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Health Equity and Quality

Frequently Asked Questions

The purpose of this Frequently Asked Questions (FAQ) document is to clarify the Health Equity and Quality (HEQ) program policies and requirements set forth by the Department of Managed Health Care (DMHC) in All Plan Letter (APL) 22-028 (dated 12/21/2022) and in Revised APL 23-029 (dated 5/13/2024). The responses to these FAQs are intended to supplement the guidance contained in the APLs.

This HEQ FAQ document includes new questions and answers in addition to those originally published in September 2023 as an attachment to APL 22-028. ***New and/or revised questions and answers are identified by italics.*** As the DMHC receives additional questions, these FAQs will be updated, and the footer will indicate the version number and issue date.

As required by Assembly Bill (AB) 133 (Committee on Budget, 2021) (Health and Safety Code (HSC) section 1399.870 et seq.), the DMHC has established a health equity and quality measure set (HEQMS) and a benchmark standard for all DMHC-licensed health care service plans (health plans). Starting with measurement year (MY) 2023, health plans will collect and report on 12 Healthcare Effectiveness Data and Information Set (HEDIS®) measures and one Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measure, stratified by race and ethnicity according to the National Committee for Quality Assurance (NCQA) methodology.[1, 2] The DMHC will use the HEQMS to evaluate health plan performance against the benchmark, with the goals of addressing long-standing health inequities and ensuring the equitable delivery of high-quality health care services across market segments. Health plans must comply with AB 133 as implemented by APL 22-028, Revised APL 23-029, and future DMHC guidance, consistent with applicable law, including HSC section 1399.870 et seq.

The information provided in these FAQs is not intended to be legal advice; it is general information only. Readers of these FAQs should contact their own attorney to obtain advice on any legal matter related to these FAQs.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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GENERAL

1. When will the HEQMS be reevaluated?

Pursuant to HSC section 1399.871, standard measures and benchmarks shall sunset at most every five years from the date the Department establishes them. At least one year before the standard measures and benchmarks sunset, the Department shall conduct a public assessment to determine if the measures and benchmarks are improving quality and equity*, and if they should be continued*. Accordingly, the current HEQMS will be effective MY 2023 and through at least MY 2027. Within that five year period, the Department will reevaluate the effectiveness of those measures and benchmarks.

In addition to the above sunset provision, the Department may reconvene the Committee to make recommendations on updating and revising the standard measures and benchmarks, pursuant to HSC section 1399.870.

2. How many months will a plan have to set appropriate targets and conduct performance improvement to reach targeted goals? For example, will MY 2023 or MY 2024 performance be used to set targets for MY 2025?

The DMHC established the HEQMS benchmark at the aggregate NCQA Quality Compass® national Medicaid HMO 50th percentile.[3] Each aggregate and stratified HEQMS measure result reported by a health plan for a given MY will be assessed against the same MY national Medicaid HMO 50th percentile. For example, each HEQMS measure result reported for MY 2023 will be assessed against the MY 2023 national Medicaid HMO 50th percentile.

The DMHC will promulgate regulations codifying the *HEQMS* measures and benchmarks by January 1, 2027. The DMHC may begin assessing administrative penalties *for any failure to meet the health equity and quality benchmarks that occurs after the regulations are promulgated. When assessing administrative penalties for failing to meet the health equity and quality benchmarks, incremental improvement in performance may be taken into consideration. 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 corrective action plans.*

[3] Quality Compass® is a registered trademark of the NCQA.

3. ***Does the DMHC have a definition of "full-service health plans"? Which health plans must comply with the DMHC health equity and quality requirements?***

   Full-service health plans provide all the basic health care services and mandated benefit requirements under the Knox-Keene Health Care Service Plan Act, including the coverage of hospital, medical, or surgical expenses (see California Code of Regulations, Title 28, section 1300.51, et seq.). For more information regarding the applicability of DMHC's health equity and quality requirements, refer to HSC section 1399.873.

4. ***What does "direct enrollment" refer to?***

   Direct enrollment is the sum of all individuals enrolled in the primary plan and includes the number of enrollees delegated to the subcontracted plan. Subcontracted plans that only have delegated enrollees (i.e., they have no direct enrollment of their own) are not responsible for reporting directly to the DMHC. However, subcontracted plans must coordinate with the contracted primary health plan responsible for any delegated enrollees to determine what reporting obligations they may have to the primary health plan.

HEQMS REPORTING

5. **What will the process be for reporting rates and the methodology?**

   Health plans must submit HEQMS rates according to the requirements and processes indicated in Revised APL 23-029.

6. **Will the DMHC require the health plans to report their audited rates (rather than having DMHC contract with an independent auditor)?**

   Yes. The DMHC will require the health plans to report their audited rates.

7. **Will health plans have flexibility on how to report hybrid measures?**

   Yes. Health plans may choose to report a hybrid measure as hybrid or administrative.

   Please refer to Revised APL 23-029 for additional information on reporting methods.

8. **What will be the timeline for reporting the required information in 2024?**

   Health plans will be required to *submit* their MY 2023 *data to the DMHC starting* in Q3 of 2024*, in accordance with the requirements and timeframes indicated in*

Revised APL 23-029. Additional reporting details will be released before the submission period.

9. **Please confirm that the DMHC will follow NCQA HEDIS and CAHPS specifications for reporting on the quality measures and data reporting methodology.**

   Yes. The DMHC can confirm that it will follow NCQA's HEDIS and CAHPS specifications and will not make any adjustments.

10. **NCQA requires health plans to stratify by race and ethnicity for only nine of the 13 measures. Is NCQA approval required for stratifying the four additional selected measures?**

    No. NCQA approval is not required for stratifying additional measures. The stratifications are part of the HEDIS Allowable Adjustments.[4] The only requirement is that they be run through a certified vendor's logic and the certified vendor then puts the appropriate disclaimers on the rate (i.e., adjusted, unaudited HEDIS rate).

    Additionally, the NCQA was a member of the Health Equity and Quality Committee and is aware of the DMHC's decision to require stratification by race and ethnicity for additional measures.

    See Table 2 and Table 3 for Revised APL 23-029 for stratification reporting requirements for MY 2023 and 2024. The DMHC will provide additional guidance in the future on the measures not stratified by the NCQA.

11. ***Do the HEQMS requirements apply to Covered CA (Exchange) plans (i.e., would health plans have to submit separate submissions for their Commercial and Covered CA populations)?***

    Yes, the HEQMS requirements apply to those Covered CA (Exchange) plans that are subject to the DMHC's regulatory authority (i.e., HMOs and some PPOs). Because Covered CA is the state's marketplace for the federal Patient Protection and Affordable Care Act, health plans will be required to report on the HEQMS for their Commercial and Covered CA populations separately.

[4] The Rules for Allowable Adjustments are included in the HEDIS Volume 2 publication after the applicable HEDIS measure specifications.

12. ***Do the HEQMS reporting requirements apply to all health plans regardless of membership size?***

    All health plans, as specified in Revised APL 23-029, are subject to reporting requirements regardless of membership size.[5] Health plans must follow the NCQA's HEDIS and CAHPS reporting processes for all measures required by the DMHC. If a measure is required by the DMHC, it should still be reported to the NCQA. For further information regarding the NCQA reporting requirements for small populations, health plans can explore the NCQA resources, contact the NCQA, and/or work with their HEDIS Compliance Auditor to resolve questions.

13. ***If a health plan is not currently accredited with the NCQA and has not previously reported HEDIS data, is the health plan allowed to report on the HEQMS using any data collection method?***

    There is no distinction in reporting methodology for the NCQA accredited health plans versus non-accredited health plans. Health plans may report to the NCQA using either the Administrative or Hybrid Data Collection Methods (Traditional Methods), unless reporting via the Electronic Clinical Data System (ECDS) is required by the NCQA or the DMHC for a specific measure. If a measure may be reported using both Traditional (Administrative or Hybrid) and ECDS, health plans must report using both available methods.

14. ***Are health plans required to report via both traditional and ECDS methods for the HEQMS measures that list both (i.e., COL/COL-E, CIS/CIS-E, and IMA/IMA-E), even if only one or the other is required by the NCQA or by the Department of Health Care Services (DHCS)? Will the NCQA-licensed HEDIS Compliance Auditor allow reporting by multiple methodologies?***

    For the DMHC HEQMS measures that can be reported through both the Traditional Methods and ECDS, Revised APL 23-029 instructs plans to report using both methodologies. For example, the Colorectal Cancer Screening measure can be reported both through traditional methods and ECDS, which is clarified in the Abbreviation column of Table 1: COL/COL-E. The NCQA's data reporting process supports the reporting of both methods where both are specified by Revised APL 23-029. The NCQA-licensed HEDIS Compliance Auditors will allow reporting by both Traditional and ECDS methodologies.

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[5] Currently, the NCQA allows health plans with less than 15,000 members to be scored on standards only for accreditation purposes, without reporting on HEDIS or CAHPS Survey data. However, the NCQA has no minimum population size for HEDIS reporting and health plans with fewer than 15,000 members will still be required to submit HEDIS and CAHPS Health Plan Survey results to the DMHC.

15. ***When a health plan reports HEQMS data to the DMHC for its enrollees, inclusive of those enrollees delegated to a subcontracted limited or restricted licensed health plan, does the subcontracted limited or restricted licensed health plan also need to report HEQMS data directly to the DMHC for the delegated enrollees?***

    No. Subcontracted plans that only have delegated enrollees (i.e., they have no direct enrollment of their own) are not responsible for reporting directly to the DMHC. However, subcontracted plans must coordinate with the contracted primary health plan responsible for any delegated enrollees to determine what reporting obligations they may have to the primary health plan.

    When a health plan delegates its enrollees to a subcontracted health plan (e.g., a restricted health plan), the health plan remains responsible for reporting on the HEQMS for all of its enrollees, including those enrollees delegated to the subcontracted plan.

16. ***What if some of the HEQMS measures (such as Well-Child Visits in the First 30 Months of Life, Child and Adolescent Well-Care Visits, Depression Screening and Follow-Up), are not within the scope of a health plan's NCQA HEDIS audit?***

    Health plans must report to the DMHC on all HEQMS measures as outlined in Revised APL 23-029. All HEDIS measures in the HEQMS are subject to HEDIS audit and other NCQA reporting requirements. Health plans are encouraged to reach out to their HEDIS Compliance Audit Licensed Organization to confirm that the scope of their HEDIS audit includes all HEQMS measures. For questions regarding data submissions to the NCQA, the DMHC recommends health plans contact their NCQA account manager for further assistance.

17. ***What are the reporting requirements for a health plan that ceases operations in 2024?***

    If a health plan had direct enrollment during MY 2023 and for a portion of MY 2024 but ceases operations at some point in calendar year 2024, then the health plan will still be required to report on all 13 HEQMS measures for both MYs consistent with Revised APL 23-029 (see Table 2).

18. ***For the NCQA's Health Plan Accreditation, the NCQA allows health plans with membership under 15,000 enrollees the option to be scored on the standards only, meaning submission of the CAHPS Health Plan Survey results is optional. Is a health plan with a membership under 15,000 required to submit the CAHPS Health Plan Survey results to the DMHC if it chooses not to report the CAHPS Health Plan Survey to the NCQA?***

Yes. Health plans must submit CAHPS Health Plan Survey results to the DMHC regardless of enrollment size or whether they are submitting this data to the NCQA for accreditation. Health plans must follow NCQA's CAHPS reporting process. When health plans submit their CAHPS data to the NCQA, they will have access to their CAHPS Health Plan Survey results through the NCQA's IDSS.

19. Is the HEQMS subject to External Quality Review Organization (EQRO) oversight?

The DMHC's HEQMS is not subject to federal Medicaid external quality review regulations, and the DMHC will not require health plans to engage a separate or additional EQRO.

20. Are county behavioral health plans required to report on the HEQMS to the DMHC?

Consistent with Revised APL 23-029, all health plans with direct enrollment that deliver hospital, medical, or surgical services and/or behavioral health services are required to report on all 13 HEQMS measures, starting in MY 2023.[6] Currently, behavioral health plans with direct enrollment, including county behavioral health plans, do not have a HEQMS reporting requirement. However, the DMHC will reconvene the Health Equity and Quality Committee in 2025 to confer on potential behavioral health measures.

21. Is the CAHPS Health Plan Survey reporting submitted at the plan level or by geographic region?

The CAHPS Health Plan Survey reporting is submitted at the health plan level.

22. For race or ethnicity data collection, some members choose "decline to state." How does a health plan categorize these members?

Per Revised APL 23-029, the DMHC has adopted the NCQA health equity methodology which uses the Office of Management and Budget standards for stratification. Per the NCQA, if a member declines to disclose their race or ethnicity, the member should be reported as "Asked, not answered/Declined to state."

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[6] See Revised APL 23-029, Table 2, for details on the HEQMS measures to be reported to the DMHC per product line.

NCQA ACCREDITATION

23. Will health plans be required to obtain NCQA Health Equity Accreditation, per the recommendation from the Health Equity and Quality Committee?

Currently, health plans are not required to obtain NCQA's Health Equity Accreditation; however, the DMHC strongly encourages it.

24. Do health plans need to monitor the NCQA accreditation status of their subcontracted plans? What happens if the delegated entity does not obtain the NCQA accreditation?

Yes, as with all delegation relationships, a plan that delegates any services or functions to another plan or any other contracting entity remains responsible for complying with the Knox-Keene Act. All plans, including behavioral health plans, restricted, and limited licensed plans, that have been delegated to deliver hospital, medical, or surgical services and/or behavioral health services are required to be accredited on or before January 1, 2026. (HSC section 1399.872(d)). The obligation of a health care service plan to comply with this article is not waived if a health care service plan delegates any services or functions to its medical groups, independent practice associations, or other contracting entities. (HSC section 1399.873(b)) Thus, any plan that delegates such services must appropriately oversee and monitor that subcontracted plan as it would with any other Knox-Keene Act provision. How each plan decides to oversee and monitor the subcontracted plan(s) is left to each plan but must nevertheless ensure compliance with the Knox-Keene Act.

25. Is there a membership threshold for health plans as it relates to the NCQA accreditation? For instance, if a health plan has a small number of members, are they required to be accredited?

HSC section 1399.871(d)(1) requires health plans to obtain and maintain NCQA accreditation by January 1, 2026. As stated in Revised APL 23-029, the accreditation requirement applies to all health plans, and their subcontracted health plans. Health plans concerned with meeting the accreditation requirements due to low membership are encouraged to reach out to the DMHC with their questions in order to address the specific circumstances of each plan.

26. Are restricted health plans that subcontract to deliver hospital, medical, or surgical and/or behavioral health services for only Medicare Advantage enrollees required to seek NCQA accreditation?

As stated in Revised APL 23-029, the DMHC health equity and quality reporting and accreditation requirements do not apply to plans that only offer Medicare Advantage

products; thus, if a subcontracted plan only provides services to Medicare Advantage enrollees, the requirements would not be applicable. If a subcontracted plans provides services for Commercial, Medi-Cal, or Exchange product lines, in addition to Medicare Advantage products, then the subcontracted plan would be responsible for obtaining the NCQA accreditation for those product lines, pursuant to the health equity and quality requirements in HSC 1399.870 et seq.

27. What are accreditation requirements for a restricted plan that does not perform any delegated function and further delegates those functions to a medical group/Management Services Organization (MSO)?

For any plan that is subcontracted to deliver hospital, medical, or surgical services and/or behavioral health care services to enrollees of Commercial, Medi-Cal, or Exchange product line(s), the subcontracted plan remains responsible for seeking NCQA accreditation by January 1, 2026. Furthermore, a subcontracted plan that further subdelegates to another entity does not waive its obligations under HSC section 1399.870 et seq. (See Section 1399.873(b)) to obtain NCQA accreditation.

Pursuant to Revised APL 23-029, the NCQA offers accreditation in certain functional areas that may be delegated to a subcontracted plan. The DMHC recommends that health plans contact the NCQA directly to confirm available accreditation options and for questions related to the applicable accreditation processes and products.

MEDICAID

28. Does the DMHC plan to make an adjustment to the benchmark for Medi-Cal health plans due to redeterminations?

No. At this time, the DMHC does not plan to make any adjustments for Medi-Cal health plans due to redetermination.

29. If a health plan is not fielding a CAHPS Health Plan Survey to meet NCQA accreditation requirements, can the health plan submit its DHCS-fielded CAHPS Health Plan Survey results to the DMHC?

For Medicaid managed care health plans, DHCS contracts with an external quality review organization (EQRO) to administer and report the results of the CAHPS Health Plan Survey. The EQRO reports the CAHPS data to the NCQA. Health plans will have access to their CAHPS Health Plan Survey results through the NCQA's IDSS. Health plans must then submit the CAHPS Health Plan Survey results directly to the DMHC.

30. Are county run Medicaid health plans required to report the 13 HEQMS measures?

All Knox-Keene licensed health plans with direct enrollment that deliver hospital, medical, or surgical services and/or behavioral health services are required to report on all 13 HEQMS measures starting in MY 2023.[7] County-run Medicaid health plans without a Knox-Keene license are not required to report.

ENFORCEMENT

31. When will the DMHC initiate enforcement actions or seek administrative penalties for deficiencies related to the health equity and quality requirements?

The DMHC will promulgate regulations codifying the measures and benchmarks by January 1, 2027. The DMHC may begin assessing administrative penalties for any failure to meet the health equity and quality benchmarks that occurs after regulations are promulgated.

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 corrective action plans.

BENCHMARKS

32. Can the DMHC provide details on the HEQMS benchmark?

The DMHC established the HEQMS benchmark at the NCQA Quality Compass national Medicaid HMO 50th percentile. This benchmark will apply to all HEQMS measure results, aggregate and stratified, across all product lines (Commercial, Medicaid, and Exchange). Health plans will be assessed annually against the national Medicaid HMO 50th percentile rate by each health plan product line and each HEQMS measure result.

REGULATIONS

33. What does DMHC intend to include in regulations?

The regulations will capture at least the 13 HEQMS, benchmark standards, and CAP requirements. The DMHC will track and consider including additional items in the regulations necessary to implement the HEQ program. Regulations will need to be in place by January 1, 2027.

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[7] See Revised APL 23-029, Table 2, for details on the HEQMS measures to be reported to the DMHC per product line.