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PRINCETON UNIVERSITY

Medicaid Managed Care Contract Language: Health Disparities and Health Equity

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Contents

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Introduction

In June 2020, State Health and Value Strategies (SHVS) published a compendium of Medicaid managed care (MMC) contract language pertaining to health equity and health disparities. This updated version as of October 2020 incorporates revised contract language from Ohio as well as a summary of Medicaid managed care requirements in Kentucky, Virginia, and Washington State, bringing the total number of managed care contracts included in the review to 10. *(See Table 1.)*

Table 1: Managed care contracts included

State / Entity Contracts Included
1. District of Columbia
2. Kentucky
3. Michigan
4. Minnesota
5. North Carolina
6. Ohio
7. Oregon
8. Virginia
9. Washington
10. Covered California, California's Health Exchange

Health equity means that everyone has a fair and just opportunity to be as healthy as possible, which requires removing obstacles to health, such as poverty, discrimination, and their consequences, including powerlessness and lack of access to housing, safe environments, and health care. In contrast, health disparities are defined more narrowly, such as differences in prevalence, incidence, or severity of diseases among different populations. Federal Medicaid rules [see 42 CFR 438.340 (b)(6)] require a state's managed care quality strategy to include: "The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status."

Initial Findings in Review of MMC Contract Provisions

Several themes emerged across the managed care contracts that contained health equity and/or health disparity provisions.

1. MMC contracts vary significantly from state to state both in terms of the approaches taken and the extent of direction given to managed care organizations (MCOs). MMC contractual language related to health equity and health disparities reflects this overall difference in state managed care approaches.
2. Health equity-related language in the MMC contracts reviewed ranges from directing contractors to implement quality improvement projects to stratifying HEDIS measures by subpopulation to identify health disparities to describing in specific detail the contractors' duties to address health disparities.

3. State MMC contracts reviewed more often focused on identifying, measuring and reducing disparities in health that adversely affect marginalized groups within Medicaid managed care populations.
4. A few states, like Oregon and Virginia, and the District of Columbia (D.C.) have taken a broader view, for example by including state agency and MMC requirements to address social determinants of health and / or underlying power structures in the pursuit of health equity at a broader, community level.

Organization of Medicaid Managed Care Contract Summaries

In this document, Medicaid managed care contract summaries are listed in alphabetical order for D.C. and the eight identified state contracts. The contract summary for the California Health Insurance Exchange is listed at the end. Health equity/health disparity excerpts from the managed care contracts reviewed are organized into the following eight categories. Not all categories may apply to a state's contract. While the language may appear in a different order in the underlying contract, health equity-related excerpts are presented in each state summary table in the following order for ease of reference across profiled contracts. Website links to the full contracts are included where available.

1. General Language (related to health equity/health disparities)
2. Population/Community Health Management
3. Measurement and Data Analytics
4. Interventions
5. Performance Monitoring and Incentives
6. Quality Improvement
7. Specialized Initiatives
8. Other

Methodology

To identify state contracts to include, a select number of managed care contracts were reviewed and a Google search was performed. The criteria for inclusion in this compendium were managed care contracts that explicitly addressed health disparities and/or health equity.

The review was not comprehensive as it did not include every state's MMC contract. SHVS will be expanding and updating this compendium to include additional MMC contract excerpts as identified as well as examples of Medicaid initiatives to advance health equity and reduce health disparities even if such initiatives are not explicitly referenced in MCO contracts.

Managed Care Contracts

District of Columbia (D.C.)

D.C.'s current Medicaid Managed Care Organization (MCO) Contract is not posted publicly.

Overview
The District's new MCO contracts went into effect October 1, 2020. This summary is based on the District's MCO model contract with insurers to provide healthcare and pharmacy services to: 1) the Medicaid managed care eligible population including Adults with Special Health Care Needs, 2) to District residents who are not eligible for Medicaid and receive healthcare services through either the DC Healthcare Alliance Program (Alliance) or the Immigrant Children's Program (ICP). *D.C.'s MCOs are required to identify health disparities in health care utilization and in health outcomes based on member demographic data including race/ethnicity, language, by D.C. ward and social determinants of health. MCOs are required to address health disparities through their quality improvement requirements, which include implementing interventions and evaluating their success.*
General Language
SECTION C: Specifications/Work Statement C.1.3 The goal of the Medicaid Managed Care Program (MMCP) is to promote healthy outcomes of the enrolled populations in the most cost-effective manner possible. The District's Medicaid population is diverse, including individuals with existing complex medical and social needs and those at high-risk or increasing risk for health care disparities. The low-income population may be impacted by a range of social factors, including homelessness that must be recognized within effective plans of care. The MMCP shall have a clear focus on achieving better health outcomes, health care innovation and cost-effective quality healthcare. It is the intent of this contract to significantly strengthen the managed care delivery system for eligible DC residents who receive services through the DCHFP, Alliance and ICP. Specifically, this contract has the following purposes: … C.1.3.6 To encourage the establishment of culturally competent and linguistically appropriate information and support activities for Enrollees representative of their native language to promote Enrollee-involvement in their health care;
Measurement and Data Analytics
C.5.32 Quality Assessment and Performance Improvement (QAPI) Analyzes data, including social determinants of health, to determine differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to enrollees; **C.5.32.3 CQI Plan** The Contractor's CQI Plan shall include the use of health information exchange and other tools to access clinical and Enrollee Encounter Data. These tools should include the capacity for, but not limited to the following:…. • Reducing racial, socioeconomic and ethnic disparities in health care utilization and in health outcomes. Comparing health care utilization data for Enrollees by Enrollee subgroups, such as, race/ethnicity, language, and by DC ward against prior year performance, and, where possible, against regional and national benchmarks

District of Columbia *(Continued)*
Quality Improvement
C.5.32 Quality Assessment and Performance Improvement (QAPI) The Contractor shall submit a QAPI Program Annual Summary in a format and timeframe specified by DHCF or its designee. The written summary must describe how the Contractor:… • Develops system interventions to address the underlying factors of disparate utilization, health-related behaviors, and health outcomes, including but not limited to how they relate to high utilization of Emergency Services; **C.5.32.5.7 Performance Measures** Contractor shall identify disparities in health services and health outcomes between subpopulations/groups (race/ethnicity and language); identify social determinants of health; and identify the causes for health disparities. The Contractor shall develop a plan of action and a timeline to remediate the social determinants of health and health disparities identified through targeted interventions and include this plan and timeline in the Contractor's QAPI program and CQI plan submissions to DHCF. This plan of action shall include a performance measurement and evaluation component, in coordination with section C.5.32.5.

Kentucky

Link to Medicaid MCO contract

Overview
Kentucky's MCO contract language pertains to the collection and reporting of stratified HEDIS and other measures. The State requires the Contractor to stratify measures and perform comparative analyses to identify health disparities. The State indicates that MCO Performance Improvement Projects (PIP) should address the specific clinical needs of enrollees where a disparity exists. *Medicaid recipients eligible to be enrolled into MCOs in Kentucky include Families and Children, persons receiving SSI, Foster Care Children, Dual Eligibles, Affordable Care Act (ACA) MAGI Adults, and ACA Former Foster Care Children.*
Measurement and Data Analytics
20.1 Kentucky Outcomes Measures and Health Care Effectiveness Data and Information Set (HEDIS) Measures All health goals, outcomes, and indicators shall comply with Federal requirements established under 42 C.F.R. 438.240 (C)(1) and (C)(2) relating to Contractor performance and reporting. The Department shall assess the Contractor's achievement of performance improvement related to the health outcome measures. The Contractor shall be expected to achieve demonstrable and sustained improvement for each measure. The Department will set specific quantitative performance targets and goals. The Contractor shall report activities on the performance measures in the QAPI work plan quarterly and shall submit an annual report after collection of performance data. The Contractor shall make comparisons across data for each measure by the Medicaid geographic regions, eligibility category, race ethnicity, gender and age to the extent such information has been provide by the Department to Contractor. This information may be used to determine disparities in health care.

Kentucky *(Continued)*

Measurement and Data Analytics

20.2 Reporting HEDIS Performance Measures:
The Contractor shall be required to collect and report HEDIS data annually. This data shall include separate data for the KCHIP population. After completion of the Contractor's annual HEDIS data collection, reporting and performance measure audit, the Contractor shall submit to the Department the Final Auditor's Report issued by the NCQA certified audit organization and an electronic (preferred) or printed copy of the interactive data submission system tool (formerly the Data Submission tool) by no later than each August 31….In addition, for each measure being reported, the Contractor shall provide trending of the results from all previous years in chart and table format. Where applicable, benchmark data and performance goals established for the reporting year shall be indicated. The Contractor shall include the values for the denominator and numerator used to calculate the measures…. For all reportable Effectiveness of Care and Access/Availability of Care measures, the Contractor shall make comparisons across each measure by Medicaid Region, Medicaid eligibility category, race, ethnicity, gender and age.

Annually, the Contractor and the Department will select a subset of targeted performance from the HEDIS reported measures on which the Department will evaluate the Contractor's performance….

Performance Monitoring and Incentives

20.4 Performance Improvement Projects (PIPs):
PIPs are intended to address and achieve significant (demonstrable) and sustained improvement in focus areas over time. The projects are designed to measure diverse aspects of care, and care provided to diverse populations of Enrollees. The Contractor must ensure that the chosen topic areas for PIP's are not limited to only recurring, easily measured subsets of the health care needs of its Enrollees. The selected PIPs topics must consider: the prevalence of a condition in the enrolled population; the need(s) for a specific service(s); Enrollee demographic characteristics and health risks; and the interest of Enrollees in the aspect of care/services to be addressed.

The Contractor shall continuously monitor its own performance on a variety of dimensions of care and services for Enrollees, identify areas for potential improvement, carry out individual PIPs, undertake system interventions to improve care and services, and monitor the effectiveness of those interventions. The Contractor shall develop and implement PIPs to address aspects of clinical care and non-clinical services and are expected to have a positive effect on health outcomes and Enrollee satisfaction….Clinical PIPs should address preventive and chronic healthcare needs of Enrollees, including the Enrollee population as a whole and subpopulations, including, but not limited to Medicaid eligibility category, type of disability or special healthcare need, race, ethnicity, gender and age. ….Non-clinical PIPs should address improving the quality, availability, and accessibility of services provided by the MCO to Enrollees and Providers. Such aspects of service should include, but not be limited to availability, accessibility, cultural competency of services, and complaints, grievances, and appeals….

The Contractor shall develop collaborative relationships with local health departments, behavioral health agencies, community based health/social agencies and health care delivery systems to achieve improvements in priority areas. Linkage between the Contractor and public health agencies is an essential element for the achievement of public health objectives… Evidence of adequate partnerships should include formal documentation of meetings, input from stakeholders and shared responsibility in the design and implementation of PIP activities.

Michigan

Link to Medicaid Health Plan (MHP) contract

Overview
Michigan's Medicaid Health Plan contract includes a broad population health management strategy with requirements related to measuring and addressing health disparities and promotion of health equity. The state is using a portion of its capitation withhold approach to incentivize MHPs to address racial disparities and improving regionally-defined performance. MHPs are required to perform data analytics and report on the effectiveness of interventions designed to reduce health disparities and to promote health equity. MI Medicaid Managed Care has a special low birth rate initiative related to reducing racial disparities in maternity outcomes and other health equity initiatives.
General Language
Contractor must provide the spectrum of primary and preventive care and use the principles of population health management to prevent chronic disease and coordinate care along the continuum of health and wellbeing. Effective utilization of these principles will maintain or improve the physical and psychosocial wellbeing of individuals through cost-effective and tailored health solutions, incorporating all risk levels along the care continuum…. Population health management also includes an overarching emphasis on health promotion and disease prevention and will incorporate community-based health and wellness strategies with a strong focus on the Social Determinants of Health, creating Health Equity, and supporting efforts to build more resilient communities. **"Community-based health"** - A strong focus on the Social Determinants of Health, creating Health Equity, and supporting efforts to build more resilient communities by coordinating Population Health improvement strategies. **"Health Disparity"** - A particular type of health difference that is closely linked with social or economic disadvantage. **"Health Equity"** - When all people have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance.
Measurement and Data Analytics
X. Population Health Management **Data Analysis to Support Population Health Management** Contractor must utilize information such as medical and dental claims data, pharmacy data, and laboratory results, supplemented by UM data, Health Risk Assessment results and eligibility status, such as children in foster care, persons receiving Medicaid for the blind or disabled and CSHCS, to address Health Disparities, improve Community Collaboration, and enhance care coordination, care management, targeted interventions, and complex care management services for targeted populations including: i. Subpopulations experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level.

Michigan *(continued)*
Measurement and Data Analytics

ii. Subpopulations demonstrating disparate levels of poor health outcomes or access issues based on factors such as race, ethnicity, gender, age, primary language, deaf and hard of hearing, ability, geographic location, or income level.
iii. Enrollees who are eligible for Medicaid based on an eligibility designation of disability.
iv. Persons with high prevalence Chronic Conditions, such as diabetes, obesity, cardiovascular disease and oral health disease.
v. Enrollees in need of Complex Care Management, including high risk Enrollees with dual behavioral health, medical and oral health diagnoses who are high utilizers of services.
vi. Women with a high risk pregnancy.
vii. Children eligible for the Children's Special Health Care Services (CSHCS) program.
viii. People with Special Health Care Needs (PSHCN).
ix. Other populations with unique needs as identified by MDHHS such as foster children or homeless members

Data Submission and Data Reporting
Contractor must measure and report annually to MDHHS on the effectiveness of its evidence-based interventions to reduce Health Disparities by considering such measures as number of Enrollees experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level, number Enrollees participating in additional in-person support services such as Community Health Worker, patient navigator, MIHP, or health promotion and prevention program delivered by a community-based organization, and changes in Enrollee biometrics and self-reported health status.

Addressing Health Disparities
1.General
a. Contractor recognizes that Population Health management interventions are designed to address the SDOH, reduce disparities in health outcomes experienced by different subpopulations of Enrollees, and ultimately achieve Health Equity.
b. Contractor must develop protocols for providing Population Health management where telephonic and mail-based care management is not sufficient or appropriate, including the following settings:
i. At adult and family shelters for Enrollees who are homeless
ii. The Enrollee's home
iii. The Enrollee's place of employment or school

c. Contractor must implement the U.S. Department of Health and Human Services Office of Minority Health National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care located at http://www.thinkculturalhealth.hhs.gov/.

2. Community Collaboration Project
a. Contractor must participate with a community-led initiative to improve Population Health in each Region the Contractor serves. Examples of such collaborative initiatives include, but are not limited to community health needs assessments (CHNA) and community health improvements plans conducted by hospitals and local public health agencies or other regional health coalitions.
b. Contractors may propose the development of their own Community Collaboration initiative to improve Population Health if such initiatives do not exist in a particular Region.
c. All Community Collaboration projects are subject to MDHHS approval prior to implementation.

Michigan *(continued)*

Measurement and Data Analytics

3. Services Provided by Community-Based Organizations
a. Contractor must, to the extent applicable, enter into agreement with community-based organizations to coordinate Population Health improvement strategies in the Contractor's Region which address the socioeconomic, environmental, and policy domains; as well as provide services such as care coordination and intensive care management as needed and supported by evidence-based medicine and national best practices.

Providing Care Management Services and Other Targeted Interventions
Targeted Interventions for Subpopulations Experiencing Health Disparities:

- Contractor must offer evidence-based interventions that have a demonstrated ability to address Social Determinants of Health and reduce Health Disparities to all individuals who qualify for those services.
- Contractor must collaborate with its high volume primary care practices to develop, promote and implement targeted evidence-based interventions. To the extent that CHIRs are functioning within the Contractor's service area, the Contractor must collaborate with CHIRs to develop, promote, and implement these targeted evidence-based interventions.
- Contractor must fully and completely participate in the Medicaid Health Equity Project and report all required information to MDHHS within the specified timeframe.

See the Appendix for Michigan's Health Equity HEDIS Performance Monitoring Standards.

Performance Monitoring and Incentives

Appendix 4 – Performance Monitoring Standards
The purpose of the performance monitoring standards is to establish an explicit process for the ongoing monitoring of health plan performance in important areas of quality, access, customer services and reporting. Through this appendix, the performance monitoring standards are incorporated into the Contract. The process is dynamic and reflects state and national issues that may change on a year-to-year basis. Performance measurement is shared with Health Plans during the fiscal year and compares performance of each plan over time, to other plans, and to industry standards, where available.

The Performance Monitoring Standards address the following:
• MDHHS Administrative Measures
• Healthy Michigan Plan (HMP) Measures
• Healthy Michigan Plan Dental Measures
• CMS Core Set Measures / Health Equity HEDIS / HEDIS / Managed Care Quality Measures
For each performance area, the following categories are identified:
Measure: Goal, Minimum Standard for each measure, Data Source, and Monitoring Intervals, (annually, quarterly, monthly).

All Health Equity HEDIS, CMS Core Set, HEDIS, and Managed Care Quality measures will be "Informational Only" for FY 20 and part of FY 21. Health Plans will not be held to these standards until the April 2021 Performance Monitoring Report.

Michigan *(Continued)*
Specialized Initiatives
FY18-FY20 Focus Bonus: Low Birth Weight (LBW) – Appendix 5B In 2017, the Michigan Medicaid Managed Care Plan Division (MCPD) identified Low Birth Weight (LBW) as a target outcome associated with the FY 2018 Pay for Performance (P4P) Initiative for the MHPs. The LBW P4P initiative supports and aligns with the Medicaid Health Equity Project, which was initiated in 2011 to promote health equity and monitor racial and ethnic disparities within the managed care population...The LBW-CH measure specification will be used to analyze and report state-wide Medicaid managed care data, which will be stratified by region and race/ethnicity. This breakdown of the date will identify health disparities and methods to improve quality care and services to pregnant women and infants. MCPD is launching this multi-year statewide P4P initiative to align MDHHS efforts to promote health equity in maternity care and infant care. For FY 2018, the goal is to involve the MHPs, existing home visiting programs, and community health worker programs to design and implement a meaningful P4P project. In order to improve infant health outcomes, the initiative will address documented health disparities and health inequities with particular focus on reducing the LBW-CH rate. The activities in FY18 will include identifying evidence-based, integrated models that address LBW through management of medical and social determinants of health. They will also incorporate parties who focus on maternity care to identify and implement models of choice through collaborative processes.
Other
MHP must fully and completely participate in the Medicaid Health Equity Project and associated initiatives and report all required information to MDHHS within the specified timeline.

Minnesota

Link to Minnesota DHS Contract for Prepaid Medical Assistance and MinnesotaCare

Overview
Minnesota requires MCO's to engage in at least one quality improvement project to address health disparities, and that a description of this project be published on the MCO's website. A listing of MCO quality improvement websites is included within the Appendix. MCO quality improvement activities include increasing colorectal cancer screenings among members of color; increasing member's with disabilities access to dental care; and reducing racial disparities in depression management.
Quality Improvement
7.8 Annual Quality Program Update. Annually, the MCO shall demonstrate how the MCO's Quality Improvement Program identifies, monitors and works to improve service and clinical quality issues relevant to the MHCP Enrollees. The MCO shall submit, on or before May 1st, a web site link to a public web page associated with the MCO describing quality improvement activities that have resulted in measurable, meaningful and sustained improved health care outcomes for the contracted populations. The MCO will describe the quality strategies, including quantitative evidence of improvements, lessons learned, and how the quality improvement outcomes will influence future activities. The web page must prominently feature the description of at least one quality improvement activity addressing health care disparities. The information on the web site shall be updated at least annually. The STATE will publish the web site link on the STATE's public web site and public comments will be accepted. The MCO will respond to public comments received.

North Carolina

Link to Medicaid Prepaid Health Plan Model Contract (not yet implemented)

Overview
In 2015, the North Carolina General Assembly enacted legislation directing the Department of Health and Human Services to transition North Carolina Medicaid and NC Health Choice from fee-for-service to capitated, full-risk managed care program with an expected implementation date of July 1, 2021. (See Notice about NC Medicaid Managed Care.) The excerpts contained in this compendium are from the model contract incorporated in the Request from Proposal (RFP) from prepaid health plans (PHPs). The State is transitioning to a capitated full risk managed care program. *Promoting health equity through reduction of health disparities will be a focus within North Carolina's Quality Management and Quality Improvement requirements. PHPs will identify disparities and implement interventions through their population health management programs to reduce disparities.*
Measurement and Data Analytics
E. Quality and Value **1. Quality Management and Quality Improvement** **j. Disparities Reporting and Tracking** • The PHP shall report measures against a set of stratification criteria that may include, but is not limited to: race and ethnicity, geography, eligibility category, and age and gender where appropriate and feasible for many of the Quality Measures. • The PHP shall address inequalities as determined by the Department during review of the PHP's performance against disparity measures. The Department will define the disparity stratifications for each measure after Contract Award and annually thereafter.
Quality Improvement
E. Quality and Value **1. Quality Management and Quality Improvement** .. [NC] will work with the PHP to develop a data-driven, outcomes-based continuous quality improvement process that builds upon this history and focuses on rigorous outcome measurement against relevant targets and benchmarks, promotes equity through reduction or elimination of health disparities, and appropriately rewards PHPs and, in turn, providers for advancing quality goals and health outcomes. The PHP shall have a robust Quality Management and Improvement Program that will focus on health outcomes, not only healthcare process measures, and align with the NC Medicaid Quality Strategy and Quality Assessment and Performance Improvement (QAPI) Plan. The Quality Management and Improvement Program Plan shall include: • Mechanisms to conduct and assess performance improvement projects (PIPs) specified by the Department; • Mechanisms to assess the quality and appropriateness of care for Members with special health care needs • Mechanisms to assess the quality and appropriateness of care provided to Members needing long-term services and supports, including assessment of care between settings and a comparison of services and supports received with those set forth in the Member's treatment/service plan;

North Carolina *(Continued)*
Quality Improvement
• Mechanisms to assess and process for identifying interventions to improve quality disparities based on age, race, ethnicity, sex, primary language, and by key population group, e.g., Long term Services and Supports (LTSS); • Mechanisms to incorporate population health programs targeted to improve outcomes measures; • Mechanisms for collection and submission of all quality performance measurement data required by the Department; • Mechanisms to detect both underutilization and overutilization of services; • Mechanisms for participation in efforts by the Department to prevent, detect, and remediate; critical incidents including those required for home and community-based waiver programs; • Mechanisms to assess and address health disparities at a statewide and regional level, including findings from the disparity report that PHPs are required to develop; • A Provider Support Plan (see additional details below in Section 11); and • The PHP's Contributions to Health-Related Resources in alignment with improvement in particular health outcomes outlined in the Quality Strategy. ii. Quality Assessment and Performance Improvement Plan c) The QAPI Plan must include the following elements: • Mechanisms to assess and process for identifying interventions to improve quality disparities based on age, race, ethnicity, sex, primary language, geography and by key population group (e.g., LTSS); • Mechanisms to assess and address health disparities, including findings from the disparity report that PHPs are required to develop;

Ohio

Link to Medicaid Managed Care Plan (MCP) Agreement

Overview
Ohio's Medicaid Managed Care Plans (MCPs) are required to identify health disparities in health care access, services and outcomes based on member demographic data. Ohio Department of Medicaid (ODM) requires MCPs to address health disparities through their quality improvement requirements, which include implementing interventions and evaluating their success. Most of the health disparities language is in Appendix K: Quality Care.
***G*eneral Language**
Appendix K Quality Care; k. Addressing Health Disparities According to the U.S. Department of Health and Human Services' Office of Minority Health, and for the purposes of this Agreement, a **health disparity** is "a particular type of health difference closely linked with social or economic disadvantage." Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on characteristics historically linked to discrimination or exclusion (e.g., race or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation; or geographic location).

Ohio (*Continued*)

Measurement and Data Analytics

Appendix K Quality Care; k. Addressing Health Disparities

The MCP shall participate in, and support, ODM's efforts to eliminate health disparities in Ohio.

To further advance ODM's efforts to achieve health equity, the MCP shall collect and meaningfully use member-identified race, ethnicity, language, and social determinants of health data to identify and reduce disparities in health care access, services and outcomes. This includes, where possible, stratifying HEDIS and CAHPs, and Health Risk Assessment results by race, ethnicity, or other relevant demographics, and implementing a strategy to reduce identified disparities.

The MCP shall maintain health equity representatives who are actively involved in improvement initiatives to reduce disparities by: obtaining input from Medicaid-insured individuals and from providers of direct services which are intended to reduce adverse health outcomes among Medicaid insured individuals, determining the root cause of inequities, developing targeted interventions and measures, and collecting and analyzing data to track progress in disparity reduction efforts.

Performance Monitoring and Incentives

Appendix O Quality Withhold

1. **Quality Withhold Program.** ODM will withhold the specified percentage for the applicable State Fiscal Year payout determination for use in the Quality Withhold Program. ODM will use Quality Indices or the evaluation of the MCP's response to COVID-19 to calculate the amount of the withhold payout. Quality Indices will be comprised of multiple performance measures related to the index topic. Quality Indices measure the effectiveness of the MCP's population health management strategy and quality improvement programs to impact population health outcomes. Determination of the Quality Withhold payout is specified in this appendix.

b. **SFY 2021 Quality Withhold Payout Determination**. The Department will use the MCPs' response to the serious public health threats posed by the spread of COVID-19 for the purpose of evaluating performance related to the Quality Withhold Program.

Performance Evaluation. ODM's performance evaluation will include the following:

1. **Population Health Management and Quality Improvement.**
    a. An organizational structure and sufficient staffing that supports common data and quality improvement processes to advance the goals of COVID-19-related requirements and interventions at an accelerated pace;
    b. An updated Population Health Strategy for communities and health plan members in response to the public health crisis posed by the spread of COVID-19;
    c. Timely implementation of COVID-19-related requirements (e.g., Appendix S and the Telehealth rule) and additional interventions needed to address the needs of members, providers, and communities;
    d. Monitoring implemented COVID-19-related requirements and interventions, (e.g., measuring of the effectiveness and degree of impact of interventions); and
    e. Frequent identification and testing of changes to interventions needed to improve the effectiveness and impact of implemented COVID-19-related requirements and interventions.

Ohio (*Continued*)

Performance Monitoring and Incentives

2. **Collaboration**.
    a. Collaboration with community entities;
    b. Collaboration with providers, those representing providers, and/or provider associations; and
    c. Collaboration with other Medicaid and non-Medicaid health plans.
3. **Results**.
    a. Achieve the SMART Aim or multiple shifts in the median in the desired direction for each SMART Aim outcome measure;
    b. Demonstrate that the MCP's implemented COVID-19-related requirements and interventions have broad impact on the targeted populations; and
    c. Demonstrate a significant impact on disparate populations, i.e., members with geographic or racial disparities and members with a gap in access to and usage of information and communication technology (the digital divide population).

Quality Improvement

Appendix K Quality Care

ii. Required QI responsibilities include…:

6. Analyzing data to identify disparities in services and/or care and tailoring interventions to specific populations when needed in order to reduce disparities.
7. Active incorporation of member and provider perspectives into improvement activities.

Quality Improvement Strategy:

The MCP shall submit a clearly delineated, outcomes-driven strategy for improvement as part of its annual QAPI submission. The strategy shall measure, analyze, and track performance indicators that reflect the ODM Quality Strategy population health focus, including: population streams (e.g., women's health, chronic conditions, and behavioral health), value-based purchasing strategies (e.g., comprehensive primary care, episode-based payments), and health equity focus.

QAPI Program Impact and Effectiveness: The MCP shall evaluate the impact and effectiveness of each effort within the QAPI program, including efforts to reduce health disparities. The MCP shall update the QAPI program based on the findings of the self-evaluation and submit both the evaluation results and updates annually to ODM for review and approval following the template provided in the QAPI guidance document. Evaluation should, at a minimum, include:

- The outcomes and trended results of each improvement project, including documentation of successful and unsuccessful interventions;
- The results of any efforts to support community integration for enrollees using long term services and supports; and
- How these results will be incorporated into the MCP's quality strategy.

Quality Improvement (QI) Program

ODM defines "quality improvement" as a deliberate and defined, science-informed approach that is responsive to member needs and incorporates systematic methods for discovering reliable approaches to improving population health. Consistent with this definition, the MCP shall make continuous and ongoing efforts to achieve measurable improvements in efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes that achieve equity and improve population health.

Ohio (*continued)*

Quality Improvement

a. **QI Program Structure**: … The MCP shall establish appropriate administrative oversight arrangements and accountability for the QAPI program. This includes: assignment of a senior QI leadership team responsible for the QI program with a specific focus on the use of improvement projects to optimize health outcomes and reduce disparities; provision for ongoing transparent communication and coordination between the QI leadership team, the CEO and relevant functional areas of the organization so that QI activities are regularly assessed and lessons are learned from failures and successes; assurance that the Medical Director is involved in all clinically-related projects; and a commitment to providing staff at all levels of the organization with the appropriate education, experience, training, and authority to test and implement improvements that promote population health.

b. **Senior QI leadership team**:
The team shall manage the organization's QI portfolio and shall be responsible for promoting a culture of QI throughout the organization with improved health outcomes and reductions in health disparities for the Medicaid population as the primary goals. The MCP shall indicate commitment to improved outcomes and encourage improvement at all levels of the organization through activities that may include the following: clearly linking the MCP's quality improvement strategy to the organization's and ODM's mission and vision, integrating the voices of members and providers into quality improvement activities (e.g., GEMBA walks, active involvement on QI teams) to determine barriers and intervention strategies, developing the capacity of MCP staff at all levels of the organization to apply quality improvement tools and principles, dedicating resources and tools to quality initiatives, consistently and frequently using data and analytics strategically to identify improvement opportunities and learn from improvement initiatives to maximize successes, and transparently sharing quality improvement opportunities and the results of quality improvement initiatives throughout the organization and with ODM.

Quality Improvement Teams. Quality improvement teams shall be composed of MCP staff dedicated to the Ohio Medicaid line of business that represent the following areas of expertise:

4. Health equity,
5. Member- and provider-perspectives; and MCP policies and processes related to the improvement topic.

Other

Appendix D Ohio Department of Medicaid (ODM) Responsibilities
ODM will provide the MCP linkages to organizations that can provide guidance on the development of effective strategies to eliminate health disparities.

Oregon

Link to Medicaid CCO 2.0 Contract

Overview
Oregon contracts with Coordinated Care Organizations (CCOs) to provide Medicaid managed care services to members in defined regions. In January 2020, 15 CCOs began service to Oregon Health Plan members across the State under its CCO 2.0 contracts. Oregon's CCO 2.0 contract requirements are intended to reduce health disparities, address the social determinants of health, and to promote health equity. The contract included in the link above dedicates an entire section, ***Exhibit K, Social Determinants of Health and Equity*** *to requirements associated with SDOH and Health Equity (SDOH-E). Exhibit K is on pages 248-271 of the linked CCO Contract and includes much more SDOH-E detail than is summarized here. Oregon's CCO requirements related to disparities or health equity included in different sections of the CCO contract are included in this summary.* *Key requirements of the Oregon contract include: the creation of a Community Advisor Council to advise the Contractor on serving the health care needs of the entire community, working in partnership with public and community partners, the collection of demographic and health data and the creation of a health equity plan for not just members but for all of the communities within the contractor's service area, the development of a spending proposal to address housing and other SDOH-E priorities, the sharing of any quality incentive dollars received with the Contractor's community partners, and requirement to consider disparities in evaluations.*
General Language
"Health Equity" means a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all sectors across Oregon, including Tribal governments, to address the equitable distribution or redistributing of resources and power and recognizing, reconciling and rectifying historical and contemporary injustices. **"Health Equity Plan"** means the Health Equity plan required to be drafted by Contractor and provided to OHA in accordance with Exhibit K and designed to address the cultural, socioeconomic, racial, and regional disparities in health care that exist among Contractor's members and the communities within the Contractor's service area. **"Learning Collaborative"** means a program in which CCOs, State agencies, and PCPCHs that provide or perform the activities that serve Health System Transformation objectives, achieve, the purposes of the Contract, and share:….. (iii) best practices and emerging practices that increase access to Culturally and Linguistically Appropriate care and reduce health disparities; **"Social Determinants of Health and Equity"** and **"SHOH-E"** each means the social, economic, and environmental conditions in which people are born, grow, work, live, and age. These conditions significantly impact length and quality of life and contribute to health inequities. SDOH fall into the following domains: neighborhood and built environment, economic stability, education, and social and Community health.

Oregon (*continued)*

Measurement and Data Analytics

Exhibit B –Statement of Work - Part 8 Accountability and Transparency of Operations

c. Contractor shall assist OHA with development and distribution of survey instruments and participate in other evaluation procedures established by OHA for evaluating Contractor's progress on payment reform and delivery system change including the achievement of benchmarks, progress toward eliminating health disparities, results of evaluations, customer satisfaction, use of Patient-Centered Primary Care Homes (PCPCHs), the involvement of local governments in governance and service delivery, or other developments as determined necessary by OHA its external review organizations, or any of its other designees, agents, or subcontractors (or any combination, or all, of them).

Quality Improvement

Exhibit B –Statement of Work - Part 10
Transformation Reporting, Performance Measures and External Quality Review
2. Transformation and Quality Strategy (TQS) Requirements

b. As set forth in the TQS Guidance Document, Contractor's TQS must include strategies and activities as required under the State's 1115 Waiver, 42 CFR §438.330 (a) and (b), and other federal obligations to improve certain elements of the services provided by Contractor to Members…as well as information about processes and procedures related to the TQS.

c. Accordingly, the TQS must include, without limitation the following:…

(1) strategies and related activities to improve Quality and appropriateness of care and Health Equity with respect to REAL+D, Cultural Competency, and CLAS standards and criteria.

4. Performance Measures: Quality Pool Incentive Payments

a. OHA has implemented a Quality Pool incentive payment program based on the Outcome and Quality Measures. The Quality Pool rewards all participating CCOs that demonstrate quality of care provided to members as measured by their performance or improvement on the Outcome and Quality Measures.

b. Contractor will, if it meets certain metrics related to performance or improvement in a Measurement Year, receive a monetary Payment from the Quality Pool. Contractor shall create a written distribution plan for Quality Pool and Challenge Pool earnings. The distribution plan must include: An overview of the methodology and/or strategy used to distribute quality pool earnings to Participating Providers, including Social Determinants of Health and Equity and public health partners, that provides information related to the Contractor's process of evaluating the contributions of Participating Providers and connecting those evaluations to distribution of funds;

5. Performance Measure Incentive Payments for Participating Providers

Contractor must offer correlative arrangements with Participating Providers (including Social Determinants of Health and Equity partners, public health partners, and other Health-Related services Providers as appropriate), providing monetary incentive payment arrangements with Providers that reflect priorities which align with the Quality Pool program for achieving the outcome and quality objectives. Contractor shall report these arrangements and amounts paid to OHA's Contract Administrator via Administrative Notice. Such arrangements and amounts paid shall be broken down by quarter and provided in an annual Report in a format determined by OHA (about which OHA shall advise Contractor's Contract Administrator via Administrative Notice) and sent to OHA in conjunction with the 4th Quarter reporting period.

6. Performance Improvement Projects…Contractor shall undertake PIPs that address at least 4 of the 8 focus areas listed below... One of the four shall be the Statewide PIP…. Contractor shall select an additional three (3) from the list as follows:… (8) Social Determinants of Health and Equity.

Oregon (*continued)*

Performance Monitoring and Incentives

Exhibit H – Value Based Payment

7. Interviews: VBP Arrangements and Data Reporting Contract Year One (2020)

In June of 2020, Contractor's executive leadership team shall engage in interviews with OHA to:… (b) Discuss outcome of Contractor's plan for mitigating adverse effects of VBPs and compare/describe any modifications to that which was included in the Application Contractor submitted in response to the RFA and those relating to VBP arrangements with Providers serving populations with complex care needs or those who are at risk for health disparities, or both complex care needs and being at risk for health disparities, and compare and describe any modifications to the plans;

8. VBP Data Reporting: Contract Year Two (2021)

In June of 2021, Contractor's executive leadership team must engage in interviews with OHA to: …(2) Discuss outcome of the Contractor's plan for mitigating adverse effects of VBPs on populations with complex care needs or those who are at risk for health disparities, or both complex care needs and being at risk for health disparities, and compare and describe any modifications to the plans;

Other

Exhibit B –Statement of Work - Part 3 Patient Rights and Responsibilities, Engagement and Choice Member and Member Representative Engagement in Member Health Care and Treatment Plans.

Contractor shall actively engage Members, Member Representatives, and their families as partners in the design and implementation of Member's individual treatment and care plans, with ongoing consultation regarding individual and cultural preferences and goals for health maintenance and improvement. Contractor shall ensure that Member choices are reflected in the development of Treatment Plans and Member dignity is respected…

Contractor shall demonstrate how it:

- Engages Members to participate in development of holistic approaches to patient engagement and responsibility that account for SDOH and health disparities;

Exhibit B –Statement of Work - Part 4 Providers and Delivery System

Delivery System Dependencies: Intensive Care Coordination (ICC) for Prioritized Populations and Members with Special Health Care Needs

Contractor shall prioritize working with Members who are eligible for ICC Services and communities experiencing health disparities (as identified in the Community Health Assessment). Contractor shall actively engage such Members in accessing and managing appropriate preventive, remedial and supportive care and services to reduce the use of avoidable Emergency Department visits and Hospital admissions.

Virginia

Link to Medicaid MCO contract

Overview
Virginia's Medicaid MCO contract language grounds the definitions of health equity and health disparities by reference to the State's Office of Health Equity. The contract contains requirements for developing programs to identify and address social factors (i.e., social determinants of health) impacting health outcomes in specific domains. The State can also opt to expand reporting of social determinants of health and related intervention activities to include Social and Community Context.
General Language
8.1.T At-Risk Populations – Health Equity: The Contractor shall consider the importance of health equity and disparities among populations in developing its various programs to provide services to Medallion 4.0 members. The Contractor must submit an annual report to the Department outlining its efforts to address health disparities for the Medallion 4.0 population. The Contractor may refer to the Virginia Department of Health's Office of Health Equity for more information regarding health disparities in the Commonwealth of Virginia. **Health Inequity**: Disparities in health [or health care] that are systemic and avoidable and, therefore, considered unfair or unjust. **Health Equity**: Health equity is achieving the highest level of health for all people. Health equity entails focused societal efforts to address avoidable inequalities by equalizing the conditions for health for all groups, especially for those who have experienced socioeconomic disadvantage or historical injustices. From Healthy People 2020 **Health Disparities**: Differences in health status among distinct segments of the population including differences that occur by gender, race or ethnicity, education or income, disability, or living in various geographic localities.
Interventions
8.8 Social Determinants of Health: The Contractor shall collaborate with the Department to continually develop programs and/or establish partnerships to address social factors that affect health outcomes, also called social determinants of health (SDOH), which contribute significantly to the cost of care and the member's health care experience. The Contractor shall provide care coordination efforts that identify and address member access to employment, food security, housing stability, education, social cohesion or resources that support Member connection to social supports, health and health care, as well as environmental needs identified by the member. These social determinants are encompassed under five key areas: Economic Stability, Education, Social and Community Context, Health and Health Care, and Neighborhood and Built Environment. On an annual basis, the Contractor shall complete the following reporting requirements: A) the Contractor shall submit its policies and procedures related to the programs and partnerships established to address SDOH; B) the Contractor shall submit Care Coordination Training Materials for both the Medallion 4.0 non-expansion and Medicaid Expansion Populations; C) the Contractor shall submit its policies and procedures related to identifying, addressing, and tracking the following three (3) determinants belonging to the SDOH areas described as Economic Stability: Employment, Food security, and Housing stability.

Virginia *(continued)*
Interventions
The Contractor shall utilize the pdf templates for submission of its policies and procedures and other reporting requirements in the format(s) specified in the MCTM. The Department has the discretion to expand the SDOH reporting criteria throughout future Contract years, to include specific data for the areas noted above or additional areas as necessary.
Quality Improvement
9. Quality Improvement (QI) and Population Health Oversight: DMAS is responsible for evaluating the quality of care provided to eligible enrollees in the contracted managed care organizations (MCOs). To ensure the care provided meets acceptable standards and Medicaid members are receiving high quality cost effective care, driven by innovation; DMAS follows both state and federal regulations in addition to DMAS' policies. DMAS partners with MCOs to provide high quality integrated physical, and behavioral services that will improve the health and wellbeing of our members. The care provided must meet standards for improving quality of care and services, access, transition of care, health disparities and timeliness. 9.3 Quality Improvement Structure 9.3.A Quality Assessment and Performance Improvement Program In compliance with 42 CFR § 438.330, the Contractor shall provide to the Department annually in accordance to the Technical Manual timeline, a written description of its ongoing Quality Assessment and Performance Improvement (QAPI) program. The Contractor shall have a comprehensive QAPI program and must include collection and submission of performance measurement data, including any required by the Department or CMS as specified: … Identify and analyze objectives for servicing diverse memberships to include but not limited to analyzing significant health care disparities gaps…
Other
8.2.II Telemedicine: Telemedicine is defined as the real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment. Telemedicine may also include 'store and forward' technology, where digital information (such as an X-ray) is forwarded to a professional for interpretation and diagnosis. The Contractor shall provide coverage for telemedicine services as medically necessary, and within at least equal amount, duration, and scope as is available through the Medicaid fee-for-service program as an innovative, cost effective means to decrease hospital admissions, reduce emergency department visits, address disparities in care, increase access to and/or enhance existing services, and increase timely interventions. The Contractor also shall encourage the use of telemedicine to promote community living and improve access to health services.

Washington State

Link to Medicaid MCO contract

Overview
Washington is directing health equity work in its MCO contracts through the Quality Assessment and Performance Improvement (QAPI) program. Contractors are required to assess health equity, including identifying health disparities as part of the QAPI framework and annually report on objectives for health equity and serving a diverse membership (geographically, culturally, and linguistically). The State also requires MCOs to collect data to monitor and evaluate Culturally and Linguistically Appropriate Services (CLAS) on health equity and outcomes.
Quality Improvement
7.1 Quality Assessment and Performance Improvement (QAPI) Program: The Contractor shall have and maintain one quality assessment and performance improvement (QAPI) program for all services it furnishes to its Enrollees that meets the provisions of 42 C.F.R. § 438.330. 7.1.1.2 The QAPI program structure shall include the following elements: ... 7.1.1.2.3 Assessment of health equity, including identification of health disparities; 7.1.1.2.15 An annual quality work plan is due March 1. The work plan shall contain: 7.1.1.2.15.1 Goals and objectives for the year, including objectives for patient safety, serving a geographically, culturally and linguistically diverse membership, individuals with special health care needs, health equity, and health care utilization; … 7.1.1.2.16 An annual written QAPI Program Evaluation due July 15, of the overall reporting of the effectiveness of the Contractor's QAPI program. (42 C.F.R. §438.330(c)(2)(i) and (ii)). The report shall reflect on required QI program structure and activities in the Work Plan and shall include at minimum: 7.1.1.2.16.1 Analysis of and actions taken to improve health equity…
Other
10 Enrollee Rights and Protections 10.2 Cultural considerations 10.2.3.8 Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery (CLAS 11); …

Covered California

Link to Covered California 2017 Individual Market QHP Issuer Contract, Attachment 7: Quality, Network Management, Delivery System Standards and Improvement Strategy

Link to Covered California's QHP Measurement Specifications Appendix 2 to Attachment 7

Link to Covered California's QHP Performance Standards (Attachment 14)

Covered California (Health Exchange)

Overview

Covered California requires Qualified Health Plans (QHPs) to identify, track, trend, and report racial/ ethnic and gender disparities in quality measures. This health care exchange has detailed performance specifications for its QHPs and has both financial incentives and penalties for QHPs based on performance to these specifications.

Covered California's QHP contract consists of a number of Attachments and Appendices. The sections most relevant to health equity are found in Attachment 7: Quality, Network Management, Delivery System Standards and Improvement Strategy, including Appendix 2 to Attachment 7 which includes measurement specifications for 41 QHP measures and Attachment 14 QHP Performance Standards. Each of these documents can be accessed via the links above.

As part of its quality measurement specifications and related reporting defined in Appendix 2, QHPs must report approximately half of the required QHP measures separately by race/ethnicity. In 2019 Covered California began requiring QHPs to choose 1-2 disparities based on review of plan specific measurement across 14 measures selected by Covered California that are determined to be disparities sensitive by the National Quality Forum. QHPs are required to participate in a quality collaborative, Smart Care California, which addresses performance in populations/measures that have significant documented Health Disparities: C-section rates, prescription of opioids and appropriate treatment for low back pain/chronic pain.

Covered California does not require implementation of specific interventions but encourages Contractors to meet the standards for NCQA's Multicultural Health Care Distinction. Covered California also identifies a path for expanding disparities-related requirements in the future.

General

Preamble: The mission of the California Health Benefit Exchange is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and Providers that give them the best value

Attachment 7: Covered California Individual Market QHP Issuer Contract: Quality, Network Management, Delivery System Standards and Improvement Strategy.
ARTICLE 3: Reducing Health Disparities and Ensuring Health Equity
Mitigation of health disparities is central to the mission of Covered California, and the California Language Assistance Act adopted as SB 853 in 2003. In alignment with these principles, Covered California and Contractor recognize that promoting better health requires a focus on addressing health disparities and health equity. Covered California will require Contractor to track, trend and reduce health disparities with the phased approach outlined below.

Health Disparities - Healthy People 2020 defines a health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."9 Racial and ethnic disparities populations include persons with Limited English Proficiency. (LEP).

Covered California *(continued)*

General

Health Equity - Healthy People 2020 defines health equity as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."

Measurement and Data Analytics

3.01 Measuring Care to Address Health Equity

Contractor must track and trend quality measures by racial or ethnic group, or both, and by gender for the Contractor's full book of business, excluding Medicare.

1) Identification:
   - (a) By year end 2019 and annually thereafter, Contractor must achieve 80% self-identification of racial or ethnic identity for Covered California enrollees.
   - (b) In annual application for certification, Contractor will be required to report percent of self-reported racial or ethnic identity for Covered California enrollees.
   - (c) To the extent Contractor does not have self-reported information on racial or ethnic identity, or both, it shall use a standardized tool for proxy identification through the use of zip code and surname to fill any gaps in information.
2) Measures for Improvement:
   - (a) Disparities in care by racial and ethnic identity and by gender will be reported annually by QHP Issuers based on its Enrollees. The tool for proxy identification shall be used to supplement self-reported racial or ethnic identity. Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business where comparative data can offer meaningful reference points.
   - (b) Measures selected for improvement beginning in plan year 2017 include Diabetes, Hypertension, Asthma (control plus hospital admission rates), and Depression (HEDIS appropriate use of medications).
   - (c) Covered California will consider adding additional measures for plan year 2021 and beyond.

See Attachment 7 Appendix 2 for full list of Measures to be analyzed for disparities by QHPs.

3.03 Expanded Measurement

Contractor and Covered California will work together to assess the feasibility and impact of extending the disparity identification and improvement program over time. Areas for consideration include: 1) Income, 2) Disability status, 3) Sexual orientation, 4) Gender identity, 5) Limited English Proficiency.

Quality Improvement

3.04 NCQA Certification

Meeting the standards for Multicultural Health Care Distinction by NCQA is encouraged as a way to build a program to reduce documented disparities and to develop culturally and linguistically appropriate communication strategies. To the extent Contractor has applied for or received NCQA Certification, Contractor must provide this information with its annual application for certification. Covered California may publicly recognize this achievement and include it in information provided to consumers.

Covered California *(continued)*

Quality Improvement

1.06 Participation in Collaborative Quality Initiatives

Covered California believes that improving health care quality and reducing costs can only be done over the long-term through collaborative efforts that effectively engage and support clinicians and other Providers of care. There are many established statewide and national collaborative initiatives for quality improvement that are aligned with priorities established by Covered California with requirements specified below.

1) Effective January 1, 2017, Contractor must participate in:

(a) Smart Care California: Sponsored by Covered California, DHCS, and CalPERS, this multi-stakeholder work group facilitated by the Integrated Healthcare Association (IHA), will provide guidance and steer the delivery system to drive appropriate use of C-sections, prescription of opioids, and low back pain. https://www.iha.org/our-work/insights/smart-care-california

i. The C-section work aligns with activities underway through the California Maternal Quality Care Collaborative (CMQCC) which provides statewide analysis of variation and promotes the appropriate use of C-sections with associated reductions in maternal and newborn mortality and morbidity. https://www.cmqcc.org/ (See Article 5, Section 5.03)

ii. A key element of the change for all three focus areas is promoting best practices through provider and consumer decision support, for example through the Choosing Wisely campaign from Consumer Reports. https://www.iha.org/our-work/insights/smart-care-california

Interventions

3.02 Narrowing Disparities

While Covered California and Contractor recognize that some level of disparity is determined by social and economic factors beyond the control of the health care delivery system, there is agreement that health care disparities can be narrowed through quality improvement activities tailored to specific populations and targeting select measures at the health plan level. Covered California and the Contractor agree that collection of data on clinical measures for the purpose of population health improvement requires development and adoption of systems for enhanced information exchange. (See Section 1.07)

1) Contractor reported baseline measurements from plan years 2015, 2016, 2017, and 2018, on the measures listed in the Measurement Specifications document, based either on self-reported identity or on proxy identification on its Enrollees. Covered California anticipates that this baseline data may be incomplete. The Measurement Specifications document is posted on the Contractors extranet website provided by Covered California (Plan Home, in the Resources folder, Health Disparities Reduction – Measurement Specifications folder).

Performance Monitoring and Incentives

3.02 Narrowing Disparities: Targets for year end 2020 and for annual intermediate milestones in reduction of disparities will be established by Covered California based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and engagement of stakeholders.

Covered California *(Continued)*
Other
Performance Guarantees outlined in Attachment 14 of the QHP contracts include the following 2 metrics related to health equity: **3.4a) Reducing Health Disparities – Attachment 7, Article 3, Sections 3.01 and 3.02** – 2% of total performance penalty for Group 3 Contractor will meet intermediate milestones for self-reported racial or ethnic identity by the end of 2018, and will meet the target of 80% self-reported racial or ethnic identity by the end of 2019. Contractor will continue to meet the 80% target during Measurement Year 2020. Baseline data was used to set an incremental target for 2018 based on information submitted in 2016, 2017, and 2018 via the Applications for Certification for 2017, 2018, and 2019. Contractor and the Exchange have established a mutually agreed upon performance goal which will be documented in the Contractor's Quality Improvement Strategy. Data will be submitted by Contractor in a run chart demonstrating improvement in percentage of self-reported identity compared to baseline reported. **3.4b) Reducing Health Disparities – Attachment 7, Article 3, Sections 3.01 and 3.02** – 3% of total performance penalty for Group 3 Contractor reports required metrics across all lines of business excluding Medicare for diabetes, asthma, Hypertension, and depression by race/ethnicity. The Exchange and Contractor will select at least one, but not more than two disparity measures against which performance in 2020 will be assessed. If the Contractor selects two disparities measures for setting 2020 performance targets, the performance level will be assessed at 1.5% for each measure. Performance will be measured based upon the mutually-agreed upon milestones in the final, Disparity Intervention Proposal which shall be incorporated into this Attachment 14 without an amendment to the Contract. **Performance Requirements:** No Assessment for Measurement Year 2017, 2018, 2019 **Measurement Year 2020** Performance Levels: Contractor does not select at least one disparity measure for reduction or does not meet mutually agreed upon milestone(s) selected for the 2020 disparity reduction target: 3% penalty Contractor meets mutually agreed upon milestone(s) selected for the 2020 disparity target: 3% credit

Appendix:

Michigan: Health Equity HEDIS Measures in SFY20 MHP Contract

HEALTH EQUITY HEDIS MEASURES

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
*Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Children three, four, five, and six years old receive one or more well child visits during measurement period.	Index of Disparity at or below 5%	MDHHS Data Warehouse	Quarterly
*Chlamydia Screening in Women (Total)	Women enrolled in a health plan, ages 16 to 24, who were identified as sexually active and who had at least one (1) test for chlamydia during the measurement period	Index of Disparity at or below 5%	MDHHS Data Warehouse	Quarterly
*Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	Members ages 18 to 75, with Type 1 or Type 2 diabetes, who had an HbA1c test.	Index of Disparity at or below 5%	MDHHS Data Warehouse	Quarterly
*Cervical Cancer Screening	Women enrolled in a health plan, ages 21 to 64, who were screened for cervical cancer using either of the following criteria: 1. Women ages 21 to 64 who had cervical cytology performed every three (3) years 2. Women ages 30 to 64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five (5) years	Index of Disparity at or below 5%	MDHHS Data Warehouse	Quarterly

(*) indicates that this measure is run with symmetry

The Index of Disparity (D) is a nationally used and well-vetted measure to assess differences across groups. It adds up all of the differences between subpopulations and the total population then averages them out to a total degree of disparity, called the Index of Disparity. The formula can be used for a variety of subpopulations (racial/ethnic groups, income levels, education levels, etc.) and can be applied to any measure. The formula is below. ID=(∑|r(n)-R| /n) / R*100
r=Subpopulation rate, R=Total population rate, n=number of subpopulations. The ID is calculated by finding the absolute difference (i.e. no negative numbers) between each subpopulation rate and the total population rate.

Minnesota: MCO Quality Improvement Websites

- Blue Plus: https://www.bluecrossmn.com/about-us/quality-improvement-program
- HealthPartners: https://www.healthpartners.com/hp/about/understanding-cost-and-quality/quality-improvement/index.html
- Itasca Medical Care: http://www.co.itasca.mn.us/657/Community
- Medica: https://www.medica.com/providers/quality-and-cost-programs/quality-improvement-program
- Hennepin Health: http://www.hennepinhealth.org/quality
- PrimeWest: https://primewest.org/annual-report
- South Country Health Alliance: http://mnscha.org/?page_id=5924
- UCare: https://www.ucare.org/About/Pages/QualityHighlights.aspx