SHARP Health Plan

Provider Alert

To: Sharp Health Plan Providers and Provider Office Staff
From: Sharp Health Plan
Date: August 12, 2024
Subject: All Plan Letter 24-013- Health Equity and Quality Program Policies and Requirements

Hello Plan Partners,

The Department of Managed Health Care (Department) issues this All-Plan Letter (APL) 24-013 to inform all health care service plans (health plans) of the DMHC Health Equity and Quality (HEQ) program policies and requirements. The instructions provided herein supersede those previously published in APL 22-028 and REVISED APL 23-029.

Attached please find the Department of Managed Health Care's All Plan Letter, APL 24-013

Best regards,
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ALL PLAN LETTER

DATE: June 28, 2024

TO: All Health Care Service Plans[1]

FROM: Nathan Nau
Deputy Director, Office of Plan Monitoring

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

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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

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[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 Plans (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.

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.

II. DMHC HEQMS

The DMHC established 13 health equity and quality 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	Measure Steward
1. Colorectal Cancer Screening	COL / COL-E	NCQA
2. Breast Cancer Screening	BCS-E	NCQA
3. Hemoglobin A1c Control for Patients with Diabetes – 3.1 HbA1c Control (<8.0%) 3.2 HbA1c Poor Control (>9.0%)	HBD	NCQA
4. Controlling High Blood Pressure	CBP	NCQA
5. Asthma Medication Ratio (Total age range)	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 (CIS Combo 10)	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
10. Child and Adolescent Well-Care Visits (Total age range)	WCV	NCQA

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

DMHC HEQ Measure Name	Abbreviation	Measure Steward
11. Plan All-Cause Readmissions (18-64 years of age)	PCR	NCQA
12. Immunizations for Adolescents (IMA Combo 2)	IMA / IMA-E	NCQA
13. CAHPS Health Plan Survey[5] (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 Table attached to this APL.[6]

III. HEQ Reporting and Accreditation Requirements

A. Health Plans Subject to HEQ Reporting

All health plans that deliver hospital, medical, or surgical services and/or behavioral health services are required to report on all 13 HEQMS measures by line of business (i.e., Commercial, Medi-Cal, and Exchange), starting with MY 2023 data submitted in reporting year (RY) 2024.[7, 8] 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.[9]

B. HEQ Reporting Requirements

Health plans subject to HEQ reporting must complete all required submissions listed

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[5] 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.

[6] The Health Equity and Quality Measure Set Table provides measure descriptions based on 2022 NCQA specifications and may change in the future. Health plans are required to report on the most updated specifications and should contact the NCQA for questions regarding such changes.

[7] 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 will reconvene the Health Equity and Quality Committee in 2025 to confer on potential behavioral health measures.

[8] Reporting year means the calendar year in which the plan is required to submit the data from the previous measurement year.

[9] Direct enrollment is the sum of all individuals enrolled in the primary plan and includes the number of enrollees delegated to the subcontracted plan.

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.

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.

  The HEQ Pre-Filing Form will be made available in the e-Filing Web Portal by the first Friday of July of each RY. Health plans must submit the Pre-Filing Form by the first Friday of September of each RY.

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

     When reporting 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.[10]

  2. Health plans must submit their NCQA summary level aggregate and stratified measure results file(s) received from NCQA to the DMHC via the DMHC

[10] Traditional and/or ECDS reporting does not apply to the CAHPS Health Plan Survey.

e-Filing Web Portal between October 1 and December 31 of each RY.[11, 12, 13]

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 and MY 2024/RY 2025 can be found in MY 2023 HEQMS Reporting Table and MY 2024 HEQMS Reporting Table respectively and are both attached to this APL. The DMHC will provide additional guidance in the future on measures not currently stratified by the NCQA.

- 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.[14] 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.[15]

  The HPDDM template will be made available in the e-Filing Web Portal by the first Friday of July of each RY. Health plans must submit the HPDDM by December 31 of each RY.

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[11] 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.
[12] 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.
[13] 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).
[14] 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.
[15] 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 subsequent RYs the DMHC will provide advance notice and guidance.

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

C. Health Plans Subject to Accreditation

All health plans, and their subcontracted health plans, including restricted and limited licensed health plans, that deliver hospital, medical, or surgical services and/or behavioral health services are required to obtain and maintain NCQA accreditation, by line of business, on or before January 1, 2026.[16]

D. Accreditation Requirements

The NCQA offers various types of accreditations that plans may be eligible for depending on the scope of their operations.[17] Full-service health plans 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 responsible for seeking accreditation in any program area(s) they have been delegated to perform on behalf of another health plan. As of the publication date of this APL, the NCQA offers accreditation in the following program areas:

- Utilization Management
- Credentialing
- Provider Networks
- Case Management
- Case Management for LTSS
- Population Health Program
- Wellness and Health Promotion

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.

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

[16] HSC section 1399.871(d)(1).
[17] 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.

for stratification, which define minimum standards for collecting and presenting data on race and ethnicity for all Federal data reporting. For MY 2023 data the NCQA uses the following OMB standards for race and ethnicity:[18]

- 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.[19] 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 for MY 2023 reported in RY 2024 will be assessed against the MY 2023 national Medicaid HMO 50th percentile.

[18] 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.

[19] 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 with respect to each identified deficiency:

1. A root cause analysis explaining why the health plan did not meet the identified benchmark;

2. The specific corrective action(s) the health plan will take (or has taken) to remedy the identified deficiency;

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);

5. The health plan's timeline for when the proposed corrective action(s) are expected to show improvement; and

6. 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 one hundred twenty (120) calendar days following the date of issuance of the Performance Findings Report.[20] Specific CAP requirements and instructions will be included with the Performance Findings Report.

[20] 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.

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 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.[21] The following represents a non-exhaustive set of examples of circumstances under 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 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.

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