2026 Health Equity Accreditation Public Comment Questions

The following template lists all public comment questions from the 2026 NCQA Health Equity Accreditation (HEA) summary. Each question includes space for inputting answers.

Updates Spanning Multiple Elements

1. Do you support changing "individuals served" to "members or patients" throughout the Health Equity and Health Equity Plus standards?

Response: Support with modification. These terms should be defined and used with precision. For health accreditation, Covered California, the California Public Employees' Retirement System (CalPERS), and the California Department of Health Care Services (DHCS) (collectively referred to as "California public purchasers" in all public comment submissions related to the 2026 Health Equity Accreditation updates) interpret patients to be health plan members with evidence of a health care encounter. There are some activities that should occur for all members regardless of their status as a "patient."

2. Do the revisions proposed for the following elements substantially change the value or relevance of the described activity or the Accreditation program: HE 1A, HE 1B, HE 5A, HE Plus 4A, HE Plus 4C?

Response: Do not support. California public purchasers do not support the revisions proposed to these elements. Removing explicit references to diversity, inclusion, equity, cultural and linguistic appropriateness, and the concept of a workforce reflective of the member population significantly weakens standards and expectations. Further, while specific examples are included with the revisions, the revisions provide organizations with too much flexibility to avoid improving health equity. We have all invested heavily in an evidence-based foundation for health equity and these revisions significantly undermine that.

3. Do the revisions proposed for titles, descriptions and intent statements in the following standard categories substantially change the value or relevance of the Accreditation program: HE 1–HE 7, HE Plus 4?

Response: Do not support. Yes, the changes throughout HE 1-HE7 are substantial, without a clear evidence base to support the degree and depth of the revisions. The changes appear to be grounded in neither needed changes unearthed through historic experience with the accreditation program, which would be typical, nor in evidence-based evolution of guidelines or best practice. Therefore, the accreditation program no longer reliably serves as a proxy for ensuring health plans have the necessary infrastructure and processes in place to identify and remedy health disparities.

HE 1: Organizational Readiness

Standard description and intent

4. Do you support the proposed revisions?

Response: Do not support. No. There are now multiple studies which show that racial and ethnic concordance between health workforce and the population served improves patient satisfaction, outcomes, and reduces mortality (Cooper, L.A., Roter, D.L,

Johnson, R.L., Ford, D.E., Steinwachs, D.M., & Powe, N.R. (2006). Patient-centered communication, ratings of care, and concordance of patient and physician race. *Annals of Internal Medicine, 139*(11), 907–915. DOI: 10.7326/0003-4819-139-11-200312020-00009; King, W.D., Wong, M.D., Shapiro, M.F., Landon, B.E., & Cunningham, W.E. (2004). Does racial concordance between HIV-positive patients and their physicians affect the time to receipt of protease inhibitors? *Journal of General Internal Medicine, 19*(11), 1146–1153. DOI: 10.1111/j.1525-1497.2004.30443.x; LaVeist, T.A., & Carroll, T. (2006). Race of physician and satisfaction with care among African-American patients. *Journal of the National Medical Association, 94*(11), 937–943; LaVeist, T.A., & Nuru-Jeter, A. (2002). Is doctor-patient race concordance associated with greater satisfaction with care? *Journal of Health & Social Behavior, 43*(3), 296–306; Snyder, J.E., Upton, R.D., Hassett, T.C., Lee, H., Nouri, Z., & Dill, M. (2023). Black representation in the primary care physician workforce and its association with population life expectancy and mortality rates in the US. *JAMA Network Open, 6*(4), e236687. DOI: 10.1001/jamanetworkopen.2023.6687). There are few interventions in health care which have a mortality impact and supplanting this focus with a less rigorously studied proxy of “direct experience” and “knowledge” undermines NCQA’s elevation of evidence-based practices in its programs. Additionally, our members and patients have affirmed that racial and ethnic concordance is a crucial factor in receiving much needed care.

HE 1A: Developing and Maintaining a Responsive Workforce

5. Do you support this element replacing former element HE 1A: Building a Diverse Staff?

Response: Do not support. No, as a diverse staff is better equipped to understand the needs of a diverse population and design equitable health care delivery systems and interventions to successfully address health disparities. Identity is important in addition to experience; the risk of monoculture is strong when explicit value isn’t placed on staff diversity. Without staff diversity, an organization will not be able to determine what is relevant for the diverse populations it serves.

6. Does the language proposed for the new element make it less feasible for your organization to demonstrate compliance by July 2026? Answer: N/A

7. Do you support the proposed Met scoring threshold of 3–4 factors? Answer: N/A

HE 1B: Trainings to Improve Care or Service Delivery

8. Do you support this element replacing former element HE 1B: Promoting Diversity, Equity, and Inclusion Among Staff?

Response: Do not support. No, removing concepts like reducing bias and promoting inclusion creates concerns that the required trainings will not address foundational inequities in the health care system, perpetuating and exacerbating existing health

disparities. California public purchasers support the addition of trainings related to reducing ableism, trauma-informed care or service delivery, and respectful, non-stigmatizing data collection practices. These trainings are not a replacement for the removed concepts.

9. Do you support the proposed Met scoring threshold of 2–5 factors? Answer: N/A

HE 1C: Incentivizing Medical Education for Practitioners

10. Do you support the inclusion of this new element?

Response: Support with modification. While California public purchasers support the new element in theory, we have concerns with the degree of flexibility with which the organization can select the focus on the education offered to practitioners. We do appreciate the inclusion of specific examples under each factor.

11. Do you support the proposed Met scoring threshold of 1–4 factors?

Response: Do not support. No, Met scoring threshold should be at least 2 factors; otherwise, this element can be satisfied with medical education specific to a single population.

12. Does your organization currently incentivize or sponsor practitioners (employed or contracted) to complete medical education on factors 1–4? Answer: N/A

HE 2: Collection of Member- or Patient-Level Data

Standard title, description and intent

13. Do you support the proposed revisions?

Response: Support with modification. No, California public purchasers do not support the proposed revisions to the standard title and description. It loses its specificity with the generic language of “demographic data.” One option would be to include in parenthesis which demographic data is included in HE 2. Alternatively, the stem could be revised to “The organization gathers member- or patient-level demographic data using standardized methods, including data on Race/Ethnicity, Language, Gender Identity and Sexual Orientation.”

HE 2A–2F: Data Collection on Race, Ethnicity, Language, Sexual Orientation, Disability Status, Disability Accommodations, Geographic Classification

14. Does scoring evidence of data collection under a separate factor in elements HE 2A–2F reduce burden for large or national organizations with multiple Accredited entities? Answer: N/A

HE 2A: Collection of Data on Race and Ethnicity

15. Do you support updating factors 1, 2, and 5 to align with OMB 2024 categories?

Response: Support. Yes, California public purchasers support updating factors 1, 2, and 5 to align with the Office of Management and Budget 2024 categories, as it ensures consistency with emerging best practices and federal guidance.

16. Do you support all proposed revisions in the element stem and factors?

Response: Support. As California public purchasers we support all proposed revisions in the element stem and factors. We applaud the inclusion of direct evidence for direct data collection as a factor.

HE 2B: Collection of Data on Language

17. Do you support all proposed revisions in the element stem and factors?
Answer: N/A

Former element HE 2D: Collection of Data on Gender Identity.

18. Do you support retirement of this element?

Response: Do not support. Emphatically, California public purchasers do not support the retirement of the element related to standardized collection of gender identity, sex assigned at birth, and pronouns. Collecting this data remains critical to understanding and addressing disparities faced by gender-diverse populations. The Trevor Project, Advocates for Trans Equality US Trans Survey (previously National Center for Transgender Equality), American Public Health Association, California Health Care Foundation and others have all conducted, funded, and published evidence of the disparities in physical and mental health, access to care, and costs of care experienced by gender-diverse populations. With this proposed removal, NCQA risks its hard-earned reputation as an organization that enacts standards and takes action based on the evidence available. As California public purchasers, we applauded NCQA's transition from Multicultural Health Care Distinction to the robust, thorough, evidence-based HEA standards and express concern with this proposed direction. Millions of people experience profound disparities regardless of political or policy shifts. In addition, in support of retiring this element, NCQA cites input from a majority of interviewees and survey respondents stating that the collection and use of this data type is infeasible. While we acknowledge and share these challenges, progress will not be made in improving collection and use of this data in the absence of naming it as a priority and maintaining it as a required element for advancing equity for this population.

HE 2D: Collection of Data on Disability Status

19. Do you support the inclusion of this new element?

Response: Support. California public purchasers enthusiastically support the inclusion of this new element that expands data collection to include disability status, which will provide critical insights to address health disparities and support regulatory priorities. While we fully support adding a focus on the disability population, it is worth articulating

that adding this as a new priority for disparities reduction efforts does not obviate the need to maintain a focus on collecting and analyzing racial, ethnic, language, and gender identity data as essential to a HEA program that meaningfully advances equity.

20. Do you support the proposed Met scoring threshold of 4–8 factors?

Response: Support with modification. California public purchasers recommend that factor 3 *evidence of direct collection,* be made a critical factor, or the minimum threshold for Met should be increased to 5 factors. As currently drafted, this factor could be met with documented processes and use of imputation which undermines the importance of direct data collection.

21. Do you agree with the minimum list of response options for factor 4? Answer: N/A

22. Do you agree with the inclusion of factor 6? Answer: N/A

23. Does your organization use any of the estimated methods described in factor 6? Answer: N/A

HE 2E: Collection of Data on Disability-Related Accommodations

24. Do you support the inclusion of this new element?

Response: Support. California public purchasers support the inclusion of this new element, as it facilitates proactive planning for accommodations at the point of care and enhances accessibility for patients.

25. Do you support the proposed Met scoring threshold of 3–5 factors? Answer: N/A

26. What use cases (if any) would make collection of these data meaningful for health plans?

Response: Support. California public purchasers identify several meaningful use cases for collecting disability-related accommodation data, including improving resource allocation, enhancing accessibility at the point of care, tailoring health interventions to meet individual needs, and ensuring compliance with regulatory requirements for equitable care delivery.

27. Are the supports described by the minimum response categories in factors 2 and 4 feasible for your organization to provide at the point of care (if applicable)? Answer: N/A

28. Are there other physical accommodations not listed under factor 2 that your organization currently provides? Answer: N/A

29. Does your organization collect information on sign language interpretation (factor 4) as a subset of language needs in HE 2B: Collection of Data on Language? Answer: N/A

HE 2F: Classification of Geographic Data

30. Do you support the inclusion of this new element?

Response: Support. California public purchasers support the inclusion of this new element while reiterating that the consideration of geography as a factor in health inequity should not displace consideration of long-established contributors to health inequity: race; ethnicity; language; sexual orientation; and gender identity.

31. Do you support the proposed Met scoring threshold of 2-4 factors?

Response: Support with modification. California public purchasers recommend factor 2, *evidence of determining geographic classification,* be made a critical factor, or the minimum scoring threshold for Met should be made 3 factors. As currently drafted, this factor could be met with two processes and without evidence these processes are followed.

32. Does your organization use RUCA codes to assign geographic categories for members/patients? Answer: N/A

HE 2G: Systems for Member- or Patient-Level Data

33. Do you support the retirement of former factor 3 (gender identity)?

Response: Do not support. No, California public purchasers do not support the retirement of factor 3 (gender identity) and reiterate the importance of the evidence of disparities in physical and mental health, access to quality care, and costs of care experienced by gender-diverse populations.

34. Do you support the inclusion of factors 4–8?

Response: Support. Yes, California public purchasers support the inclusion of factors 4-8, though not at the expense of gender identity.

35. Do you support the proposed Met scoring threshold of 4–8 factors? Answer: N/A

36. Does your member- or patient-level system (e.g., EHR) currently allow you to report on factor 3 (sexual orientation) at the population level? Answer: N/A

HE 2H: Privacy Protections for Demographic Data and Notification and HE 2G: Notification of Demographic Data Privacy Protections

37. Do you support the proposed revisions to the stem and factors 1–3?

Response: Do not support. California public purchasers support the proposed revisions to the stem and factors 1–3 with modifications. While we support efforts to enhance flexibility and privacy protections, we do not support the removal of gender identity as a data type, or its exclusions from patient privacy protections. Collecting gender identity data is critical for addressing disparities and ensuring equitable care for gender-diverse populations.

38. Do you support the inclusion of new factors 4–5?

Response: Support. California public purchasers support the inclusion of new factors 4–5, as they expand privacy protections to include additional data types and ensure comprehensive safeguards.

39. Do you support the proposed Met scoring threshold of 4–5 factors?

Response: Support with modification. No, California public purchasers do not support the proposed Met scoring threshold of 4–5 factors and recommend a minimum scoring threshold of 5 factors since this new element is intended to address privacy protections for patient data. All specified patient data (and patient data not specified in the element, like gender identity) should be subject to these protections.

HE 3: Access and Availability of Language Services

HE 3A: Written Documents

40. Do you support the revisions proposed for the element stem and factors 4–6?

Response: Support. California public purchasers support the revisions proposed for the element stem and factors 4–6.

41. Do you support the inclusion of new factors 2, 3 and 5?

Response: Support. Yes, California public purchasers support the inclusion of new factors 2, 3, and 5, as they expand the scope of requirements to address disability-related content and improve clarity by capturing commonly missed existing requirements.

42. Do you support the proposed Met scoring threshold of 3–6 factors? Answer: N/A

43. Is it feasible for care delivery organizations to operationalize the proposed minimum list for vital information (Explanation) for factors 1–6? Answer: N/A

HE 3B: Spoken Language Services

44. Do you support the proposed inclusion of factors 1–2?

Response: Support. California public purchasers support the inclusion of factors 1–2, as they improve clarity by separately scoring existing requirements and adapting them to organizational functions more directly relevant to care delivery operations.

45. Do you support the proposed Met scoring threshold of 3–6 factors? Answer: N/A

46. Is it feasible for care delivery organizations to operationalize the proposed minimum list for organizational functions (Explanation) for factors 1–2? Answer: N/A

HE 3D: Notification of Language Services

47. Do you support the revisions proposed for the element stem?

Response: Support. California public purchasers support the revisions proposed for the element stem, as they improve clarity and align the scope with HE 2, Element B, ensuring consistency in addressing the language needs of members or patients within the specified population thresholds.

HE X: Access and Availability of Disability Accommodations

HE XA: Availability of Disability Accommodations

48. Do you support the inclusion of this new element?

Response: Support. Yes, California public purchasers support the inclusion of this new element, as it aligns with NCQA's milestone standards to improve data collection, training, and processes that identify and address health disparities for persons with disabilities. This addition ensures a more equitable and accessible health care experience across all program segments.

49. Do you support the proposed Met scoring threshold of 1–2 factors?

Response: Support. California public purchasers support the proposed Met scoring threshold of 1–2 factors, as it provides a reasonable starting point to assess organizations' efforts in implementing accessible digital content while considering feasibility across different program segments.

50. Is it feasible for your organization to demonstrate implementation of these activities by July 2026? If not ("do not support"), when is feasible? Answer: N/A

51. Is the minimum list of planned functions (Explanation) meaningful and feasible? Answer: N/A

HE XB: Accessible Digital Content

52. Do you support the inclusion of this new element?

Response: Support. California public purchasers support the inclusion of this new element, as it reinforces the importance of providing accommodations to mitigate barriers and address health disparities for persons with disabilities.

53. Do you support the proposed Met scoring threshold of 3–6 factors?

Response: Support. California public purchasers support the proposed Met scoring threshold of 3–6 factors, as it appropriately reflects the complexity and scope of implementing meaningful disability accommodations.

54. Is the minimum list of digital content feasible and meaningful? Answer: N/A

HE XC: Support for Disability Accommodations

55. Do you support the inclusion of this new element?

Response: Support. Yes, California public purchasers support the inclusion of this new element, as it ensures health care organizations actively address disability-related health disparities through accommodations at the point of care.

56. Do you support the proposed Met scoring threshold of 3–6 factors?

Response: Support. California public purchasers support the proposed Met scoring threshold of 3–6 factors, as it balances rigorous evaluation with the feasibility of implementing accommodations.

57. Is the inclusion of factors 3 and 5 feasible and meaningful? Answer: N/A

HE 4: Practitioner and Care Site Cultural Responsiveness

Standard title, description and intent

58. Do you support the proposed revisions?

Response: Support with modification. California public purchasers support the proposed revisions, as they align practitioner and care site requirements with emerging best practices and emphasize responsiveness to diverse cultural, linguistic, and accessibility needs. We do not support removing language describing patient diversity.

HE 4A: Practitioner and Site-Level Information

59. Do you support moving factors 4–6 to a new element HE 4B: Availability of Information on Practitioners and Care Sites?

Response: Support with modification. California public purchasers support moving factors 4–6 to a new element HE 4B, as it improves clarity, streamlines surveyability, and enhances the focus on practitioner and care site accessibility. We do not support removing language describing patient diversity and specifying the need to meet their unique cultural and linguistic needs.

60. Do you support the proposed Met scoring threshold of 3–5 factors?

Response: Support. California public purchasers support the proposed Met scoring threshold of 3–5 factors, as it provides a balanced framework for evaluating organizations' efforts to meet patient choice and accessibility needs.

61. Do you support revisions proposed for the element stem and factor 4?

Response: Support. California public purchasers support the revisions proposed for the element stem and factor 4, as they enhance clarity and align with NCQA's emphasis on responsiveness to cultural, linguistic, and accessibility needs.

62. Do you support the inclusion of new factors 3 and 5?

Response: Support. California public purchasers support the inclusion of new factors 3 and 5, as they address population-specific focus areas and auxiliary aids, ensuring care sites are equipped to meet diverse member and patient needs effectively.

HE 4B: Availability of Information on Practitioners and Care Sites

63. Do you support the inclusion of this new element?

Response: Support. California public purchasers support the inclusion of this new element, as it provides organizations with a structured approach to collecting and publishing essential information about practitioners and care sites, promoting transparency and informed patient choice. We also strongly support the focus on collecting and sharing provider demographics, as this has been studied and published and is considered best practice based on patient and member demand and desire.

64. Do you support the proposed Met scoring threshold of 3–6 factors?

Response: Support. California public purchasers support the proposed Met scoring threshold of 3–6 factors, as it ensures a comprehensive evaluation of organizations' efforts to provide accessible and meaningful information while maintaining flexibility.

65. Do you support the inclusion of factors 4, 5 and 6?

Response: Support. California public purchasers support the inclusion of factors 4, 5, and 6, as they emphasize language access, auxiliary aids, and member or patient access to practitioner and care site features, which are critical for universal care delivery.

66. Does your organization currently collect and publish directory data on physical accommodations or accessible site features (e.g., wheelchair accessible parking or ramps)?

Response: Support. Covered California does not currently collect and publish directory data on physical accommodations or accessible site features but supports initiatives to implement such practices to improve accessibility and transparency for members or patients.

HE 4C: Enhancing Network Responsiveness

67. Do you support proposed updates to the language and scope of factors 1–2?

Response: Do not support. California public purchasers do not support the proposed updates to the language and scope of factors 1–2 of section HE 4C. We do not support removal of factor 2 language referring to assessment of the demographic profile of individuals served, assessment of practitioners' attitude about working with people of other cultures, or assessment of participation in cultural humility CME as the evidence demonstrates both the importance of provider-patient concordance for healthcare quality and mortality as well as the role of implicit bias and discrimination in health inequity. While strongly opposing the proposed changes, if they are finalized as written, we recommend that NCQA embed a requirement for community representative review and feedback on network analysis findings and proposed gap closures (informed by HE 5 standards).

HE 4D: Information on Accessible Equipment

68. Do you support the inclusion of this new element?

Response: Support. California public purchasers support the inclusion of the new element HE 4D on Accessible Equipment. Accessible medical diagnostic equipment, such as exam tables and scales, is essential for improving accessibility, health care experiences and outcomes for people with disabilities and patients in bodies of all sizes.

69. Do you support the proposed Met scoring threshold of 2–3 factors?

Response: Support. California public purchasers support the MET scoring threshold of 2–3 factors for this new element. It reflects both operational feasibility and meaningful representation of accessible features in provider directories and reporting systems.

70. Is it feasible for your organization to demonstrate this activity by July 2026?
Answer: N/A

HE 4E: Enhancing Care Site Accessibility

71. Do you support the inclusion of this new element?

Response: Support. California public purchasers support the inclusion of the new element HE 4E. It aligns with our mission to increase health equity and reduce disparities, including for Californians with disabilities and in bodies of all sizes.

72. Do you support the proposed Met scoring threshold of 3–5 factors?

Response: Support. California public purchasers support the proposed Met scoring threshold of 3–5 factors, emphasizing meaningful representation and practical adoption of equity standards over symbolic compliance or excessive administrative burden.

73. Is it feasible for your organization to demonstrate this activity by July 2026?
Answer: N/A

HE 5: Program to Improve Service Appropriateness and Accessibility

Standard title, description and intent

74. Do you support the proposed revisions?

Response: Support with modification. California public purchasers support with modifications the proposed revisions that expand prior focus on “Culturally and Linguistically Appropriate Services Programs” to a broader framework. Proposed changes emphasize accessibility, meaningful community involvement, and continuous quality improvement, though we do not support removal of explicit references to culturally and linguistically appropriate care. Use of the more generic “appropriateness and accessibility of its services” creates a permission structure for accredited entities to ignore the cultural and linguistic needs of its member or patients, which evidence demonstrates increases health care disparities.

HE 5A: Program Description

75. Do you support the proposed revisions for the element stem?

Response: Do not support. California public purchasers do not support the proposed revisions to the element stem. Removal of language explicitly naming culturally and linguistically appropriate services and multicultural populations removes the most meaningful *protections from the element.*

76. Do you support the proposed revisions for factors 1 and 3?

Response: Do not support. California public purchasers do not support the proposed revisions for factors 1 and 3. Changes in factor 3 definitions like replacing requirements that accredited entities seek advice from community representatives who “reflect the diversity of the community” with “people who have direct experience, knowledge, or expertise relevant to …needs of the member or patient population it serves” removes the core of meaningful community engagement effort and opens the door to hollow and

ineffective programs that fail to meet diverse patient needs and further exclude certain patient populations from assessing and informing the provision of culturally and linguistically appropriate services.

77. Do you support the inclusion of factor 2?

Response: Support. California public purchasers support the inclusion of factor 2 for its ability to support advancing health equity through actionable steps, stakeholder input, and continuous improvement, while avoiding undue administrative burden or diluting accreditation goals.

78. Do you support the proposed revisions for factor 4?

Response: Do not support. California public purchasers do not support the proposed revisions for factor 4, given the removal of language naming and defining health inequities as well as the removal of language naming the demographic factors demonstrated through extensive evidence to be associated with health inequities, and the systemic causes of inequities.

HE 5B: Annual Evaluation

79. Do you support the proposed revisions for the element stem and factors 1 and 4?

Response: Do not support. California public purchasers do not support the proposed revisions to the element stem and factor 1, as we do not support the removal of language explicitly naming culturally and linguistically appropriate services. We have no objection to the revisions of factor 4. Following our comments in response to question #76, we continue to emphasize the importance of meaningful diverse stakeholder engagement to advance health equity. We recommend clearer guidance on documenting the depth, frequency, and impact of diverse community review to ensure engagement goes beyond symbolic compliance and includes diverse stakeholders that are representative of the community.

HE 6: Reducing Health Disparities

Standard description and intent

80. Standard description and intent. Do you support the proposed revisions?

Response: Do not support. No, California public purchasers do not support most of the proposed revisions to description and intent: removing language related to cultural and linguistic appropriate services, naming specific demographic factors long demonstrated to be associated with health disparities, and the removal of gender identity from the element. We also express significant concern at the introduction of such broad flexibility for organizations to select subpopulations and measures of care for focus. This permissive structure could lead to organizations ignoring the impacts of race, ethnicity, sexual orientation and gender identity on member health outcomes and experiences of care.

HE 6A: Reporting Stratified Measures

81. Do you support the inclusion of 8 new measures as factors for this element?

Response: Support with modification. California public purchasers support the proposed expansion of Healthcare Effectiveness Data and Information Set (HEDIS) measures to be stratified by race and ethnicity. We recommend adding Childhood Immunization Status (CIS) and Depression Screening and Follow-Up for Adolescents and Adults to identify and address possible disparities in childhood immunizations and a common behavioral health condition.

82. Is the new Met threshold of 4 or more measures feasible for your organizations? Answer: N/A

HE 6B: Stratifying Measures to Assess Disparities

83. Do you support the proposed Met scoring threshold of 4–7 factors?

Response: Do not support. No, California public purchasers do not support the proposed Met scoring minimum threshold of 4 factors. As alternatives, we suggest either requiring a minimum of 5 factors (as currently drafted, the factor could be met without including any stratification of race and ethnicity, language, gender identity, or sexual orientation – all demographic factors with extensive evidence of health disparities) or, if a minimum threshold of 4 factors is maintained, then requiring that at least one of the four factors must be race and ethnicity, language, gender identity, or sexual orientation.

84. For factor 1, is it feasible for non-HEDIS-reporting entities (e.g., care delivery organizations) to demonstrate analysis of four or more measures, stratified by race and ethnicity? Answer: N/A

85. Do you support the proposed revisions to the element stem and factors 1–2?

Response: Do not support. No, California public purchasers do not support the revisions to the element stem. We are not opposed to the revisions of factors 1–2.

86. Do you support the proposed revisions to factor 3?

Response: Do not support. No, California public purchasers do not support the removal of gender identity stratification as a factor. The ability to identify and address disparities in care for gender-diverse and LGBTQ+ populations is foundational for health equity, and removal from this element undermines that foundation and the credibility of the element given the extensive evidence of health and health care discrimination and disparities experienced by members of the gender-diverse community.

87. Do you support the inclusion of factors 4 and 5?

Response: Support. California public purchasers support the inclusion of factors 4 and 5. These changes enable targeted, data-driven interventions that are fundamental to reducing disparities and achieving equitable health outcomes for all Californians. Again, the addition of these important demographic factors should not displace the role of race, ethnicity, language, sexual orientation and gender identity in a disparities identification program.

88. Is it meaningful to include stratification by an additional characteristic of the organization's choice (factor 6)?

Response: Support with modification. Support with modification to scoring threshold; while California public purchasers support the inclusion of stratification of an additional characteristic, we reiterate our concerns that an overly permissive structure that enables avoidance of analysis by race, ethnicity, and language, in particular, is not a reliable disparities identification program.

89. Do you support the proposed revisions to the scope and number of measures for factor 7?

Response: Support with modification. California public purchasers support the proposed revisions to the scope and number of measures for factor 7 with modifications. We strongly recommend that gender identity data collection and stratification be maintained as a core requirement alongside race, ethnicity, disability status, sexual orientation, and geography throughout the HEA framework.

HE 6C: Using Multi-Factor Analysis to Assess Disparities

90. Do you support the inclusion of this new element for Renewal surveys, only?

Response: Support. California public purchasers support the inclusion of the new element for renewal surveys only. The proposed element reflects our strong commitment to raising the bar on health equity analytics and leverages lessons learned about the operational feasibility of advanced data used in organizations with at least one accreditation cycle completed. The proposed element could also be added to initial surveys for HEA Plus, to allow organizations to demonstrate their advanced data capabilities.

91. Do you support the proposed Met scoring threshold of 3–5 factors?

Response: Support. California public purchasers support the proposed Met scoring threshold of 3–5 factors, reflecting meaningful effort to identify health inequities and produce actionable analytics.

HE 6D: Assessing Language Services, Auxiliary Aids/Services and Accommodations

92. Do you support the inclusion of new factors 4, 5, and 7?

Response: Support with modification. California public purchasers support the inclusion of factors 4, 5, and 7 with modifications. The inclusion of these new factors ensures organizations are more inclusive of their patients and members with disabilities. However, we do not support the proposed Met scoring threshold of 3–7 factors. We recommend revising this to 4–7 factors to ensure that organizations assess at least one factor relating to language services.

93. Is it feasible for care delivery organizations to operationalize the proposed minimum list for organizational functions (Explanation) for factors 1–3? Answer: N/A

HE 6E: Evaluating Effectiveness of Interventions

94. Do you support the proposed revisions to the element stem?

Response: Support with modification. California public purchasers support the proposed revisions due to the increased specificity of the element stem. While we appreciate the inclusion of “health care disparities” and retention of “language services” in the element stem, we emphasize we do not support removing the term “inequities” from the stem or subsequent factors.

95. Do you support the proposed revisions to factors 1–6?

Response: Support with modification. While California public purchasers support the concept and the specific factors that hold organizations accountable for addressing identified disparities, we do not support the language revisions removing explicit references to health inequities and CLAS.

96. Do the revisions proposed for factors 1, 3, and 5 substantially change the value, effectiveness or relevance of this element or the Accreditation program?

Response: Support with modification. California public purchasers support with modifications the proposed revisions, particularly elements 3 and 5, which require organizations to address the root cause of a disparity. We do not support the removal of the term (and later definition, along with the definition of “disparities”) “inequities” as this weakens the element.

HE 7: Delegation of Program Activities

Standard title, description and intent

97. Do you support the proposed revisions?

Response: Do not support. No, California public purchasers do not support the proposed revisions to the element stem and intent which include the replacement of the term “health equity” activities with the generic “program to improve service appropriateness and accessibility.” We reiterate and emphasize the importance of naming culturally and linguistically appropriate services, and if the term “inequity” must be removed, at minimum it should be replaced with explicit references to disparities.

HE 7A: Delegation Agreement and HE 7D: Opportunities for Improvement

98. Do you support the proposed revisions to scoring?

Response: Support. Yes, California public purchasers support the proposed revisions to scoring, which clarify and meaningfully increase the requirements for this element.

Global Questions

148. Will the proposed updates help your organization meet its objectives or sustain its investments? If so (“support”), how? If not (“do not support”), why not?

Response: Do not support. Proposed updates move HEA away from the health equity priorities of California’s public purchasers and our reliance on evidence and use of data to identify, address, and prevent health disparities. They fundamentally undermine the evidence-based foundation of health equity to which we have all been dedicated.

149. Are the expectations and scope of requirements feasible? Answer: N/A

150. Are the specified frequencies (e.g., annual) of requirements feasible? Answer: N/A

151. Are the requirements clearly written and framed in a manner representative of the organizations that perform the activities? Answer: N/A

152. Do proposed new elements or factors improve the value or relevance of the program for your organization?

Response: Do not support. No. As drafted, the proposed modifications to the HEA standards do not meet our purpose for which California public purchasers originally adopted HEA as a contractual requirement for our plans: to ensure that contracted plans were investing in and implementing rigorous, evidence-based practices to identify, address, and prevent health disparities among our members. Adoption of the HEA requirement by contract enabled the public purchasers to advance expectations for health equity accountability as the foundational components of a health equity program consistent with our values, and the evidence could be assumed to be in place.

153. Do proposed updates to existing requirements make the program less valuable or relevant to your organization?

Response: Do not support. Yes. As drafted, the proposed modifications to the HEA standards are weakened, significantly less relevant to our needs as public purchasers, and considerably less effective in identifying and addressing health disparities in our member populations. Decades of research points to the role of race, ethnicity, language, sexual orientation, and gender identity in health disparities. Permitting entities to selectively avoid analysis and intervention to address these disparities is disheartening and not true to the evidence. The proposed modifications are not equitable.

154. Do proposed updates to existing requirements substantially change the value, effectiveness, relevance of the required activity?

Response: Do not support. Diluting the HEA standards means they can no longer be trusted and relied upon to represent the evidence or best practice across the industry, therefore presenting us with the question of the value in continuing to require HEA. All available evidence does not support these sweeping modifications.

155. Do proposed updates to existing requirements reflect the way your organization operationalizes the requirement and/or submits survey evidence? Answer: N/A

156. Do proposed updates to existing requirements make it less feasible for your organization to earn Accredited status? Answer: N/A

157. What else should NCQA know or consider as it makes decisions about the final standards?

Response: Do not support. NCQA's stated purpose for this significant modification of HEA standards is to provide flexibility in response to federal policy changes (which are not evidence based), "…which some organizations might not be able to meet, regarding diversity, equity, inclusion programs and gender identity." The impact and practical

result of these sweeping modifications, however, will be an anemic and disjointed response to identifying, addressing, and preventing health disparities nationwide.

California public purchasers acknowledge the challenging position NCQA faces in its role as a federal contractor and navigating pressure to demonstrate responsiveness to the current Administration's policy priorities while continuing to set the standard for health care organizations in advancing health equity. However, attempting to navigate this challenge by diminishing or eliminating elements addressing fundamental drivers of health inequity effectively renders moot the role of HEA as a standard and core tool for advancing equity. Potential alternative approaches for navigating the current policy environment while maintaining integrity of the Accreditation could include:

- Maintaining the accreditation standards originally developed through NCQA's rigorous application of the evidence, robust stakeholder engagement, and continuous improvement, and institute factor- or element-level exemptions or alternate requirements for organizations that demonstrate they cannot comply due to the federal policy environment.
- Making any proposed changes that diminish focus on race, ethnicity, language, or sexual orientation/gender identity time-limited to allow temporary flexibilities for health care organizations facing challenges meeting these requirements in the current environment.
- Pausing or sunsetting the HEA as a standalone program, and gain efficiencies by incorporating specific elements into the Health Plan Accreditation requirements in alignment with overall quality and population health improvement activities.