees delegated to any subcontracted health plan(s).[15]

Some health plans may be eligible for an exemption from specific HEQ Reporting requirements. HSC section 1343(b) allows the director to issue orders exempting health plans from portions of Chapter 2.2 of Division 2 of the Health and Safety Code "if the director finds the action to be in the public interest and not detrimental to the protection of subscribers, enrollees, or persons regulated under this chapter, and that the regulation of the [health plan] is not essential to the purpose of this chapter." Health plans with under

[10] The NCQA transitioned the Immunizations for Adolescents measure to ECDS-only beginning MY 2025.
[11] The NCQA is using CAHPS Health Plan Survey, Version 5.1H ("H" demonstrates it is part of HEDIS reporting) for MY 2023. AHRQ periodically updates the CAHPS Health Plan Survey instruments, and health plans will need to confirm which CAHPS survey version the NCQA has adopted for a given measurement year. The Health Equity and Quality Committee report and APL 22-028 identified CAHPS Health Plan Survey, Version 5.0 as the survey instrument to be utilized, which has since changed.
[12] Behavioral health plans with direct enrollment do not currently have an HEQMS Data Reporting requirement; however, they must still submit the HEQ Pre-Filing Form and Health Plan Demographic Data Metric, as described in Section III. B. "HEQ Reporting Requirements." The DMHC may reconvene the Committee to confer on potential behavioral health measures.
[13] Reporting year or RY means the calendar year in which the plan is required to submit the data from the previous measurement year or MY.
[14] The NCQA refers to Commercial, Medicaid, and Exchange as "product lines."
[15] Direct enrollment is the sum of all individuals enrolled in the primary plan and includes the number of enrollees delegated to the subcontracted plan.

15,000 total direct enrollment for all product line(s) within a line of business (Commercial, Medicaid, or Exchange) may submit a material modification pursuant to HSC section 1352(b) requesting an exemption from two HEQ reporting requirements: the HEQ Pre-Filing Form and the HEQMS Data Reporting. If approved, the exemption will be granted for one MY.

Starting in MY 2025 and forward, a health plan seeking an exemption will be required to submit a material modification by December 1st of the MY for which it seeks the exemption. With each request, the health plan must provide total direct enrollment data for all product line(s) within a line of business (Commercial, Medicaid, or Exchange) for which it seeks an exemption. The health plan is expected to conform to standard e-Filing instructions, found on the Department's public website.

B. HEQ Reporting Requirements

Health plans subject to HEQ reporting must complete all required submissions listed below through the DMHC e-Filing Web Portal according to the timeline specified for each submission type. Detailed instructions on the reporting process can be found in the Health Equity and Quality Program Submission Instructions attached to this APL.

Health plans must only submit data pertaining to products licensed and regulated by the DMHC.

For each RY, health plans must submit each of the following to the DMHC:

- HEQ Pre-Filing Form

  This form collects preliminary information from health plans prior to the submission of HEQMS data. It will inform the DMHC of each plan's collection details pertaining to product lines, NCQA Accreditation, and plan-to-plan contracts.

  Health plans must submit the HEQ Pre-Filing Form by the first Friday of May each RY.[16]

- HEQMS Data Reporting

  The DMHC has aligned its HEQMS reporting timeline with the NCQA's data submission timeline to ease the burden on health plans. The process for calculating and reporting rates for the HEQMS is as follows:

  1. Each health plan must follow the NCQA data reporting process and submit their final data to the NCQA by the NCQA's deadline in Q2 of each RY.

     The DMHC follows, and health plans must adhere to, the NCQA's HEDIS, CAHPS, or other applicable technical specifications for each MY. Health plans must follow the DMHC's and the NCQA's timeline for collecting, calculating,

[16] The most current Pre-Filing Form is available in the Downloads section of the e-Filing Web Portal.

auditing, and reporting rates. More information on the NCQA's timeline can be found on the NCQA HEDIS Data Submission website.

When reporting HEDIS data to the NCQA, health plans may use either the Administrative or the Hybrid Data Collection Method (Traditional Methods), unless reporting via the Electronic Clinical Data System (ECDS) is required by the NCQA or the DMHC for a specific measure. However, when both Traditional and ECDS methods are available for a given measure, health plans must report using both methods.[17]

2. Health plans must submit their NCQA summary level aggregate and stratified measure results file(s) per line of business received from the NCQA to the DMHC via the DMHC e-Filing Web Portal by the first Friday of August each RY.[18, 19, 20]

   Starting with MY 2023 data, the DMHC has aligned its HEQMS measure stratification requirements with the NCQA. Specific measure stratification and reporting requirements for MY 2023/RY 2024, MY 2024/RY 2025, and MY 2025/ RY 2026 can be found in the HEQMS Reporting Tables attached to this APL.

- Health Plan Demographic Data Metric (HPDDM) Template

  The HPDDM template collects information on what demographic data health plans are collecting and for what percentage of their enrollees.[21] Beginning with MY 2023/RY 2024, the DMHC will use data collected via the HPDDM template to inform the DMHC of the nature of demographic data health plans currently collect – the terms and categories used as well as the extent to which health plans have been able to capture the data to date – prior to the establishment of any new standards or requirements for health plan demographic data collection. The information collected will also support discussions with the Committee about new areas where stratification of the HEQMS can be expanded to better track health plans' progress where disparate outcomes may exist.[22]

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[17] Traditional and/or ECDS reporting does not apply to the CAHPS Health Plan Survey.
[18] For the purposes of this APL, "aggregate" refers to summary level (non-stratified) measure result(s) of the individual (not composite) HEDIS measures that are in the HEQMS.
[19] For the purposes of this APL, "Stratify" or "Stratification" refers to the subcategorization of HEQMS measure result(s) by race and ethnicity, as described in Section IV. "Stratified Rates" are defined as HEQMS measure result(s) that are subcategorized by those same race and ethnicity categories.
[20] Health plans will have access to their summary level aggregate and stratified measure result(s) files via the NCQA's Interactive Data Submission System (IDSS).
[21] For purposes of this APL, "Demographic Data" is defined as information that describes the characteristics of enrollee populations within a managed care entity. These characteristics may include, but are not limited to, gender identity, sexual orientation, race, ethnicity, and disability status.
[22] Starting with RY 2024, the DMHC will collect the following demographic data: race, ethnicity, gender identity, sexual orientation, sex, sex listed on original birth certificate, primary written language, primary spoken language, disability status. Should these categories and/or reporting requirements change in

Health plans must submit the HPDDM by the first Friday of August each RY.

Health plans must submit all required filings listed above, even if they fail to meet the deadline. Health plans must also amend a filing if they discover that they previously filed information that was incomplete or materially inaccurate. Health plans must file an amendment within thirty (30) calendar days of discovering a material inaccuracy or omission, even if the filing deadline has passed.

Data from late filings or from amendments to a filing based on discovery of incomplete or materially inaccurate information may not be included in public reporting if operationally infeasible.

C. Health Plans Subject to Accreditation

All health plans, and their subcontracted health plans, including restricted and limited licensed health plans, licensed with the department as of July 27, 2021, that deliver hospital, medical, or surgical services, or behavioral health services, or both, are required to obtain and maintain NCQA accreditation, by line of business, on or before January 1, 2026.[23, 24]

Where a health plan subject to HEQ accreditation requirements, including subcontracted health plans, became newly licensed with the Department after July 27, 2021, the plan must obtain NCQA accreditation within two (2) years of becoming licensed with the Department or by January 1, 2026, whichever is later. Where a health plan, including subcontracted health plans, has been approved to offer a new product line after July 27, 2021, the health plan must obtain NCQA accreditation inclusive of the new product line, within two (2) years of approval or by January 1, 2026, whichever is later. Where a subcontracted health plan has been delegated to perform a new function, the subcontracted health plan must earn any additional NCQA accreditation(s) required by Section III. D. below within two (2) years of the delegation or by January 1, 2026, whichever is later.

The Department will require all health plans and their subcontracted health plans to submit evidence of NCQA accreditation.

As stated in Section III. A. of this APL, HSC section 1343(b) allows the director to issue orders exempting health plans from portions of Chapter 2.2 of Division 2 of the Health and Safety Code when the action is in the public interest. Health plans with under 15,000 total direct enrollment for all product line(s) within a line of business (Commercial or Exchange) may submit a material modification pursuant to HSC section 1352(b) requesting an

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subsequent RYs the DMHC will provide advance notice and guidance.

[23] AB 133 became effective July 27, 2021.

[24] HSC section 1399.871(d)(1). Pursuant to HSC section 1399.871(d)(2), the HEQ accreditation requirement does not apply to plans that only offer Medi-Cal products. These plans have separate NCQA accreditation requirements pursuant to section 14184.203 of the Welfare and Institutions Code.

exemption from NCQA accreditation. If approved, the exemption will be granted for one MY.

For MY 2025 forward, a health plan seeking an exemption will be required to submit a material modification by December 1st of the MY for which it seeks the exemption. With each request, the health plan must provide total direct enrollment for all product line(s) within a line of business (Commercial or Exchange) for which it seeks the exemption. The health plan may seek an exemption from both HEQ reporting requirements specified in Section III. A. and NCQA accreditation in the same e-Filing submission. The health plan is expected to conform to standard e-Filing instructions, found on the Department's public website. The health plan will have two (2) years from the expiration of the Order to obtain NCQA accreditation for the product line(s) for which it previously had an approved exemption.

D. Accreditation Requirements

The NCQA offers various types of accreditations for which plans may be eligible, depending on the scope of their operations.[25] Full-service health plans with direct enrollment that deliver hospital, medical, or surgical services are required to obtain NCQA Health Plan Accreditation. Behavioral health plans are required to obtain NCQA Managed Behavioral Healthcare Organization Accreditation. Subcontracted health plans that do not have Health Plan Accreditation and/or Managed Behavioral Healthcare Organization Accreditation are required to obtain all NCQA accreditation(s) applicable to the following functions, if they have been delegated to perform those functions on behalf of a primary plan:

- Utilization management
- Credentialing
- Case management
- Provider network management
- Population health management
- Any other function the subcontracted plan has been delegated to perform on behalf of a primary plan and for which the NCQA offers accreditation.

The DMHC recommends that health plans contact the NCQA directly to confirm any changes made to available accreditation options and for questions related to the applicable accreditation processes and products.

[25] The NCQA also offers Health Equity Accreditation. While not currently required, the DMHC strongly encourages health plans to obtain Health Equity Accreditation. The DMHC intends to include information regarding each health plan's accreditation status in its publicly posted HEQ reports.

IV. HEQMS Stratification

The DMHC has adopted the NCQA health equity methodology for stratifying its HEQMS. The NCQA follows the Office of Management and Budget (OMB) Standards for stratification, which define minimum standards for collecting and presenting data on race and ethnicity for all Federal data reporting. The NCQA uses the following OMB standards for race and ethnicity:[26]

- Race
    - White
    - Black or African American
    - American Indian or Alaska Native
    - Asian
    - Native Hawaiian or Other Pacific Islander
    - Some other race
    - Two or more races
    - Asked but No Answer
    - Unknown
- Ethnicity
    - Hispanic or Latino
    - Not Hispanic or Latino
    - Asked but No Answer
    - Unknown

V. Benchmarks Established by the DMHC

The Committee reconvened on October 16, 2023, to discuss setting a benchmark for the HEQMS. Based on the Committee's recommendations, the DMHC established a benchmark at the aggregate NCQA Quality Compass® national Medicaid Health Maintenance Organization (HMO) 50th percentile.[27] Each aggregate and stratified HEQMS measure indicator result reported by a health plan for a given MY will be assessed against the prior MY aggregate national Medicaid HMO 50th percentile. For example, each HEQMS measure result for MY 2024 reported in RY 2025 will be assessed against the MY 2023 national Medicaid HMO 50th percentile.

[26] As of March 28, 2024, the OMB issued revised race and ethnicity stratification standards, which must be implemented as soon as possible, but no later than March 28, 2029. The DMHC will attempt to align future MY HEQMS stratification requirements with the NCQA's implementation of these new OMB standards.
[27] Quality Compass® is a registered trademark of the NCQA.

VI. Performance Findings Report and Corrective Action Plans

A. Performance Findings Report

Pursuant to HSC section 1399.872, the DMHC will determine a health plan's compliance with established HEQ standards and issue an HEQ Performance Findings Report to each health plan. The DMHC will also publish each report on its public website. The HEQ Performance Findings Report will specify whether a health plan met or exceeded, or failed to meet, the benchmark for all applicable measures, and may also address any administrative deficiencies (e.g., untimely or incomplete filings).

B. Corrective Action Plans

Where applicable, the Performance Findings Report will identify the deficiencies for which the health plan is required to submit a corrective action plan (CAP). A plan's CAP must include the following information:

1. A root cause analysis explaining why the health plan did not meet the identified benchmark(s);
2. The specific corrective action(s) the health plan will take (or has taken) to remedy the identified deficiencies;
3. A description of how the health plan will monitor and evaluate the effectiveness of the proposed corrective action(s);
4. The health plan's timeline for implementation of the proposed corrective action(s); and
5. An explanation for any repeated deficiency findings from prior measurement years.

A health plan may also be required to submit a CAP where it has failed to report timely, accurate, or complete information. CAPs must be submitted within ninety (90) calendar days following the date of issuance of the Performance Findings Report.[28] Detailed instructions on the CAP e-Filing process can be found in the Health Equity and Quality Program Submission Instructions (Revised) attached to this APL.

VII. Enforcement

The DMHC has until January 1, 2027, to promulgate regulations codifying the measures and benchmarks. The DMHC may begin assessing administrative penalties for any failure to meet the health equity and quality benchmarks that occur after the regulations are promulgated. When assessing administrative penalties for failing to meet the health

[28] The Department encourages health plans to start any corrective action(s) as soon as possible if they are able to self-identify deficiencies prior to receiving their Performance Findings Report.

equity and quality benchmarks, incremental improvement in performance may be taken into consideration.

Starting with MY 2023 data and prior to regulations being promulgated, the DMHC may assess administrative penalties for certain conduct, including failing to report complete and accurate data and failing to file and monitor required CAPs.[29] The following represents a non-exhaustive set of examples of circumstances for which the Director may take enforcement action against a health plan if it fails to comply with requirements set forth in HSC Section 1399.870 et seq. and this APL:

1. The health plan fails to submit, or timely submit, any required filings;

2. The health plan fails to submit, or timely submit, a CAP, fails to comply with the DMHC's CAP instructions, or fails to implement or monitor the CAP; or

3. There is any material misrepresentation, inaccuracy, or omission in any of the health plan's filings or its data used to calculate its measure rates.

The Office of Plan Monitoring may refer any of these deficiencies to the Office of Enforcement. The Director may seek any combination of the civil, criminal, and administrative remedies available under the Knox-Keene Act.

VIII. DMHC HEQ Frequently Asked Questions

To further assist health plans and provide clarification on the HEQ program, the DMHC has published frequently asked questions (FAQs), which can be found in the Health Equity and Quality FAQs, attached to this APL. FAQs will be updated on a regular basis.

If you have any questions about this APL or technical questions related to the HEQMS reporting, please contact the DMHC Health Equity and Quality Team at HEQ@dmhc.ca.gov.

[29] HSC section 1399.872 (d)(4) and (e)(1).