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PROMISE

# 2026

# Quality Improvement and Health Equity Transformation Program Description

# Medi-Cal Product

**Authored by Blue Shield Promise Health Equity Office**

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## Executive Summary

The 2026 Quality Improvement and Health Equity Transformation (QIHET, or QIHETP) Program Description outlines Blue Shield of California Promise Health Plan's (BSCPHP, or Blue Shield Promise) comprehensive strategy to advance equity, improve quality, and transform care for Medi-Cal members. Through this comprehensive, multi-year transformation effort, Blue Shield Promise is building a healthcare delivery system that is equitable, evidence-based, community-informed, and worthy of our families and friends. The 2026 QIHET Program Description represents a decisive step toward eliminating disparities, strengthening accountability, and delivering high-quality, whole-person care to all Medi-Cal members.

Grounded in the Department of Health Care Services (DHCS) contractual requirements, National Committee for Quality Assurance (NCQA) Health Outcomes Accreditation standards, and the California Health Care Foundation (CHCF) Health Equity Framework, the program integrates regulatory compliance, data-driven decision making, and community-centered approaches to eliminate disparities and improve outcomes.

The Health Equity Office (HEO), led by the Chief Health Equity Officer and in partnership with the Chief Medical Officer (CMO), operationalizes this commitment through governance structures, policies, analytics, and interventions designed to strengthen whole-person care. The Quality Improvement and Health Equity Committee ensures oversight of all quality and equity activities, reporting to the Medi-Cal Committee and the Blue Shield of California Board of Directors.

The Health Equity Office was formed in September 2022. The Office has evolved from building a solid operational foundation into a fully integrated program. In 2026, Blue Shield Promise will continue to advance four core health equity program principles: 1) Advancing Information in Action; 2) Building Sound Infrastructure and Operations; 3) Embedding Equity; and 4) Designing Interventions that Matter. Investments in data modernization, including a unified health equity data and analytics platform, enhanced stratification and expanded dashboard insights to enable real-time identification of disparities. The Health Equity Advancements Resulting in Transformation or (HEART) Measure Set, co-developed with functional areas, serves as the health plan's mechanism for tracking equity performance across clinical quality, behavioral health, member experience, access, grievances, and provider network outcomes.

Blue Shield Promise's infrastructure has matured into a fully integrated system supporting cross-functional accountability. The Health Equity Integration Plan (HEIP) is now implemented across all major operational units, ensuring measurable, department-specific initiatives. Also advancing in 2026, are the intersectional partnerships between teams to address access, provider engagement, maternal health equity, member engagement, and quality. This collaboration further strengthens the organization's capacity to drive change and coordinate meaningful interventions.

The Health Equity program aligns with major state priorities, including CalAIM, DHCS Bold Goals, Network Adequacy requirements, and the reimagined Population Needs Assessment (PNA) and Population Health Management (PHM) Strategy. Emphasis in 2026 will be placed on improving outcomes for populations experiencing disproportionate barriers, including Black/African American members, Limited English Proficient members, members with behavioral health needs, and communities affected by housing instability, justice involvement, and chronic conditions. Maternal health equity and pediatric preventive care continue to be priority domains per the DHCS Comprehensive Quality Strategy.

Blue Shield Promise 2026 goals include:

- Maintaining NCQA Health Outcomes Accreditation
- Achieving 100% compliance with health equity contractual deliverables
- Increasing Social Drivers of Health (SDOH) data collection
- Improving care post-partum and well-child visit gap closure using equity analytics
- Completing 90% of Health Equity Integration Plan activities

Planned interventions seek to improve postpartum care visits, well-child visits, birth equity, depression screening, and access to culturally and linguistically appropriate services in 2026.

Through the QIHEC and the Medi-Cal Committee, progress is monitored quarterly and transparently reported to stakeholders and published publicly. The annual evaluation assesses QIHET program effectiveness, informing future planning, and drives strategic planning to ensure that quality and equity remain embedded in all operational processes.

# CONTENTS

# I. INTRODUCTION AND BACKGROUND

The Blue Shield of California Promise Health Plan (BSCPHP, or Blue Shield Promise) Health Equity program was developed with consideration to evidence-based programs, Medi-Cal contractual requirements, white papers, policies, All Plan Letters (APL), National Committee for Quality Assurance Health Outcomes Accreditation, strategic plans, and focuses its efforts on an equitable whole-system, person-centered approach reducing health inequities and health disparities among the membership and communities served. These considerations include but are not limited to the following:

## A. Centers for Medicare and Medicaid Services (CMS) Framework for Health Equity.

The framework sets the foundation and priorities for CMS's work strengthening its infrastructure for assessment, creating synergies across the health care system to drive structural change, and identifying and working to eliminate barriers to CMS-supported benefits, services, and coverage. This Framework reinforces the concept that to attain the highest level of health for all people, focused and ongoing attention must be given to addressing avoidable inequalities and eliminate health and health care disparities (CMS, 2026).

## B. Medi-Cal Managed Care Boilerplate Contract

The Medi-Cal Managed Care Boilerplate contract includes more than 150 Quality Improvement and Health Equity Transformation Program deliverables that reinforce governance, policy implementation, language access, quality outcomes, cross-functional integration, data analytics, continuous improvement, and member-centered operations.

## C. California Department of Health Care Services (DHCS) 2025 Comprehensive Quality Strategy.

**The 2022 Comprehensive Quality Strategy (CQS)** introduced the Department of Health Care Services' (DHCS) ten-year vision for the Medi-Cal program where members served should have longer, healthier, and happier lives. The strategy introduces DHCS' Bold Goals: 50x2025 initiative that, in partnership with stakeholders across the state, will help achieve significant improvements in Medi-Cal clinical and health equity outcomes by 2025.

The 2025 CQS Report evolved to include six organizational goals as part of its Strategic Plan, all of which align with its core values of Belonging, Equity, Innovation, Stewardship, and Sustainability. Recommended organizational goals include:

1. **Be person centered:** Put people first and design programs and services in the community for the whole person.
2. **Increase meaningful access:** Ensure individuals get care when, where, and how they need it by strengthening health care coverage, benefits, and provider and service capacity.
3. **Achieve excellence in health outcomes:** Improve quality outcomes, reduce health disparities, and transform the delivery system.
4. **Be an employer of choice:** Attract, develop and retain a diverse and talented team that is empowered and impactful.
5. **Strengthen operations:** Enhance organizational structures, processes, and systems to improve program administration.
6. **Leverage data to improve outcomes:** Drive better decisions and results with meaningful information.

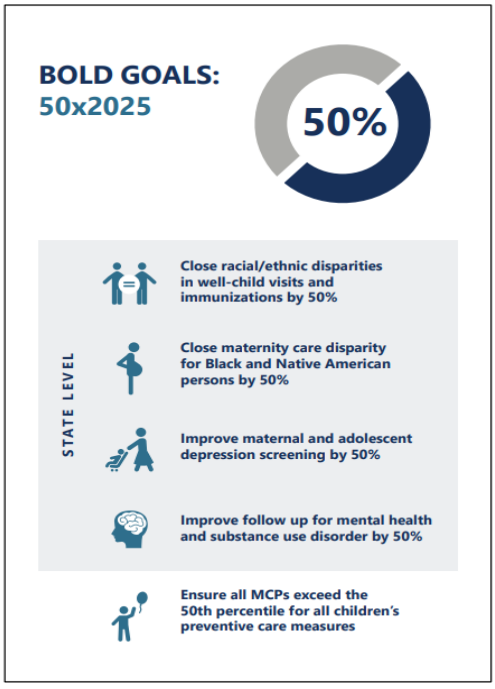


Figure 1. California Department of Health Care Services Bold Goals

The 2025 CQS Report highlights the reinforcing commitment to reducing health disparities in program activities including the following:

1. **Partnerships will be critical** members, communities, community-based organizations (CBO), schools, correctional facilities, public health agencies, counties, local health jurisdictions, schools, county Behavioral Health Plans (BHP), child welfare entities, and health care systems will be essential to preventing illness, supporting needs, addressing health disparities, and reducing the effects of poor health.
2. **Three (3) clinical focus** areas children's preventive care, maternal outcomes and birth equity, and behavioral health integration. The importance of the continuation of the Bold Goals that build upon the work done in the last three years focusing on health equity within these key domains. These goals were identified to ensure a comprehensive quality approach across multiple populations. To achieve DHCS' vision of eliminating health care disparities, DHCS

has defined needed improvements in data collection and stratification, workforce diversity and cultural responsiveness, and disparity reduction efforts (DHCS, 2025; Reference Figure 1).

3. **Expanded population health approach** to include behavioral health delivery systems, establishing 14 population-level outcomes for improvement. This behavioral population health work is also focused on key priority populations – individuals with behavioral health conditions who are chronically homeless and/or experiencing homelessness, those at risk of, or experiencing, justice system involvement, child-welfare involved youth, and individuals at high risk of institutionalization.
4. DHCS builds upon the work done in the last three years and outlines its strategy for community and member engagement in Medi-Cal policies and programs. DHCS furthers its **Value Based Payment (VBP) portfolio**, especially around primary care spending and alternative payment models, in partnership with the Office of Health Care Affordability.
5. Focus on 1) the implementation of **population health management (PHM)**; 2) **Medi-Cal Managed Care Accountability Set (MCAS)** performance as an aggregate; 3) **External Quality Review Organization (EQRO)** reports; and 4) **network adequacy**.
6. Includes annual results including enforcement actions against Manage Care Plans (MCPs).
7. **Workforce diversity and cultural responsiveness** whereby Medi-Cal workforce, at all levels, should reflect the diversity of the Medi-Cal population and always provide culturally and linguistically appropriate care. Findings from DHCS focus groups found members would like to see more practitioners that are representative of the people served.
8. **Digital access needs** expressed by beneficiaries emphasized that **addressing language barriers** through enhanced interpretation services is essential. Members also underscored the **importance of strengthening the overall access infrastructure**, including improved transportation options, user-friendly online scheduling portals, automated text reminders, and expanded telehealth services.

## D. DHCS California Advancing and Innovating Medi-Cal (CalAIM) Guide requirements.

California Advancing and Innovating Medi-Cal (CalAIM) is a long-term commitment to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory. The DHCS is innovating and transforming the Medi-Cal delivery system. CalAIM is moving Medi-Cal towards a population health approach that prioritizes

prevention and whole person care. The goal is to extend support and services beyond hospitals and health care settings directly into California communities. The vision is to meet people where they are in life, address social drivers of health, and break down the walls of health care. CalAIM will offer Medi-Cal enrollees coordinated and equitable access to services that address their physical, behavioral, developmental, dental, and long-term care needs, throughout their lives, from birth to a dignified end of life (DHCS CalAIM, 2026).

## E. Reimagined Population Needs Assessment (PNA) and Population Health Management (PHM) Strategy.

The PNA and PHM Strategy identifies member health and social needs, health disparities across populations, gaps in services across the continuum of care, and inequities at the local level, all with the goal of enhancing member health outcomes and ensuring BSCPHP effectively meets the needs of all Medi-Cal members. The reimagined approach, reflected in DHCS APL 23-021, promotes greater alignment with Local Health Departments and community stakeholders, strengthens community engagement, and deepens understanding of the members BSCPHP serves by emphasizing collaboration that extends beyond clinical needs to include the evaluation of social drivers of health (SDOH) and broader community context.

Consistent with the DHCS PNA Concept Paper, the redesigned PNA evaluates Medi-Cal member and community needs by identifying priority health issues, key health disparities, and the social factors influencing outcomes, while assessing disparities through stratification by race, ethnicity, language, geography, age, disability, and other demographic characteristics. The PNA also includes an evaluation of the effectiveness of Managed Care Plan (MCP) collaboration with local health departments, nonprofit hospitals, clinics, tribal partners, community-based organizations, and other stakeholders, making multi-sector partnerships a central component.

Furthermore, content in the PNA emphasizes alignment with Community Health Assessments and Community Health Improvement Plans to reduce duplicative efforts and develop a unified understanding of county-level health needs. It assesses how plans identify upstream opportunities and implement preventive, equity-focused interventions to support population-wide health improvement, while highlighting the integration of data across systems and the use of population health analytics including tools connected to the PHM Service and statewide risk stratification to develop a comprehensive picture of member needs. The PNA is used to ensure MCP accountability within the PHM Framework by requiring strategies

that are data-driven, equity-focused, responsive to member needs, and grounded in meaningful cross-sector collaboration.

## F. Diversity, Equity, and Inclusion Training Program Requirements.

The DHCS APL 24-016 Diversity, Equity, and Inclusion (DEI) Training Program Requirements are a core part of increasing capacity to deliver culturally competent care. The DEI training program will support creating better relationships and connectivity with diverse members across populations who have been disadvantaged by the system. The training program will create an inclusive environment within the Blue Shield Promise Health Plan and externally with Network Providers and other community-based contractors and staff with lived experience improving members' outcomes by enhancing access to care, reducing health disparities, and overall better quality of care.

## G. The California Department of Managed Health Care (DMHC) Health Equity and Quality Measure Set and Reporting Process.

The DMHC has established the Health Equity and Quality Measure Set (HEQMS) and measure stratification requirements, which are provided in APL 24-013. HEQMS were recommended with the goal of addressing long-standing health inequities and ensure 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. The DMHC established the HEQMS and initial measure stratification requirements, which were shared with health plans in APL 22-028 Health Equity and Quality Measure Set and Reporting Process.

The HEQMS became effective Measurement Year (MY) 2023 through at least MY 2027. BSCPHP will comply with Assembly Bill (AB) 133 as implemented by this APL and future DMHC guidance, consistent with applicable law, including Health and Safety Code section 1399.872. Pursuant to AB 133, the DMHC will promulgate regulations codifying the measures and benchmarks by January 1, 2027.

The HEQMS is comprised of 13 Healthcare Effectiveness Data and Information Set (HEDIS®) and one Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measure:

1. Colorectal Cancer Screening
2. Breast Cancer Screening
3. Glycemic Status Assessment for Patients with Diabetes
4. Controlling High Blood Pressure
5. Asthma Medication Ratio

6. Depression Screening and Follow-Up for Adolescents and Adults
7. Prenatal and Postpartum Care
8. Childhood Immunization Status
9. Well-Child Visits in the First 30 Months of Life
10. Child and Adolescent Well-Care Visits
11. Plan All-Cause Readmissions
12. Immunizations for Adolescents
13. CAHPS® Health Plan Survey, Version 5.0 (Medicaid and Commercial): Getting Needed Care

The DMHC will require health plans to report HEQMS measure rates at the statewide aggregate level by product line. The DMHC has adopted the NCQA health equity methodology for stratifying its HEQMS.

## H. National Committee for Quality Assurance (NCQA).

In 2025, BSCPHP obtained NCQA Health Equity Accreditation (HEA), as set forth by the DHCS contractual requirements. The NCQA Health Outcomes Accreditation (formerly HEA) focuses on the foundation of health equity work: building an internal culture that supports the organization's external health equity work; collecting data that helps the organization create and offer language services and provider networks mindful of individuals' cultural and linguistic needs; and identifying opportunities to reduce health inequities and improve care.

BSCPHP has adopted an actionable framework for improving health equity and prioritizing health equity for all members and the communities served.

## I. California Health Care Foundation (CHCF) and NCQA White Paper. Advancing Health Equity: A Recommended Measurement Framework for Accountability in Medicaid.

BSCPHP's HEO has been integrating health equity throughout the organization. The health plan has adopted the California Health Care Foundation (CHCF) and NCQA recommended measurement framework for accountability in Medicaid to advance health equity. This framework represents an effort to centralize health equity in quality measurement through a set of domains to track progress over time and assess performance.

The framework informs the development of quality improvement programs, helps to focus resources on programs and/or interventions most likely to contribute to improving health equity and provide an opportunity to align quality and

performance strategies with equity centered approaches to address disparities and close gaps in health care and health outcome.

Thus, BSCPHP's Health Equity program has been designed to meet the considerations listed above. Additionally, the Health Equity program is comprised of activities, procedures, investments, member engagement, clinical programs, and provider partnerships that will help drive transformation of the health care system, improving quality, expanding access, and ensuring equity for all members.

The scope of the Quality Improvement and Health Equity Transformation Program Description covers services provided to BSCPHP Medi-Cal members.

## II. BLUE SHIELD PROMISE HEALTH PLAN'S HEALTH EQUITY MISSION

Blue Shield of California (Blue Shield), founded over 80 years ago, operates exclusively in California, understands the state's diversity, and lives by the organization's values as a nonprofit. BSCPHP's mission is "to ensure all Californians have access to high-quality health care at an affordable price," and are guided by the vision to "create a healthcare system that is worthy of our family and friends and sustainably affordable" is based in equity.

BSCPHP is a licensee of the Blue Cross Blue Shield Association and is an affiliate of Blue Shield of California. BSCPHP holds Health Plan Accreditation and most recently received Health Equity Accreditation for its Medicaid product line from the National Committee for Quality Assurance (NCQA), will maintain accreditation through the next survey cycle under the Health Outcomes Accreditation program.

The Health Equity Office (HEO) champions Blue Shield of California's commitment to eliminating disparities both within the organization and across the counties served. Advancing health equity requires an honest examination of pervasive issues affecting the communities like systemic racism, implicit bias, quality of services, and funding. It also demands stakeholder buy-in, sustained action, resilience, authentic connection with individuals who share their lived experiences, and a workforce equipped to transform those stories into meaningful change.

This work cannot be achieved without authenticity; the willingness to acknowledge current realities, confront challenges head-on, and maintain the fortitude to advance equity, uphold what is right, and safeguard communities. By fostering an integrated culture of collaboration and partnership, BSCPHP will continue to improve the lives of all Californians

under the health plan's care. BSCPHP is committed to conducting health equity work in a manner worthy of our family and friends, recognizing that doing so requires sustained resourcing, organizational commitment, and a focused strategy.

Health equity ensures that members receive care when, where, and how they need it driving quality, affordability, and growth. Promise remains dedicated to advancing Growth, Quality, and Equity as core pillars of success.

This strategy incorporates all activities necessary to meet regulatory requirements, including close collaboration with the Blue Shield of California Health Equity team, and is informed by regulatory direction and best practices essential to designing a high-performing, distinguished program.

At Blue Shield of California health equity work is continuous. This strategy builds upon foundational efforts established in Year 1 and propels BSCPHP forward on the journey to embed equity throughout operations and demonstrate measurable reductions in health disparities and inequities. The strategic focus areas remain clear: Compliance, Quality, Data, Culture and Workforce.

## III. QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM VALUES

BSCPHP's Health Equity program is founded in the following values.

1) Quality and Health Equity are one and the same. A high quality, high-performing health plan cannot exist without health equity. High quality, whole person care requires commitment and teamwork of the entire community. A commitment to quality, equity, and the best possible outcomes for California's diverse Medi-Cal population advances a shared vision for all Californians.

2) BSCPHP is never bound by convention. Unable to solve today's problems with yesterday's solutions, BSCPHP steps beyond the traditional role of a health plan to completely reimagine showing up for members. Relentless in drive to co-create novel solutions that have the power to significantly impact the health and wellness of Californians.

3) Trust is earned. Work is grounded in deep respect for an understanding of the root causes of trauma and inequities in communities. Members' experiences by being physically present in the neighborhoods where they live. Where life happens. Deep listening and centering community wisdom in everything that is done.

4) Leading transformative shift. Physical presence in the communities served is essential. Whole selves are brought to the mission of eliminating disparities in the communities served.

## IV. QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM TENETS

BSCPHP seeks to eliminate disparities within the organization, counties, and members served. Therefore, BSCPHP's HEO will embed health equity into everything done across the enterprise. The HEO has established a process and framework for embracing the program values, solidifying a culture and a practice of equity across the organization, and in accordance with regulatory requirements. The HEO continuously works to implement the Quality Improvement and Health Equity Transformation Program (QIHETP) tenets and activities to support the drive to eliminate disparities among populations served (Reference Figure 2).

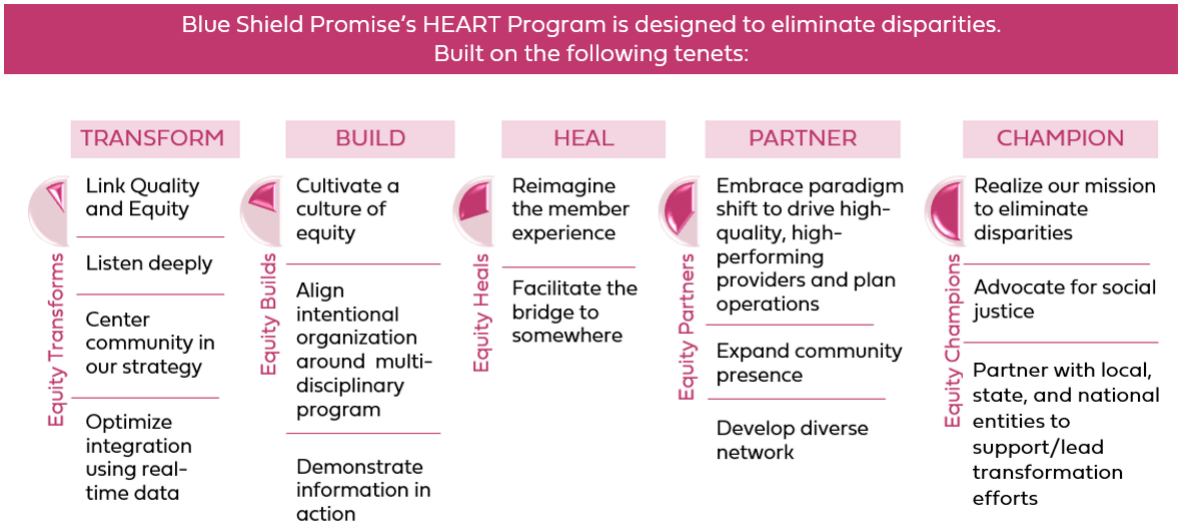


Figure 2 Quality Improvement and Health Equity Transformation Program Tenets

The following details are the QIHETP activities for each tenet listed as depicted in Figure 2 above:

A. Transform. Transforming equity includes the necessary link between quality and equity and listening deeply to the members, providers, and community partners served. Centering strategies on that feedback, leveraging real-time data, understanding that integration of multiple data sources is required to optimize understanding of where disparities and inequities exist. BSCPHP's HEO has developed a series of action items to implement the Health Equity program. This

includes creating a governance structure, defining health equity metrics, and developing a monitoring plan to identify disparities. The HEO has developed interventions to address these health disparities.

B. Build. BSCPHP's HEO has developed a comprehensive Health Equity program that both meets regulatory requirements and supports BSCPHP's commitment to addressing health disparities. In addition, BSCPHP's HEO has developed a plan to monitor, identify, and address health disparities across populations. Building equity includes cultivating a culture of equity internally and externally with providers and community partners. BSCPHP's Quality Improvement and Health Equity Transformation Program is multidisciplinary across the enterprise with alignment on equity principles.

C. Heal. BSCPHP will not only be equipped to best identify a member's needs but also facilitates coordination of care to address social drivers of health. Most importantly, BSCPHP confirms members are obtaining needed care, placing additional emphasis on members in most need. DHCS has issued several mandates requiring health plans to initiate health disparity work. Such mandates include requirements to identify specific member needs via the reimagined Population Needs Assessment (PNA), PHM Strategy, and CalAIM program requirements (DHCS CalAIM, 2026), and stratified reporting of HEDIS® data for specific measures as outlined in the DHCS CQS report. These requirements will continue to be integrated into this Health Equity program. BSCPHP is fully committed to support disparity work as needs are identified.

D. Partner. BSCPHP will support providers and operations to maximize health care delivery, understanding that equity work extends beyond the four walls of an exam room. BSCPHP not only supports the member journey, but also rely on partners, ensuring they are equipped to meet the unique needs of each member. BSCPHP continues to work to diversify the provider network, supporting cultural competency, health equity training, attempting to dismantle systemic racism and teach skills to reduce implicit bias, all lending to an improved member experience while facilitating optimal outcomes.

E. Champion. BSCPHP is committed to eliminating health disparities. Confidence in the ability to catalyze lasting change guides this work. Achieving health equity requires steadfast advocacy for social justice and strong state partnership to lead health equity transformation. Looking ahead to the future state, building the capacity of individuals and internal and external stakeholders is essential to advancing health equity.

## V. ACTIVITIES

BSCPHP seeks to create a healthcare system that is worthy of our family and friends and is sustainably affordable. BSCPHP has defined a set of health plan strategies to achieve this goal. A health equity lens has been applied to each of these guiding principles to create a unique set of Health Equity Strategies.

| Activities | Health Equity Strategy |
|---|---|
| Doing what's right | Actively working on correcting systemic inequities in health and social systems to address member needs, deliver a high-quality experience, and integrate an internal culture of inclusivity. |
| Being a trusted and reliable partner | Collaborating with community-based organizations, other managed care plans and all levels of government to implement tools, exchange information for the benefit of all, bring healthcare into the digital age and ensure the accountability and long-term affordability of health care. |
| Keeping members first | Driving whole person, person-centered care that meets the health needs of all members, addresses SDOH, reduces disparities, and gives every member the opportunity to attain their full health potential. |
| **Strengthening** Community engagement | Aligning with community-based organizations, public plans, and county partners to improve community health and meet members where they are born, live, work, worship, and play with innovative programs to improve health outcomes. |
| **Fostering** Provider collaboration | Helping providers focus on delivering quality care by providing technology and resources that remove barriers, inefficiencies, and administrative burden. |
| **Driving** continuous improvement | Developing innovative advancements powered by leading edge technology, grounded in comprehensive, real-time data designed to improve care integration, outcomes, and delivery of health care services. |
| Creating a personal, high-quality experience | Integrate shared opportunities to meet the needs of the members served across departments to create a personal high-quality experience at various touchpoints across the organization. |

| | |
|---|---|
| Serving more people | Understand that health equity is intersectional, and diversity exists within the communities and members served. Ensuring all employees, contracted staff and providers take annual sensitivity, diversity, cultural competency, and health equity training with the goal of changing behavior with interpersonal interactions and address all people inclusively, accurately, and respectfully (CDC, 2021). |
| Being a great place to do meaningful work | Actively recruit employees who represent the ethnic and cultural community groups served or who have extensive experience of working with diverse populations. |

Table 1. Health Equity Strategies and Activities

## VI. BUILDING A COMMON UNDERSTANDING OF HEALTH EQUITY

Health equity is a priority across the entire organization. The Health Equity framework drives work to develop a common language and shared understanding to achieve the transformation members deserve. To facilitate this common language, health-equity related terms are defined in BSCPHP's *Advancing Health Equity* training. All BSCPHP employees are required to take this course to meet APL 24-016 DEI training program requirements (Reference Appendix 1).

## VII. QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM STRUCTURE

The Blue Shield Board of Directors (Board) is comprised of community and provider leaders and is responsible for the Quality Improvement and Health Equity Transformation Program. The Board approves the Quality Improvement and Health Equity Transformation Program Strategy, and is presented with related goals, metrics, and recommendations for BSCPHP. The Board provides oversight of performance against quality goals, including ensuring compliance and regulatory requirements are met. The Board has delegated oversight of all quality and health equity activities to the Medi-Cal Committee.

The Quality Improvement and Health Equity Transformation Program's (QIHETP) governance structure includes the following, at a minimum:

1. BSCPHP's Governing Board maintains oversight of the QIHEC and participates in QIHETP planning.
2. The QIHEC will report to the Medi-Cal Committee. The Medi-Cal Committee reports to the Blue Shield of California Board of Directors via consent agenda.

3. QIHETP activities are supervised by BSCPHP's Medical Director or the Medical Director's designee, in collaboration with BSCPHP's Chief Health Equity Officer (CHEO).
4. The participation of a broad range of Network Providers, including but not limited to hospitals, clinics, county partners, physicians, community health workers, and other non-clinical providers in the process of QIHETP development and performance review.

The Quality Improvement and Health Equity Transformation Program governance structure is depicted in Figure 3.


**Figure 3. Quality Improvement and Health Equity Transformation Program Governance Structure**

BSCPHP's QIHEC reports to the Medi-Cal Committee of the Board. The Medi-Cal Committee of the Board reports to the Blue Shield of California Board of Directors via consent agenda.

Additionally, leveraging Blue Shield Promise's best practices, the Blue Shield Promise HEO will continue to strengthen how to enhance quality and health equity programs across the enterprise by participating in the Health Equity Oversight Committee (HEOC) in partnership with Blue Shield of California and Blue Shield of California Life & Health Insurance Company. The HEOC is responsible for oversight of all health equity related activities conducted by Blue Shield of California, Blue Shield of California Life & Health Insurance Company, and Blue Shield of California Promise Health Plan lines of businesses. This includes all Commercial Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO), Exchange HMO and PPO, Medicare HMO and PPO, Medi-Cal, and Life & Health insurance products.

This alignment will ensure a cohesive and effective approach to interfacing operational models, bridging initiatives, fostering outcomes in member experience, clinical quality, and equitable care delivery across all Products.
The HEOC is an accountability body for health equity enterprise-wide strategies and opportunities to expand/scale between lines of business and is co-chaired by Blue Shield of California's Chief Health Equity Officer and Blue Shield of California Promise Health Plan's Chief Health Equity Officer, or other designated personnel on an ad hoc basis.

## VIII. QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE

BSCPHP's QIHEC is charged with reviewing all Health Equity related activities and documents. The QIHEC will report to the Medi-Cal Committee. The Medi-Cal Committee reports to the Blue Shield of California Board of Directors via consent agenda.

The Blue Shield of California Board of Directors delegates the authority to review and approve the Health Equity related activities, including the annual Culturally and Linguistically Appropriate Services (CLAS) Program Evaluation and associated documents and/or reports to the Medi-Cal Committee. The Medi-Cal Committee reviews information from internal and external stakeholders including but not limited to data, reporting, and feedback from the Community Advisory Committee (CAC).

BSCPHP's QIHEC is responsible for Quality Improvement and Health Equity activities. The QIHEC is charged with reviewing and approving health equity activities. The QIHEC reviews CLAS, Population Needs Assessment (PNA), CAHPS®, HEDIS® results as related to health equity, results of the Health Equity Advancements Resulting in Transformation (HEART) Measure Set, and the review, feedback, and approval of the annual written evaluation of the QIHETP.

The QIHEC will leverage members and community feedback to have an equity-centered approach to program management, planning, policies, and procedures. The responsibilities of the QIHEC include the following:

1. Review and approve annual QI and Health Equity plan.
2. Develop, implement, maintain, and periodically update policies and procedures to ensure compliance with health equity requirements.
3. Analyze and evaluate the results of Quality Improvement (QI) and health equity activities, including but not limited to, the annual review of the results of performance measures, utilization data, consumer satisfaction surveys or CAHPS®, and the findings and activities of other BSCPHP committees such as the CAC and incorporate results into the design of quality improvement and health equity activities.
4. Institute actions to address performance deficiencies, including policy recommendations.
5. Ensure appropriate follow-up of identified performance deficiencies.
6. Implement and maintain a charter including the role, structure, and function of the QIHEC.
7. Continuously monitor, review, evaluate and improve quality and health equity of covered services including clinical care services, case management, coordination

and continuity of services provided to all members.
8. Review and provide feedback on BSCPHP NCQA Health Outcomes Accreditation (formerly Health Equity Accreditation) activities, reports, and policies.

### Reporting

1. BSCPHP's CHEO or designee will provide a written summary of QIHEC activities, findings, recommendations, and actions following each meeting to the Board Quality Improvement Committee (BQIC) for the remainder of the year, in addition, to the Medi-Cal Committee and to DHCS upon request.
2. BSCPHP's CHEO or designee will provide a written summary of the QIHEC activities that will be made available publicly on the Plan's website at least on a quarterly basis.
3. BSCPHP's CHEO will produce an annual Promise Health Equity report to the QIHEC and DHCS upon request.
4. Designated staff will provide annual copies of all final reports of independent accrediting agencies to DHCS.
5. The HEO will post Quality Improvement and Health Equity Plan to the BSCPHP public website annually.

### Membership Composition

1. BSCPHP's QIHEC membership includes:
    a. Medical Director or designee as the Chair.
    b. CHEO as the Co-Chair.
    c. Representatives from leaders in BSCPHP functional areas.
    d. A broad range of Network Providers, including but not limited to the following:
        i. Hospitals, clinics, county partners, physicians, and members.
        ii. BSCPHP Network Providers that are part of the QIHEC must be representative of the composition of the BSCPHP Provider Network and include, at a minimum, Network Providers who provide health care services to:
            1. Members affected by Health Disparities.
            2. Limited English Proficiency (LEP) members.
            3. Children with Special Health Care Needs (CSHCN).
            4. Seniors and Persons with Disabilities (SPD).
            5. Persons with chronic conditions.

The BSCPHP QIHEC meets quarterly and will conduct off-cycle meetings as needed. Formal minutes are maintained for all meetings of the BSCPHP QIHEC.

## IX. EXECUTIVE LEADERSHIP

BSCPHP' HEO champions the holistic drive to eliminate disparities among members and communities served. The HEO structure is designed for maximal integration throughout BSCPHP to readily implement and prioritize policies, programs, and procedures to address health inequities.

The HEO is led by BSCPHP's CHEO who reports directly to the BSCPHP President and Chief Executive Officer (CEO). This reporting structure ensures that the top leaders and the organization align to health equity principles across the enterprise.

The HEO is comprised of the following BSCPHP leaders:

A. President and CEO, BSCPHP: The President and CEO of BSCPHP reports to the Executive Vice President (EVP) and Chief Growth Officer of Blue Shield of California and is responsible for providing strategic leadership for BSCPHP by working with the Board and other management to establish long-range goals, strategies, plans and policies. This role provides oversight of quality plans and outcomes, ensuring the plans developed improve quality performance and drive equitable outcomes.

B. CMO, BSCPHP: The BSCPHP CMO reports to the BSCPHP President and CEO, and the Senior Vice President (SVP)/CMO of Blue Shield, and works in conjunction with the VP, Clinical Quality, and the Clinical Quality organization to develop, implement, and evaluate the quality program. The CMO chairs the BSCPHP QMC and QIHEC and is responsible for oversight of all QI and HE activities.

C. CHEO, BSCPHP: The CHEO will report directly to the BSCPHP President and CEO and will work cross functionally across the entire organization. The CHEO works in partnership with DHCS to reduce health disparities and advance the DHCS Bold Goals 50x2025 Initiative.

D. Vice President, Clinical Quality, Blue Shield of California: the VP, Clinical Quality reports to the SVP/CMO and has direct operational accountability of the Clinical Quality Department for BSCPHP. Functional responsibilities include quality assurance, clinical quality improvement, quality analytics, clinical quality review, and clinical quality member experience.

BSCPHP recognizes and fully supports the CMO playing a central role in the design and implementation of the PHM Strategy, which includes the implementation of Quality Improvement (QI) and Health Equity (HE) activities, and in engaging with local health departments. Additionally, BSCPHP's CMO is the leader accountable for the Blue Shield QI Program. In this capacity, the CMO is responsible for the design, priorities, work plan, activities, implementation, and evaluation of the entire scope of the QI Program. The scope of the QI Program, which is reviewed and updated annually, includes but is not limited to the PHM Strategy, QI and Health Equity initiatives, and provider collaborations including engaging with local health departments. Progress on the QI Program and PHM Strategy are reported quarterly to the BQIC.

The CMO also plays a critical role in collaborating with the CHEO to drive the development, implementation, and measurement of initiatives to reduce health disparities and drive greater health equity. The CMO works with the CHEO to lead the QIHEC, ensuring appropriate oversight and engagement in activities. BSCPHP recognizes that addressing health disparities and SDOH requires the commitment and engagement of a multi-disciplinary community. BSCPHP's CMO, therefore, works collaboratively with local health departments, community-based organizations, and members to drive towards the most effective quality and health equity programs.

# X. QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM GOALS AND OBJECTIVES

## A. Quality Improvement Health Equity Transformation Program Goals

BSCPHP's mission is to transform its health care delivery system into one that is worthy of families and friends and sustainably affordable. BSCPHP seeks to advance health equity by implementing health equity activities supporting BSCPHP's mission.

BSCPHP ensures 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 that all Covered Services are provided in a culturally and linguistically appropriate manner.

BSCPHP has established the subsequent QIHETP principles since the inception of the program and seeks continuous implementation and monitoring of the milestones listed in Figure 4.

1. **Advance Information in Action**: BSCPHP integrates data and analytics platforms to generate valid, actionable, and meaningful information to increase quality and health equity.
2. **Build Sound Infrastructure and Operations**: BSCPHP builds a sound infrastructure to support QIHETP. Integrating feedback provided by members, families and Network Providers, and community partners in the design, planning, and implementation of the QIHETP.
3. **Embed Equity**: BSCPHP has established a process and multi-disciplinary framework for solidifying a culture and practice of equity across the organization.
4. **Design Interventions that Matter**: BSCPHP embeds equity-focused initiatives across the enterprise to consistently prioritize addressing health disparities and in accordance with regulatory requirements and strategies. BSCPHP utilizes a health-equity lens to continuously drive and refine meaningful interventions, meeting members where they are for maximum impact. BSCPHP works to identify disparities, develop data-driven, scalable, customized interventions that sustainably address health inequities.

| Information in Action | Sound Infrastructure and Operations | Equity Embedded | Interventions that Matter |
|---|---|---|---|
| • Develop a comprehensive data strategy for stratification and analysis of health disparities<br>• Capture and validate health equity related demographic data<br>• Enable a simplified reporting and analytics platform that drives the delivery of equitable, whole-person care | • Maintain compliance with operational governance framework in accordance with BSCPHP's current operating model and in alignment with regulatory requirements<br>• Define regular reporting and information flow/data analysis expectations<br>• Maintain NCQA Health Outcomes Accreditation | • Establish organization-wide expectations that achieving health equity is everyone's responsibility<br>• Incorporate health equity informaiton sharing across BSCPHP | • Adopt a robust, data driven health equity intervention development process<br>• Develop customized interventions that target equitable whole-person care in marginalized populations and/or communities |

Figure 4. QIHETP Principles

The QIHETP principles align with the QIHETP tenets in section IV, to transform, build, heal, partner and champion. For example, Advancing Information in Action activities integrate data and analytics platforms to generate actionable, meaningful information. Data will be used to identify disparities and develop data-driven, customized interventions that sustainably address health inequities linking quality and equity. Sound Infrastructure and Operations are the building blocks of the QIHETP. Having established an HEO that

champions integration and transformation that drives Quality and Health Equity in Medi-Cal. The HEO will maintain and/or enhance regular reporting and information flow/data analysis expectations across functional departments. Embedding Equity in everything and everywhere is part of the strategic approach to both healing and championing health equity, serving as a catalyst for change. Finally, the HEO will continue to develop customizable interventions that target equitable whole-person care in marginalized populations and/or communities. This member-centric approach will provide the HEO with the opportunity to partner with cross functional departments and external community and provider partners.

Moreover, BSCPHP's HEO will operationalize program activities to meet the four program goals.

1. ## Advance Information in Action

   BSCPHP facilitates a simplified reporting and analytics platform that enables delivery of equitable, whole-person care for Promise members. BSCPHP will build and launch accessible, integrated data and analytics platforms that generate actionable, meaningful information, identity and sustainably address health disparities. BSCPHP recognizes that creative and multi-pronged solutions are urgently needed to capture and validate member data (e.g., Race, Ethnicity, Age, Language [REAL], Sexual Orientation and Gender Identity [SOGI], SDOH, etc.) that will uncover statistically significant health disparities. Real-time access to the most recent data as well as actionable, high-quality data is critical for key functions like Social Services, Enhanced Care Management (ECM), and PHM to facilitate delivery of individualized and equitable care to members.

   BSCPHP has committed to the following Information in Action strategies:

   a. Develop a Comprehensive Data Strategy for Stratification and Analysis of Health Disparities.
   b. Capture/Validate Health Equity-Related Demographic Data.
   c. Enable a simplified reporting and analytics platform that enables delivery of equitable whole-person care for BSCPHP members.
   d. Institute processes to close gaps in care and maintain ongoing data accuracy.
   e. Enable demographic data captures along each member-facing touchpoint.
   f. Develop and/or update internal staff and Provider trainings for BSCPHP and network providers to include responsibilities and evidence-based best practices for capturing key demographic data.
   g. Enabling real-time user-customizable reporting and analysis (e.g., drop down menus, etc.) and advanced member segmentation/analytics that

address health-equity focused questions, including establishing a clear understanding of the reporting needs for different functional areas. Subsequently develop enhancements to the health equity dashboards.

h. Assess the value of third-party data and/or analytics, integrating where able.
i. Define scope and milestones for accessing actionable data and analytics that address health equity-focused questions and allow internal teams to:
    i. Surface insights regarding complex health issues, ex. severe maternal morbidity or primary care deserts.
    ii. Highlight disparities in health outcomes and access to healthcare.
    iii. Generate custom, targeted analysis looking at a wide range of utilization measures, selected HEDIS® measures, and provider access measures.
    iv. Generate custom, targeted analysis using community-level social drivers of health data at zip code and census tract level.
    v. Access provider-level and reporting data for analysis.
j. Develop a cross-functional process that enables organization-wide access to actionable data and analytics that address health equity focused questions.
    i. Identify areas where health disparities exist as seen by open care gaps.
    ii. Track performance of ongoing outreach activities.
    iii. Plan member outreach activities through a health equity lens.
    iv. Display characteristics of members who did not engage in care and/or past outreach activities.
    v. A wide range of HEDIS®.
    vi. Community-level social drivers of health data at zip code and census tract level.
    vii. Provider group-level reporting.
    viii. Use SDOH data to understand the unique journeys and challenges of member experience.
k. The data and analytics platform also provide connectivity to county Health Information Exchanges (HIEs)/Community Information Exchanges (CIEs) which will support increased quality of care management and identification/engagement of community resources and partners. BSCPHP will select external data sources that best enable this connectivity and establish sustainable partnerships operating to enhance design of high impact interventions.

## 2. Sound Infrastructure and Operations

### Enterprise Integration between BSCPHP and Blue Shield of California

BSCPHP's journey to create a health equity infrastructure throughout the enterprise started several years ago. Work was initiated within the enterprise-wide innovation unit to maximize creative, rapid solutions with a focus on Medi-Cal. Creating pillars of health equity, the organization is anchored in common language and process. The journey has culminated in the design and vision for the BSCPHP HEO.

BSCPHP's HEO supports and leads health equity projects across the organization. The CHEO leads the HEO and enterprise-wide initiatives, investments, and programs to drive health equity goals. The HEO structure is designed for maximal integration throughout the organization to readily implement and prioritize policies, programs, and procedures to address health inequities. The CHEO reports directly to the BSCPHP CEO.

### Health Equity Office

The CHEO is supported by a team with deep expertise in structural racism, bias and discrimination, health equity, social work, evaluation, and community engagement, to embed the health equity framework work throughout the organization. The CHEO and key supporting staff are integral to ensuring all strategies and programs prioritize health equity and address health disparities. Their work will be highly cross-functional and require a team to execute effectively. Their roles maintain appropriate authority and decision rights to be effective throughout the enterprise. The HEO convenes regularly to review the QIHETP updates.

The HEO is comprised of the following BSCPHP staff (Reference Figure 5):

a. President and CEO
b. CMO
c. CHEO
d. VP, Clinical Quality, Blue Shield of California
e. Director of Clinical Quality
f. Health Equity Principal Program Manager
g. Health Equity Business Analyst

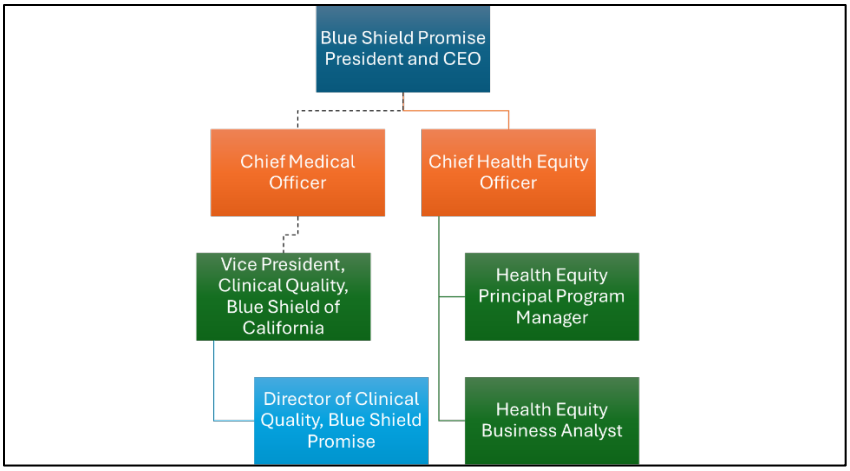


Figure 5. BSCPHP Health Plan Health Equity Office Organizational Chart

The President and CEO of BSCPHP reports to the EVP and Chief Growth Officer of Blue Shield of California and is responsible for providing strategic leadership for BSCPHP by working with the Board and other management to establish long-range goals, strategies, plans and policies. The CEO provides oversight of quality plans and outcomes, ensuring the plans developed improve quality performance and drive equitable outcomes.

The BSCPHP CMO reports to the SVP/CMO of Blue Shield and works in conjunction with the VP, Clinical Quality, and the Clinical Quality organization to develop, implement, and evaluate the quality program. The CMO is responsible for oversight of all QI and Health Equity activities.

The BSCPHP CHEO reports directly to the BSCPHP President and CEO and will work cross functionally across the entire organization to advance efforts to reduce disparities and inequities.

The VP of Clinical Quality and Quality Improvement is responsible for the development and execution of the Medi-Cal clinical quality improvement strategy and works collaboratively with the CHEO to support QIHETP activities.

The Director of Clinical Quality is responsible for the strategy, development, and implementation of clinical quality improvement activities for BSCPHP.

BSCPHP's HEO staff are responsible for the planning, execution, and oversight of QIHETP daily operations and activities and regulatory compliance.

## Governance

Furthermore, BSCPHP has established an HEO operational model and governance in accordance with the organization's current operating model and in alignment with the requirements set forth by the DHCS. BSCPHP has established committees, such as the implementation and maintenance of the QIHEC responsible for creating the QIHETP Annual Plan, the CAC, Provider Advisory Committee (PAC), and other committees identified by leadership and the community.

## Policies and Procedures

BSCPHP's QIHTEP policy and procedures are designed to integrate and promote health equity, addressing inequities, where possible including but not limited to:

a. Marketing strategy
b. Medical and other health services policies
c. Member and provider outreach
d. CAC
e. Quality Improvement activities
f. Grievance and Appeals
g. Utilization Management

BSCPHP develops new and modifies existing policies and procedures that result in reducing health disparities and increasing health equity in the Medi-Cal population; establishes equity-focused medical and other health services policies in alignment with DHCS goals and requirements; establishes a CAC with the power to drive meaningful health-equity directed change; and establishes protocols for data presentation and the public posting of required and relevant Health Equity-related content on the BSCPHP website. Policies and procedures are reviewed and approved by the QIHEC.

BSCPHP has established a process for presenting data and information for various projects and/or initiatives as documented in the Annual QIHETP, meeting minutes from the quarterly QIHEC, functional area policies and procedures, CAC. Additionally, the HEO has developed a standard process for collaborating with cross functional departments across the enterprise to monitor health equity metrics beyond the required DHCS Medical- Managed Care Accountability Set (MCAS) for health care delivery systems, or HEDIS® data.

## Monitoring and Oversight

The HEO, under the leadership of the CHEO and QIHEC, will review and monitor all QIHETP and QIHEC activities by maintaining a plan to monitor performance toward QIHETP goals, identify, and address health disparities across populations. The HEO will integrate and build efforts enabling a central mechanism to systematically monitor the effectiveness of programs and interventions. Specifically, the HEO will analyze data gathered for a specific set of metrics as listed in the HEART Measure Set.

The HEO establishes a baseline analysis of the status and develops a process for rigorous monitoring and evaluation of improvement initiatives. Connectivity across this data captures diverse perspectives to deeply understand all discovered disparities among members experience, and speed the development of comprehensive, member-focused solutions with a sustainable impact and data to guide continuous quality improvement (CQI) efforts.

Written QIHEC progress reports describing actions taken, progress in meeting QIHETP objectives, and future opportunities for improvement will be submitted to the Medi-Cal committee for formal review and approval. A comprehensive assessment and list of all QIHETP activities is presented in a fluid QIHETP work plan.

### Accreditation

As of January 2025, BCPHP has acquired NCQA Health Equity Accreditation (HEA) and in accordance with DHCS requirements. To maintain NCQA HEA accreditation, BSCPHP will monitor required reporting, activities, and report appropriate updates to the QIHEC. NCQA is making changes to its Health Equity Accreditation program. Effective January 15, 2026, Health Equity Accreditation will be renamed Health Outcomes Accreditation (HOA). BSCPHP will remain informed as NCQA releases the standards and guidelines for Standards Year 2026. The standards include expanded content and enhancements designed to help organizations sustain long-term strategies for improving outcomes for their unique members, patient and community needs. BSCPHP will update documents, processes, and reports as needed to prepare for the next HOA survey.

## 3. Equity Embedded

BSCPHP continuously seeks to embed Health Equity into everything done across the enterprise. BSCPHP has established a process and expectations framework for solidifying a culture and practice of equity across the organization. BSCPHP recognizes that achieving health equity is everyone's responsibility and the

organization-wide expectation. BSCPHP provides Diversity, Equity and Inclusion staff training entitled Advancing Health Equity, which encompasses sensitivity, diversity, cultural competency, cultural humility, and health equity topics. BSCPHP seeks to recruit and retain a diverse workforce with varying cultural backgrounds, spoken languages, and lived experiences that are not only representative of the populations served but enable a culturally sensitive approach to member interaction.

BSCPHP's policy and procedures are designed to integrate and promote health equity, addressing inequities, where possible throughout the enterprise. BSCPHP has convened the QIHEC co-chaired by the CMO and CHEO to thoroughly review and analyze all health plan policies and procedures, identifying areas that promote inequity. The HEO advises recommendations to promote equity into policies, programs, and operations.

### 4. Interventions that Matter

BSCPHP recognizes that relentless focus and determination is required to address the deeply rooted systems of bias toward and oppression of marginalized people. In response, BSCPHP will continue to develop data-driven, innovative, member-centric interventions that drive quality and health equity in Medi-Cal. Further, this work is conducted in partnership with key cross functional areas and in alignment with DHCS Bold Goals (Summarized in Figure 1).

BSCPHP seeks to develop customized interventions that target equitable, whole-person care in marginalized populations and/or communities. BSCPHP recognizes consistent, incremental health equity work that builds momentum over time leading to potentially exponential, scalable results.

BSCPHP has adopted a robust health equity intervention development process defining and solidifying a cross-functional process that enables the identification of disparity root causes and enables effective, sustainable intervention deployment. The development process includes reviewing root causes of disparities identified and prioritized based on importance and feasibility, defining multiple levels of influence to target such as patient, provider, community, and various delivery modes of communication such as print, social media, in-person settings, etc. BSCPHP plans meaningful interventions defining outcomes and process measures, culminating in demonstrated outcomes for interventions that matter.

B. QIHETP Program Goals and Objectives

The HEO seeks to meet a set of objectives that contribute to accomplishing the QIHET program goals. Objectives are established by the HEO on an annual basis and revised as needed. Progress is assessed routinely and reported to the QIHEC. Results are incorporated into the QIHETP Annual Evaluation and reported to the QIHEC and other committees by the established governance structure.

| 2026 QIHET Program Goals and Objectives | |
|---|---|
| **Goal** | **Objective** |
| Sound Infrastructure and Operations<br><br>*Maintain NCQA Health Outcomes Accreditation (formerly HEA)* | Complete 100% of all Health Outcomes Accreditation activities as required by 12/31/2026 |
| Sound Infrastructure and Operations<br><br>*Ensure contract compliance* | 100% of health equity related contract deliverables will be compliant by 12/31/2026 |
| | For Well Child Visits HEDIS® measure, the compliance rate among Black/African American members and Asian members will meet or exceed the minimum performance level or achieve improvement equivalent to at least 6 points (based on the DHCS Quality Withold and Incentive Program). |
| | For Post-Partum Care HEDIS® measures, Black/African American members will meet or exceed the minimum performance level or demonstrate a statistically significant increase in directional improvement |
| | At least 30% of network providers complete Diversity Equity and Inclusion training by 12/31/2025 |
| Equity embedded in everything we do<br><br>*Build and Integrate a Culture of Equity* | 90% of finalized Health Equity Integration Plan activities will be completed by 12/31/2026 |
| | Member social drivers of health data collection increases by 5% by 12/31/2026 |
| | 85% of members with 1+ social driver will be addressed by 12/31/2026 |

Table 2. 2026 QIHET Program Goals and Objectives

# XI. BLUE SHIELD PROMISE INTERNAL KEY FUNCTIONAL AREAS AND RESPONSIBLE DEPARTMENTS

Health Disparities transcends across departments impacting multiple cross-functional areas, thus, BSCPHP's policy and procedures are designed to integrate and promote health equity, addressing inequities, where possible including but not limited to the following cross functional areas: Marketing (Community Engagement) strategy, Medical and other health services policies, Member and provider outreach, CAC, Health Education, Quality Improvement activities, Grievance and Appeals, and Utilization Management.

The HEO coordinates with functional areas such as but not limited to Population Health Management, Grievances and Appeals, Utilization Management, and Behavioral Health within BSCPHP to identify and address disparities. Applying a health equity lens to program oversight across each functional area is key in identifying health disparities and/or inequities across vulnerable populations.

The HEO seeks to engage functional areas in health equity planning and oversight. The HEO conducted a roadshow with functional area leaders in calendar year 2024 to facilitate identification of select health equity measures and allow for planning in recognition of the intersection between health equity in various functional areas. The goal of the roadshow was to discuss opportunities for health equity integration and identify specific health equity measures to monitor disparities. The multi-disciplinary measures discussed in roadshows now comprise the HEART Measure Set. The HEO initiated monitoring of the data for the selected measures to identify disparities and/or trends over time. Integrated data results and outcomes are shared at the QIHEC meetings to provide transparent information sharing for cross-collaboration and understanding. Based on this analysis, and in partnership with the cross functional areas at the direction of the CHEO, will implement initiatives to resolve the known health disparities, gaps, and opportunities (Reference Figure 4). Additional roadshows are hosted with other functional area leaders as the HEO seeks to engage leaders in the cross section between health equity and other functional areas across the health plan.

Health Equity efforts are integrated, targeting a wide range of inequities e.g., populations, measures, access to care, utilization, satisfaction, engagement, etc. For example, the CHEO collaborates with BSCPHP CL staff to review and update its cultural and linguistic services programs to align with the PNA and PHM strategy. BSCPHP ensures its Network Providers cultural, and health equity linguistic services programs also align with the Reimagined PNA and PHM Strategy.

The HEO also integrates health equity activities externally, via engagement with members, providers, and community-based organizations. The CHEO remains an active member of the CAC and PAC, sharing updates and integrating feedback into the design and implementation of the QIHETP. The CHEO serves as a voting member on key committees including Population Health Management, Access and Availability, Behavioral Health, and AI Governance, providing a unique vantage-point across clinical, operational, and technical functions. This cross-committee presence enables the CHEO to surface intersectional issues, align strategies, and embed a health equity lens into decision-making, reporting, and operational processes. Insights gathered through these forums also catalyze opportunities for innovation and inform the development of data-driven health equity improvement initiatives and health equity integration plan work.

BSCPHP also completes and submits to the DHCS the CAC report. The CHEO reviews the annual report to ensure CAC membership is representative of the Communities in BSCPHP's service area. The annual report integrates health equity by including a description of the CAC's ongoing role and impact in decision-making about health equity, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives, including examples of how CAC input impacts and shapes initiatives and/or policies.

## XII. HEALTH EQUITY INTEGRATION FRAMEWORK

BSCPHP's HEO created a standardized model to integrate health equity throughout the organization. The health plan adopts the California Health Care Foundation (CHCF) and NCQA recommended measurement framework for accountability in Medicaid to advance health equity. Specifically, the measurement framework supports a robust, comprehensive approach to monitoring disparities that may exist when assessing various health plan operations and data sources.

This framework represents an effort to centralize health equity in quality measurement through a set of domains to track progress over time and assess performance. The framework informs development of quality improvement programs, helps to focus resources on programs and/or interventions most likely to contribute to improving health equity, and provides an opportunity to align quality and performance strategies with equity centered approaches to address disparities and close gaps in health care and health outcome.

The framework includes six domains - each domain representing the perspectives of a range of internal stakeholders and partners. The framework also provides an opportunity to garner a consensus for measure selection across all impacted partners and build on the health equity strategic plan across the organization.  Building consensus and buy-in is a

critical factor to be successful in advancing and improving health equity. The identified measures were then categorized under the most applicable domain.

The framework is as follows (reference Figures 6 and 7):

1. Equitable Social Interventions. Measures of unmet social needs and the interventions and services designed to address them.
2. Equitable Access to Care. Measures of access to high value health care services, including the timeliness and convenience of getting care.
3. Equitable High-Quality Clinical Care. Measures of clinical care process and outcomes, including prevention and management of chronic disease.
4. Equitable Experiences of Care. Member-reported measures of health care experience.
5. Equitable Structures of Care. Measures that assess an organization's culture and system of care for meeting the needs of individuals from diverse backgrounds and lived experiences.
6. Overall Well-Being. Self-reported survey metrics of physical and mental health and overall well-being.


Figure 6. Health Equity Measurement Framework for Medicaid Accountability Domains

Domains are structured to recognize overlaps within the domain categories. For example, access to care is a prerequisite for many measures of health outcomes, and social drivers of health can impact both access and overall well-being. **Achieving equitable health care and outcomes will require success across domains.**

The framework contains recommended quality metrics to support evaluation of each domain. Domains and associated measures reflect elements that contribute to or reveal equities and inequities in health care and health outcomes. The HEO and leaders from functional areas have identified measures as recommended in the CHCF and NCQA framework, and/or add additional metrics to meet state regulatory compliance.

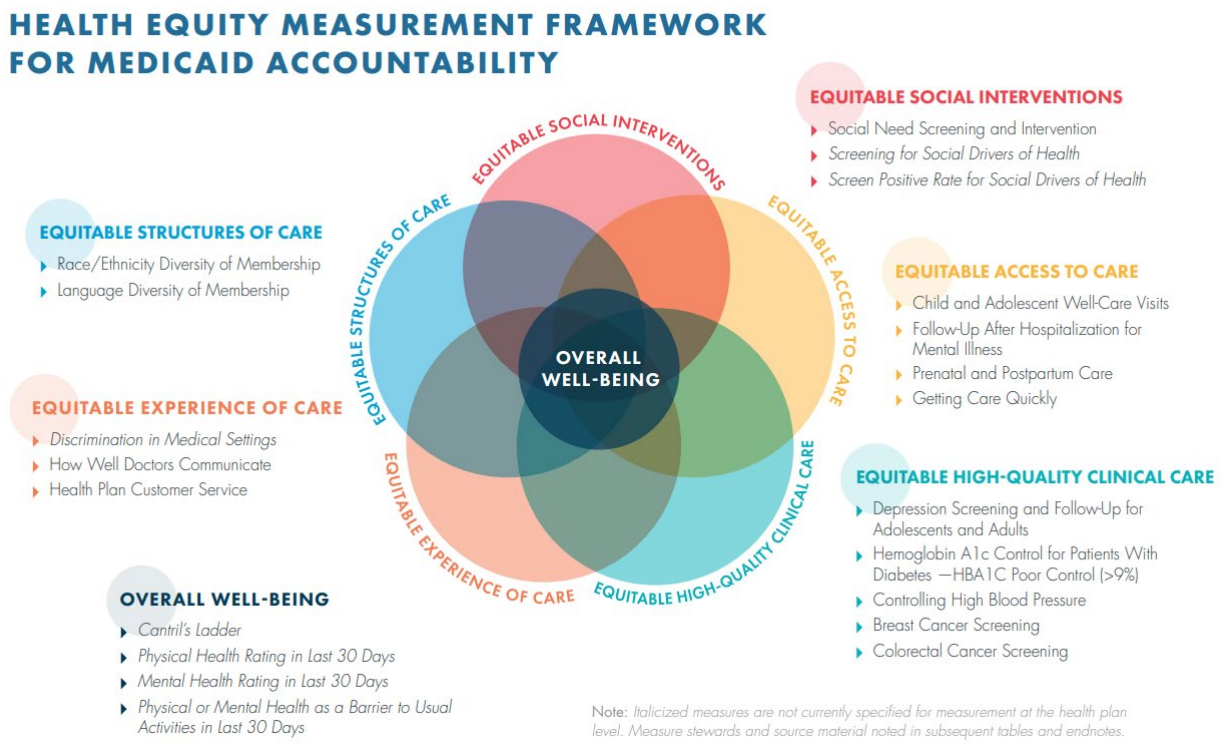


Figure 7. Health Equity Measurement Framework for Medicaid Accountability Summarized

Health Equity is integrated across the organization and disparities transcend departments impacting multiple cross-functional areas. BSCPHP will apply a health equity lens to program oversight across each functional area. As Figure 7 demonstrates, data and analytic sets extend beyond HEDIS® measures. The six domains span across functional departments throughout BSCPHP.

Select measures outlined in the HEART Measure Set are stratified and analyzed for health disparities. When possible, metrics are stratified by race, ethnicity, gender, age, and spoken language (REGAL) to inform health equity initiatives and mitigate health disparities. Key measures or metrics for each data set will need to be selected by the HEO in collaboration with each functional area. Reporting and dashboards have been designed

for each data set and/or use case to monitor metrics and identify disparities and trends in each department. Identifying where the health disparities are will facilitate strategic implementation of targeted initiatives and sharing of results, outcomes, and lessons learned. Health equity efforts will be integrated, targeting a wide range of inequities and will allow a cross sharing of transparent information for collaboration and understanding across departments providing insight into potential underlying reasons for variations. BSCPHP's HEO, in collaboration with the leaders of each functional area, identified priority populations and focus areas to assess and monitor health disparities across the health plan.

These areas of focus include:

- Quality HEDIS® measures
- Managed Care Accountability Set (MCAS) measures
- Grievances and Appeals
- Behavioral Health
- Provider Relations and Contracting
- Health Education
- Cultural and Linguistics
- CalAIM and subsidiary population health management functional area
- Customer Experience
- Clinical Access Programs
- Maternal Health
- Utilization Management

The HEART Measure Set incorporates regulatory reporting requirements and stretches BSCPHP to consider health equity in oversight of metrics and outcomes. BSCPHP understands that health equity integration goes beyond establishing a HEART Measure Set. Integration includes a responsibility to ensure covered services continue to meet the needs of the members served and are suitably integrated within QIHETP. These were considered as the HEART Measure Set was developed. Functional areas will refer to data in the HEART Measure Set to support continuous monitoring and support insights into understanding population needs and addressing disparities and inequities.

Below is a detailed list of the health equity measures set selection by department. Oversight of the HEART Measure Set outcomes and/or performance results will follow the CQI process.

## A. Customer Experience

Member experience is critical to member engagement, satisfaction, and can influence member utilization of services and health outcomes. The HEO and Customer Experience Department selected specific regulatory measures that meet both regulatory and health equity intent and purposes. Customer Experience will focus on:

- Call center metrics include tracking BSCPHP Customer Experience and vendor requested interpreter service calls by the member's preferred language.
- Tracking and trending the total number of multi-cultural/multilingual staff to ensure Customer Experience member-facing staff are representative of entire membership.
- Tracking and trending the total number of translated documents by language or alternative format requested by members.

The Customer Experience team will also note any notable operational challenges that impact on health equitable structures and access to care.

## B. Appeals and Grievances

BSCPHP tracks and reports grievances to ensure that all services are equitable and free of discrimination. BSCPHP's comprehensive Grievance and Appeal system facilitates root cause analysis utilizing data analytics. This creates an effective and efficient process for trend analysis used to improve the quality of clinical care and impacts to internal and external processes and behaviors. In support of BSCPHP's health equity infrastructure, member Grievance and Appeal data is assessed to appropriately identify trends related to evidence of social drivers of bias, health inequities, disparities, and inequality issues. The data gathered is shared with oversight committees and will be shared with BSCPHP's HEO to support a broad approach to addressing these issues and improve members' health outcomes.

The BSCPHP HEO and Appeals and Grievances Department selected specific measures that meet both regulatory and health equity intent and purposes. Measures include:

- Grievance category stratified by race and ethnicity for all grievances received during the measurement period.
- Percentage of Discrimination grievances based on all grievances received during the measurement period.
- Overturned appeals stratified by race and ethnicity for all appeals received during the measurement period.

Over the past several years, the HEO and the Appeals and Grievances Department have partnered closely to review member feedback, analyze grievances with potential equity implications, and identify early signals of inequities in care or member experience. This collaboration enabled cross-departmental learning, improved understanding of systemic drivers of complaints, and informed several health-equity–focused quality initiatives.

Building on this foundation, the BSP HEO and Appeals and Grievance Department formally established the *Health Equity and Grievance Taskforce, or GRT* workgroup in 2026 to strengthen the rigor, consistency, and visibility of this work. The GRT represents the natural evolution of prior informal collaboration into a structured, data-driven taskforce with dedicated governance and cross-functional membership.

Chaired by the Appeals and Grievance Director of Operations and supported by the BSP HEO, the workgroup meets to review select discrimination, cultural, and linguistic grievances, conduct trend analyses across REGAL demographics, and identify indicators of inequity or bias within member interactions.

The GRT serves as a centralized forum to integrate qualitative member experiences with quantitative grievance trends, enabling more precise identification of root causes and opportunities for intervention. Insights generated through this review process now directly inform policies, corrective actions, cultural competency training efforts, and future Integration Plan (IP) initiatives, ensuring that member grievances meaningfully drive health equity improvements across the organization.

By transitioning from partnership to a formal taskforce with chartered responsibilities, escalation pathways, and reporting to the QIHEC, BSCPHP demonstrates its continued commitment to elevating member voice, addressing differential experiences of care, and embedding equity into operational oversight.

## C. CalAIM

California Advancing and Innovating Medi-Cal, or CalAIM is a long-term commitment to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory. Health Equity is naturally integrated and interspersed throughout CalAIM; all HEART Measure Set metrics apply to all Medi-Cal members served.

CalAIM seeks to transform health care for Californians through providing access and transforming health (PATH), population health management, enhanced care

management, community supports (or In Lieu of Services), new dental benefits, behavioral health delivery system transformation, services and supports for justice involved adults and youth, statewide managed long-term care, integrated care for dual eligible beneficiaries, Medi-Cal's strategy to support health and opportunity for children and families, a standard enrollment with consistent managed care benefits, and a delivery system transformation.

The HEO will work collaboratively with CalAIM functional area leaders including the Population Health Management Department, Quality Department, and Behavioral Health, to report and monitor all required metrics. These metrics are a mix of guided CalAIM program measures, population health management program metrics, behavioral health program metrics and select Quality MCAS priority measures that tie back to DHCS' Bold Goals. In collaboration with the HEO, all functional area leaders will stratify the select health equity set by race, ethnicity, gender, age and language (REGAL) to identify any disparate populations within BSCPHP's membership for select measures.

## D. Quality

Quality metrics support measurement of outcomes such as preventive care screenings and chronic disease management. The Quality Department closely monitors the Managed Care Accountability Set (MCAS) comprised of metrics assessing utilization, preventive care screening, and management of chronic health conditions. Quality and health equity intersect when disparities exist between reported MCAS results.

Select MCAS measures and DHCS Bold Goals also intersect with the CalAIM program. These measures will be monitored to assess disparities and differences between populations, especially among populations of focus.

Select MCAS measures include:

- **Perinatal Immunization Status – Influenza:**
  Percentage of deliveries in which members received an adult influenza vaccine on or between July 1 of the year prior to the measurement period and the delivery date or had a documented adverse reaction to the influenza vaccine at any time during or before the measurement period.
- **Perinatal Immunization Status – Tdap:**
  Percentage of deliveries in which members received at least one Tdap vaccine during pregnancy (including the delivery date), or had a documented medical exclusion, including anaphylactic reaction to Tdap or Td vaccine or vaccine

components, or encephalopathy due to Td or Tdap vaccination, at any time during or before the measurement period.

- **Pharmacotherapy for Opioid Use Disorder by REGAL:**
  Percentage of eligible members receiving pharmacotherapy for opioid use disorder during the measurement period, stratified by REGAL.
- **Follow-Up After ED Visits for Substance Use – 30 Days by REGAL:**
  Percentage of emergency department visits for substance use that were followed by a treatment visit within 30 days, stratified by REGAL.
- **Colorectal Cancer Screening by REGAL:**
  Percentage of adults ages 50–75 who received appropriate colorectal cancer screening using any approved test (e.g., annual fecal occult blood test, flexible sigmoidoscopy every five years, colonoscopy every ten years, CT colonography every five years, or stool DNA test every three years), stratified by REGAL.
- **Hemoglobin A1c Control for Patients with Diabetes by REGAL:**
  Percentage of members ages 18–75 with type 1 or type 2 diabetes whose most recent HbA1c value was less than 8.0 percent during the measurement year, stratified by REGAL.
- **Controlling High Blood Pressure by REGAL:**
  Percentage of members ages 18–85 with diagnosed hypertension whose blood pressure was controlled at less than 140/90 mm Hg during the measurement year, stratified by REGAL.
- **Child and Adolescent Well-Care Visits by REGAL:**
  Percentage of members ages 3–21 who received at least one comprehensive well-care visit with a primary care provider or OB/GYN during the measurement period, stratified by REGAL.
- **Childhood Immunization Status by REGAL:**
  Percentage of children who turned two years of age during the measurement period and completed the recommended vaccine series (DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, rotavirus, and influenza) by their second birthday, stratified by REGAL.
- **Immunizations for Adolescents by REGAL:**
  Percentage of adolescents who turned 13 years of age during the measurement period and received a meningococcal vaccine, a Tdap vaccine, and completed the HPV vaccine series by their 13th birthday, with individual and combination rates reported, stratified by REGAL.
- **Prenatal and Postpartum Care – Postpartum Visit by REGAL:**
  Percentage of deliveries with a postpartum visit occurring between 7 and 84 days after delivery during the measurement period, stratified by REGAL.
- **Prenatal and Postpartum Care – Timeliness of Prenatal Care by REGAL:**

Percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment during the measurement period, stratified by REGAL.

- **Well-Child Visits in the First 30 Months of Life by REGAL:**
  Percentage of children who turned 15 months of age during the measurement year and received at least six well-child visits with a primary care provider during their first 15 months of life, stratified by REGAL.
- **Follow-Up After ED Visit for Mental Illness – 30 Days by REGAL:**
  Percentage of emergency department visits for mental illness that were followed by a mental health visit within 30 days, stratified by REGAL.
- **Breast Cancer Screening by REGAL:**
  Percentage of women ages 50–74 who received a mammogram to screen for breast cancer within the past two years, stratified by REGAL.
- **Depression Screening and Follow-Up for Adolescents and Adults by REGAL:**
  Percentage of adolescents and adults who were screened for depression using a standardized tool and, if screening positive, received appropriate follow-up care during the measurement period, stratified by race, ethnicity, gender, age, language, and/or REGAL.

Additionally, the Quality Department will also track the CAHPS® Getting Needed Care and Getting Care Quickly measure by REGAL during the measurement period. The HEO will collaborate with the Quality Department on the DHCS Bold Goals (Reference Appendix 2).

To support compliance with regulatory requirements, the Health Disparities Report will undergo a standardized review and approval process through the QIHEC. Formal approval through QIHEC ensures consistent application of requirements, documented compliance, and ongoing regulatory readiness.

## E. Behavioral Health

The scope of the Quality Improvement and Health Equity Transformation Program extends into the delivery of behavioral health services. The HEO and Behavioral Health Department will monitor the recently released CalAIM metrics related to behavioral health and DHCS Bold Goals required for monitoring. These metrics will be stratified by the REGAL dataset. Additionally, the Behavioral Health Department will track the total number of prenatal and postpartum depression screenings. This will help BSCPHP to identify any disparate populations within the prenatal/postpartum membership and identify any other populations that may be impacted by mental illness specifically

among the most vulnerable populations including adolescents, homeless, and LGBTQ+ members for select measures.

The select metrics include the following:

- Positive maternal mental health screening results by REGAL during the measurement period
- **Perinatal Depression Screening**:
  Percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument during the measurement period
- **Postpartum Depression Screening and follow-up:**
  Percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care during the measurement period.
- **Depression Screening and Follow-Up for Adolescents and Adults by REGAL:**
  Percentage of adolescents and adults who were screened for depression using a standardized tool and, if screening positive, received appropriate follow-up care during the measurement period, stratified by race, ethnicity, gender, age, language, and/or REGAL.

Reference Appendix 2 for the complete HEART Measure Set as it relates to behavioral health.

Beginning in 2026, the scope of integration plan work expanded to include the Behavioral Health (BH) team as a designated functional area within Medical Services. Building on the insights surfaced through cross-functional opportunities, the BH team will now maintain its own Integration Plan focused on health equity initiatives. This expansion reflects the growing recognition that behavioral health outcomes, member experience, and access disparities are closely intertwined with social drivers of health and cultural and linguistic needs.

The inclusion of BH within the Integration Plan structure creates new opportunities for aligned, cross-departmental action—particularly as BH brings forward unique data trends, population-specific needs (e.g., prenatal and postpartum depression screenings, LGBTQ+ member experience, behavioral health complexities related to unhoused populations), and opportunities for targeted interventions. Integrating BH into the health equity Integration Plan process enables BSCPHP to more fully apply an equity lens across the continuum of care and ensure consistent monitoring, targeted improvement activities, and shared accountability across teams.

## F. Provider Contracting and Relations

Provider contracting supports the delivery of health care services via an adequately accessible, culturally competent network. The HEO and Provider Contracting and Relations team have committed to monitoring the percentage of providers that reflect the needs of the Medi-Cal population in the Contractor's Service Area (for example, assessing what percentage of providers speak threshold languages (per geographic area).

Furthermore, BSCPHP will also ensure Network Providers complete cultural competency, sensitivity, health equity, and diversity training and provided for employees and staff at key points of contact with members in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C (Cultural and Linguistic Programs and Committees), and All Plan Letter (APL) 24-016: Diversity, Equity, and Inclusion Training Program Requirements.

The CHEO will collaborate with BSCPHP staff to ensure that the Network Provider bi-annual mandatory training includes information on all member rights specified in Exhibit A, Attachment III, Section 5.1 (Member Services), and diversity, equity, and inclusion training (sensitivity, diversity, communication skills, and cultural competency training) as specified in Exhibit A, Attachment III, Subsection 5.2.11.C (Diversity, Equity, and Inclusion Training).

This process includes an educational program for Network Providers regarding health needs to include but not be limited to, seniors and persons with disabilities (SPD) population, members with chronic conditions, members with Specialty Mental Health Service needs, members with substance use disorder needs, members with intellectual and developmental disabilities, and Children with special health care needs. Training includes Social Drivers of Health and disparity impacts on members' health care. Attendance records will be reviewed and maintained by BSCPHP staff. The Provider Contracting and Relations Department will work closely with the HEO and HE/CL Department to track health equity provider training.

Finally, the Provider Contracting and Relations Department will work closely with the Clinical Access Programs Department to monitor the percentage of Physical Accessibility Review Survey (PARS) requirements met by the facility site review (FSR) audit to assess for accessibility for disabled members. These select outcomes metrics will allow us to identify the need to address health disparate areas across functional areas.

## G. Health Education and Cultural and Linguistics

The Health Education and Cultural and Linguistics (HE/CL) team support member education activities, staff and provider training. They also ensure materials and programs are culturally competent, advising recommendations to support health literacy, alternative formats, and interpreter services. The HE/CL team supports the development and implementation of health equity provider training. The HEO and HE/CL teams selected relevant health equity measures including:

- tracking of cultural competency training is completed by member-facing staff.
- tracking health education materials available in all threshold languages within service areas.
- total number of cultural competency trainings completed
- track the utilization of interpreter services in partnership with Customer Experience.
- tracking the rate of bilingual member-facing health plan staff to ensure enough coverage is representative entire membership.
- tracking cultural and linguistic grievances filed by members.
- stratified Diabetes Prevention Program enrollment outcome metrics by REGAL.

To support compliance with regulatory requirements, CLAS-related documents including but not limited to policies and procedures, CLAS Program Description, CLAS Workplan, CLAS Assessment and Evaluation will undergo a standardized review and approval process through the Quality and Health Equity Committee (QIHEC). Formal approval through QIHEC ensures consistent application of CLAS requirements, documented compliance, and ongoing regulatory readiness.

## H. Maternal Health

The Maternal Health Department housed under the Office of the CMO supports the delivery of perinatal services. The HEO and Maternal Health team will monitor existing metrics to measure health disparate populations including metrics that directly address the DHCS Bold Goals.

The Maternal Health functional area will track the following metric:

- C-section rates stratified by REGAL to identify any disparate trend within the population.

In partnership with the Behavioral Health Department, the Maternal Health functional area will also track maternal mental health screening and positive mental health

screening results by REGAL and the total rate of members with a positive maternal mental health screening referred to behavioral health services. The selection of these metrics is sound and evidence-based to have determined disparate populations most seen among BSCPHP Black, African American, and Hispanic or Latino populations. Given its critical importance, this effort is intentionally aligned with the DHCS CQS and Bold Goals and has been established as a program goal for the year.

### I. Clinical Access Programs

The Clinical Access Programs Department supports the delivery of clinical programs including the FSR program and Initial Health Appointments. The HEO and Clinical Access Programs selected specific metrics across various areas managed by the Department. The HEART measure set for this functional area will support identification of any health disparities among the provider network through the medical record review and facility site review audits.

The Clinical Access Programs functional area will:

- track compliance rate for FSRs and ensuring providers are completing *Site personnel receive training on member rights* to ensure BSCPHP's provider network is meeting minimal language assistance program requirements. track initial health appointment rate completion and stratify by REGAL to determine if there is a specific vulnerable population identified to be disparate and have a need for a targeted intervention.

In previous years, the HEO has worked together to develop the HEART measure set with several cross-functional departments. These individual exercises provided opportunities to leverage existing equity-related work and allowed the HEO to deepen partnership and collaboration efforts for future work. The HEO will continue to meet with functional areas across the health plan to build upon the BSCPHP Integrated Health Equity Measurement Set to ensure the measure set is encompassing and includes all impacted departments. The HEO will optimize the use of the Health Equity Measurement Framework to identify disparities and inequities occurring between populations.

In 2026, BSCPHP initiated work to enhance the health equity analytics dashboard to support deeper insights and expanded use cases. These enhancements are intended to strengthen the identification of emerging trends across member groups and to support future opportunities for additional population-specific analyses as the program matures.

## XIII. HEALTH EQUITY INTEGRATION PLAN

To drive the goal of embedding equity into everything done across the enterprise, BSCPHP's HEO will maintain a Health Equity Integration Plan (HEIP). The HEIP documents

planned activities and outcomes to integrate health equity across the following functional areas listed below:

- Health Education and Cultural and Linguistics
- Marketing and Community Engagement
- Network
- Population Health Management
- Grievances and Appeals
- Utilization Management
- Medical Services: Case management, Maternal Management Office of the Chief Medical Officer
- Quality

Starting in 2026, the Health Equity Office took a significant step toward a more comprehensive integrated approach by expanding the HEIP to include Behavioral Health as a designated functional area under Medical Services. Behavioral Health will maintain its own integration plan with initiatives focusing on addressing behavioral health services, care, and outcomes. This expansion acknowledges the critical role behavioral health plays in overall wellness and creates pathways for more seamless support for patients. By adding Behavioral Health, this aims to improve outcomes, reduce barriers to care, and ensure that health equity principles are applied consistently across the health plan.

The purpose of the HEIP is to ensure that contract requirements to "integrate health equity into functional areas" are met. HEIP activities span across the health plan and align with Health Equity Program Pillars and regulatory trajectory. The process incorporates a model for business-led planning, implementation, and monitoring measurable outcomes using a data driven approach. Each functional area will be able to successfully demonstrate they are integrating and prioritizing health equity into program plans and operations (Reference Figure 8 and Appendix 3).

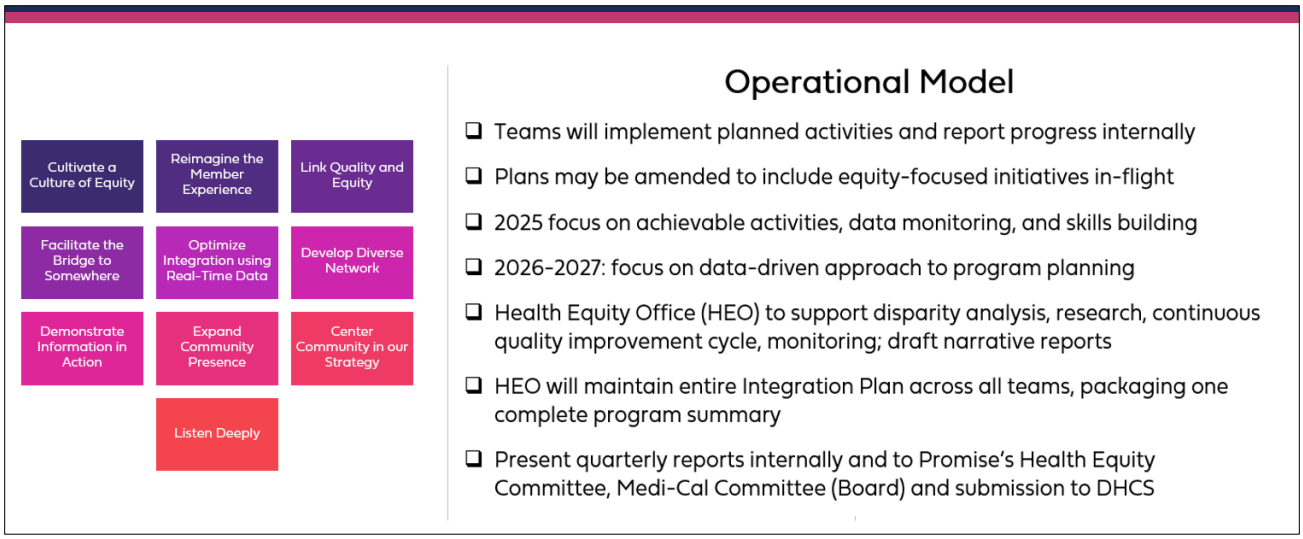


Figure 8. Health Equity Integration Plan Operational Model

Each functional area leader is accountable for monitoring their respective workstreams and is responsible for presenting comprehensive updates, key accomplishments, and outcome metrics during the internal Performance Operations Driver's meeting. These presentations will occur on a quarterly basis and will serve as a forum to evaluate progress, promote cross-departmental collaboration, and ensure that all operational efforts remain on track to meet established goals. Escalation criteria will be included as part of the tracking and monitoring process.

The Blue Shield Promise HEO will prepare and successfully finalize Health Equity Integration Plan activities as determined by the select business units by Quarter 2 of each year. Beginning in 2026, functional area leaders will plan a set of health equity initiatives as documented on the Integration Plan template. Initiatives will continue to focus on data-driven interventions and identifying opportunities to reduce disparities and inequities. Leaders are encouraged to leverage the HEART Dashboard to support insights and planning. Initiatives may include activities to improve access to care, increase preventive care screenings, or enhance systems to reduce barriers. All integration plans will be approved by the CHEO and CMO. Activities will be implemented across the functional areas and progress will be routinely reported. The HEO and designated departments will track current timelines, operationalizing implementing activities and report progress while focusing on interventions.  Activities will be determined by each functional area and will evolve from the initial set of activities established in 2025 (reference Figure 9).

| *Cultivate a culture of equity* | *Reimagine the member experience* | *Link Quality and Equity* | *Facilitate the Bridge to Somewhere* | *Optimize integration using real-time data* | *Develop diverse network* | *Demonstrate information in action* | *Expand community presence* | *Center community in our strategy* | *Listen deeply* |
|---|---|---|---|---|---|---|---|---|---|
| • Staff Training- Advancing Health Equity<br>• Expand provider training to include health equity topics<br>• Health Equity Office to train UM leaders in the Diversified Talent Acquisition Toolkit | • Implementing Lucina and Maternity Care Team operations<br>• Add availability of ASL interpretation to health education materials<br>• Translate updated health education referral letter into all threshold languages<br>• Increase availability of health education materials in threshold languages | • Host well-child visits in Los Angeles and San Diego in areas with highest need<br>• Host mobile mammogram events | • Include SDOH assessments in Quality Health Partners visits<br>• Diabetes Management Health Education classes among members diagnosed with Diabetes | • Offer health education classes in multiple languages leveraging member data<br>• Include C-section disparities between Black and White birthing people in the over/under utilization analysis<br>• Stratify overturned appeals by REGAL during measurement period<br>• Outreach calls for identified care gap measures | • Well Child Visits health disparity Performance Improvement Project<br>• Pilot Skilled Nursing Facility preferred placement arrangement from acute setting due to social and health disparities<br>• Obtain data on member and provider ethnic and racial background to evaluate network needs<br>• LGBTQ+ Network enhancements to expand services | • Partner with LA County Doula Hub and community partners supporting doula Hub implementation<br>• Implement staff training on Writing in Plain Language and Readability Assessment<br>• Health Equity Office to review Grievance and Appeals member letters for equity lens and develop process | • Implement health education classes at Community Based Organizations and faith-based sites in San Diego County<br>• Marketing plan integrates health equity focus to identify events and communities in need | • Community Advisory Committee features health equity approaches to inclusion and program planning | • Host listening sessions to inform member and family engagement strategy |

Figure 9. Health Equity Integration Plan Activities

Integration plan activities will span across the health plan in alignment with the Health Equity program tenets. There will be emphasis on completing regulatory staff training, provider network access, provider engagement, maternal health equity, community engagement, and preventative care. New intersectionality between teams has been identified to partner on initiatives, enabling departments to work together more effectively through aligned goals, shared resources, and collaborative planning.

The HEO will support disparity analysis, research, continuous quality improvement cycle, monitoring, and draft narrative reports to best support each business unit. The HEO will maintain one comprehensive integration plan across all teams, packaging one complete program summary and present quarterly reports internally and to QIHEC, Medi-Cal Committee and submission to DHCS.

## XIV. NATIONAL COMMITTEE FOR QUALITY ASSURANCE

BSCPHP's commitment to quality improvement and health equity is deeply rooted in the organizations' mission and values. Health Equity Accreditation, now known as Health Outcomes Accreditation, is important to BSCPHP because it complements BSCPHP's ongoing commitment to improving health equity. Health Outcomes Accreditation focuses on the foundation of health equity work building an internal culture that supports the organization's external health equity work; collecting data that helps the organization

create and offer language services and provider networks mindful of individuals' cultural and linguistic needs; identifying opportunities to reduce health inequities and improve care.

BSCPHP has adopted an actionable framework for improving health equity and prioritizing health equity for BSCPHP's members and the communities served. BSCPHP will use data to identify and address disparities in care to support better health outcomes, reduce unmet social needs and minimize overall costs of care; align the organization and work culture with inclusive principles; catalyze a culture that prioritizes and incorporates equity into plan operations by creating a consistent infrastructure for improving outcomes and narrowing disparities; while simultaneously meet DHCS contractual requirements.

In 2025, BSCPHP was awarded the NCQA Health Equity Accreditation (HEA) in accordance with DHCS contractual requirements. BSCPHP will ensure reporting of accreditation activities by providing copies of reports from the NCQA to the DHCS. Copies of the reports may include, but are not limited to, accreditation status, survey type, level, results from the accrediting agency, and the applicable accreditation expiration date. BSCPHP will maintain NCQA accreditation and monitor required reports and planned activities. Updates will be reported to the QIHEC and other committees as appropriate.

## XV. MONITORING AND OVERSIGHT

Ongoing monitoring of the QIHETP is a key mechanism to evaluate the progress of quality activities, as outlined in the Work Plan, and are submitted to the Medi-Cal Committee who reports to the Blue Shield of California Board of Directors via consent agenda for review and approval at least quarterly. Quality reports are submitted to DHCS on a quarterly basis.

BSCPHP's Medi-Cal Committee will review and monitor all QIHETP and QIHEC-related policies and procedures. The Medi-Cal Committee directs necessary modifications of QIHETP and QIHEC policies and procedures to ensure compliance with health equity regulatory requirements.

BSCPHP's Medi-Cal Committee coordinates with the QIHEC to approve the overall QIHETP and the annual plan. The Medi-Cal Committee will regularly receive written QIHEC progress reports describing actions taken, progress in meeting QIHETP objectives, and future opportunities for improvement. A comprehensive assessment and list of all QIHETP activities is presented in a fluid QIHETP work plan.

As part of the initial monitoring plan, the QIHETP work plan will integrate required reporting that addresses regulatory requirements and tracks and trends the HEART

Measure Set. The work plan activities will support a data driven strategy to inform resources and initiatives to reduce disparities. BSCPHP's HEO in partnership with cross-functional areas and/or departments will continuously collaborate to build a robust HEART Measure Set, identify priority populations, and focus areas, and prioritize initiatives to address disparities and inequities.

## A. Priority Populations and Focus Areas

The HEO leverages the PNA to identify member demographics, utilization trends, top diagnoses, and quality outcomes. The HEO and impacted cross functional departments have identified the following priority populations and focus areas as opportunities to assess differences between populations, disparities, and inequities:

1. Maternal health
2. Pediatric health
3. Members with open care gaps
4. Over- and under- utilization of services
5. Member experience
6. Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+)
7. Justice-involvement
8. Housing insecurity

These clinical focus areas are designed to complement the significant CalAIM initiatives that are targeted at specific high-risk and align with the vulnerable populations as outlined by the DHCS' Comprehensive Quality Strategy, 2025. Functional area leaders in collaboration with the HEO will conduct comprehensive assessments to assess utilization of services, outcomes, and experiences to identify gaps in service delivery and opportunities to increase utilization, design or improve program activities, increase inclusivity, expand access, establish collaborative partnerships, etc. Addressing the needs for these vulnerable populations will help reduce disparities and inequities that may exist for vulnerable populations.

## B. HEART Measure Set

The HEO and impacted functional area and/or department(s) have met in an introductory roadshow series experience conducted in calendar year 2024 to collaboratively develop the HEART Measure Set. The HEART Measure Set is built on the CHCF and NCQA recommended measurement framework for accountability in Medicaid to advance BSCPHP health equity work. The HEART Measure Set incorporates regulatory reporting requirements and stretches to consider health equity within the oversight of metrics and outcomes across health plan functional areas.

The HEART Measure Set is routinely assessed and may change over time. In 2026, BSCPHP will expand its analytics capabilities to strengthen how health equity performance is monitored and communicated across the organization. All HEART measures continue to be tracked within the health equity dashboard, which now includes enhanced visualization and analytic features to support more nuanced interpretation of trends. Through this work, teams identify opportunities to incorporate additional population perspectives in future dashboard iterations, allowing for deeper equity-focused analyses as data maturity increases. In parallel, new analytic tools such as provider profile reports and top-card insights are being piloted to improve the visibility of provider-level performance and surface emerging disparities more quickly. Together, these enhancements reflect BSCPHP's year-over-year evolution in leveraging data to drive actionable insights, inform integration plan activities, and strengthen health equity oversight across functional areas.

The HEO and designated areas(s) will work together to conduct a comprehensive assessment and analysis of the HEART Measure Set. Each measure will be stratified as applicable, assessing disparities or differences by race, ethnicity, age, gender, and/or language. Oversight of the HEART Measure Set, outcomes and performance results will follow the CQI process. Elements of the HEART Measure Set will be monitored at least quarterly and reported to the QIHEC and other relevant workgroups. Reference Appendix 2 for the complete HEART Measure Set by department.

## XVI. QUALITY IMPROVEMENT PROCESS

BSCPHP's quality improvement and health equity programs are comprehensive and designed to monitor, evaluate, and improve the quality and equity of care and services delivered to members and providers objectively, systematically, and continuously. BSCPHP uses a CQI process to measure performance, conduct quantitative and qualitative analysis, and assess and identify barriers and opportunities for improvement. Interventions are implemented to improve performance and are measured to determine effectiveness of the interventions.

BSCPHP is responsible for all quality improvement and health equity functions applicable to the business and members. Quality improvement and health equity are not delegated.

BSCPHP recognizes that quality and health equity are deeply intertwined, and BSCPHP cannot have a high-quality plan without equity. BSCPHP's HEO and Quality team collaborate to conduct quality improvement and health equity activities in all areas and dimensions of clinical and non-clinical member care and service. BSCPHP annually

develops a QIHETP work plan steeped in health equity that outlines quality improvement activities for the year and focuses on reducing health disparities. The plan is reviewed by the CHEO and CMO and submitted to the QIHEC and the Medi-Cal Committee for review, comment, and approval.

BSCPHP seeks to meet the DHCS-established minimum performance level (MPL) for each required Quality Performance Measure and Health Equity measure selected by DHCS and meet health disparity reduction targets for specific populations and measures as identified by DHCS. BSCPHP applies the principles of CQI to meet benchmarks and all aspects of service delivery. The CQI model applied includes analysis, evaluation, and systematic enhancements related to health equity. Both quantitative and qualitative data collected, and data-driven decision-making are applied. Up-to-date evidence-based practice guidelines are applied where applicable as explicit criteria developed by recognized sources or appropriately certified professionals. Where evidence-based practice guidelines do not exist, consensus of professionals in the field, incorporate feedback provided by members, families, and Network Providers in the design, planning, and implementation of its CQI activities, and incorporate other issues identified by BSCPHP, DHCS, DMHC, and/or NCQA (Reference Figure 10).

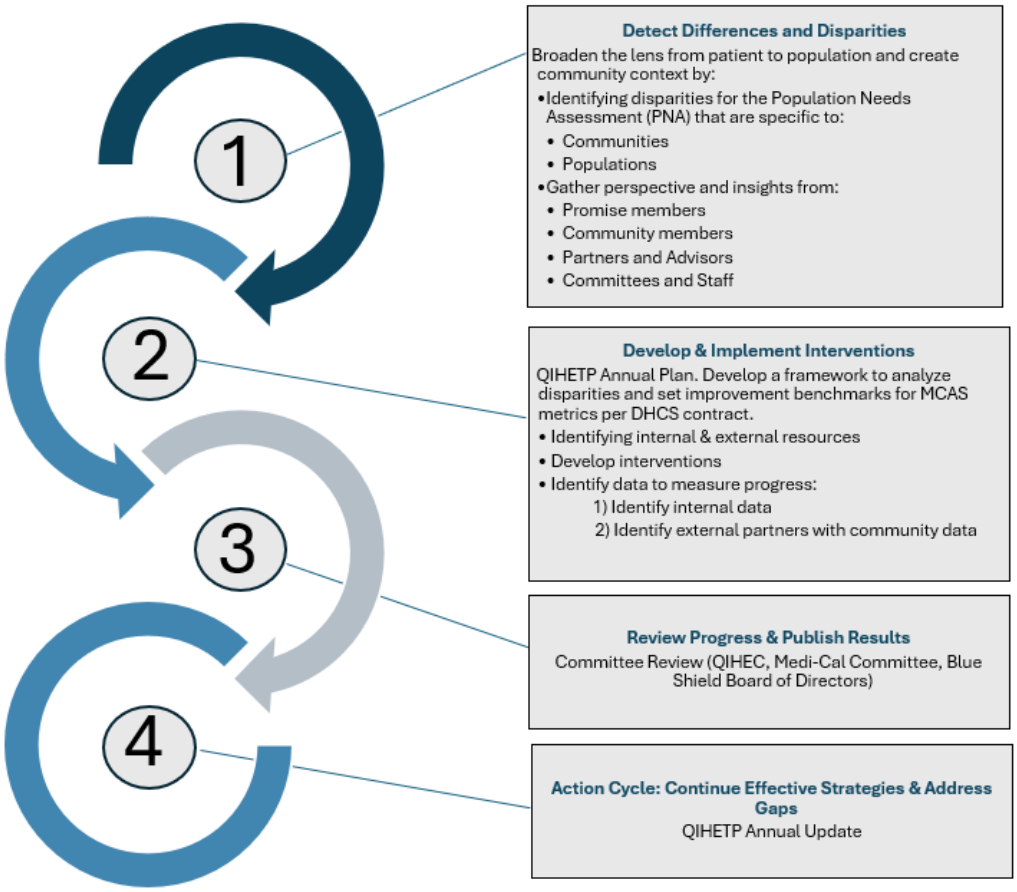


Figure 10. Principles of Continuous Quality Improvement in Action

BSCPHP will apply the CQI model to ensure the identification, evaluation, and reduction of health disparities by:

- Analyzing data to identify differences in quality of care and utilization, as well as, assessing the underlying reasons for variations in the provision of care to its members.
- Developing equity-focused interventions to address the underlying factors of identified health disparities, including SDOH.
- Meeting disparity reduction targets for specific populations and/or measures as identified by DHCS and as directed under Exhibit A, Attachment III, Subsection 2.2.9.A (External Quality Review (EQR) Requirements, Quality Performance Measures).
- Deploying mechanisms to detect both over- and under-utilization of services including, but not limited to, outpatient prescription drugs.
- Analyzing multiple data sources (e.g., encounter data, pharmacy data, utilization data, health outcomes), stratifying by race, ethnicity, age, gender, and language

spoken to inform health equity initiatives and efforts to mitigate health disparities undertaken by the DHCS.

- Deploying mechanisms to continuously monitor, review, evaluate, and improve access to and availability of all Covered Services. The mechanisms must include oversight processes that ensure members are able to obtain Medically Necessary appointments within established standards for time or distance, timely access, and alternative access in accordance with APL 23-001, and W&I Code sections 14197 and 14197.04.
- Deploying mechanisms to continuously monitor, review, evaluate, and improve quality and health equity 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.

As part of the CQI process, the Quality Department disseminates and monitors the use of clinical practice guidelines. The CHEO partners with Quality to assess where health equity elements can be integrated into the QIHETP.

BSCPHP teams will develop interventions designed to address PHM and Social Drivers of Health, reduce disparities in health outcomes experienced by different subpopulations of members, and work towards achieving health equity. BSCPHP teams will develop equity-focused interventions intended to address disparities in the utilization and outcomes of physical and behavioral health care services. BSCPHP leaders will deploy a member and family-centric approach in the development of interventions and strategies, and in the delivery of all health care services. BSCPHP will ensure that the QIHETP requirements are applied to the delivery of both physical and behavioral health services.

Additionally, the CHEO collaborates with Quality department staff as they conduct and participate in Performance Improvement Projects (PIPs), including any PIP required by CMS, in accordance with 42 CFR section 438.330 as directed by DHCS. BSCPHP will participate in statewide collaborative PIP work groups. BSCPHP complies with the PIP requirements outlined in APL 19-017 and must use the PIP reporting format as designated therein to request DHCS' approval of proposed PIPs. PIPs will include measurement of performance using objective quality indicators including: 1) Implementation of equity-focused interventions to achieve improvement in the access to and quality of care, 2) Evaluation of the effectiveness of the interventions based on the performance measures, and 3) Planning and initiation of activities for increasing or sustaining improvement. BSCPHP will report the status of each PIP as requested by DHCS.

## XVII. ANNUAL REVIEW OF THE QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM

The Quality Improvement and Health Equity Transformation Program Description may be amended to reflect changes in scope and identified needs resulting from new or revised regulatory and/or accreditation requirements or significant changes in membership, provider scope, scope of services or operations occurring during the year. The Quality Improvement and Health Equity Transformation Program Description is reviewed at least annually and is approved by the QIHEC and the Medi-Cal Committee.

## XVIII. QUALITY IMPROVEMENT AND HEALTH EQUITY WORK PLAN

The QIHETP Action Plan lists all actions and milestones needed to formally build and implement BSCPHP's QIHETP. The Action Plan will be managed by the HEO (Reference Appendix 4).

The goal for the QIHETP is to at minimum meet all state requirements and maintain compliance. The QIHETP Work Plan outlines key activities for the year, and includes any activities not completed during the previous year, unless identified in the Annual Evaluation as issues that are no longer relevant or feasible to pursue. It is reviewed, approved, and monitored regularly by the QIHEC and the Medi-Cal Committee. The QIHETP Work Plan is a fluid document, updated as needed throughout the program year. BSCPHP prepares a comprehensive assessment of QIHETP activities no less than 12 months apart.
The scope of the annual work plan includes the following:

1. Goals and objective descriptions.
2. Planned equity-focused interventions and activities.
3. Performance target or measurable goals.
4. Time frame for all yearly planned activities including initiation and completion.
5. The person(s) responsible for each activity.
6. Root cause and corrective action if an activity is at risk of not being completed.
7. Examples of monitoring previously identified issues.
8. Reporting requirements and frequency.
9. Status updates.
10. Summary of PHM interventions to address SDOH, reduce disparities in health outcomes experienced by different subpopulations of members, and work towards achieving health equity. BSCPHP will incorporate PHM findings as outlined in Exhibit A, Attachment III, Section 4.3 (PHM and Coordination of Care).

11. Assessment of quality performance measure results with a plan to address deficiencies related to health equity that include BSCPHP Network Providers.
12. Incorporates methods to address EQR technical report and evaluation report recommendations as related to health equity.
13. Utilizes data from various sources to include performance results, encounter data, grievances and appeals, utilization review, and consumer satisfaction surveys to analyze delivery of services and quality of care for Network Providers.
14. Details methods for equity-focused interventions to identify patterns for over- or under-utilization of physical and behavioral health care services.
15. Summarizes community engagement with commitment to members and family focused care, and uses CAC findings, member listening sessions, focus groups/surveys, and uses information to inform policies.
16. Incorporates PHM findings as outlined in Exhibit A, Attachment III, Section 4.3 (PHM and Coordination of Care).
17. Uses PIP findings and outcomes, consumer satisfaction surveys, and collaborative initiatives.
18. Track and trend the HEART Measure Set.
19. Monitor interventions targeting priority populations and focus areas.

The Workplan is revised as needed, to meet changing priorities, regulatory requirements, and identified areas for improvement. The status of QIHETP Work Plan items is reported as appropriate to the QIHEC and the Medi-Cal Committee.

A written summary of the QIHETP and QIHEC activities, findings, recommendations, and actions will be prepared after each QIHEC meeting and submitted to the Medi-Cal Committee, and DHCS upon request. BSCPHP shall make a written summary of the QIHEC and QIHETP activities publicly available on the BSCPHP website at least on a quarterly basis.

BSCPHP's CHEO coordinates the submission of QIHETP and QIHEC documents to DHCS. The CHEO ensures QIHETP reports are publicly available on BSCPHP website and annually.

## XIX. ANNUAL EVALUATION

BSCPHP 's HEO assesses the effectiveness of the QIHETP via a formal evaluation process. The QIHETP Evaluation is prepared at least annually. Findings from the annual QIHETP Evaluation are considered at the time of the QIHETP revision.

The assessment of activities in the QIHETP Work Plan is conducted to evaluate the success of individual activities in meeting the specific goals and objectives of the QIHETP. The annual review of the QIHETP ensures that the overall program is comprehensive, meets current industry standards and is effective in continuously improving the quality of health care and services delivered. Identified opportunities are addressed in the following year's program and work plan.

During the first quarters of each calendar year, a written report based on activities of the previous calendar year is compiled and is then submitted to the QIHEC and the Medi-Cal Committee.

The evaluation includes a detailed description of completed and on-going QIHETP activities that include trending of BSCPHP's HEART Measure Set to assess performance, an analysis of the overall effectiveness of the QIHETP and ability to identify and reduce disparities. The HEO incorporates recommendations for QIHETP revisions as received from functional area leaders, committees, members, and Network Provider.

An executive summary is presented to the QIHEC and the Medi-Cal Committee for review and action which may include acceptance, clarification, modification, and follow-up as appropriate. An informational summary of the annual evaluation is available to members, member representatives, and providers.

## XX. DATA SOURCES

BSCPHP's QIHETP provides a formal structure to monitor the QIHETP and services provided to members and to act on identified opportunities for improvement. BSCPHP ensures through monitoring that the provision and utilization of services meet professionally recognized standards of practice.

Quality Improvement and Health Equity are a data-driven process. BSCPHP uses a variety of data sources to monitor, analyze, and evaluate quality improvement goals and objectives.

Data sources include, but are not limited to:

1. Healthcare Effectiveness Data and Information Set (HEDIS®): HEDIS® report as submitted to NCQA for the reporting year.
2. Consumer Assessment of Healthcare Providers and Systems (CAHPS®): CAHPS® 5.0H survey conducted during the measurement year.

3. Provider Satisfaction Surveys (PSS): A provider satisfaction survey assesses provider satisfaction and access. The PSS is conducted to meet the Department of Managed Health Care (DMHC)'s Timely Access and the California Department of Insurance (CDI's) Network Adequacy requirement.
4. Customer Experience call data: collection, measurement, and reporting of performance metrics within the call center as it relates to DHCS and DMHC language assistance program requirements.
5. Pertinent medical records: medical record review results as minimum necessary.
6. Appointment access surveys: A provider satisfaction survey to assess provider appointment access and satisfaction.
7. Geo-access data: information about geographic locations and geo-access data by member and provider ratio.
8. Encounter and claims data: ICD-10 codes received via member encounter and claims data.
9. Member and provider complaint data: Cultural, linguistics, or discrimination related complaints data suggestive of disparity from the measurement year.
10. Appeals data: Cultural, linguistics, or discrimination related appeals suggestive of disparity from the measurement year.
11. Pharmacy data: data collection and compilation of data for various drug codes received.
12. Case management/care coordination data: data and procedures for resolving cases to identify morbidity and mortality data.
13. Utilization reports: Case review data, including over- and under-utilization.
14. Authorization and denial reporting: prior authorization and claims denials reporting, ICD- 10 claims denied.
15. Statistical, epidemiological, and demographic member information: validated individual member data as of measurement year and/or year end.
16. Enrollment and disenrollment data: enrollment and disenrollment data within the measurement year.
17. Race, Ethnicity, Gender, Age, and Language (REGAL) data: data collection on a member's race, ethnicity age, and language preferences.
18. Sexual Orientation and Gender Identity (SOGI) data: data collection on a member's sexual orientation and gender identity preferences.
19. Vendor performance data: competency assessment results for language assistance, and behavioral health data.

## XXI. CONFIDENTIALITY AND INFORMATION SECURITY

All information related to the QIHETP process is considered confidential. All data and information, inclusive of but not limited to minutes, reports, letters, correspondence, and

reviews are stored in designated, secured locations, and access is granted based on minimum necessary standards. All aspects of quality review are deemed confidential. All individuals involved with review activities will adhere to the confidentiality guidelines applicable to the appropriate committee. All QIHETP program activities including correspondence, documentation and files are protected by State Confidentiality Statutes, the Federal Medical Information Act SB 889, and the Health Insurance Portability and Accountability Act (HIPAA) for patient's confidentiality. Only designated employees by the nature of their position will have access to member health information as outlined in the policies and procedures.

All individuals attending the QIHEC, or its related committee meetings, are informed of the Confidentiality Statement annually. All BSCPHP personnel are required to sign a Confidentiality Agreement upon employment.

No individuals shall be involved in a review process of quality improvement issues in which they were directly involved. If potential for conflict of interest is identified, another qualified reviewer will be designated. There is a separation of medical and/or financial decision making, and all committee members, committee chairs, and the Chief Medical Officer sign a statement of this understanding.

## XXII. RESOURCES


1. Agency for Healthcare Research and Quality (2026). Frequently asked questions about CAHPS®. Retrieved from https://www.ahrq.gov/cahps/faq/index.html .
2. Blue Shield of California Promise Health Plan Quality Improvement and Health Equity Committee Charter.
3. Blue Shield of California Promise Health Plan Quality Improvement and Health Equity Committee Policy.
4. Blue Shield of California Promise Health Plan Quality Improvement and Health Equity Transformation Program Policy.
5. California Department of Health Care Services (DHCS) All Plan Letter (APL) 23-021: Population Needs Assessment and Population Health Management Strategy retrieved from https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
6. California Department of Managed Health Care (DMHC) APL 24-013-Health Equity and Quality Program Policies and Requirements-REVISED (10/1/2025) retrieved from https://www.dmhc.ca.gov/LicensingReporting/HealthPlanLicensing/AllPlanLetters.aspx .
7. California Health Care Foundation (CHCF) and National Committee for Quality Assurance (NCQA) (2022). White Paper. Advancing Health Equity: A Recommended Measurement Framework for Accountability in Medicaid. Retrieved from https://www.ncqa.org/wp-content/uploads/2022/10/NCQA-CHCF-EquityFrmwrkMedicaid-Sep22_FINAL.pdf.
8. California Health and Human Services Agency (CHHS, 2022). Guiding Principles and Strategic Priorities. Retrieved from https://www.chhs.ca.gov/wp-content/uploads/2022/03/CalHHS-Guiding-Principles_condensed_R1.pdf.
9. Centers for Medicare and Medicaid Services (CMS) Framework for Health Equity (2026). Retrieved from https://www.cms.gov/priorities/health-equity/minority-health/equity-programs/framework .
10. Concept Paper: Strengthening Medi-Cal Community Collaboration Through a Reimagined Population Needs Assessment May 2023. Retrieved from https://www.dhcs.ca.gov/CalAIM/Documents/DHCS-PNA-Concept-Paper-May-2023.pdf .
11. DHCS APL 24-016: Diversity, Equity, and Inclusion Training Program Requirements.
12. DHCS APL 23-001: Network Certification Requirements.
13. DHCS APL 21-009: Collecting Social Determinants of Health Data retrieved from https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx .
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15. DHCS Comprehensive Quality Strategy 2022 retrieved from https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf.
16. DHCS 2025 Comprehensive Quality Strategy retrieved from https://www.dhcs.ca.gov/services/Pages/DHCS-Comprehensive-Quality-Strategy.aspx .
17. DHCS Medi-Cal Managed Care Plans Blue Shield of California Promise Health Plan Contract 22-20516.
18. DMHC APL 22-028 – Health Equity and Quality Measure Set and Reporting Process.
19. Kaiser Family Foundation (KFF) (2022). Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them. Retrieved from https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/#:~:text=Maternal%20and%20infant%20health%20disparities,outcomes%20for%20people%20of%20color.
20. KFF (2021). State Policies Connecting Justice-Involved Populations to Medicaid Coverage and Care. Retrieved from https://www.kff.org/medicaid/issue-brief/state-policies-connecting-justice-involved-populations-to-medicaid-coverage-and-care/.
21. Medicaid and CHIP Payment and Access Commission (MACPAC) (2022). Access in Brief: Experiences of Lesbian, Gay, Bisexual, and Transgender Medicaid Beneficiaries with Accessing Medical and Behavioral Health Care. Retrieved from https://www.macpac.gov/wp-content/uploads/2022/06/Access-in-Brief-Experiences-in-Lesbian-Gay-Bisexual-and-Transgender-Medicaid-Beneficiaries-with-Accessing-Medical-and-Behavioral-Health-Care.pdf.
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## XXIII. APPENDICES

Appendix 1.  2026 Advancing Health Equity Training Terms

Appendix 2. HEART Measure Set

Appendix 3. Health Equity Integration Plan

Appendix 4. Quality Improvement and Health Equity Transformation Program Action Plan