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ALL PLAN LETTER

DATE: November 4, 2026

TO: All Health Plans Subject to Health Equity and Quality Program Requirements

FROM: Nathan Nau
Deputy Director, Office of Plan Monitoring

SUBJECT: APL 26-016 – Health Equity and Quality Program Policies and Requirements

The Department of Managed Health Care (hereafter "Department" or "DMHC") issues this All Plan Letter (APL) to remind health care service plans of California Health and Safety Code (HSC) section 1399.872 annual submission of the Health Equity and Quality Measure Set (HEQMS) and annual health equity and quality compliance reporting obligations for measurement year (MY) 2026, reporting year (RY) 2027, forward.[1]

I. BACKGROUND

On December 21, 2022, the Department issued APL 22-028 – Health Equity and Quality Measure Set and Reporting Process, which established the HEQMS, consistent with Assembly Bill 133 (Committee on Budget, 2021) (HSC section 1399.870 et seq.). On December 27, 2023, the Department issued APL 23-029 – Health Equity and Quality Measure Set Benchmark, which established the HEQMS benchmark, accreditation, and stratification requirements.

II. HEALTH EQUITY AND QUALITY PROGRAM STANDARDS

A. Application

This APL applies to health plans that cover hospital, medical, or surgical services, including restricted, limited license, or health plans that contract with the State Department of Health Care Services to provide health care services to Medi-Cal beneficiaries, and specialized mental health plans that provide behavioral health care services.

Primary health plans are subject to all Health Equity and Quality (HEQ) Reporting requirements, as set forth in this APL. Primary health plan means a Knox-Keene Act licensed plan that holds a contract with a group, individual subscriber, or public agency to

[1] MY has the same meaning provided in HSC section 1399.872(e)(3). RY means the calendar year in which the health plans are required to report the data collected from the previous MY.

arrange for the provision of hospital, medical, or surgical services, or behavioral health care services, or both. Subcontracted health plans are only subject to the National Committee for Quality Assurance (NCQA) Accreditation Compliance Reporting requirement, as set forth in this APL. Subcontracted health plan means a Knox-Keene Act licensed plan, including a specialized mental health plan that provides behavioral health care services, that is contracted to arrange for the provision of hospital, medical, or surgical services, or behavioral health care services, or both, for a primary health plan's enrollees.

This APL does not apply to health care service plans that only offer Medicare Advantage products or specialized health care service plan products, including specialized dental, vision, chiropractic, acupuncture or Employee Assistance Programs (EAPs).

B. Standard Health Equity and Quality Measures

All primary health plans are required to report on the following HEQMS for each MY, per line of business, including any specified measure indicators, as applicable, from the most recent version of the Healthcare Effectiveness Data and Information Set (HEDIS®) Volumes 1, 2, and 3: [2, 3]

1. Colorectal Cancer Screening (Total age range)
2. Breast Cancer Screening (Total age range)
3. Glycemic Status Assessment for Patients with Diabetes
    a. Glycemic Status < 8.0%
    b. Glycemic Status > 9.0%
4. Controlling High Blood Pressure
5. Depression Screening and Follow-Up for Adolescents and Adults
    a. Depression Screening
    b. Follow-Up on Positive Screen
6. Prenatal and Postpartum Care
    a. Timeliness of Prenatal Care
    b. Postpartum Care
7. Childhood Immunization Status (Combination 10)
8. Well-Child Visits in the First 30 Months of Life
    a. First 15 Months
    b. Age 15 Months – 30 Months
9. Child and Adolescent Well-Care Visits (Total age range)
10. Plan All-Cause Readmissions (18-64 years of age)
11. Immunization for Adolescents (Combination 2)
12. CAHPS® Health Plan Survey: Getting Needed Care
    a. Adult Survey
    b. Child Survey

[2] The NCQA refers to Commercial, Medicaid, and Exchange as "product lines" rather than lines of business.
[3] HEDIS® is a registered trademark of the NCQA.

All primary health plans reporting on the above measures must use the NCQA stratification methodology for race and ethnicity found in the most recent version of HEDIS® Volume 2.

C. Benchmark

The HEQ program benchmark standard is the aggregate NCQA Quality Compass® national Medicaid HMO 50th percentile.[4] Each aggregate and stratified measure indicator result reported by a primary health plan for a given MY will be assessed against the prior MY benchmark standard.

D. Accreditation

All primary and subcontracted health plans, other than those exempted by HSC section 1399.871(d)(2), must earn and maintain NCQA accreditation for each product line for which the plan holds a Knox-Keene Act license.[5, 6]

i. Accreditation Requirements

Primary health plans that arrange for the provision of hospital, medical, or surgical services must earn and maintain NCQA Health Plan Accreditation (HPA). Primary behavioral health plans that arrange only for the provision of behavioral health services and subcontracted plans that arrange for the provision of behavioral health services must earn and maintain NCQA Behavioral Health Accreditation (BHA).

A subcontracted health plan that does not have HPA or BHA must earn and maintain all NCQA accreditation(s) applicable to the following functions, if it has been delegated to perform those functions on behalf of a primary health plan: utilization management, credentialing, case management, provider network management, population health management, or any other function the subcontracted health plan has been delegated to perform on behalf of the primary health plan and for which NCQA offers accreditation.

ii. Accreditation Timelines

Accreditation must be obtained by January 1, 2026, unless an exemption has been granted or one of the following applies:[7]

- For a newly licensed health plan, the plan must earn the required NCQA accreditation within two years of becoming licensed with the Department.

- For a health plan that has been approved to add a new product line, the plan must

[4] Quality Compass® is registered trademark of the NCQA.
[5] "This subdivision does not apply to a health care service plan that contracts with the State Department of Health Care Services to provide health care services to Medi-Cal beneficiaries. NCQA accreditation for these plans shall be in accordance with Section 14184.203 of the Welfare and Institutions Code."
[6] Product line means the combination of the plan's products (e.g. health maintenance organization (HMO), preferred provider organization (PPO), point of service (POS), and exclusive provider organization (EPO)) and market segments (e.g., individual, large group, small group, government) that are grouped in one of the three lines of business: Commercial, Exchange, and Medi-Cal.
[7] Accreditation exemptions are discussed in section III.B of this APL.

earn the required NCQA accreditation within two years of approval.

- For a subcontracted health plan without HPA or BHA that has been delegated to perform a new function, the subcontracted health plan must earn the required NCQA accreditation within two years of the delegation.

Health plans must regularly reassess NCQA accreditation options and eligibility. If a health plan's products, delegation arrangements, or any other factor make the health plan eligible for a required NCQA accreditation, as set forth in Section II.D.i, it must earn that accreditation within two years of eligibility.

III. REPORTING

A. Reporting Requirements

Health plans subject to HEQ Reporting must annually complete all required submissions, as identified below, through the DMHC e-Filing Web Portal and as specified in the Health Equity and Quality Program Submission Instructions attached to this APL. Any reporting required of the primary health plan must be inclusive of the primary health plan's direct enrollment and all enrollees delegated to any subcontracted health plan(s).

- NCQA Accreditation Compliance Filing by the first Friday of May each RY.

  ~Required for primary and subcontracted health plans.

- Health Equity and Quality Pre-Filing Form by the first Friday of May each RY.

  ~Required for primary health plans only.

- HEQMS Data Reporting via NCQA summary level aggregate and stratified measure result file(s) per line of business received from the NCQA then sent to the Department by the first Friday of August each RY.[8]

  ~Required for primary health plans only.

- Health Plan Demographic Data Metric (HPDDM) Template by the first Friday of August each RY.

  ~Required for primary health plans only.

For all reporting requirements, health plans must submit data and/or information for only those product lines that are licensed and regulated by the Department. All reporting and information submitted must be timely, accurate, and complete.

[8] Primary plans that only arrange for the provision of behavioral health services do not currently have an HEQMS Data Reporting requirement.

B. Exemptions to HEQ 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." Primary health plans with under 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 requirements: (1) the HEQ Pre-Filing Form and HEQMS Data Reporting and/or (2) NCQA accreditation.[9]

A health plan may seek an exemption from both the above-mentioned requirements in a single material modification submission. 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.

IV. COMPLIANCE DETERMINATIONS

A. Performance Findings Reports

Pursuant to HSC section 1399.872, the Department will determine a health plan's compliance with the HEQ Reporting requirements and issue an HEQ Performance Findings Report (PFR) to each health plan. The PFR will specify whether the health plan met, exceeded, or failed to meet the benchmark for all applicable measures and address any administrative deficiencies. The reports will be published on the Department's public website.

B. Corrective Action Plans

Where applicable, the PFR will identify the deficiencies for which the health plan is required to submit a corrective action plan (CAP). CAPs are due within ninety (90) calendar days of issuance of the PFR. However, the Department encourages health plans to start corrective actions as soon as they are able to self-identify deficiencies prior to receiving the PFR. CAPs must be submitted through the DMHC e-Filing Web Portal as specified in the Health Equity and Quality Program Submission Instructions attached to this APL.

C. Enforcement

Health plans that fail to demonstrate compliance are subject to actions as set forth in section 1399.872(d) and (e), including administrative penalties.

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.

[9] An exemption from the HEQ Pre-Filing Form and HEQMS Data Reporting requirement does not remove the primary plan's obligation to report the HPDDM Template as specified in this APL.