

**Medicaid Managed Care Contract Language:
Health Disparities and Health Equity
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Introduction

This is the third revision of this publication since its original release in June 2020. It has been updated to incorporate language from requests for proposals in Hawaii, Oklahoma, and North Carolina (for the state’s managed behavioral health care program) and excerpts from Ohio’s request for applications for managed care and managed behavioral health care. In addition, this version includes language from New York’s Value-Based Payment Roadmap, bringing the total number of documents included in the compendium to 15 (*see Table 1*).

Table 1: State Documents Reviewed

State / Entity Contracts Included
1. District of Columbia
2. Hawaii
3. Kentucky
4. Michigan
5. Minnesota
6. New York Value Based Payment Roadmap for Medicaid
7. North Carolina
8. North Carolina (managed behavioral health care)
9. Ohio
10. OhioRISE (managed behavioral health care)
11. Oklahoma
12. Oregon
13. Virginia
14. Washington
15. Covered California, California’s Health Exchange

While state Medicaid managed care programs may define health equity differently, in general, health equity means that everyone has a fair and just opportunity to attain their optimal health, regardless of race, ethnicity, disability, gender identity, sexual orientation, or socioeconomic status. In contrast, health disparities are avoidable differences in health outcomes experienced by people with one characteristic (race, gender, sexual orientation) as compared to the socially dominant group.

In this document, summaries of Medicaid managed care disparities and/or equity contract language and efforts are listed in alphabetical order by state, including the District of Columbia (D.C.). The contract summary for the California Health Insurance Exchange is listed at the end since it is not a Medicaid managed care example.

Health equity/health disparity excerpts from the managed care contracts and other Medicaid managed care initiatives reviewed are organized into the eight categories listed below. 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 order listed below 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

The authors reviewed a select number of Medicaid managed care contracts that incorporated health equity and/or health disparities. The authors examined Medicaid managed care contracts, requests for proposals (RFPs) and requests for applications (RFAs) that explicitly mentioned health disparities and/or health equity. In addition, the authors reviewed Medicaid quality strategies, including External Quality Review Organizations (EQRO) technical reports, vendor contracts, value-based payment initiatives, and strategic priorities. The criteria for inclusion in this compendium were managed care contracts that explicitly addressed health disparities and/or health equity. This compendium does not reflect an exhaustive review of all states' Medicaid managed care program activities or contracts.

Note: Information in this compendium will be updated on an ongoing basis. The authors have noted the date when materials were last reviewed for the purposes of this compendium. The “last reviewed date” that is included with each state is the date when authors reviewed and updated information – it is not necessarily the date when a state issued new or updated information. As new information becomes known and is added to or modified in the compendium, the authors will indicate the dates accordingly.

General Findings

States vary in contract provisions and actions to advance health equity in their Medicaid managed care programs. This reflects differences overall in state managed care approaches and the heightened attention to health equity across states. Most of the contracts that included references to health equity or health disparities incorporated definitions of key concepts and terms, many of which were adapted from national initiatives (e.g., Healthy People 2020) or organizations (e.g., the Robert Wood Johnson Foundation). Many states require their Medicaid MCOs to stratify quality measures by race, ethnicity, and language preference, which was among the more common provisions in the contracts reviewed. Many states also require their Medicaid MCOs to implement the national standards for Culturally and Linguistically Appropriate Services (CLAS), which are intended to advance health equity, improve quality, and help eliminate health care disparities.ⁱ Less common but notable requirements states are imposing on their Medicaid MCOs include: MCO staff training in health equity, race equity, and implicit bias; creation of key staff positions, for example a Health Equity Director,ⁱⁱ with specific qualifications and responsibilities to advance equity; and reporting the race and ethnicity of its contracted providers.ⁱⁱⁱ

Table 2 provides an overview of high-level contract requirements and indicates states that have included provisions related to a specific area.

Table 2: Overview of Contract Requirements

State / Entity	State indicates / specifies HEDIS or other measures that must be stratified by REL	Health equity terms defined	Requires implementation of National CLAS Standards	MCO staff training and / or position requirements	Incentive program to address health equity / reduce disparities	Disparities or health equity report requirement*	Separate health equity plan requirement**
Covered California	✓	✓			✓		
District of Columbia	✓						
Hawaii	✓			✓			✓
Kentucky	✓						
Michigan	✓	✓	✓		✓		
Minnesota	✓						
North Carolina (RFP)	✓					✓	
North Carolina (BH RFA)	✓	✓		✓			
Ohio (RFA)	✓	✓	✓	✓			
Ohio (BH)	✓	✓	✓	✓			
Oklahoma (RFP)	✓	✓					✓
Oregon		✓	✓	✓	✓	✓	✓
Virginia		✓				✓	
Washington		✓	✓				

*Separate from Quality Assurance and Performance Improvement requirements

**Inclusive of Cultural Competency and Sensitivity Plans

Managed Care Contracts

District of Columbia (D.C.)

D.C.'s current Medicaid Managed Care Organization (MCO) contract is not posted publicly.^{iv}

(Last reviewed December 2020)

Overview
<p><i>The District's MCO contracts became effective October 1, 2020. MCOs are required to identify health disparities in health care utilization and in health outcomes based on member demographic data including race, ethnicity, and language, by District ward. MCOs are required to address health disparities through quality improvement requirements.</i></p>
General Language
<p>SECTION C: Specifications/Work Statement</p> <p>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.</p> <p>Specifically, this contract has the following purposes: ...</p> <p>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...</p>
Measurement and Data Analytics
<p>C.5.32 Quality Assessment and Performance Improvement (QAPI)</p> <p>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;</p> <p>C.5.32.3 CQI Plan</p> <p>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...</p> <ul style="list-style-type: none">• 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

D.C. (continued)

Quality Improvement

C.5.32 Quality Assessment and Performance Improvement (QAPI)

The Contractor shall submit a QAPI Program Annual Summary...[which] 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.

Hawaii

[Link](#) to the RFP.

(Last reviewed January 2021)

Overview

Hawaii's Quality requirements direct MCOs to develop a SDOH Transformation Plan to address health disparities, develop a cultural competency plan and to stratify disparities measures by race/ethnicity, language, and other measures, among additional requirements.

Quality Improvement

SECTION 5 – Quality, Utilization Management, and Administrative Requirements

5.1 Quality

2. In order to achieve the objectives of DHS Quality Strategy, the Health Plan shall collaborate with DHS, other state agencies, and as needed with other Health Plans, to:
 - b. Develop and adopt an SDOH work plan within its QAPI that adopts a whole person care approach throughout the QAPI through the provision of SDOH resources at the community and Member levels.
 - c. Develop and adopt a comprehensive cultural competency plan within its QAPI that allows the Health Plan to effectively provide services to its diverse membership, with targeted efforts to address and mitigate disparities and cultural gaps.
6. The SDOH Transformation Plan will represent DHS' plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on factors such as age, race, ethnicity, gender, primary language, and disability status. The SDOH Transformation Plan is expected to develop a shared DHS and Health Plan road map to comprehensively and systematically address health disparities. This will include the use of analytic methods to identify, monitor, and address unmet social needs, such as:
 - a. Collection of new, or collation of existing SDOH data, at the community and individual levels;
 - b. Enhanced use of SDOH data as inputs in predictive and actuarial models, as well as in hot spotting and other advanced analytic methods, leading in turn to:
 1. Improved identification of Members and Member communities disproportionately impacted by SDOH and at high risk for poor health outcomes; and
 2. Improved application of SDOH-based adjustment factors into VBP arrangements.
 - c. Enhancing awareness of and access to community-based SDOH supports and resources;
 - d. Addressing social needs in the delivery of care and resources provided to beneficiaries;
 - e. Adapting the delivery of care and resources provided to beneficiaries based on their SDOH needs;
 - f. Developing targeted strategies to addressing the SDOH needs of special populations disproportionately impacted by SDOH and at high risk for adverse health outcomes;
 - g. Promoting statewide collaboration with the other Health Plans, DHS and other state agencies and/or partners in implementing SDOH strategies; and
 - h. Collecting and incorporating community input in establishing effective partnerships with existing community resources in the implementation of SDOH strategies
7. The SDOH Transformation Plan will outline the supports, resources, and improvements DHS will make to support the Health Plan's SDOH work plan and facilitate shared learning and statewide collaboration.
8. The SDOH Transformation Plan will be reviewed and updated as part of DHS Quality Strategy. The Health Plan shall align its SDOH work plan to describe the on the ground community and Member-level activities that will realize the overall goals and strategies of the SDOH Transformation Plan.

Hawaii (continued)

Quality Improvement

B. Quality Assessment and Performance Improvement Program

1. QAPI Plan – General Requirements

- e. The QAPI program shall, at a minimum, address the following elements and requirements:
 - 10. Submitting a report that identifies disparities in health services and health outcomes between subpopulations/groups including, but not limited to, race/ethnicity and language. The report shall be submitted along with a plan of action and a timeline to remediate the SDOH and health disparities identified through targeted interventions. The plan of action should include a performance measurement and evaluation component.
 - 24. Use of sophisticated IT infrastructure and data analytics to support DHS’ vision and goals for quality improvement, measurement and evaluation, including the capability to identify sub-populations by age, race, ethnicity, primary language, special populations, or other demographics experiencing disparities. The Health Plan shall also use predictive analytics to identify populations at risk for poor health outcomes and high cost, stratify and report metrics at the state and regional or service area level, and by sub-population, and be able to report data at the patient or provider level to DHS as required.

5. Practice Guidelines

a. The Health Plan shall include, as part of its QAPI program, practice guidelines that meet the following requirements as stated in 42 CFR §438.236 and current NCQA standards. Each adopted practice guidelines shall be:

- 4) Designed as systematic strategies to enhance use and implementation of evidence-based practices in 209 support of addressing disparities, improving quality, enhancing adoption of evidence-based models and practices, and increased adoption of HIT-based strategies;

8. DHS Review of Health Plan QAPI Activities

- 2) DHS shall evaluate the Health Plan’s QAPI activities utilizing a variety of methods, including but not limited to:
 - j) Reviewing and validating the Health Plan’s approach to identifying addressing health disparities and proposed SDOH interventions

Specialized Initiatives

SECTION 5 – Quality, Utilization Management, and Administrative Requirements

6. Cultural Competency Plan

- a. The Health Plan shall have a comprehensive written cultural competency plan that shall:
 - 1. Design programs, interventions, and services, which effectively address cultural and language barriers to the delivery of appropriate and necessary health services, and address cultural disparities identified via the Disparities Report in §5.1.B.1.e.10;
 - 2. Describe how the Health Plan will ensure services are provided in a culturally competent manner to all Members so that all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, understand their condition(s), the recommended treatment(s), and the effect of the treatment on their condition, including side effects;
 - 3. Describe how the Health Plan will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes, affirms, and respects the worth of the individual Members and protects and preserves the dignity of each; and

Hawaii (continued)

Specialized Initiatives (continued)

4. Comply with, and ensure providers participating in the Health Plan’s provider network comply with, Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, 45 CFR Part 80 and 42 CFR §§438.6(d)(4), 438.6(f), 438.100(d), and 438.206(c)(2).

SECTION 6 – Health Plan Reporting and Encounter Data Responsibilities

6.2 Report Descriptions

4. Quality

2) Quality Assessment and Performance Improvement Reports

b) The Health Plan’s Medical Director shall review these reports prior to submittal to DHS. The QAPI Plan submitted at the start of the contract shall not include a progress report component, and the QAPI Progress Report submitted at end of the contract shall not include a plan update component. QAPI work plans and progress reports shall meet submission requirements noted in §5.1, and be submitted using templates and formats specified by DHS. As noted in §5.1, the QAPI work plans and progress reports shall incorporate reports of disparities and a work plan to address identified disparities, supporting DHS compliance with 42 CFR §438.340.

SECTION 11 – Health Plan Personnel

11.3 Position Descriptions

4. Data Analytics Officer:

a. The Health Plan shall have a Data Analytics Officer to support and oversee all data analytics activities of the contract including, but not limited to, the implementation of sophisticated predictive analytic tools to identify target populations for various programs, conducting disparities and trend analyses, informing the incorporation and use of SDOH data into clinical and administrative data, operationalizing non-standard performance and quality metrics, and supporting the reporting and evaluation needs of the Contract.

Kentucky

[Link](#) to Medicaid MCO contract
(Last reviewed December 2020)

Overview
<p><i>Kentucky's MCO contract provisions include collecting and reporting stratified HEDIS and other measures and performing comparative analyses to identify health disparities. The contract states that MCO Performance Improvement Projects (PIP) should address the specific clinical needs of enrollees where a disparity exists.</i></p>
Measurement and Data Analytics
<p>20.1 Kentucky Outcomes Measures and Health Care Effectiveness Data and Information Set (HEDIS) Measures</p> <p>... 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 provided by the Department to Contractor. This information may be used to determine disparities in health care.</p>
Measurement and Data Analytics
<p>20.2 Reporting HEDIS Performance Measures:</p> <p>.... 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.</p>
Performance Monitoring and Incentives
<p>20.4 Performance Improvement Projects (PIPs):</p> <p>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....</p> <p>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.</p>

Michigan

[Link](#) to Medicaid Health Plan (MHP) contract

(Last reviewed December 2020)

Overview
<p><i>Michigan’s Medicaid Health Plan (MHP) contract includes a broad population health management strategy with requirements related to measuring and addressing health disparities and promoting health equity. The state is using a portion of its capitation withhold approach to incentivize MHPs to address racial disparities and improve regionally-defined performance. MHPs must analyze data and report on the effectiveness of interventions designed to reduce health disparities and advance health equity. MI Medicaid Managed Care has a special low birth rate initiative related to reducing racial disparities in maternity outcomes, in addition to other health equity initiatives.</i></p>
General Language
<p>Population health management includes an overarching emphasis on health promotion and disease prevention and incorporates 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.</p> <p>“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.</p> <p>“Health Disparity” - A particular type of health difference that is closely linked with social or economic disadvantage.</p> <p>“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.</p>
Measurement and Data Analytics
<p>X. Population Health Management</p> <p>Data Analysis to Support Population Health Management</p> <p>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:</p> <ol style="list-style-type: none">i. Subpopulations experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level.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.

Michigan (continued)

Measurement and Data Analytics (continued)

- 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.

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.

Michigan (continued)

Measurement and Data Analytics (continued)

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 [Appendix A](#) of this compendium 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.

Appendix 5A Performance Bonus Template

This portion of the Michigan contract allocates 50 points from the state’s Medicaid health plan withhold/bonus approach related to plan’s reporting on sickle cell, as well as statistically significant improvement in reducing the disparity on the following HEDIS measures for members who identify as African American, White, and Hispanic:

- Adults’ Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years ; Breast Cancer Screening BCS; Cervical Cancer Screening CCS; Chlamydia Screening in Women - Total CHL Post-Partum Care PPC; Childhood Immunizations - Combination 3 CIS; Immunizations for Adolescents - Combination 1 IMA; Lead Screening in Children LSC; Well Child Visits 3-6 years W34; Comprehensive Diabetes Care - HbA1c Testing CDC1; Comprehensive Diabetes Care - Eye Exams CDC2

Michigan (continued)

Specialized Initiatives

FY18-FY20 Focus Bonus: Low Birth Weight (LBW) – Appendix 5B

In 2017, the Michigan Medicaid Managed Care Plan Division identified Low Birth Weight (LBW) as a target outcome associated with the Pay for Performance (P4P) Initiative for the MHPs. The LBW portion of the Michigan contract allocates 30 points from the state’s Medicaid health plan withhold/bonus approach related to plan’s reporting on six month and twelve months intervention results in FY21.

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 data 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.

Minnesota

[Link](#) to Minnesota DHS Contract for Prepaid Medical Assistance and MinnesotaCare
(Last reviewed January 2021)

Note: On January 4, 2021, the Minnesota Department of Human Services (DHS) released a [Medicaid managed care RFP](#) for contracts beginning January 1, 2022. The contracts will cover seven counties in Minnesota. See [Appendix B](#) for an excerpt of the RFP and questions the state is asking respondents related to health equity, racial equity, reduction of disparities, and the provision of culturally-specific care.

Overview
<i>Minnesota requires MCO's to engage in at least one quality improvement project to address health care disparities. The state requires that MCOs publish a description of the selected disparities project on their websites. A listing of MCO quality improvement websites is included within Appendix C. MCO quality improvement activities include increasing colorectal cancer screenings among members of color; increasing access to dental care for members with disabilities; and reducing racial disparities in depression management.</i>
Quality Improvement
7.8 Annual Quality Program Update. 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.

New York Value Based Payment Roadmap for Medicaid Payment Reform

[Link](#) to the 2019 Value Based Payment Roadmap for Medicaid Payment Reform

(Last reviewed December 2020)

Overview
<p><i>The New York Value Based Payment Roadmap provides best practices and lesson learned to guide implementation of New York’s vision for payment reform. The 2019 Value Based Payment Roadmap includes health equity as a consideration within value based benefit and value based payment design.</i></p>
General Language
<p>Incentivizing the Member: Value Based Benefit Design</p> <p>... While member incentives can be a powerful tool, these programs need to be thoughtfully designed to ensure there are no unintended consequences, for example increasing disparities or limiting access. To this end, the State has developed guidance to encourage all MCOs and providers to take into account the following set of guiding principles in their design and implementation as building blocks of member incentives:...</p> <ul style="list-style-type: none">b. Culturally sensitive – Ensuring cultural sensitivity is necessary to provide successful outcomes, as cultural norms differ and may need to be incentivized differentlyc. Unbiased – Creating unbiased incentives is necessary to comply with federal laws. Incentives must not leave out any groups on the basis of ethnicity, education, race, social class etc.)d. Possess equity – Equality is not enough when providing incentives, rather maintaining equity should also be considered (equality would be providing a pair of size 10 shoes to everyone; equity is providing a pair of the correct size shoes to everyone)...g. Communicated appropriately in a timely manner – Incorporate the most appropriate and farthest reaching vehicle to communicate the incentive so as not to exclude members (e.g. lack of literacy and technology should be considered). Appropriate messaging should capture high quality outcomesh. Be relevant – If barriers exist that prevent the members from using the incentive, the incentive will not hold much value (e.g. a member is given a gym membership as an incentive but does not have the transportation to get to the gym)... <p>It is important to note that the process of designing member incentives is complex and will need to consider underlying disparities and social determinants of health including community needs, and local planning efforts. Above all, member incentives must not reinforce disparities or perpetuate inequality within or between communities, particularly in terms of how disparate subpopulations access wellness services and support.</p>
Specialized Initiatives
<p>Children’s Subpopulation</p> <p>Future adoption of an appropriate payment model will be influenced and guided by this framework and by the American Academy of Pediatrics’ “Bright Futures” guidelines for Pediatric Primary Care practices. In addition, the following goals shall remain intact for 2019 around optimizing measurement in Children’s Medicaid that shall provide the appropriate underpinnings for a sound Children’s arrangement:...</p> <ul style="list-style-type: none">• Encouraging the use of quality measurement to improve clinical practice and reduce health disparities;

North Carolina – Medicaid Managed Care

[Link](#) to Medicaid Prepaid Health Plan Model Contract (*not yet implemented*)

(Last reviewed December 2020)

Overview
<p><i>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 a 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 RFP from prepaid health plans (PHPs). Reducing health disparities will be a focus of North Carolina's Quality Management and Quality Improvement requirements. Health plans will be required to identify disparities and implement interventions through their population health management programs to reduce disparities.</i></p>
Measurement and Data Analytics
<p>E. Quality and Value</p> <p>1. Quality Management and Quality Improvement</p> <p>j. Disparities Reporting and Tracking</p> <ul style="list-style-type: none">• 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
<p>E. Quality and Value</p> <p>1. Quality Management and Quality Improvement</p> <p>.. [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.</p> <p>The Quality Management and Improvement Program Plan shall include...</p> <ul style="list-style-type: none">• 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 assess and address health disparities at a statewide and regional level, including findings from the disparity report that PHPs are required to develop;

North Carolina – Managed Behavioral Health Care

[Link](#) to the RFA. [Link](#) to the Scope of Services.

(Last reviewed December 2020)

Overview

North Carolina’s Behavioral Health and Intellectual/Developmental Disability Tailored Plan will serve populations with severe behavioral health conditions (mental health and substance use), individuals diagnosed with Intellectual/Developmental Disabilities, and individuals diagnosed with Traumatic Brain Injury. One of North Carolina’s goals of the procurement is to address health disparities. Plans will be required to provide culturally and linguistically appropriate services, track and report on health disparities, participate in statewide efforts to reduce health disparities, screen for social risk factors, and refer members to community-based organizations with an emphasis on housing services.

General Language

I. Introduction

A. Vision for North Carolina’s Medicaid Managed Care Program

...

5. The Department envisions that through Medicaid Managed Care and provision of State-funded Services BH I/DD Tailored Plans will address the unique needs of Historically Marginalized Populations including people of color and others who have been marginalized across Department service sectors. The Department recognizes to combat historical health inequities, a disproportionate share of resources needs to be committed to disparate populations.

C. Specific Background Regarding BH I/DD Tailored Plans

...2. With the transition to BH I/DD Tailored Plans, the Department seeks to emphasize the following priorities of the delivery of State-funded Services and aims to:

- i. Promote consistency and equity in access to State-funded Services to those with the greatest needs;

III. Definitions, Abbreviations, Contract Term, General Terms and Conditions, Other Provisions and Protections

A. Definitions

90. Historically Marginalized Populations: Individuals, groups, and communities that have historically and systematically been denied access to services, resources and power relationships across economic, political, and cultural dimensions as a result of systemic, durable, and persistent racism, discrimination and other forms of oppression. Long standing and well documented structural marginalization has resulted in poor health outcomes, economic disadvantage, and increased vulnerability to harm and adverse social, political and economic outcomes. Historically Marginalized Populations are often identified based on their race, ethnicity, social economic status, geography, religion, language, sexual identity and disability status.

26. Care Management [includes] ... Management of unmet health-related resource needs and high-risk social environments;

199. Unmet Health-Related Resource Needs: Non-medical needs of individuals that foundationally influence health, including but not limited to needs related to housing, food, transportation and addressing interpersonal violence/toxic stress.

North Carolina Managed Behavioral Health Care *(continued)*

Population / Community Health Management

V. Scope of Services

viii. Written and Verbal Recipient Materials

a) The BH I/DD Tailored Plan shall provide all written materials to recipients and potential recipients consistent with the following:

7. Includes taglines in the top fifteen (15) prevalent non-English languages in North Carolina, as well as large print, explaining the availability of written translation or verbal interpretation to understand the information provided and the toll-free and TTY/TDD telephone number of the BH I/DD Tailored Plan's Member and Recipient Service Line. *(Note, the state identifies the top 15 prevalent non-English languages in the RFA.)*

c. Marketing

vii. The BH I/DD Tailored Plan shall ensure that all marketing materials and marketing strategies shall abide by the BH I/DD Tailored Plan's Non-discrimination Policy. In addition, the BH I/DD Tailored Plan shall not discriminate against recipients or potential recipients who may:

- a) Live or receive health care in rural or underserved areas; or
- b) Experience income disparities

Measurement and Data Analytics

5. Quality

viii. Disparities Reporting and Tracking

a) The BH I/DD Tailored Plan 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.

c) The BH I/DD Tailored Plan shall address inequalities as determined by the Department during review of the BH I/DD Tailored Plan's stratified performance on measures identified by the Department as relevant to disparities in health outcomes.

d) The Department will define the disparity stratifications for each measure after Contract Award and annually thereafter.

ix. The BH I/DD Tailored Plan shall be an active partner in [Healthy NC 2030](#) goals' planning by...joining planning meetings; Designating a senior level clinical staff person to engage in public health issue discussions; and Aligning QI activities to support Healthy NC 2030 goals.

x. Public Health Reporting and Tracking

a) The BH I/DD Tailored Plan shall work with the Department to target areas of collaboration and develop programs as part of Quality Improvement efforts that can:

1. Remove barriers (e.g., services coverage, implementation challenges, recipient education);

North Carolina Managed Behavioral Health Care (continued)

Interventions

xiii. Staffing and Training Requirements for Care Managers Serving Recipients with I/DD or TBI Diagnoses

e) Care Management Training for Care Managers Serving Recipients with I/DD or TBI Diagnoses

1. The BH I/DD Tailored Plan shall develop and implement a care management training curriculum that includes ...

c) Cultural and Linguistic Competency, including LTSS needs, considerations for tribal populations, nonwhite populations, and forms of bias that may affect recipients.

f.ii System of Care Staffing Requirements

d) The BH I/DD Tailored Plan shall implement the State System of Care training curriculum for System of Care Coordinators and Family Partners that includes the following:

1. Identifying and addressing barriers to care including strategies to improve the Cultural and Linguistic Competency of the BH service delivery system; ...

2. Partnering with families and youth in Care Plan development, implementation, and evaluation process;

3. Engaging with a diverse set of public, private, and natural supports stakeholders to ensure that Care Plans are comprehensive and implementation is shared across sectors; ...

5. Identifying and addressing racial, ethnic, cultural disparities in the access, availability, and quality of service delivery; and ...

iii. System of Care Policy

d) The System of Care Policy shall include the BH I/DD Tailored Plan's policies and processes for implementing the System of Care Staffing Requirements...:

5. Conducting outreach to families with lived experience to ensure they are engaged as partners in the service delivery process, and are incorporated into advisory bodies addressing System of Care-related training, workforce development, and development of service array, including Community Collaboratives;

8. Describing how the BH I/DD Tailored Plan will work with local and State public agency partners to...Reduce disparities in access to services and supports, availability and quality and completion rates based on race, ethnicity, gender, sexual orientation, and geography

Quality Improvement

5.a Quality Management and Quality Improvement

iii. ... The QI process will build upon the Department's experience and focuses on rigorous outcome measurement against relevant targets and benchmarks, promotes equity through reduction or elimination of health disparities, and appropriately rewards BH I/DD Tailored Plans and, in turn, providers for advancing quality goals and health outcomes.

a) QAPI Plan...[will include]

9. Mechanisms to assess for and a process for identifying interventions to reduce quality outcome disparities based on age, race, ethnicity, sex, primary language, geography and by key population group;

11. Mechanisms to assess and address health disparities, including findings from the disparity report that BH I/DD Tailored Plans are required to develop.

Ohio – Medicaid Managed Care

[Link](#) to Ohio Medicaid Managed Care RFA

(Last reviewed December 2020)

Overview

The Ohio Department of Medicaid (ODM) seeks to advance health equity through Medicaid managed care population health strategies, which are designed to address health inequities and disparities and achieve optimal outcomes for the holistic well-being of individuals receiving Medicaid. The state identifies specific staff responsible for advancing health equity, including a Health Equity Director and identifies expectations of senior leadership related to monitoring health disparities and promoting health equity. The contract also specifies the population health management systems requirements to advance health equity. The state establishes that health plans must share information about effective strategies and interventions to reduce disparities with other plans.

General Language

Definitions and Acronyms

Health Disparity – 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).

Health Equity – Exists when everyone has a fair opportunity to attain their full health potential.

Population Health Management – An approach to maintain and improve physical and psychosocial wellbeing and address health disparities through cost-effective, person-centered health solutions that address members' health needs in multiple settings at all points along the continuum of care.

Social Risk Factors – Economic and social conditions that may influence individual and group differences in health and health outcomes. These factors may include age, gender, income, race, ethnicity, nativity, language, sexual orientation, gender identity, disability, geographic location, and many others.

Appendix A – General Requirements

4. Member Requirements

a. Health Equity

i. ... the MCO must address health care disparities and ensure equitable access to and the delivery of services to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, or disabilities; and regardless of gender, sexual orientation, or gender identity.

ii. "Equitable access" for purposes of this Agreement means meeting the standards as defined by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (<https://www.thinkculturalhealth.hhs.gov/clas>)...

iv. The MCO's health equity efforts must align with the requirements in Appendix C, Population Health and Quality.

Ohio Medicaid Managed Care (continued)

General Language (continued)

f. MCO Member and Family Advisory Council

iii. The MCO must ensure that the composition of the council is diverse and representative of the MCO's current membership throughout the region with respect to the members' race, ethnic background, primary language, age, Medicaid eligibility category

iv. As new populations are enrolled in managed care, the MCO must actively ensure the council's membership reflects the diversity of its enrolled population.

7. MCO Website Requirements ...the MCO must ensure its website is Americans with Disabilities Act Section 508 compliant and meets health equity requirements.

8. Staffing Requirements

c. Key staff

ix. Health Equity Director

1. The Health Equity Director must: a. Hold at least a bachelor's degree from a recognized college or university and a minimum of five years professional work experience, preferably in public health, social/human services, social work, public policy, health care, education, community development, or justice; b. Have demonstrated community and stakeholder engagement experience; and c. Have experience in actively applying or overseeing the application of science-based quality improvement methods to reduce health disparities.

2. The primary roles and responsibilities of the Health Equity Director are to:

a. In close coordination with the Population Health Director, oversee the MCO's strategic design, implementation, and evaluation of health equity efforts in the context of the MCO's population health initiatives;

b. Inform decision-making around best payer practices related to disparity reductions, including the provision of health equity and social determinant of health resources and research to leadership and programmatic areas;

c. Inform decision-making regarding best payer practices related to disparity reductions, including providing MCO teams with relevant and applicable resources and research and ensuring that the perspectives of members with disparate outcomes are incorporated into the tailoring of intervention strategies;

d. Collaborate with the MCO's Chief Information Officer to ensure the MCO collects and meaningfully uses race, ethnicity, and language data to identify disparities;

e. Coordinate and collaborate with members, providers, local and state government, community-based organizations, ODM, and other ODM contracted managed care entities to impact health disparities at a population level; and

f. Ensure that efforts addressed at improving health equity, reducing disparities, and improving cultural competence are designed collaboratively with other ODM-contracted managed care entities to have a collective impact for the population and that lessons learned are incorporated into future decision-making.

d. MCO Organizational Staff

iv. Population Health Staffing ...3. The MCO's population health staffing must include health equity staff, and staff in the fields of analytics, statistics, and informatics.

e. MCO Staff Training Requirements

iv. The MCO must submit an MCO Staff Training Plan, including the topics and frequency of training, to ODM for prior review and approval as specified in Appendix P, Chart of Deliverables. At a minimum, the MCO training must include...Training on health equity and implicit bias;

APPENDIX C – POPULATION HEALTH AND QUALITY

2. Population Health Infrastructure

b. Senior Leadership Support

iii. The MCO, through its senior leadership, must:

3. Ensure a focus on both individual- and system-wide levels of improving the quality of care and reducing health disparities;

6. Ensure that all MCO population health initiatives support health equity;

7. Ensure the MCO shares results of improvement activities with other ODM contracted managed care entities, care coordination entities (CCEs), and ODM to work collaboratively to develop and implement strategies to have a collective impact in improving population health outcomes, including addressing health equity and social determinants of health (SDOH);

c. Staffing Resource Allocation

iii. Health Equity Staffing

1. The MCO must have sufficient health equity staffing resources to:

a. Actively contribute to QI projects within each of the ODM-identified population streams;

b. Attend ODM-led meetings and make connections with health equity staff from ODM and other ODM-contracted managed care entities; and

c. Establish relationships with communities and community-based entities to inform and address local health equity issues.

iv. Quality improvement Staffing

3. The MCO must have QI teams composed of MCO staff fully dedicated to the Ohio Medicaid program that represent the following areas of expertise...d. health equity

d. Population Health Information System

ii. System Capabilities

6. The MCO's data system must support health equity efforts by:

a. Allowing for the identification of disparities in areas such as service access, utilization, health outcomes, intervention effectiveness, social risk factors, and survey (e.g., CAHPS) results by member characteristics; and

b. Supporting the monitoring and comparison of process and outcome measures over time to inform disparity reduction efforts.

3. Population Identification and Segmentation

a. Population Stream Assignment

iii. The MCO must, in its Population Health Management Strategy, describe each population stream and include the incidence and prevalence of medical and behavioral health conditions and issues that may impact health status, such as:

Age, gender, race, ethnicity, geography, language, and other socio-economic barriers;

APPENDIX C – POPULATION HEALTH AND QUALITY

4. Population Health Improvement Strategies

a. General

- i. The MCO's population health improvement strategies must include...Care Coordination:
 - 2. Optimizing the delivery system through quality and performance improvement activities, health equity, and the identification and promotion of clinical and payer best practices; and

c. Health Equity

- i. The MCO must participate in and support ODM's efforts to reduce health disparities, address social risk factors, and achieve health equity. The MCO's health equity efforts must include the following:
 - 1. Identifying disparities in health care access, service provision, satisfaction, and outcomes. This includes: a. Obtaining data on member demographics and social determinants; and b. Stratifying MCO data (e.g., claims, Healthcare Effectiveness Data and Information Set [HEDIS], CAHPS, health risk assessment, member-identified race, ethnicity, geography, language, and SDOH) to determine populations with the highest needs.
 - 2. Ensuring the delivery of services in a culturally appropriate and effective manner to all members by promoting cultural humility at all levels of the MCO and with network providers, including promoting awareness of implicit biases and how they impact policy and processes;
 - 3. Engaging families when designing services and interventions that integrate care and address childhood adversity and trauma;
 - 4. Obtaining ongoing input from members within population streams who have disparate outcomes to: a. Create strategies for reducing disparities that incorporate the perspective of the member; b. Define metrics, timelines, and milestones that indicate success; and c. Establish credibility and accountability through active member involvement and feedback.
 - 5. Ensuring that each functional area with outward facing communications tests potential publications with members for understanding and conveyance of the intended message, as well as cultural appropriateness;
 - 6. Collaboratively partnering with members, other ODM-contracted managed care entities, network providers, and internal staff to test, refine, and share successful strategies for reducing disparities;
 - 7. Connecting and engaging with individuals and organizations within the communities the MCO serves to understand community needs and resources;
 - 8. Partnering with community-based organizations and contribute to solutions addressing SDOH-related needs...

d. Optimal Delivery System

- ii. The MCO must develop and apply clinical and payer best practice guidelines for service delivery decisions pertaining to: utilization management (UM), member grievance and appeals, provider dispute resolution, member education, coverage of services, QI projects, addressing disparities and other areas to which these guidelines apply.

e. MCO Specialized Services and Resources

- iii. The MCO must identify community services and resources that can be offered to members and build working relationships with community organizations to refer to and support provision of those services....The MCO is responsible for ensuring that the community services meet health equity expectations, the member's needs, honor member preference...

Ohio Medicaid Managed Care (continued)

Measurement and Data Analytics

APPENDIX I – QUALITY MEASURES

2. Quality Measures

c. Reporting Only

ii. The MCO must stratify certain performance measures by race, as determined by ODM. Stratification by race is for informational/reporting purposes only.

APPENDIX C – POPULATION HEALTH AND QUALITY

h. Quality Improvement

i. General Requirements

iv. MCO Clinical and Non-Clinical Improvement Projects

1. The MCO must design and conduct improvement projects in clinical and non-clinical topic areas that improve population health (including health equity) across the care continuum.

4. In conducting improvement projects, the MCO must: f. Analyze data to identify disparities in services and/or care and tailoring interventions to specific populations when needed in order to reduce disparities;

Performance Monitoring and Incentives

APPENDIX H – VALUE BASED PAYMENT

4. Value Based Initiatives

c. Comprehensive Primary Care Practice Requirements

iii. The MCO must support each of the CPC's activities and the overall CPC initiative as follows:

15. As requested by the CPC, participate in the CPC's improvement opportunities aimed at reducing health care disparities and improving outcomes and member experience.

Other

APPENDIX D – CARE COORDINATION

2. Care Coordination Requirements

a. Staffing and Training

iii. The MCO must provide onboarding and ongoing training for MCO care coordination staff that includes health equity (cultural competency), person-centered care planning, trauma-informed care, motivational interviewing, grievance and appeal processes and procedures, community resources within the MCO's service areas, strategies for any disease specific processes, incident reporting requirements, and Health Insurance Portability and Accountability Act (HIPAA) requirements.

Ohio – Managed Behavioral Health Care

[Link](#) to the OhioRise RFA

(Last reviewed December 2020)

Overview
<p><i>The Ohio Resilience through Integrated Systems and Excellence (OhioRISE) Program is a statewide managed care program for children and youth involved in multiple state systems or children and youth with other complex behavioral health needs. Within this RFA, the strategies that Ohio is using to promote health equity include dedicating staff to address health equity, promoting the use of trauma informed care, addressing member’s social needs, promoting member and community engagement, and addressing health equity through population health management, quality improvement, and care coordination.</i></p>
General Language
<p>Appendix A – General Requirements</p> <p>2. Definitions</p> <p>Health Disparity – 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 challenges; sexual orientation; or geographic location).</p> <p>Health Equity – Exists when everyone has a fair opportunity to attain their full health potential and that no one is disadvantaged from achieving this potential.</p> <p>Population Health – The health outcomes of a group of individuals, including the distribution of such outcomes within the group. Within Ohio Medicaid, these groups may be defined by health care service utilization, common diagnoses, physical or behavioral health need, demographic characteristics, geography, or social determinants (e.g., homelessness).</p> <p>Population Health Management – An approach to maintain and improve physical and psychosocial well-being and address health disparities through cost-effective, person-centered health solutions that address members' health needs in multiple settings at all points along the continuum of care.</p> <p>4. Member Requirements</p> <p>a. Health Equity</p> <p>i. ... the OhioRISE Plan must address health care disparities and ensure equitable access to and the delivery of services to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.</p> <p>ii. "Equitable access" for purposes of this Agreement means meeting the standards as defined by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (https://www.thinkculturalhealth.hhs.gov/clas).</p> <p>iii. ... OhioRISE Plan must ensure that the OhioRISE Plan, its subcontractors, and network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities.</p> <p>iv. The OhioRISE Plan's health equity, including racial equity efforts must align with the requirements in Appendix C, Population Health and Quality.</p> <p>v. The OhioRISE Plan must participate in ODM's health equity initiatives as requested by ODM.</p>

Ohio Managed Behavioral Health Care (continued)

General Language (continued)

b. Member Information

2. Written Materials

f. The OhioRISE Plan must ensure that all member materials are clearly legible, and use person-centered, trauma-informed, and easily understood language and format.

i. The OhioRISE Plan must write member materials at or below a sixth grade reading level, unless otherwise approved by ODM.

ii. If the OhioRISE Plan must include medical terminology that is not understandable from a layperson perspective, the OhioRISE Plan must offer the member an opportunity to speak to an OhioRISE Plan's representative to explain the information.

8. Staffing Requirements

b. Key Staffing Requirements

vi. Population Health Director

2. The primary roles and responsibilities of the Population Health Director are to...Provide leadership for programmatic initiatives to reduce health disparities and address SDOH.

xv. Family Engagement Director

3. The primary functions of the Family Engagement Director are to...Support population health objectives by assisting with outreach to and obtaining input from populations experiencing disparities in access to care or disproportional service use;

xvi. Youth Engagement Director

2. The primary functions of the Youth Engagement Director are to:

a. Work closely with OhioRISE Plan's senior management and staff and the OhioRISE Program Member and Family Advisory Council to assist in the development, evaluation, and improvement of services to ensure adherence to the OhioRISE Program's mission and values of authentic youth engagement, building community, equitable practices that promote race equity, diversity and inclusion, and strengths-based, youth-guided practice;

b. Develop and provide support to a Youth subgroup of the OhioRISE Program Member and Family Advisory Council, including outreach to recruit young people to the subgroup with lived experience in behavioral health, foster care, juvenile justice, or who are experiencing homelessness to participate in opportunities to inform OhioRISE Plan's operations, population health strategies, and quality improvement;

c. Conduct orientation, as well as initial and ongoing training for young people on various topics;

d. Provide ongoing support, guidance, and coaching to young people engaged in opportunities and programming, including life domain development, conflict resolution, emotional and moral support, and providing transportation as needed;

e. Provide ongoing input, information, and materials (as requested) that support internal and external communication efforts about youth-guided care;

e. OhioRISE Plan's Staff Training Requirements

At a minimum, the OhioRISE Plan's training must include...Training on health and race equity and implicit bias;

APPENDIX C – POPULATION HEALTH AND QUALITY

2. Support for the Children with Behavioral Health Conditions Population Stream

a. Population Streams

i. To organize its population health work, ODM has identified six population streams for the Ohio Medicaid system: women (mothers and infants), children with behavioral health conditions, adults with behavioral health conditions, healthy children, healthy adults, and individuals with chronic conditions. Each MCO must stratify populations within its membership to drive the MCO population health management approach, prioritization of initiatives, and resource allocation and to optimize health outcomes.

ii. The OhioRISE Plan must, at the direction of ODM, play a primary role in driving population health efforts for high-risk children and youth in the population stream focused on children with behavioral health conditions, including:

1. Work with ODM and the MCOs to develop cross-cutting population health and quality improvement initiatives for high-risk children and youth within this population stream;
2. Providing consultation, upon ODM request, to ODM, the MCOs, the SPBM, and other ODM-contracted managed care entities in the following areas related to this population stream:
 - a. The development and implementation of population health strategies;
 - d. Health and race equity issues; and
 - e. Strategic initiatives and other quality improvement activities.
3. Monitoring and evaluating population health and quality improvement activities under this population stream.

3. Population Health Infrastructure

b. Senior Leadership Support

iii. The OhioRISE Plan, through its senior leadership, must:...

3. Ensure a focus on both individual and systemic levels of improving quality of care and reducing health disparities;
4. Ensure that gaps in behavioral health care are remedied at both the individual and systemic levels and ensure that any physical health gaps identified at either level are reported to the MCOs of the impacted members;
6. Ensure that the OhioRISE Plan works collaboratively with the MCOs, other ODM-contracted managed care entities, SPBM, CMEs and OhioRISE' Plan network providers, care coordination entities (CCEs), and ODM to work collaboratively to share results of improvement activities, and to develop and implement strategies to have a collective impact in improving population health outcomes, including addressing health and race equity and social determinants of health (SDOH);

c. Staffing Resource Allocation

iii. Health Equity Staffing

1. The OhioRISE Plan must have sufficient health equity staffing resources, which may be organized under the Population Health Director, to:
 - a. Actively contribute to quality improvement projects within each of the ODM identified children's population health streams;
 - b. Attend ODM-led meetings and make connections with health equity staff from ODM, MCOs, and other ODM-contracted managed care entities;
 - c. Coordinate health equity work with other ODM-contracted managed care entities;
 - d. Provide support to CMEs and OhioRISE Plan's network providers related to OhioRISE Plan's health equity and quality improvement efforts;
 - e. and Establish relationships with communities and community-based entities to inform and address local health and race equity issues.

Ohio Managed Behavioral Health Care (continued)

Population/Community Health Management (continued)

iv. Quality Improvement Staffing

3. The OhioRISE Plan must have staff fully dedicated to the OhioRISE Program who represent the following areas of expertise:...Population health and health and race equity

4. Population Health Improvement Strategies

a. General

i. The OhioRISE Plan will coordinate with each MCO to support its population health management strategies, including support for:

1. Care coordination, consistent with the requirements in Appendix D, Care Coordination;
2. Optimizing the delivery system through quality and performance improvement activities, health and race equity, and the identification and promotion of clinical and payer best practices; and
3. Supportive payment structures to promote a system-wide population health management approach.

c. Health Equity

i. The OhioRISE Plan must participate in and support ODM's efforts to reduce health disparities, address social risk factors, and achieve health equity for its members. The OhioRISE Plan's health equity efforts must include the following:

1. Identifying disparities in health care access, service provision, satisfaction, and outcomes that includes:
 - a. Obtaining data on member demographics and social determinants; and
 - b. Stratifying OhioRISE Plan data (e.g., claims, CANS, care plan data, member-identified race and ethnicity, geography, language, and SDOH) to determine populations with the highest needs.
2. Ensuring the delivery of services in a culturally appropriate and effective manner to all members by promoting cultural humility at all levels of the OhioRISE Plan and with CMEs and other community-based behavioral health providers, including promoting awareness of implicit biases and how they impact policy and processes;
3. Engaging youth and families when designing services and interventions that integrate care and address childhood adversity and trauma;
4. Obtaining ongoing input from members and families to:
 - a. Create strategies for reducing disparities that incorporate the perspective of the member and their family;
 - b. Define metrics, timelines, and milestones that indicate success; and
 - c. Establish credibility and accountability through active member and family involvement and feedback.
5. Ensuring that each functional area with outward-facing communications tests potential publications with members and families for understanding and conveyance of the intended message, as well as cultural appropriateness;
6. Collaboratively partnering with members, families, MCOs, other ODM contracted managed care entities, SPBM, network providers, and internal staff to test, refine, and share successful strategies for reducing disparities;
7. Connecting and engaging with individuals, families, and organizations within the communities the OhioRISE Plan serves to understand community needs and resources;

Ohio Managed Behavioral Health Care (continued)

Population/Community Health Management (continued)

- 8. Supporting CMEs to partner with community-based organizations to address SDOH-related needs...
- 9. Ensuring the active referral to and follow-up on identified needs related to SDOH such as those outlined above by:
 - a. Supporting CMEs to maintain validated and up-to-date community resource lists for member and provider use;
 - b. Sharing Health Risk Assessments, CANS, and other sources identifying SDOH needs, subject to state and federal privacy requirements, with CMEs, network providers, HUBS and community health workers;
 - c. Ensuring SDOH needs and strategies are included in the child and family-centered care plans developed by the child and family teams;
 - d. Reimbursing SDOH codes (z codes); and
 - e. Reimbursing network providers for follow-up after referral to confirm that the member received the service (e.g., HIEs).
- 10. Staying informed of innovations and research findings that impact the health of populations experiencing disparities; and
- 11. Tracking data over time and increasing performance targets when milestones are met.
- ii. The OhioRISE Plan must describe how the OhioRISE Plan meets the requirements for addressing health disparities as part of its Quality Assurance Performance Improvement (QAPI) submission as described below in this appendix.
- d. Optimal Delivery System
 - ii. The OhioRISE Plan must develop and apply clinical and payer best practice guidelines for service delivery decisions pertaining to: utilization management, including medical necessity determinations, care coordination, member grievance and appeals, provider dispute resolution, member education, coverage of services, quality improvement projects, addressing disparities, and other areas to which these guidelines apply.

Measurement and Data Analytics

Appendix A – General Requirements

7. OhioRISE Plan's Website Requirements

a. General

- i. The OhioRISE Plan must ensure its website is Americans with Disabilities Act Section 508 compliant, is accessible to individuals with limited English proficiency, and meets health equity requirements.

Appendix C – Population Health and Quality

d. Population Health Information System

6. The OhioRISE Plan's data system must support health equity efforts by:

- a. Allowing for the identification of disparities in areas such as service access, utilization, health outcomes, intervention effectiveness, social risk factors, and OhioRISE Plan-specific member survey results by member characteristics; and
- b. Supporting the monitoring and comparison of process and outcome measures over time to inform disparity reduction efforts.

7. The OhioRISE Plan's data system must efficiently and securely share data with ODM, the Centers of Excellence (COEs), CCEs, MCOs, the SPBM, CMEs, and other community-based behavioral health organizations, subject to state and federal privacy requirements, including:...

- c. Risk factor related to SDOH and other relevant information

Ohio Managed Behavioral Health Care (continued)

Interventions

Appendix D – Care Coordination

2. Care Coordination Requirements

iii. The OhioRISE Plan must provide onboarding and ongoing training for OhioRISE Plan's care coordination staff that includes: health equity (cultural humility), racial equity, social determinants of health (SDOH) and health disparities, Child and Adolescents Needs and Strengths (CANS) process, child and family-centered care planning, needs for multi-system children and youth, early childhood development, member engagement, shared decision-making, trauma-informed care (including secondary trauma to caregivers and family members), motivational interviewing, grievance and appeal processes and procedures, community resources within the OhioRISE Plan's service areas, incident reporting requirements, and Health Insurance Portability and Accountability Act (HIPAA) requirements.

Quality Improvement

Appendix C – Population Health and Quality

h. Quality Improvement

i. General Requirements

2. The OhioRISE Plan's QI program must employ a deliberate, defined, and science-informed approach that is responsive to member and provider needs and incorporates systematic methods for discovering reliable approaches to improving the health outcomes and reducing health disparities for the OhioRISE Plan-enrolled population.

4. The OhioRISE Plan's QI program must include the voice, experience, and participation of enrolled members and their families, including but not limited to the Member and Family Advisory Council, member complaints/appeals, surveys, and other methods.

iii. Quality Improvement Program Structure and Accountability

1. Organizational and Cross-Organizational Quality Improvement Efforts

b. The OhioRISE Plan must ensure that staff at all levels of the organization are fully equipped and committed to improving health outcomes and reducing health disparities.

iv. OhioRISE Plan's Clinical and Non-Clinical Improvement Projects

3. The OhioRISE Plan's improvement projects must aim to achieve significant and sustained improvement over time in population health outcomes; quality of life; health disparities; child, youth, young adult, and family satisfaction; and provider satisfaction (e.g., increase utilization/penetration for evidence-based services, increased engagement in care, or increased tenure in the home/community and school).

4. In conducting improvement projects, the OhioRISE Plan must:...

f. Analyze data to identify disparities in services or care, and tailor interventions to specific child, youth, and young adult populations when needed in order to reduce disparities; and

g. Actively incorporate children, youth, and family, provider, child serving state and local agency perspectives into improvement activities.

Oklahoma

[Link](#) to the Oklahoma Sooner Select RFP

(Last reviewed December 2020)

Overview
<p><i>The Oklahoma Health Care Authority's (OHCA) 2020 SoonerSelect RFP incorporates requirements to address health equity through quality improvement and data collection activities, including the collection of race, ethnicity, and language data, and identification and reduction of disparities in health care access, services and outcomes. This RFP also includes specific attention to cultural competency and SDOH.</i></p>
Population/Community Health Management
<p>1.8.2.1 Assessment Tool</p> <p>The Contractor shall develop a Comprehensive Assessment instrument, subject to OHCA approval. The instrument must assess a Health Plan Enrollee's physical health, behavioral health, community and social support needs. At a minimum, the Comprehensive Assessment shall include questions from the following domains:</p> <ul style="list-style-type: none">• Trauma, abuse, neglect, violence and/or sexual assault history of self and/or others, including Department of Human Services involvement;• Educational attainment, skills training, certificates, difficulties and history;• Family/caregiver and social history;• Social profile, community and social supports (e.g., transportation, employment, living arrangements, financial, community resources) and support system, including peer and other recovery supports;• Present living arrangements;• Health Plan Enrollee strengths, needs and abilities;• Home environment; and• Health Plan Enrollee cultural and religious preferences.
Measurement and Data Analytics
<p>1.10.7 Addressing Health Disparities</p> <p>The Contractor shall participate in, and support OHCA's efforts to reduce health disparities. According to the U.S. Department of Health and Human Services' Office of Minority Health, and for the purposes of this Model Contract, 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). To further advance OHCA's efforts to achieve health equity, the Contractor shall collect and meaningfully use Health Plan Enrollee-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 Contractor shall maintain health equity representatives who are actively involved in improvement initiatives to reduce disparities by: obtaining input from Health Plan Enrollees and from Providers of direct services which are intended to reduce adverse health outcomes among Health Plan Enrollees, determining the root cause of inequities, developing targeted interventions and measures, and collecting and analyzing data to track progress in disparity reduction efforts</p>

Oklahoma (continued)

Quality Improvement

1.3.6 Staffing

The Quality Management Director will be responsible for developing and managing the Contractor's portfolio of improvement projects and will work collaboratively with all Contractor's and OHCA to improve population health outcomes, including addressing health equity and Social Determinants of Health.

1.10.3 Quality Assessment and Performance Improvement (QAPI) Program

1.10.3.1 QAPI Program

The Contractor shall review outcome data at least quarterly for performance improvement, recommendations and interventions. The Contractor shall include QAPI activities to improve health care disparities identified through data collection.

Specialized Initiatives

1.11.2 Cultural Competency

Pursuant to 42 C.F.R. § 438.206(c)(2), the Contractor shall participate in OHCA's efforts to promote the delivery of services in a culturally competent manner to all Health Plan Enrollees, including those with LEP and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. The Contractor shall develop a cultural competency and sensitivity plan for review and approval by OHCA at the time of Readiness Review. The plan shall include guidelines for evaluating and monitoring disparities in membership and service quality, especially with regard to minority groups. Elements of this plan shall address how the Contractor will:

- Identify organizations and advocates that could work with LEP communities and individuals in a culturally competent way;
- Incorporate cultural competence into the Contractor's medical, behavioral health, and care management programs, including outreach and referral methods;
- Recruit and train culturally diverse staff that will be able to operate fluently with all Health Plan Enrollee communities throughout the State;
- Ensure Health Plan Enrollee assessments inquire about language preference;
- Conduct self-assessments of cultural and linguistic competence before services commence and with annual frequency thereafter;
- Ensure cultural competence outcomes through internal audits and performance improvement targets;
- Develop a set of cultural competency standards designed to help all parts of the care management process deliver culturally sensitive care;
- Identify and develop intervention strategies for high-risk health conditions found in certain cultural groups; and
- Provide annual training to Care Managers, Participating Providers and Health Plan Enrollee facing staff (e.g., Health Plan Enrollee Services) to ensure the delivery of culturally and linguistically appropriate care.

1.15.2 OHCA Tribal Government Relations Unit

OHCA Tribal Government Relations unit acts as an AI/AN liaison between OHCA and CMS, Indian Health Service, Urban Indian facilities and Indian Tribes of Oklahoma for State and national level issues, including (without implied limitation) AI/AN work groups, policy development and compliance, tribal consultation, payment issues and elimination of health disparities. The Contractor's Tribal Government Liaison shall serve as a single point-of-contact for OHCA Tribal Government Relations unit and shall attend AI/AN consultative meetings held by OHCA.

Oregon

[Link](#) to Medicaid CCO 2.0 Contract

(Last reviewed December 2020)

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 at 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

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
(Last reviewed December 2020)

Overview
<p><i>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 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.</i></p>
General Language
<p>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.</p> <p>Health Inequity: Disparities in health [or health care] that are systemic and avoidable and, therefore, considered unfair or unjust.</p> <p>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</p> <p>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.</p>
Quality Improvement
<p>9. Quality Improvement (QI) and Population Health Oversight: 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.</p> <p>9.3 Quality Improvement Structure</p> <p>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...</p>
Other
<p>8.2.II Telemedicine: .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.</p>

Washington State

[Link to Medicaid MCO contract](#)
(Last reviewed December 2020)

Overview
<p><i>Washington's Medicaid managed care program centers on the implementation of a Health Care Disparities Workgroup. MCOs are required to participate in the workgroup with the Department of Health to identify a performance measure that will become a targeted area of disparities reduction. The state describes the responsibilities of the workgroup in the contract. Additional activities are directed through the Quality Assessment and Performance Improvement (QAPI) program. Washington also requires MCOs to collect data to monitor and evaluate Culturally and Linguistically Appropriate Services (CLAS) on health equity and outcomes.</i></p>
General Language
<p>"Health Disparities" means preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.</p>
Measurement and Data Analytics
<p>7.5 Performance Measures</p> <p>7.5.15 Health Care Disparities Workgroup. The Contractor shall collaborate with peer MCOs and the DOH to form a Health Care Disparities Workgroup aimed at reducing disparities in one performance measure. The Health Care Disparities Workgroup shall consult with community experts and organizations as appropriate to disaggregate data on at least one performance measure and examine the data for racial/ethnic disparities. The Workgroup shall implement interventions aimed at reducing health care disparities in the selected measure. The Health Care Disparities Workgroup shall perform the following work:</p> <p>7.5.15.2 Collect and examine data on ethnicity, race, and language markers as provided by HCA on all Enrollees and augmented by MCOs.</p> <p>7.5.15.3 Cooperate with the Department of Health to complete the analysis of one performance measure no later than June 30.</p> <p>7.5.15.4 Define interventions to address observed disparities.</p> <p>7.5.15.5 Implement defined interventions aimed at addressing disparities.</p> <p>7.5.15.6 Evaluate the effectiveness of interventions to reduce health care disparities.</p> <p>7.5.15.7 Provide adequate funding, resources, and staff to plan, execute, and evaluate the project.</p> <p>7.5.15.8 Submit quarterly progress reports providing an update on the status of the Health Care Disparity Workgroup activities. Reports shall be submitted to HCA quarterly on the third Friday of the month of January, April, July and October.</p> <p>7.15 Practice Guidelines</p> <p>7.15.4 The Contractor shall develop health promotion and preventive care educational materials for Enrollees using both print and electronic media. In developing these materials, the Contractor shall:</p> <p>7.15.4.3 In collaboration with peer Managed Care organizations, disaggregate data on at least one (1) preventive care measure and examine the data for racial/ethnic disparities.</p> <p>7.15.4.4 In collaboration with peer Managed Care Organizations, target interventions with known disparities in preventive care utilization and measure the impact of the interventions on utilization patterns.</p>

Washington State (continued)

Quality Improvement

7.1 Quality Assessment and Performance Improvement (QAPI) Program:

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)

(Last reviewed December 2020)

Covered California (Health Exchange)
Overview
<p><i>Covered California requires Qualified Health Plans (QHPs) to identify, track, trend, and report racial/ethnic and gender disparities in quality measures. The exchange has detailed performance specifications for its QHPs and as well as financial incentives and penalties for QHPs based on performance to these specifications.</i></p> <p><i>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.</i></p> <p><i>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.</i></p> <p><i>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.</i></p>
General Language
<p>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</p> <p>Attachment 7: Covered California Individual Market QHP Issuer Contract: Quality, Network Management, Delivery System Standards and Improvement Strategy.</p> <p>ARTICLE 3: Reducing Health Disparities and Ensuring Health Equity</p> <p>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.</p>

Covered California (continued)

General Language (continued)

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).

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.

Covered California (continued)

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.

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.ihc.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).

Covered California (continued)

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.

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 A: Michigan Health Equity HEDIS Measures in SFY20 MHP Contract

HEALTH EQUITY HEDIS MEASURES

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
<u>*Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life</u>	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
<u>*Chlamydia Screening in Women (Total)</u>	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
<u>*Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing</u>	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
<u>*Cervical Cancer Screening</u>	Women enrolled in a health plan, ages 21 to 64, who were screened for cervical cancer using either of the following criteria: <ol style="list-style-type: none"> 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. $ID = (\sum |r(n) - R| / n) / R * 100$
 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.

Appendix B: Excerpt of Minnesota Medicaid Managed Care RFP

The following is an excerpt from the Minnesota Department of Human Services Medicaid Managed Care Request for Proposals. The RFP in its entirety can be found [here](#). This section has been incorporated into the compendium as an attachment to show equity and disparities language from one state in an RFP.

3. Proposal Requirements

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3.1 Proposal Contents

.....

3.2 Detail of Proposal Components

5. Performance and Service Deliverables

The following sections include questions that will receive a numerical score...These questions reflect both State and County priorities and should address, where applicable, racial disparities, county and community collaboration, and person-centered design even if the question does not expressly state those themes...

Section 1: Enrollee Engagement and Communication (15 points)

1. Describe the accessibility and availability of your organization's customer service operations. Please describe how your customer service operations address the various types of diversity that exist within the MHCP populations. Examples of the types of diversity included in a response are racial and ethnic diversity, languages spoken, employment status and availability to contact a health plan, disability and neurodiversity, and proficiency of health literacy.
2. Describe the development and implementation of your organization's enrollee communications strategy. Describe how you determine what information to communicate to various populations of enrollees, beyond what is required by the DHS managed care contracts. Describe the various methods used to communicate those messages.
3. Describe how your organization solicits and/or receives enrollee feedback regarding enrollee satisfaction, communications, service delivery, provider networks, and health plan operations. Describe how that feedback is used in your organization's operations. Describe efforts to use this feedback to assess how structural racism impacts enrollees' experiences and to improve health outcomes for the MHCP population.
4. Describe your organizations' efforts to help your enrollees remain enrolled in coverage, prior to the public health emergency. Describe your organizations' recommendations to DHS as to how to better prevent lapses in coverage for enrollees following the end of the public health emergency as well as the role MCOs should play in the process of preventing them in the future.

Section 2: Improving Outcomes and Eliminating Disparities (30 points)

1. How does your organization address structural racism? What steps have you taken to become an antiracist organization? How do you plan to improve your systems and processes to be more antiracist?

2. Describe a specific initiative your organization has implemented to address racial disparities you see within populations you serve. Describe the selection of the initiative, the planning process, implementation, evaluation, and learnings from that initiative.
3. Describe the various populations that receive coverage through MHCP who experience barriers to health care and describe those barriers. Describe the initiatives you have provided to help improve the experiences for communities that experience barriers and disparities in health care outcomes.
4. Describe your organization's approach to addressing social drivers of health to improve population health and prevention. Describe your organization's work regarding community collaboration efforts, provider and other stakeholder partnerships, and data collection including social drivers of health and analysis. If applicable, provide examples for populations in the various regions of your current or proposed service area covered by this RFP.
5. Describe how your organization connects enrollees to the behavioral health benefits offered through the Families and Children Medical Assistance (MA) and MinnesotaCare programs and helps them move through the continuum of behavioral health care services. Describe any differences in your approach between adults and children/youth.
6. How does your organization establish and maintain processes that are culturally responsive and that support the integration and coordination of an enrollee's primary care, behavioral health, and dental care? How do you identify the enrollees that will benefit from further coordination?
7. Describe your internal processes and your collaborative work with providers to identify enrollees in need of lower intensity services that can prevent the utilization of emergency or more restrictive placements. Describe your organization's work to connect enrollees to those services. Describe the outcomes of these efforts.
8. Describe steps your organization has taken and/or will commit to taking to reduce implicit, explicit, and institutional bias experienced by Black and Indigenous people during pregnancy, delivery, and postpartum care. How are these actions monitored? How will these actions be sustained and/or adjusted in the future? How will these actions improve health outcomes and address disparities in health outcomes for Black and Indigenous people during and after pregnancy?
9. How has your organization approached disparities in well child visits? What have you learned from these efforts and how will you apply these learnings to future efforts? How are you connecting families to broader social supports?
10. Describe what your organization has learned from the COVID public health emergency with respect to care delivery. Describe strengths and vulnerabilities within the health care delivery system that have been magnified during the crisis. Describe any innovations your organization has implemented to respond to the public health emergency and what should continue beyond the public health emergency.

Section 3: Payment Policy and Innovation (14 points)

1. How does your organization use value-based purchasing or other incentive arrangements to improve racial equity in quality of care and health outcomes?

2. How does your organization use value-based purchasing or other incentive arrangements to address social drivers of health to improve quality of care and health outcomes?
3. How does your organization use payment strategies to ensure access to culturally-specific care or a broader range of non-traditional medical care?
4. How has your organization used innovative payment strategies to respond to COVID-19 and maintain provider network adequacy?
5. Describe your organization's approach to reimbursement rate development for physician and clinic services, behavioral health services, and services that are unique or especially important to the MHCP population?
6. Describe your organization's approach to reimbursement rate development for dental services and how it is used as a tool to ensure or increase access to services?

Section 4: Community and County Collaboration (12 points)

1. Describe your involvement in the development of the County Public Health Community Needs Assessment or the county or local public health goals of a comparable Medicaid market in which you participate. How have you supported activities related to the goals and objectives identified from the County Public Health Community Needs Assessment or the expressed needs of the counties or local districts?
2. Describe an initiative you have implemented or supported resulting from the outcomes of the County Public Health Community Health Needs Assessment or expressed needs of local counties or districts. Describe your role in the initiative and your working relationship with the counties/districts and community organizations in the implementation.
3. Describe your engagement strategy with the counties in your metropolitan service area or the counties/local districts in the comparable service area. Provide a detailed overview of the activities related to your most recent county engagement strategy. Include initiatives implemented or planned as a result of your engagement efforts.
4. Describe your process for fielding and responding to enrollee issues raised by counties or local districts. How are you evaluating response time and county satisfaction in the resolution of these issues?

Section 5: Provider Networks (15 points)

1. How is your organization working to diversify its provider network to meet your enrollees' cultural and linguistic needs and preferences? How are you ensuring your provider networks are reflective of the communities served by MHCP?
2. Describe your organization's criteria for evaluating out of network exceptions.
3. How does your organization triage calls received from providers to ensure that calls are addressed by the appropriate staff at your organization? Describe how you train provider customer service staff to handle questions related to new or complex services. Describe any tools used to assess

provider satisfaction and feedback as well as how those results are used to improve your provider customer service operations.

4. Describe how you define, evaluate, and ensure the adequacy of your provider networks, beyond what is required under Minnesota Statutes § 62D.124 and the MHCP contracts. Describe how you ensure the availability of providers of services often unique to the Medicaid program and who are positioned to address social risk factors.
5. How do your network providers advance equity and reduce health disparities? What percentage of your network is included in the initiatives described?

Section 6: Administrative Responsibilities (14 points)

1. Describe how your organization, including any subcontractors, ensures prompt payment of all clean claims as required in the model contract. Describe your process for resolving any timely payment claim payment issues. Provide details regarding the amount of interest paid to providers on claims paid late, the number of claims on which interest was paid due to timely payment issues, and, for comparison, the number of clean claims adjudicated timely for all MHCP claims paid for State fiscal year 2020.
2. Describe how the Responder will ensure that Medicaid encounter claims data submitted to DHS are timely, accurate, complete and consistent. Describe how the Responder envisions the process of voiding and resubmitting data to DHS to make corrections.
3. Describe how your organization uses grievance data to improve services delivered to your enrollees. Provide examples of trends identified and what you implemented to improve enrollee outcomes. Provide details on how you are measure the improvements.
4. Describe how your organization and your subcontractor, if applicable, use prior authorization including your objectives in implementing prior authorization. Describe the process for evaluating the impact of these prior authorization policies and any subsequent revisions to those polices.
5. Describe how your organization prevents, detects and responds to instances of fraud, waste and abuse (FWA) by providers and enrollees. Describe all relevant practices, including methods used to detect aberrant billing patterns; prevent payment on improper claims; investigate suspected FWA; impose consequences for providers responsible for FWA; report pertinent information related to FWA investigations, refer suspected fraud to the appropriate authorities; and decide when an enrollee's placement in the Restricted Recipient Program is appropriate.
6. Describe the staff of the unit that investigates FWA in your organization, including, the number of staff dedicated to FWA investigations, the level of experience and/or education required for staff members, and any relevant training that staff receive from your organization. Responses to this question should include proposed program integrity practices as they relate to both providers and enrollees.
7. Describe your process for enrollees to request benefit exceptions. Describe how enrollees are educated as to how to request a benefit exception. Describe your organization's processes for review of the requests and how the evaluation criteria are developed and applied.

8. Describe methods used to monitor new subcontractors during the implementation of a new contract to ensure services and provider payments are accurate and timely. Describe a time when it was discovered that one of your subcontractors was not meeting a contractual obligation that affected enrollee access or provider payments. Describe what the issues were, and how they were identified and addressed. Describe lessons learned and what your organization put in place to prevent the problems from reoccurring.

Appendix C: 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>

ⁱ National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. Accessed December 18, 2020. <https://thinkculturalhealth.hhs.gov/clas>.

ⁱⁱ See Request for Applications, Ohio Medicaid Managed Care Organizations. Issued September 30, 2020. Accessed December 18, 2020 at <https://procure.ohio.gov/PDF/ODMR202100249302020115355ODMR20210024.pdf>.

ⁱⁱⁱ See State of Michigan Contract No. Comprehensive Health Care Program for the Michigan Department of Health and Human Services. FY20. Accessed December 18, 2020 at https://www.michigan.gov/documents/contract_7696_7.pdf.

^{iv} The summary for D.C. is based on the 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).