

**Medicaid Managed Care Contract Language:
Health Disparities and Health Equity
Prepared by Bailit Health
Updated January 2022**

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Support for this document was provided by the Robert Wood Johnson Foundation.

The views expressed here do not necessarily reflect the views of the Foundation.

Introduction

This is the fifth update to this State Health and Values Strategies (SHVS) publication highlighting health disparity and health equity components of state Medicaid managed care programs since its original release in June 2020. This latest iteration includes updated language from Medicaid programs in Michigan, North Carolina, Ohio, Oregon, Virginia, and Washington, as well as new language from Pennsylvania and Rhode Island.ⁱ Table 1 identifies the state programs that are summarized in this compendium.

Table 1: State Documents Reviewed

State / Entity Contracts Included
1. California (draft Medicaid RFP)
2. District of Columbia
3. Hawaii
4. Indiana
5. Kentucky
6. Louisiana
7. Michigan (<i>updated</i>)
8. Minnesota
9. New York Value Based Payment Roadmap for Medicaid
10. Nevada
11. North Carolina (<i>updated</i>)
12. North Carolina (managed behavioral health care)
13. Ohio (<i>updated</i>)
14. OhioRISE (managed behavioral health care)
15. Oklahoma
16. Oregon (<i>updated</i>)
17. Pennsylvania (<i>new</i>)
18. Rhode Island (<i>new</i>)
19. Virginia (<i>updated</i>)
20. Washington (<i>updated</i>)

SHVS defines health equity to mean that everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, gender identity, sexual orientation, socioeconomic status, geography or any other social barriers/factor.ⁱⁱ In addition, SHVS defines health disparities as avoidable differences in health outcomes experienced by people with one characteristic (race, gender, sexual orientation) as compared to the socially dominant group (e.g., white, cis-gender, heterosexual male, etc.).

In this document, summaries of Medicaid managed care disparities and/or equity contract language and efforts are listed in alphabetical order by state and the District of Columbia (D.C.).

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.ⁱⁱⁱ

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 examined a select number of 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 mention health disparities and/or health equity. This compendium is not 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. Strategies to promote health equity within Medicaid managed care contracts continue to evolve. Most Medicaid managed care documents that reference health equity or health disparities include 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 Medicaid MCOs to collect member race, ethnicity and language data and stratify quality measures by those same demographics. Some state Medicaid programs also require MCOs to identify health disparities by disability, sexual orientation, gender identity, or other demographics. Additional and notable state requirements for managed care plans include:

- a. Requiring 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.^{iv}
- b. Conducting MCO staff training in health equity, racial equity, and/or implicit bias.^v
- c. Creating key staff positions, for example a Health Equity Director,^{vi} with specific qualifications and responsibilities to advance equity.
- d. Reporting the race and ethnicity of contracted providers.^{vii}
- e. Implementing alternative payment models to encourage MCOs to reduce health disparities, such as through a maternity care bundled payment which offers a financial incentive to reduce racial inequities in birth-related outcomes.^{viii}
- f. Requiring MCOs to submit a disparities or health equity report to the state, which may include, for example, the MCO's progress collecting member demographic data and implementing and evaluating the effectiveness of activities designed to reduce health disparities.^{ix}

Table 2 provides an overview of high-level Medicaid managed care contract and program requirements and indicates states that have included provisions related to a specific area. The authors identified the most common provisions across Medicaid managed care programs. Some states may have other provisions related to health equity and health disparities not listed here.

Table 2: Overview of Managed Care Contract and Program Requirements Related to Equity and Disparities

State / Entity	Stratification of quality measures by REL	Health equity terms defined	MCO staff training and / or position requirements	Require the National CLAS Standards	Incentive program to address health equity / reduce disparities	Disparities or health equity plan or report requirement
California		✓	✓	✓		✓
District of Columbia	✓					
Hawaii	✓		✓			✓
Indiana			✓	✓		✓
Kentucky	✓					
Louisiana	✓	✓	✓	✓	✓	✓
Michigan	✓	✓		✓	✓	
Minnesota	✓					
Nevada	✓		✓		✓	✓
North Carolina	✓				✓	✓
North Carolina (BH RFA)	✓	✓	✓			
Ohio	✓	✓	✓	✓	✓	✓
Ohio (BH)	✓	✓	✓	✓		
Oklahoma	✓	✓				✓
Oregon	✓	✓	✓	✓	✓	✓
Pennsylvania					✓	✓
Rhode Island	✓	✓	✓			✓
Virginia	✓	✓				✓
Washington	✓	✓	✓	✓		✓

Managed Care Contracts

California (Medi-Cal)

[Link](#) to the California Medi-Cal Managed Care Plans (MCP) Draft Request for Proposals (RFP).

(Last reviewed July 2021)^x

Overview

California's draft RFP and sample contract include requirements for a Health Equity Officer; diversity, equity, and inclusion training for contractor staff, subcontractors and network providers; a Population Needs Assessment to assess, provide and maintain culturally competent services and health equity; payment based on performance against specified equity benchmarks; a Quality Improvement System to address needed improvements in equity of care, including the creation of a Quality Improvement and Health Equity Committee and development of a Quality Improvement and Health Equity Annual Report; and a Cultural and Linguistic Program to monitor, improve and evaluate cultural and linguistic services that support the delivery of member services.

General Language

RFP Main

Our vision is to preserve and improve the overall health and well-being of all Californians and particularly, to address the needs of populations experiencing disparities in health outcomes.

...DHCS is looking for Managed Care Plans that demonstrate their ability to:

7. Reducing health disparities: Identify health disparities and inequities in access, utilization, and outcomes among racial, ethnic, language, and Lesbian, Gay, Bisexual, and Transgender and Questioning (LGBTQ) groups and have focused efforts to improve health outcomes within the groups and communities most impacted by health disparities and inequities.

Exhibit A – Attachment 1 – Definitions and Acronyms

Health Disparity means differences in health outcomes closely linked with social, economic, and environmental disadvantage, which are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics including race, ethnicity, disability, sexual orientation or gender identity, socio-economic status, geographic location, and other factors historically linked to exclusion or discrimination are known to influence the health of individuals, families, and communities.

Health Equity means the reduction or elimination of Health Disparities.

Health Inequities means differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which Members are born, grow, live, work, and/or age.

Population Needs Assessment (PNA) means a process for: A. Identifying Member health needs and Health Disparities; B. Evaluating health education, Cultural & Linguistic (C&L), delivery system transformation and Quality Improvement (QI) activities and other available resources to address identified health concerns; and C. Implementing targeted strategies for health education, C&L, and QI programs and services.

Quality Improvement and Health Equity Committee (QIHEC) means a committee facilitated by Contractor's medical director, in collaboration with the health equity officer or a Physician-designee, to meet at least quarterly to follow-up on all QIS findings and required actions.

California Medicaid (continued)

General Language (continued)

Exhibit A – Attachment III – Operations; 1.1.7 Health Equity Officer

Contractor must maintain a full-time health equity officer... The health equity officer responsibilities must include, but should not be limited to, the following: A. Provide leadership in the design and implementation of Contractor’s strategies and programs to ensure Health Equity is prioritized and addressed; Ensure all Contractor policy and procedures consider Health Inequities and are designed to promote Health Equity where possible, including but not limited to: 1) Marketing strategy; 2) Medical and other health services policies; 3) Member and provider outreach; 4) CAC; 5) Quality Improvement activities, including delivery system reforms; 6) Grievance and Appeals; and 7) Utilization Management. B. Develop and implement policies and procedures aimed at improving Health Equity and reducing Health Disparities; C. Engage and collaborate with Contractor staff, Subcontractors, Network Providers, local community based organizations (CBOs), public health, behavioral health and social services, and Members in Health Equity efforts and initiatives; D. Implement strategies designed to identify and address root causes of Health Inequities; E. Develop targeted interventions designed to eliminate Health Inequities; F. Develop quantifiable metrics that can track and evaluate the results of the targeted interventions designed to eliminate Health Inequities; G. Ensure all Contractor, Subcontractor, and Network Provider staff receive mandatory sensitivity, diversity, communication skills, and cultural competency training.

1.1.11 Diversity, Equity and Inclusion Training

Contractor, Subcontractors, and Network Providers shall ensure that all staff who interact with, or may potentially interact with, Members and any other staff deemed appropriate by Contractor or DHCS, shall receive annual sensitivity, diversity, communication skills, and cultural competency training as specified in Exhibit A, Attachment III, Subsection 5.2.11.C (DEI Training).

4.3 Population Health Management (PHM) and Coordination of Care

Contractor must conduct a PNA at least annually. Contractor must use the PNA to provide and maintain culturally competent and linguistically appropriate services and translations, Health Equity, health education, and continuous Quality Improvement (QI) programs and services for all Members, and determine relevant subpopulations for targeted, person-centered interventions. Contractor’s PNA must evaluate, at a minimum, the following factors for its entire Member population: 1) General characteristics and health needs; 2) Health status and behaviors; 3) Health education and cultural and linguistic needs; 4) Health Disparities; 5) Social Determinants of Health (SDOH); and 6) Any gaps in needed services and resources even if they are not Covered Services.

Contractor must use reliable data sources to conduct and update the PNA, which include, but are not limited to, most recently available Member satisfaction surveys and the DHCS Health Disparities data.Case Manager must ensure all services are delivered in a culturally and linguistically competent manner that provides Health Equity for the Member.

Contractor’s Population Health quality assurance reviews must examine the following, at a minimum: ... Referrals in terms of timeliness, cultural and linguistic appropriateness, and rate of completion.

Performance Monitoring and Incentives

Exhibit B – Budget Detail and Payment Provisions

1.5 Determination and Redetermination of Capitated Payment Rates. DHCS reserves the right, subject to actuarial judgment and generally accepted actuarial principles and practices, to consider Contractor’s performance on specified quality and equity benchmarks, as determined by DHCS and communicated to MCPs in advance of each applicable Rating Period, within the determination of Capitation Payment rates for that Rating Period.

California Medicaid (continued)

Quality Improvement

2.2.3 Quality Improvement and Health Equity Committee (QIHEC): Contractor shall implement and maintain a QIHEC designated by, and accountable to, its Governing Board. The medical director ...shall head QIHEC in collaboration with Contractor's health equity officer. Subcontractors and Network Providers that are part of QIHEC shall be representative of the composition of the Provider Network including but not limited to, Network Providers who provide health care services to Members affected by Health Disparity, Limited English Proficient (LEP) Members, Children with Special Health Care Needs (CSHCN), Seniors and Persons with Disabilities (SPDs) and persons with chronic conditions...

2.2.5 Delegation of QI Activities: Contractor is accountable for all QI and Health Equity functions and responsibilities that are delegated to Subcontractors. Contractor shall, at a minimum, specify the following requirements in the Subcontractor Agreement: 1) QI or Health Equity responsibilities, and specific delegated functions and activities of the Subcontractor;... and 4) Subcontractor's obligation to report findings and actions of QI or Health Equity activities at least quarterly to Contractor. Contractor shall maintain adequate oversight procedures to ensure Subcontractor's compliance with all QI or Health Equity delegated activities that, at a minimum: ...2) Ensures Subcontractor meets QI and Health Equity standards set forth in this Contract;

2.2.6 QIS Policies and Procedures: Contractor shall develop, implement, maintain, and periodically update its QIS policies and procedures that includes, at a minimum, the following:

- Contractor's org. chart showing key staff and committees responsible for QI and Health Equity activities, including reporting relationships of QIS committee(s) to executive staff;
- Qualification & identification of staff responsible for Health Equity activities & QI activities;...
- Policies and procedures to ensure that all Medically Necessary Covered Services are available and accessible to all Members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56, and that all Covered Services are provided in an appropriate cultural and linguistic manner;
- The policies and procedures designed to identify, evaluate and reduce Health Disparities;
- Mechanisms to continuously monitor, review, evaluate, and improve quality and Health Equity of clinical care services provided...
- Mechanisms to continuously monitor, review, evaluate, and improve, case management, coordination and continuity of care services to all Members...

2.2.7 Contractor shall develop and submit an annual QI and Health Equity report to DHCS:

Contractor's report shall include, but are not limited to: 1) A comprehensive assessment of the QI and Health Equity activities undertaken; 2) An evaluation of areas of success and needed improvements in services rendered within the QI and Health Equity program, including but not limited to, the collection of aggregate data on utilization; ...5) The results of efforts to reduce Health Disparities; Providing an annual report to DHCS that includes an assessment of all Subcontractors' performance of delegated QI or Health Equity activities.

California Medicaid (continued)

Other

Exhibit A, Attachment II Operational Readiness Deliverables and Requirements

Contractor shall submit policies and procedures for ensuring that all appropriate staff and Network Providers (and Subcontractors at key points of contact) receives annual diversity, Health Equity, and inclusion training (sensitivity, diversity, communication skills, and cultural competency training).

Submit an analysis demonstrating the ability of Contractor’s Provider Network to meet the ethnic, cultural, and linguistic needs of Contractor’s Members;

Exhibit A – Attachment III – Operations

Contractor shall ensure that Network Provider training includes information on all Member rights...and inclusion training (sensitivity, diversity, communication skills, and cultural competency)...

This process must include an educational program for Network Providers... Trainings must include SDOH and disparity impacts on Members’ health care. Trainings and records must be reviewed and maintained by Contractor’s health equity officer.

Marketing strategies must align with Contractor’s efforts in improving Health Equity.

Contractor shall ensure its Member Services staff are educated on assisting Members with disabilities, chronic conditions and components of Health Equity... This includes assisting Members with access barriers, disability access issues, referral to appropriate clinical services, Grievance and Appeal resolution and State Fair Hearings.

Network Composition: Contractor must continually ensure that the composition of its Network meets the Health Equity, ethnic, cultural, and linguistic needs of Contractor's Members.

Contractor must comply with Title VI of the Civil Rights Act and 42 CFR 438.10(d) and have capacity to provide, at minimum, the following linguistic services at no cost to Members or Potential Members: c) Referrals to culturally and linguistically appropriate community service programs

Diversity, Equity, and Inclusion Training: Contractor must provide annual sensitivity, diversity, cultural competency and Health Equity training for its staff, Network Providers, and Subcontractors. Training must consider structural and institutional racism and Health Inequities and their impact on Members, staff, Network Providers, and Subcontractors.

The training must include the following requirements: 1) Promote access and delivery of services in a culturally competent manner to all Members and Potential Members, regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56; and 2) Information about the Health Inequities and identified cultural groups in Contractor’s Service Area which includes but is not limited to: the groups’ beliefs about illness and health; methods of interacting with Providers and the health care structure; traditional home remedies that may impact what the Provider recommends to treat the patient; and language and literacy needs.

California Medicaid (continued)

Other (continued)

Cultural and Linguistic Programs and Committees: 1) Contractor must develop and implement policies and procedures for assessing the performance of its employees, Subcontractors, Network Providers, staff and other individuals who provide linguistic services as well as for overall monitoring and evaluation of its cultural and linguistic services programs. 2) Contractor must have in place and continually monitor, improve and evaluate cultural and linguistic services that support the delivery of Covered Services to Members. Contractor must ensure it has proper policies and procedures in place to provide appropriate cultural and linguistic services for all Members. 3) Contractor must take immediate action to improve the delivery of culturally and linguistically appropriate services when deficiencies are noted. 4) Contractor must have a cultural and linguistic services program that incorporates all requirements of applicable federal and state law... Contractor must ensure immediate translation of all critical Member Information as required. 5) Contractor must review and update its cultural and linguistic services, and those of its Subcontractors' and Network Providers', programs to align with the PNA. 6) Contractor must implement and maintain a written description of their cultural and linguistic services program which must include the following:

- organizational commitment to deliver culturally & linguistically appropriate health care
- Services that comply with Title VI of the Civil Rights Act ...
- Use of National standards for CLAS for reference;
- An organizational chart showing the key staff with overall responsibility for cultural and linguistic services programs;
- A narrative explaining the organizational chart and describing the oversight and direction to the CAC, requirements for Contractor's support staff, and reporting relationships.
- Qualifications of Contractor's staff, including appropriate education, experience, and training.
- The role of the PNA to inform Contractor's cultural and linguistic services program priorities
- The implementation and maintenance of annual sensitivity, diversity, communication skills, Health Equity, and cultural competency training and related trainings for employees, contracted staff (clinical and non-clinical), Subcontractors, and Network Providers, and
- Contractor's administrative oversight and compliance monitoring of the cultural and linguistic services program and requirements for the delivery of culturally and linguistically appropriate health care services.

D. Community Advisory Committee:

1) Contractor must have a diverse CAC to implement and maintain community partnerships with stakeholders, community advocates, and Traditional and Safety-Net Providers. 2) CAC Membership...b) The CAC Selection Committee must ensure the CAC membership reflects the general Medi-Cal population in Contractor's Service Area and be modified as the population changes.

The CAC Selection Committee must make good faith efforts to include representatives from diverse and hard-to-reach populations on the CAC, with a specific emphasis on persons who are representative of populations that experience Health Disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities.

California Medicaid (continued)

Other (continued)

Duties of the CAC include, but are not limited to: a) Identifying and advocating for preventive care practices to be utilized by the Contractor; b) Contractor must ensure that the CAC is included and involved in developing and updating cultural and linguistic policy and procedure decisions including those related to Quality Improvement, education, and operational and cultural competency issues affecting groups who speak a primary language other than English. The CAC may also advise on necessary Member or Provider targeted services, programs, and trainings; c) The CAC must provide and make recommendations to Contractor regarding the cultural appropriateness of communications, partnerships, and services; d) The CAC must review PNA findings and have a process to discuss improvement opportunities with an emphasis on Health Equity and SDOH. Contractor must allow its CAC to provide input on selecting targeted health education, cultural and linguistic, and Quality Improvement (QI) strategies; e) Contractor must provide sufficient resources for the CAC to support the required CAC activities outlined above; and f) The CAC must provide input and advice, including, but not limited to, the following: i. Culturally appropriate service or program design; ii. Priorities for health education and outreach program; iii. Member satisfaction survey results; iv. Findings of health education and cultural and linguistic group needs assessment; v. Plan marketing materials and campaigns; vii. Communication of needs for Provider network development and assessment; viii. Community resources and information; ix. Population Health Management; x. Quality; xi. Health Delivery Systems Reforms to improve health outcomes; xii. Carved Out Services; xiii. Coordination of Care; and xiv. Health Equity.

Contractor's Annual CAC Demographic Report: To ensure Contractor's CAC membership is representative of the Communities in Contractor's Service Area, Contractor must complete and submit to DHCS annually an Annual CAC Member Demographic Report by April 1 of each year. The Annual CAC Demographic Report must include descriptions of all of the following:

- demographic composition of CAC membership;
- How Contractor defines demographics and diversity of its Members and Potential Members within Contractor's Service Area;
- The data sources relied upon by Contractor to validate its CAC membership align with Contractor's Member demographics;
- Barriers to and challenges in meeting or increasing alignment between CAC membership with the demographics of Members within Contractor's Service Area;
- Ongoing, updated and new efforts and strategies undertaken in CAC membership recruitment to address the barriers and challenges to achieving alignment between CAC membership with demographics of the Members within Contractor's Service Area; and
- a description of the CAC's ongoing role in decision-making about Health Equity, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives.

District of Columbia (D.C.)

D.C.'s current Medicaid Managed Care Organization (MCO) contract is not posted publicly.^{xi}
(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, and 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 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...</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 SDOH, 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 [that] ...include the capacity for, but not limited to...</p> <ol style="list-style-type: none">a. 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.
Quality Improvement
<p>C.5.32 Quality Assessment and Performance Improvement (QAPI)</p> <p>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;</p> <p>C.5.32.5.7 Performance Measures</p> <p>Contractor shall identify disparities in health services and health outcomes between subpopulations/groups (race/ethnicity and language); identify SDOH; and identify the causes for health disparities. The Contractor shall develop a plan of action and a timeline to remediate the SDOH 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.</p>

Hawaii

[Link](#) to the December 2020 Medicaid Managed Care RFP.

(Last reviewed January 2021)

Overview

Hawaii's 2020 RFP and model contract requirements direct MCOs to develop a SDOH Transformation Plan to address health disparities, develop a cultural competency plan, and stratify disparities measures by race/ethnicity, language, and other measures.

As part of its 2021 Community Care Services Program [RFP](#), Hawaii will also require its Medicaid Behavioral Health Organizations (BHOs) to address health disparities within their Quality Assurance and Performance Improvement programs. BHOs will use analytics to identify populations experiencing disparities, design practice guidelines to promote health equity, and create a work plan to address identified disparities.

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;
- 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.

Hawaii (continued)

Quality Improvement (continued)

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.

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 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;

Hawaii (continued)

Specialized Initiatives (continued)

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
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.

Indiana

[Link](#) to the RFP. The language in the table below was taken from the Hoosier Care and Health Indiana Plan (HIP) RFPs. The state issued the RFPs at the same time and the language related to equity and disparities was identical across RFPs.

(Last reviewed June 2021)

Note: On June 7, 2021, the Indiana Office of Medicaid Policy and Planning (OMPP) released two Medicaid managed care RFPs for contracts beginning January 2022. The state seeks to contract with entities to provide managed care services to enrollees in the Hoosier Healthwise and Healthy Indiana Plan (HIP) programs. See [Appendix A](#) for an excerpt of the RFP questions respondents will need to answer in their technical proposals related to health equity.

Overview
<p><i>Indiana will require Medicaid managed care contractors to employ a full-time health equity officer to lead and evaluate strategies to reduce disparities and inequitable access to care. The state will also require contractors to deliver culturally competent services and apply a health equity lens to the provision of services. Indiana will require contractors to engage members and providers to identify root causes of inequities and inform strategies to reduce inequities.</i></p>
General Language
<p>2.3 Administrative and Organizational Structure</p> <p>2.3.2 Key Staff</p> <p>Health Equity Officer – The Contractor must employ a full-time Health Equity Officer dedicated to Indiana Medicaid. The Health Equity Officer will provide leadership and management to define, implement, and evaluate strategies to achieve equitable access and reduce disparities in clinical care and quality outcomes. This strategy must include tracking, assessing, and improving disparities in care, and supporting the diverse cultural, language, economic, education and health status needs of those served by the Contractor.</p> <p>4.0 Member Services</p> <p>4.11 Health Equity</p> <p>In accordance with 42 CFR 438.206, the Contractor shall participate in the State’s efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Per 42 CFR 438.204, at the time of enrollment with the Contractor, the State shall provide the race, ethnicity and primary language of each member. This information shall be utilized by the Contractor to ensure the delivery of culturally competent services. Furthermore, the Contractor will ensure all services are delivered through a health equity lens. The MCP shall maintain health equity representatives who are actively involved in improvement initiatives to reduce disparities by: obtaining input from Medicaid-insured individuals and from providers of direct services which are intended to reduce adverse health outcomes among Medicaid insured individuals, determining the root cause of inequities, developing targeted interventions and measures, and collecting and analyzing data to track progress in disparity reduction efforts. The Contractor will utilize Community Health Workers as part of broader community health integration initiatives and promotion of culturally competent care. The Contractor shall submit an annual health equity plan for FSSA approval which incorporates the Office of Minority Health’s National Standards on CLAS. The CLAS standards are available at https://www.thinkculturalhealth.hhs.gov/clas/standards.</p>

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>

Louisiana

[Link](#) to the Louisiana Medicaid Managed Care Organizations (MCO) Request for Proposals (RFP) and Model Contract. (Last reviewed July 2021)

Note: On June 23, 2021, the Louisiana Department of Health (LDH) released its Medicaid MCO RFP for new contracts with an anticipated operational start date of July 1, 2022. 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

Louisiana's RFP and Model Contract include requirements for a Health Equity Administrator key position; health equity and social determinant of health training for contractor's staff; a Health Equity Plan to address disparities in care that exist in contractor's member population; a health equity withhold linked to the Health Equity Plan; preferred value-based payment arrangements that reduce health disparities and improve equity; and specific quality performance measures that must be stratified by race/ethnicity and rural/urban status.

General Language

RFP Part 1. Administrative and General Information

1.3 Goals and Objectives

The Department will hold contracted MCOs accountable for:

1.3.4.9 Addressing health equity by focusing on improving population health, working to reduce identified disparities for Medicaid populations, maximizing enrollee health, and addressing priority SDOH which include aspects of housing, food insecurity, physical safety, and transportation;

1.43 LDH Diversity and Inclusion Statement

LDH characterizes diversity as representing the differences and similarities of all of us that include, for example, individual characteristics (e.g., disability, age, education level, poverty status, rural/urban setting, race, ethnicity, and sexual orientation), values, beliefs, experiences and backgrounds. LDH also characterizes inclusion as creating a work environment in which all individuals are treated fairly and respectfully, have equal access to opportunities and resources, and can contribute fully to the work of our agency. This is inclusive of LDH also building its capacity to create, support and/or fund (i.e., via programming projects and contracts) efforts that do not discriminate against people, populations, and/or communities due to disability, age, education level, poverty status, rural/urban setting, race, ethnicity, and sexual orientation. LDH believes that diversity and inclusion aid in more equitably achieving its mission "...protect and promote health and to ensure access to medical, preventive and rehabilitative services for citizens of the State of Louisiana."

Model Contract Part 1: Glossary and Acronyms

Cultural Competency – A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with Enrollees. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse Enrollee needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications...

Louisiana (continued)

General Language (continued)

Health Disparity – The preventable differences in health outcomes in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by disadvantaged populations.

Health Equity – Achieved when every person in a community has the opportunity to reach their full health potential and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances."

Health Equity Plan – The Contractor’s strategic initiatives and approaches to activate practices, protocols, and resources that equitably and effectively support the wellness and well-being of all the people, populations, and communities LDH serves, consistent with the LDH Health Equity Plan (see https://ldh.la.gov/assets/cphe/Equity_Framework.pdf).

Social Determinants of Health (SDOH) – The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. SDOH are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.

Model Contract

Part 2: Contractor Responsibilities

2.2 Administration and Contract Management

Staffing Requirements (key personnel)

The Health Equity (HE) Administrator shall serve as the single point of contact responsible and accountable for all matters related to health equity within the Contractor’s organization and provider network to support the effectiveness and efforts of the Contractor’s Health Equity Plan. The HE Administrator must be a high-level employee (i.e., director level or above) but may have more than one area of responsibility and job title. The roles and responsibilities of the HE Administrator are to:

- Oversee the Contractor's strategic design, implementation, and evaluation of health equity efforts in the context of the Contractor's population health initiatives;
- Inform decision-making around best payer practices related to disparity reductions, including the provision of health equity and SDOH resources and research to leadership and programmatic areas;
- Inform decision-making regarding best payer practices related to disparity reductions, including providing Contractor teams with relevant and applicable resources and research and ensuring that the perspectives of Enrollees with disparate outcomes are incorporated into the tailoring of intervention strategies;
- Collaborate with the Contractor’s Chief Information Officer to ensure the Contractor collects and meaningfully uses race, ethnicity, language, disability and geographic data to identify disparities;
- Coordinate and collaborate with Enrollees, providers, local and state government, community-based organizations, LDH, and other LDH contracted managed care entities to impact health disparities at a population level; and
- Ensure that efforts addressed at improving health equity, reducing disparities, and improving cultural competence are designed collaboratively and that lessons learned are incorporated into future decision-making.

Louisiana (continued)

General Language (continued)

2.2.2.7 Staff Training, Licensure, and Meeting Attendance

... The Contractor shall ensure that all staff members having contact with Enrollees or providers receive initial and ongoing training on health equity and SDOH, beyond CLAS requirements and with regard to the appropriate identification and handling of quality of care concerns.

2.4 Services

2.4.1 MCO Covered Services.

The Contractor and its providers shall deliver services in a culturally competent manner to all Enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity and provide for cultural competency and linguistic needs, including the Enrollee prevalent language(s) and sign language interpreters in accordance with 42 C.F.R. §438.206(c).

2.14 Marketing and Education.

The Contractor shall comply with the National Standards for Culturally and Linguistically Appropriate Services in health and health care... Additionally, the Contractor shall participate in the State’s efforts to promote the delivery of services in a culturally competent manner to all Enrollees.

Population / Community Health Management

Model Contract

Part 2: Contractor Responsibilities

2.5 Population Health and Social Determinants of Health

The Contractor shall develop a Population Health Strategic Plan aligned with the Louisiana Medicaid Managed Care Quality Strategy (LDH Quality Strategy) and submit it to LDH during Readiness Review and annually thereafter. The population health strategy shall include:

- Plan to address priority SDOH which include housing, food insecurity, physical safety, and transportation;
- Description of how the Health Equity Plan as described in the Health Equity section is incorporated into the population health strategy.

2.6 Health Equity

The Contractor must participate in, and support, LDH's efforts to reduce health disparities, address social risk factors and achieve health equity. The Contractor must engage a variety of Enrollees and populations to develop and implement a Health Equity Plan designed to address the cultural, socioeconomic, racial, and regional disparities in health care that exist among the Contractor’s Enrollees and communities within the State. The Health Equity Plan shall be developed in alignment with the Contractor’s Population Health Strategic Plan, The LDH Quality Strategy, and the LDH Health Equity Plan.

2.6.1 The Contractor’s Health Equity Plan shall be composed of three main sections, as follows:

- Narrative of the Health Equity Plan development process, including meaningful community engagement;
- Action plan consisting of focus areas, goals within each focus area, specific measurable objectives within each goal that define metrics and timelines that indicate success, and mechanisms to close the referral loop to act on identified social risk factors.

Louisiana (continued)

Population / Community Health Management (continued)

- Overall strategies and specific activities to achieve each measurable objective must include, but are not limited to:
 - a. Ensuring the delivery of services in a culturally appropriate and effective manner to all Enrollees by promoting cultural humility at all levels of the Contractor’s organization and with Network Providers, including promoting awareness of implicit biases and how they impact policy and processes;
 - b. Engaging diverse families when designing services and interventions that integrate care and address childhood adversity and trauma;
 - c. Obtaining ongoing input from Enrollees who have disparate outcomes to incorporate the perspective of the Enrollee;
 - d. Ensuring that each functional area with outward facing communications tests potential publications with Enrollees for understanding and conveyance of the intended message, as well as cultural appropriateness;
 - e. Plan to conduct cultural responsiveness and implicit bias training within the Contractor’s organization and among Network Providers.

2.6.2 Health Equity Plan Timeline

The Contractor shall submit its Health Equity Plan to LDH as part of Readiness Review. The Contractor shall provide updates to LDH on implementation of its Health Equity Plan in an annual report of its progress on meeting Health Equity Plan objectives in prior calendar year.

Measurement and Data Analytics

Model Contract

Part 2: Contractor Responsibilities

2.6 Health Equity

2.6.3 Transparency of MCO Performance on LDH Incentive-based Measures:

- The Contractor shall ensure that data collection, data systems, and analysis allow for the identification of disparities by Enrollee characteristics. As directed by LDH, the Contractor shall stratify and annually report on quality measures by race, ethnicity, language, geographic location (urban/rural parish) and/or by disability in a format provided by LDH.
- LDH may publicly share these stratified results, including comparing performance across MCOs, over time, and to state and other available benchmarks.

2.16.8 Performance Measures: Reporting of quality measures shall include stratification of performance measure results across different populations with attention to geography, ethnicity, race, and disability status.

Attachment H: Quality Performance Measures

Requires specific quality measures to be stratified by race/ethnicity and rural/urban status:

- a. Pregnancy: Percentage of Low Birthweight Births, Contraceptive Care – Postpartum Women Ages 21–44
- b. Child: Well Child Visits in the First 30 Months of Life, Childhood Immunizations (Combo 3), Immunizations for Adolescents (Combo 2)
- c. Adult: Colorectal Cancer Screening, HIV Viral Load Suppression, Cervical Cancer Screening
- d. Behavioral Health: Follow-Up After Emergency Department Visit for Mental Illness (within 30 days), Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (within 30 days), Follow-Up After Hospitalization for Mental Illness

Model Contract Part 2:

Contractor Responsibilities

2.6 Health Equity. LDH may designate certain health equity related tasks and/or benchmarks to be linked to a portion of the MCO performance withhold....

2.17 Value-Based Payment. Preferred VBP arrangements are priorities for LDH based on the potential to improve health care and cost-efficiency. The Contractor shall indicate in its VBP Strategic Plan.... which of the following preferred VBP arrangements it intends to implement and when it will implement such arrangements during the Contract period: ...

- Other models as identified by LDH, including, but not limited to, VBP models specifically designed to reduce health disparities and improve equity.

Part 4: Payment and Financial Provisions

4.4.1 MCO Performance Withhold Amount. LDH may withhold a portion of the Contractor's monthly Capitation Payments to incentivize quality, health outcomes, value-based payments, and health equity. The withhold amount will be equal to 2% of the monthly Capitation Payments....

- Half of the total withhold amount (i.e., 1.0% of the monthly Capitation Payments) shall be considered the quality withhold and applied to incentivize quality and health outcomes for Enrollees. The remaining half of the total withhold amount shall be divided and allocated in equal proportion to VBP (i.e., 0.5% of the monthly Capitation Payment) and Health Equity (i.e., 0.5% of the monthly Capitation Payment) withholds, respectively...

4.4.4 Earning Health Equity Withhold. For each Contract year, the Contractor may earn back the Health Equity withhold based on its reporting and performance relative to health equity requirements as established by this Contract and LDH as described in the Health Equity section.

The MCO must develop a multi-year Health Equity Plan and submit the finalized plan thirty Calendar Days after the Operational Start Date. The Contractor's Health Equity Plan must:

- Stratify MCO results on certain quality measures to identify/address disparities.
- Include staff/provider training requirements related to equity, beyond CLAS requirements.
- Include social needs/equity questions in Health Needs Assessment and develop mechanisms to close the referral loop to act on identified social risk factors.
- Engage a variety of Enrollees/populations in the MCO's health equity approach.

The MCO must submit updates to the Health Equity Plan twice per year.. The mid-year report must include a status update on progress made on health equity strategies submitted with the initial plan. The annual report ...must demonstrate progress on meeting Health Equity milestones and goals as outlined in Section 2.7 of the contract. LDH shall retain the amount of the Health Equity withhold not earned back by the Contractor.

Louisiana (continued)

Quality Improvement

Model Contract

Part 2: Contractor Responsibilities

2.16 Quality Management and Quality Improvement

LDH's Quality Strategy" defines and drives the overall vision for advancing health outcomes and quality of care provided to Enrollees...It articulates priority areas for quality improvement, and details the standards and mechanisms for desired outcomes, integration with population health priorities, and the advancement of health equity through reduction of health disparities.

The Contractor shall deliver quality care that enables Enrollees to maintain good health, prevent poor health outcomes and, if necessary, manage a chronic illness or disability. Quality care refers to:

- Enrollee experience with respect to quality, access, availability, cultural and linguistic appropriateness of services, and continuity and coordination of care.

At a minimum, the Quality Assessment and Performance Improvement (QAPI) Program shall:

- Include specific mechanisms to assess the quality and appropriateness of care provided to Enrollees at risk for health disparities due to: race, ethnicity, sex, primary language, and sexual orientation;
- Include QM/QI activities to improve health care disparities identified through data collection;

The Contractor shall implement an ongoing program of Performance Improvement Projects (PIPs) that focus on clinical and non-clinical performance....non-clinical PIPs include projects focusing on availability, accessibility, low-value care, addressing SDOH, and cultural competency of services.

Other

Model Contract

Part 2: Contractor Responsibilities

2.9 Provider Network, Contracts, and Related Responsibilities

2.9.10 Mainstreaming

LDH considers mainstreaming of Enrollees into the broader health delivery system to be important. The Contractor shall ensure that all Network Providers accept Enrollees for treatment and that Network Providers do not intentionally segregate Enrollees in any way from other persons receiving services.

To ensure mainstreaming of Enrollees, the Contractor shall take affirmative action to confirm that Enrollees are provided MCO Covered Services without regard to race, color, creed, sex, gender identity, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or physical, behavioral, or cognitive disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

- Denying or not providing to an Enrollee any medically necessary MCO covered service or availability of a facility; and
- Discriminatory practices with regard to Enrollees such as separate waiting rooms, separate appointment days, separate physical locations, or preference to private pay or FFS patients.

When the Contractor becomes aware of a Network Provider's failure to comply with mainstreaming, the Contractor shall develop a written plan for coming into compliance with the Contract requirement for mainstreaming with the Network Provider within thirty Calendar Days and provide the plan to LDH in writing.

Michigan

[Link](#) to Medicaid Health Plan (MHP) contract Fiscal Year 21

(Last reviewed December 2021)

Overview

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. Michigan uses a portion of its capitation withhold approach to incentivize MHPs to address racial disparities and improve disparities based on race/ethnicity and geography. 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, [Appendix C](#) provides information on Michigan's Health Equity Measures.

General Language

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.

"Community-based health" - A strong focus on the SDOH, creating Health Equity, and supporting efforts to build more resilient communities by coordinating Population Health improvement strategies.

"Health Disparity" - A particular type of health difference that is closely linked with social or economic disadvantage.

"Health Equity" - When all people have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance.

Measurement and Data Analytics

X. Population Health Management

Data Analysis to Support Population Health Management

Contractor must utilize information... to address Health Disparities, improve Community Collaboration, and enhance care coordination, care management, targeted interventions, and complex care management services for targeted populations including:

- i. Subpopulations experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level.
- 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...

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:

Michigan (continued)

Measurement and Data Analytics (continued)

- 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 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...

Providing Care Management Services and Other Targeted Interventions

- 2a. Contractor must offer evidence-based interventions that have a demonstrated ability to address SDOH and reduce Health Disparities to all individuals who qualify for those services...
- b. Contractor must collaborate with its high volume primary care practices to develop, promote and implement targeted evidence-based interventions...
- c. Contractor must fully and completely participate in the Medicaid Health Equity Project and report all required information to MDHHS within the specified timeframe.
- d. 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 of 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.

See [Appendix C](#) of this compendium for Michigan's Health Equity HEDIS Performance Monitoring Standards.

Performance Monitoring and Incentives

XI. Quality Improvement and Program Development

7. The written [QAPI] plan must describe how the Contractor must...
- p. Defining roles, responsibilities, and procedures for monitoring and continuously improving the following activities:...
 - iii. Interventions targeting subpopulations experiencing Health Disparities.

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 P4P initiative supports and aligns with the Medicaid Health Equity Project, which was initiated by MCPD in 2011 to promote health equity and monitor racial and ethnic disparities within the managed care population. It also aligns with the state's [Infant Mortality Reduction Plan \(IMRP\)](#) and statewide [Regional Perinatal Quality Collaborative](#) efforts. The [LBW P4P initiative] will utilize the 2017 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Live Births Weighing Less Than 2,500 Grams (LBW-CH) measure. Michigan has been reporting the LBW-CH measure rate since 2014 and it has ranged from 8.50% to 10.40% over the past 3 years...

The LBW-CH measure specification will be used to analyze and report state-wide Medicaid managed care data, which will be stratified by prosperity 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.

PROJECT GOAL

MCPD is launching this multi-year statewide Pay for Performance (P4P) initiative to align MDHHS efforts to promote health equity in maternity care and infant care... 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...

PURPOSE

The purpose of the LBW project model will be to encourage active participation by using data analysis to identify partnerships and risk factors associated with LBW (including social determinants of health). The evidence-based intervention will utilize a three-prong approach: Preconception; Timeliness of prenatal care; [and] Post-partum care...

MDHHS has provided the MHPs with the following guidance:

1. Literature Review: MHPs will conduct a literature review with respect to Low-Birth Weight...
2. Member Data: ... MHPs are expected to provide a barrier and gap analysis report to identify the data collection method used for their intervention...
3. Partnership Scan: MHPs must gather input from members who receive prenatal care and identify barriers and gaps based on the regional data analysis. MHPs are required to identify and partner with external organizations in specific regions...
4. Intervention Considerations: MHPs will be required to create and describe potential interventions to improve LBW rates. The intervention considerations will include the identification risk factors by race/ethnicity and prosperity region as well as establishing and maintaining partnerships...

SUBMISSION AND SCORING

There are four components of the LBW project in which the health plans must complete: Baseline Analysis; Intervention Proposal; Intervention Implementation and Timeline Form; and Intervention Reporting.

- Baseline Analysis: The purpose of the Baseline Analysis activity is to develop an in-depth understanding of low birth weight that includes a review of literature; data collection and analysis.
- Intervention Proposal: The purpose of the Intervention Proposal activity is to develop interventions that target low birth weight from findings of the baseline analysis. The Intervention Proposal must be approved by MDHHS to proceed with the Intervention Implementation and Reporting.

Michigan (continued)

Specialized Initiatives (continued)

- **Intervention Reporting:** The purpose of the Intervention Report is to report the results of the intervention and ongoing assessments at six and twelve month intervals.

Requesting guidance from the QIPD Section is highly encouraged. MDHHS offers the MHPs the opportunity to submit a Review submission at least a month prior to the Final due date. The review submission allows MDHHS to review and provide feedback (if necessary) to the Plans before submission date.

Performance Bonus Integration of Behavioral Health and Physical Health Services - Appendix 5e

To ensure collaboration and integration between Medicaid Health Plans (MHPs) and the Pre-paid Inpatient Health Plans (PIHPs), the State has developed the following joint expectations for both entities. There are 100 points possible for this initiative...

- **Follow-up After Hospitalization for Mental Illness within 30 Days (FUH) (40 points)...** Data will be stratified by race/ethnicity and provided to plans. Plans will be incentivized to reduce the disparity between the index population and at least one minority group...

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) (25 points)... Data will be stratified by MDHHS by race/ethnicity and provided to plans. Plans will be incentivized to reduce the disparity between the index population and at least one minority group...

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 D](#) 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

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. 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.

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 SDOH 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;

Nevada

[Link](#) to Nevada’s March 2021 MCO RFP.

(Last reviewed July 2021)

Overview

One of Nevada’s procurement goals is to “identify and address ethnic and racial disparities in health care.” MCOs will be required to address health disparities through population health programs, perform risk stratification to identify populations that experience health disparities, promote health equity within value-based payment designs, and collect data on race and ethnicity, among additional strategies. Nevada’s health equity related RFP questions are included within [Appendix E](#).

Nevada’s Medicaid managed care procurement includes robust requirements related to screening and addressing the SDOH, improving maternal and infant health through value-added services, and addressing cultural competency (e.g., participate in a cultural competency program, create a cultural competency plan, educate and train staff on cultural competency, provide culturally competent services and translation/interpretation services, and evaluate cultural competency programs). The procurement also requires Contractors to reinvest a portion of its profits to support population health strategies in the communities served, such as financial support for Project ECHO and Nevada’s Perinatal Quality Collaborative.

Population / Community Health Management

7.2 Contractor Administrative Requirements

7.2.6. Participation in Meetings and Consortium Activities

7.2.6.2. The Contractor must participate in meetings with the State and county or state-level consortiums focused on mental health or other health conditions or services... These reports include, without limitation, information on health equity, SDOH, and other information...

7.5 Population Health and Care Management

7.5.1 Population Health Programs

7.5.1.2. Population Health management involves an overarching emphasis on health promotion and disease prevention and incorporates community-based health and wellness strategies with a strong focus on SDOH, creating health equity, and supporting efforts to build more resilient communities.

7.5.1.3. The Contractor’s Population Health program must align the efforts and resources of the Contractor’s Care Management programs (i.e., disease management, Care Coordination, Case Management, and programs that address SDOH and racial and ethnic disparities in health care), Quality Management, and the Contractor’s value based contracting strategies to achieve population health improvements.

7.5.2. Population Health Annual Strategy

Within ninety (90) Calendar Days of Contract execution and by January 31 of each Contract Year thereafter, the Contractor must submit a Population Health Annual Strategy to the State for approval that addresses the following:

7.5.2.3. An overview of the stratification algorithm used to risk-stratify the membership, including the following: the data sources utilized; how socio-economic and SDOH factors are considered in the algorithm; how cultural, ethnic and racial factors are considered with the algorithm; and the levels or types of risk categories that result in a Care Management Referral or any type of outreach by the Contractor.

Nevada (continued)

Population / Community Health Management (continued)

7.5.2.4. Overview of the Cultural Competency Plan (CCP) required in Section 7.5.3.2, including how cultural preferences are identified within the membership and a description of how information on culture is used to build a culturally sensitive delivery system.

7.5.2.6 A description of the approach to identify and address racial and ethnic disparities in health care, including:

- 7.5.2.6.1. The process to identify racial and ethnic disparities within the membership;
- 7.5.2.6.2. A summary of the racial and ethnic membership distribution and summary of all identified racial and ethnic disparities within the membership;
- 7.5.2.6.3. A description of how information is used to design targeted clinical programs to improve health care disparities based on race and/or ethnicity;
- 7.5.2.6.4. A description of training provided to all Contractor staff related to addressing racial and ethnic disparities, diversity, and inclusion; and
- 7.5.2.6.5. A description of reporting and/or training provided to Network Providers specifically related to addressing racial and ethnic disparities in health care.

Measurement and Data Analytics

7.5 Population Health and Care Management

7.5.6.5. Member Stratification

7.5.6.5.1. Consistent with Section 7.5.2.3, the Contractor must utilize predictive modeling tools to stratify Members by risk and identify Members who are appropriate for Care Coordination and/or Case Management supports. The stratification model must consider physical, behavioral, and social determinant of health needs identified through a variety of data sources, including but not limited to, claims, pharmacy, utilization data, laboratory results, health needs assessments and other Contractor screenings and/or assessments, referral information, census or other geographic data, and should include methods to identify racial and ethnic health disparities.

7.5.6.5.2. The Contractor is encouraged to incorporate a broad array of data sources such as the American Community Survey (provides population, race, gender, age, income by zip code), Public Health Registries, CDC Chronic Disease Indicators, CDC National Environment Public Health Tracking, Public Safety Reports, School Performance Reports, USDA Food Atlas, and CDC Behavioral Risk Factor Surveillance System (BRFSS).

Interventions

7.5 Population Health and Care Management

7.5.6.7. Level 2 – High: Case Management

7.5.6.7.5. The Contractor’s stratification algorithm must be designed to identify emerging risk, at-risk, and high-risk populations, including Members who are experiencing racial and ethnic disparities in health care.

7.5.6.7.6. The Contractor’s stratification algorithm should incorporate data sources beyond cost and utilization, such as the American Community Survey (provides population, rate, gender, age, and income by zip code), Public Health Registries, CDC Chronic Disease Indicators, CDC National Environment Public Health tracking, Public Safety Reports, School Performance Reports, USDA Food Atlas, and CDC BRFSS.

7.5.6.7.7. Members are identified for Case Management through an array of methods including risk stratification, health needs assessment or other physical or Behavioral Health screenings, Provider referral, State agency referral, Member self-referral, or health event that triggers Case Management such as:... being at-risk for or experiencing racial and/or ethnic health disparities; complex health and/or social factors that adversely influence health outcomes; screening positive SDOH...

Nevada (continued)

Quality Improvement

7.9 Quality Improvement and Performance Program

7.9.2. Standards for Internal Quality Assurance Programs

7.9.2.2. In accordance with the requirements set forth in 42 USC 300kk, the Contractor must develop and maintain the ability to collect and report data on race, ethnicity, sex, primary language, and disability status for the Member and Member's parents or legal guardians if Members are minors or legally incapacitated individuals.

7.9.2.11. The Contractor's senior leadership must foster and create an ongoing dynamic culture of innovation, continuous quality improvement and health care excellence through its Population Health and quality management programs. The Contractor, through its senior leadership, must:...

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

7.9.2.11.6. Ensure the Contractor works collaboratively with other Contractors and the State 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 equity and SDOH;

7.9.4. Systematic Process of Quality Assessment and Improvement

7.9.4.7.4. The Contractor must work collaboratively with the State to determine Member race and ethnicity. The Contractor must organize interventions specifically designed to reduce or eliminate disparities in health care, see Section 7.5 Population Health requirements.

7.9.4.13. Adequate Resources

The IQAP must have sufficient material resources and staff with the necessary education, experience, or training to effectively carry out its specified activities...

7.9.4.13.2. The Contractor must have QI teams composed of Contractor staff fully dedicated to the managed care program that represent the following areas of expertise:...

7.9.4.13.2.4. Health equity;

7.9.5. Performance Improvement Projects (PIPs)

7.9.5.5. The Contractor must participate in one (1) statewide PIP focusing on reduction in African American maternal and infant morbidity and mortality as defined by the State.

7.9.5.6. The Contractor must select an additional two (2) projects from the list below, to serve as the Contractor's required PIPs in accordance with 42 CFR 438.330(a)(2) and 42 CFR 438.358:...

7.9.5.6.4. SDOH and health equity.

Specialized Initiatives

7.7. Payment to Providers

7.7.6. Value Based Purchasing

7.7.6.2. The Contractor must focus its APM contracting strategies to support the Population Health goals and plan... the APM contracting strategies should focus on incentivizing Providers to address the social determinant health needs of Members, improving health equity in access to and delivery of health care services, improvements in maternal and child health outcomes, diversions from emergency rooms, and psychiatric hospital placement into outpatient clinics, when appropriate.

North Carolina – Medicaid Managed Care

[Link](#) to Medicaid Prepaid Health Plan Model Contract; [Link](#) to Amendment Number 3/4
(Last reviewed December 2021).

Overview

Health plans are required to focus their Quality Management and Quality Improvement activities on reducing health disparities, and to identify disparities and implement interventions through their population health management programs. Health plans are also required to develop a member engagement plan that engages historically marginalized populations, incorporate a health equity angle into external and internal policies and procedures, and to make financial contributions to promote health equity if the PHP's Department-defined Medical Loss Ratio (MLR) is less than the minimum MLR threshold.

Population / Community Health Management

V.A Administration and Management

9. Staffing and Facilities

j. In support of the Department's Health Equity goals, the PHP shall establish and maintain a Health Equity Council that reports to the CEO no less than quarterly. The council members shall be reflective of the diverse populations served by the PHP and at a minimum:

- i. Identify and analyze health disparities through review of utilization and quality data,
- ii. Address stakeholder representation and engagement improvements,
- iii. Identify areas for improving diversity of staff, especially those in leadership positions, serving NC Medicaid members,
- iv. Develop new initiatives that would address health disparities, and
- v. Examine existing policies that can be amended to improve health equity and reduce health disparities.

V.B. Members

3. Member Engagement

v. In support of the Department's Health Equity goals, the PHP shall develop a Member Engagement and Marketing Plan for Historically Marginalized Populations for review by the Department. The plan shall include the PHP's goals and strategies for engaging with historically marginalized populations, specific initiatives to address disparities, and expected outcomes of the plan. The plan shall be submitted no later than August 31, 2021 and annually thereafter to the Department.

Measurement and Data Analytics

E. Quality and Value

1. Quality Management and Quality Improvement

j. Disparities Reporting and Tracking

- The PHP shall report measures against a set of stratification criteria that may include, but is not limited to: race and ethnicity, geography, eligibility category, and age and gender where appropriate and feasible for many of the Quality Measures.

The PHP shall address inequalities as determined by the Department during review of the PHP's performance against disparity measures. The Department will define the disparity stratifications for each measure after Contract Award and annually thereafter.

North Carolina (continued)

Interventions

V.G. Program Operations

4. PHP Policies

e. In support of the Department's Health Equity goals, the PHP shall revise and resubmit for approval the follow policies to the Department for review and approval to specifically acknowledge how the PHP is addressing health disparities and incorporating health equity into their internal and external policies, and procedures. The PHP shall submit no later than August 31, 2021:

- i. Network Access Plan,
- ii. VBP/APM Strategy,
- iii. Care Management Policy,
- iv. Provider Support Plan,
- v. Provider Training Plans,
- vi. Opioid Misuse Prevention Program, and
- viii. Local Community Collaboration Plan.

Performance Monitoring and Incentives

Section V.I. Financial Requirements

2. Medical Loss Ratio

b.iv.a)1. The PHP is permitted to include expenditures made for voluntary contributions to health-related resources and initiatives that advance public health and Health Equity that align with the Department's Quality Strategy and meet the following conditions:

- i. Meet standards established in the Department's Quality Strategy that such contributions reflect meaningful engagement with local communities and are non-discriminatory with respect to individual Members and North Carolina geographic regions, including rural areas.
- ii. Meet standards established in the Department's Quality Strategy that the expenditures are spent directly on improving outcomes for beneficiaries, such as housing initiatives or support for community-based organizations that provide meals, transportation or other essential services.

c. The following requirements apply to both the CMS-defined MLR and the Department-defined MLR:

i. The PHP's classification of activities that improve health care quality, including contributions to health-related resources and initiatives that advance public health and Health Equity, shall be subject to Department review and approval.

d. If the PHP's Department-defined MLR is less than the minimum MLR threshold, the PHP shall do one of the following...

- iii. Contribute to initiatives that advance public health and Health Equity in alignment with the Department's Quality Strategy, subject to approval by the Department;
- iv. Allocate a portion of the total obligation to a mix of Department-approved contributions to health-related resources and/or Department-approved public health and Health Equity investments and the remaining portion to a rebate to the Department, with amounts for each subject to review and approval by the Department.

4. Risk Corridor

iv. The Reported Services Ratio numerator shall be the PHP's expenses for the Risk Corridor Measurement Period specific to the North Carolina Medicaid and NC Health Choice managed care programs. The numerator shall be defined as the sum of:...

f) Contributions to community-based health-related resources and initiatives that advance Health Equity, subject to Department review and approval.

North Carolina (continued)

Quality Improvement

E. Quality and Value

1. Quality Management and Quality Improvement

.. [NC] will work with the PHP to develop a data-driven, outcomes-based continuous quality improvement process that builds upon this history and focuses on rigorous outcome measurement against relevant targets and benchmarks, promotes equity through reduction or elimination of health disparities, and appropriately rewards PHPs and, in turn, providers for advancing quality goals and health outcomes.

The Quality Management and Improvement Program Plan shall include...

- 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 will launch the Behavioral Health and Intellectual/Developmental Disabilities (I/DDs) Tailored Plan Dec. 1, 2022. The Behavioral Health I/DD Tailored Plan will serve populations with severe behavioral health conditions, 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

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

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.

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)

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.

North Carolina Managed Behavioral Health Care (continued)

Interventions (continued)

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...

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 2021 Ohio Medicaid Managed Care Contract

(Last reviewed December 2021)

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. Additional strategies to promote health equity include the creation of population health management systems to address health equity, engaging members within a MCO Member and Family Advisory Council, addressing health disparities as part of MCO's Quality Assurance Performance Improvement submissions, and determining quality withhold payouts based on an evaluation of the MCOs population health programs.

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 CLAS...
- iv. The MCO's health equity efforts must align with the requirements in Appendix C, Population Health and Quality.
- v. The MCO must participate in ODM's health equity initiatives as requested by ODM.

Ohio Medicaid Managed Care (continued)

General Language (continued)

f. MCO Member and Family Advisory Council

ii. The MCO, through council support and activities, must engage members in such a way as to elicit meaningful input into the MCO's population health and quality improvement (QI) strategies, and strengths and challenges with serving members.

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

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

8. Staffing Requirements, Key Staff, 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, At a minimum, the MCO training must include...Training on health equity and implicit bias;

Ohio Medicaid Managed Care (continued)

Population / Community Health Management

3. Population Health Approach

- a. ODM seeks to advance ODM's population health approach through the Ohio Medicaid managed care program. ODM's population health approach requires the MCO to use the following population health management principles to address health inequities and disparities to achieve optimal outcomes for the holistic well-being of the populations it serves:...
- b. The MCO's population health approach must include the following strategies...
- iii. Ensuring health equity in all policies, practices, and operations

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;
- 4. Ensure that gaps in care are remedied at both the individual and systemic levels;
- 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 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

Ohio Medicaid Managed Care (continued)

Population / Community Health Management (continued)

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:

1. Age, gender, race, ethnicity, geography, language, and other socio-economic barriers;
2. Current and previous trauma experiences that might impact the effective provision of health care services;

4. Population Health Improvement Strategies

a. General:

i. The MCO's population health improvement strategies must include...

2. Optimizing the delivery system through quality and performance improvement activities, health equity, and the identification and promotion of clinical and payer best practices;

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...
 11. Staying informed of innovations and research findings that impact the health of populations experiencing disparities.
- ii. The MCO must describe how the MCO meets the requirements for addressing health disparities as part of its quality assurance performance improvement (QAPI) submission as described below in this appendix.

Ohio Medicaid Managed Care (continued)

Population / Community Health Management (continued)

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....

1. Specialized Services for High Risk Populations

d. The MCO is responsible for ensuring that the community services meet health equity expectations, the member's needs, honor member preference...

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.

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.

APPENDIX J – QUALITY WITHHOLD

2. SFY 2023 Quality Withhold Payout Determination

a. Quality Withhold Payout Determination

i. ODM will use the performance of the MCO's collective efforts to advance ODM's population health strategy using the Model for Improvement for the purpose of determining the return of the quality withhold.

b. Performance Evaluation

i. ODM's performance evaluation of the MCO will include the following:...

b. An updated Population Health Management Strategy as described in Appendix C, Population Health and Quality, that addresses the needs of the MCO's members and the communities the members live in that is aligned with ODM priorities.

c. Adherence to the Model for Improvement, including:

i. Actively and continually assessing member and provider perspectives to inform intervention selection, design, and modifications, paying particular attention to disparities and high-risk populations;

ii. Conducting active primary and secondary research to develop changes to the MCO's normal processes (e.g., care coordination, vendor agreements, data tracking and analysis, coverage of services, addressing health-related social needs) to better serve members experiencing disparities;

3. Results...c. Demonstrating a significant impact on disparate populations (e.g., members with geographic or racial disparities and members with a gap in access to and usage of information and communication technology [the digital divide population]).

Ohio Medicaid Managed Care (continued)

Quality Improvement

h. Quality Improvement

1. The MCO must establish and implement an ongoing, comprehensive QI program...
2. The MCO's QI program must employ a deliberate and defined, science-informed approach that is responsive to member and provider needs and incorporates systematic methods for discovering reliable approaches to improving population health and reducing health disparities.

iii. Quality Improvement Program Structure and Accountability

1. Organizational and Cross-Organizational Quality Improvement Efforts
- b. The MCO must ensure that staff at all levels of the organization are fully equipped and committed to improving health outcomes and reducing health disparities.

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;

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 2021 OhioRise Contract

(Last reviewed December 2021)

Overview

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. 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.

General Language

Introduction

3. Population Health Approach

- b. The OhioRISE Plan's population health approach must include the following strategies:....i.ii. Ensuring health equity in all policies, practices, and operations

Appendix A – General Requirements 2. Definitions

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).

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.

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).

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.

4. Member Requirements

a. Health Equity

- 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.
- 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>).
- 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.
- iv. The OhioRISE Plan's health equity, including racial equity efforts must align with the requirements in Appendix C, Population Health and Quality.
- v. The OhioRISE Plan must participate in ODM's health equity initiatives as requested by ODM.

Ohio Managed Behavioral Health Care (continued)

General Language (continued)

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;...

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;

Population/Community Health Management

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...

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.

Ohio Managed Behavioral Health Care (continued)

Population/Community Health Management (continued)

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 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.

iv. Quality Improvement Staffing

3. The OhioRISE Plan must have staff fully dedicated to the OhioRISE Program who represent the following areas of expertise:...
- d. 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:...

2. Optimizing the delivery system through quality and performance improvement activities, health and race equity...

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.

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:... addressing disparities.

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 competency, , racial equity, SDOH and health disparities...

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

1. The OhioRISE Plan must design and conduct improvement projects in clinical and non-clinical topic areas that improve population health outcomes (including health equity)...

3. The OhioRISE Plan's improvement projects must aim to achieve significant and sustained improvement over time in population health outcomes...; health disparities;...

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

f. Analyze data to identify disparities in services or care, and tailor interventions... to reduce disparities; and

Oklahoma

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

(Last reviewed December 2020)

This managed care program was suspended in June 2020 prior to going into effect. The Oklahoma Supreme Court ruled that the actions of the Oklahoma Health Care Authority (OHCA) to implement a capitated managed care plan for Medicaid expansion members violated state law and was therefore void. The Court said OHCA acted without legislative authorization and without first adopting necessary administrative rules for the bidding process.

Overview

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.

Measurement and Data Analytics

1.10.7 Addressing Health Disparities

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 SDOH 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

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 SDOH.

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.

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 effective January 1, 2021

(Last reviewed December 2021)

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 SDOH, 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), excerpts of which are included in [Appendix F](#). **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. Additional information about Oregon’s definitions of and requirements related to the social determinants of health and health equity can be found in [Oregon’s Administrative Rule 410-141-3735](#).*

Key requirements of the Oregon contract include: the creation of a Community Advisory 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 members and for the communities within the Contractor’s service area, the sharing of any quality incentive dollars received with the Contractor’s community partners, addressing the SDOH and equity within performance improvement projects, and creating plans to assess and improve community health.

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.

“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...

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).

Oregon (continued)
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.

e. Contractor shall create a written distribution plan for Quality Pool and Challenge Pool earnings.

1. The distribution plan must include:

(a) 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 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 SDOH 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) SDOH and Equity.

Performance Monitoring and Incentives

Exhibit H – Value Based Payment

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

b. In June of each Contract Year, Contractor 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;

Oregon (continued)

Other

Exhibit B –Statement of Work - Part 3 Patient Rights and Responsibilities, Engagement and Choice

1. 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:

- a. Uses Community input and the Community Health Assessment process to help determine the most Culturally and Linguistically Appropriate and effective methods for patient activation, with the goal of ensuring that Members are partners in maintaining and improving their health
- b. Engages Members to participate in development of holistic approaches to patient engagement and responsibility that account for SDOH and health disparities;
- f. Works with Providers to develop best practices for care and delivery of services to reduce waste, and improve health and well-being of all Members which includes ensuring Members have a choice of Providers within Contractor’s network, including those who can provide culturally and linguistically appropriate services;

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

- 1. 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.

Pennsylvania

[Link](#) to the 2021 Medicaid MCO contract; [Link](#) to the 2020 Quality Strategy

(Last reviewed December 2021)

Overview
<p><i>Pennsylvania is leveraging its Medicaid MCO contracts and Quality Strategy to promote health equity. MCOs are required to partner with community-based organizations to support reduction of health disparities. The state has also implemented a financial incentive program to improve maternity-related care for Black / African American members. MCOs are required to implement strategies to reduce health disparities across regions or subpopulations and design quality improvement initiatives to address racial and ethnic disparities in perinatal health. Relevant excerpts from the state’s Quality Strategy are included in Appendix G.</i></p>
Population/Community Health Management
<p>Exhibit B(5) COMMUNITY BASED CARE MANAGEMENT PROGRAM (CBCM) The PH-MCO shall submit CBCM proposals that increase the partnership with Community-Based Organizations (CBOs), encourage the use of preventive services, mitigate SDOH barriers, reduce healthcare disparities and improve maternal and child health...</p> <p>I. CBCM Program Requirements</p> <p>A. The PH-MCO must propose CBCM activities and funding focused on partnerships with CBOs and providers, integrating a holistic approach to patient care and education to:</p> <ol style="list-style-type: none"> 1. Assess, refer and mitigate Social Determinants of Health; 2. Promote maternal, infant and early childhood assessment, education and referral... 6. Reduce healthcare disparities. <p>EXHIBIT M(1a) QUALITY MANAGEMENT REQUIREMENT FOR REGIONAL ACCOUNTABLE HEALTH COUNCILS The MCO must form... a Regional Accountable Health Council (RAHC)...to serve as a forum for regional strategic health planning and coordination of community-wide efforts to improve health outcomes across each region in the state. This planning shall be focused on areas of high burden of disease and on demographic groups impacted by health disparities...in order to identify the root causes of those disparities and to establish strategies and interventions...to address those root causes of these disparities.</p> <ol style="list-style-type: none"> 1. In serving as a forum for regional strategic health planning and coordination of community-wide efforts, with a special focus on addressing the root causes of disparities, the RAHC’s goals shall be to: <ol style="list-style-type: none"> a. Promote health equity and eliminate health disparities; b. Address regional SDOH needs;... e. Center health improvement efforts in the communities where people live. 4. The membership of the council should reflect the racial and ethnic diversity of the HealthChoices Zone. G. The RAHC shall be a part of a statewide RAHC learning network developed by the Department, so each RAHC can learn best practices from one another in improving population health, reducing costs, improving health equity, and addressing SDOH needs. H. The RAHC shall be responsible for providing CBOs technical assistance that is available on consultation. The MCOs shall also support a regional or statewide learning network that is informed by frequently asked questions or topics. The goals of the technical assistance will be to help support

administrative functions of CBOs that are important in their ability to improve population health, improve equity, and address the SDOH needs of the region.

2. Each Regional Health Transformation Plan (RHTP) shall:

- a. Identify demographic groups impacted by health disparities, and geographic areas with significant health disparities (“health equity zones”) and strategies for eliminating disparities in these groups and areas;
- b. Identify SDOH needs in the area and strategies for addressing them;
- c. Identify population health priority measures... and population health strategies for improvement;..
- e. Identify CBOs and other trusted community partners and how they are incorporated into the overall plan;
- f. Identify strategies and interventions to continuously monitor for improvement in health equity, SDOH, and population health priority measures established by the regional transformation plan, including a rapid-cycle quality improvement strategy to rapidly scale interventions that are successful.

Pennsylvania (continued)

Performance Monitoring and Incentives

EXHIBIT B(7)

MATERNITY CARE BUNDELED PAYMENT

1. Maternity Care Bundle: As part of VBP, the MCO must utilize a Maternity Care Bundled Payment for Network Providers (that elect to take part in the model, use a maternity care team, and have at least twenty (20) births annually attributed to the maternity care team.

7. Quality Measures: The MCO shall use the following quality measures to determine its incentive payments:...

8. Scoring of Quality Measures: Point totals for each quality measures are listed below. Virtual or telehealth visits should count for calculation of quality scores.

i. Health Equity score:

i. 0.5 points for reaching NCQA 75th percentile for four (4) out of the seven (7) HEDIS® measures within the Black/ African American community

ii. 1 point for reaching NCQA 75th percentile for five (5) out of the seven (7) HEDIS® measures within the Black/ African American community

iii. 1.5 points for reaching NCQA 75th percentile for six (6) out of the seven (7) HEDIS® measures within the Black/ African American community

Quality Improvement

EXHIBIT M(1)

QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT PROGRAM REQUIREMENTS

The PH-MCO’s QM and UM programs must, at a minimum:

C. Be based on statistically valid clinical and financial analysis of Encounter Data, Member demographic information, HEDIS, CAHPS, Pennsylvania Performance Measures and other data that allows for the identification of prevalent medical conditions, barriers to care and racial/ethnic disparities to be targeted for quality improvement and disease management initiatives;

Specialized Initiatives

Exhibit B(5a)

HOME VISITING PROGRAM

I. Home Visiting Program Requirements and Goals

A. The PH-MCO must implement a home visiting program...

C. Home visiting activities must be primarily be focused on:

1. Maternal and Infant Health promotion and prevention...

8. Reducing disparities in perinatal health

Rhode Island

[Link](#) to the 2021 Medicaid Managed Care Request for Qualifications (RFQ).

(Last reviewed December 2021)

Overview

Rhode Island's 2021 MCO RFQ contains many provisions related to reducing health disparities and addressing SDOH in order to promote health equity. The new MCO contracts will begin July 1, 2023. MCOs will be required direct key personnel to develop and implement health equity initiatives, to promote health equity for members who have behavioral health needs, to create a health equity strategy, and to collect and stratify performance measures by race, ethnicity, language, and disability. RFQ bidder questions related to health equity are included as [Appendix H](#) of the Compendium.

General Language

Appendix B: Model Contract

1. Definitions

Health Disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations. Populations can be defined by factors such as race or ethnicity, gender, education or income, disability, geographic location (e.g., rural or urban), or sexual orientation. Health disparities are inequitable and are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources.

Health Equity is defined as the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically.

3.1.3 Contractor's Key Personnel

Key personnel include the Chief Executive Officer (CEO); Medical Director; Chief Diversity, Equity, and Inclusion...

3.1.5.4 The Medical Director is responsible for development, implementation, and oversight of:...k) Diversity and Health Equity initiatives.

3.1.5.5. The Medical Director shall serve as a liaison between the Contractor and its Providers and communicate regularly with Providers, addressing areas of clinical relevance including but not limited to: ... c) Health Equity, promotion, and disease management programs.

3.1.6. Chief Diversity, Equity, and Inclusion (DEI) Officer...shall report to the CEO or Director of Human Resources and is responsible for managing and overseeing the Contractor's efforts to:

- a) Create a diverse and inclusive workforce.
- b) Identify and address potential discrimination or biases in the workforce.
- c) Ensure compliance with yearly workforce trainings, such as anti-bias, antiracist, sexual harassment, and health inequities training.
- d) Launch initiatives to change culture.
- e) Create a supportive environment for underrepresented Members of the organization.
- f) Develop, execute, and monitor compliance with a comprehensive, organization-wide Strategic Health Equity, Diversity and Inclusion Plan.

3.1.6.2. The Chief DEI Officer shall serve as a leader in the organization and has primary responsibility for:

- a) Submitting the Strategic Diversity and Inclusion Plan to EOHHS during Readiness Review, then annual reports describing Plan activities and outcomes.
- b) Developing training programs for staff.
- c) Reviewing and assessing the impact and effectiveness of diversity and inclusion programs.

3.4 Behavioral Health Benefits

3.4.2.1. The Contractor shall participate in an ongoing workgroup with EOHHS, BHDDH, DCYF, health plans, AEs, Member advocates, and other stakeholders and interested parties identified by EOHHS. The purpose of the workgroup is to identify:

- a) Practices and protocols to promote health equity and access to integrated and coordinated physical health, behavioral health, SUD, and social determinants of health (SDoH) services.
- d) Standardized and evidence-based provider education and training tools to address workforce challenges, early diagnosis and intervention, health equity, and SDoH. When appropriate, trainings should be designed to meet continuing education requirements for maintaining provider licensure or certification.

3.4.14. Behavioral Health Innovation Plan

3.4.14.1 To promote seamless transitions through the care continuum and expanded capacity for services, the Contractor shall develop programs to support and promote practice transformation and coordinated care for Members with cooccurring physical health, behavioral health, SDoH, and/or substance use disorder needs.

3.4.14.2 ... The revised Plan is subject to EOHHS approval and shall, at a minimum, include...

- d) Promoting Health Equity by implementing processes to identify specific populations (i.e., racial/ethnic, geographic, etc.) that have experienced disproportionately poor health outcomes, then developing a methodology to improve outcomes and Health Equity and access to Behavioral Health Services for these populations. This section should include strategies to train Contractor staff, Network Providers, and Provider offices on DEI topics, such as cultural competency and implicit bias.

3.12 Population Health

3.12.1.1. EOHHS seeks to advance Health through population health management strategies. Strategies should be designed to promote equity, redress health disparities, and achieve optimal health outcomes for all Medicaid Members.

3.12.1.2. Achieving Health Equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and disparities.

3.12.2. Health Equity Strategy

3.12.2.1. The Contractor shall participate in and support EOHHS's efforts to achieve Health Equity by reducing health disparities and social risk factors. The Contractor shall develop and implement a Health Equity, Diversity and Inclusion Plan and strategy that complies with this Agreement.

3.12.2.1. The Contractor's Health Equity, Diversity and Inclusion Plan and strategy shall:

- a) Be developed in consultation with the Contractor's subcontracted AEs.
- b) Reflect specific Member populations, communities, languages spoken and sociocultural dynamics.
- c) Identify disparities in health care access, service provision, satisfaction and outcomes and the factors that drive those outcomes including social risk factors.
- d) Prioritize the Health Equity outcomes that align with EOHHS' priorities and are most meaningful to the Contractor's Members.
- e) Establish measurable targeted reductions for specified health disparities.
- f) Identify programs, strategies and interventions to meet established targets to reduce disparities and address social risk factors.
- g) Set near and long-term goals to incorporate Health Equity measures into the Contractor's value-based payment arrangements with its Subcontractors and Network Providers in accordance with guidance issued by EOHHS.

Rhode Island (*continued*)

Population / Community Health Management (*continued*)

- h) Solicit engagement and feedback from a representative group of Members to ensure that Contractor’s Health Equity, Diversity and Inclusion Plan and strategy reflects the ethnic and cultural diversity of Members.
- i) Identify and help coordinate community services and resources that can be offered to Members to address SDoH needs and demonstrate working relationships with community organizations to refer to and support provision of those service.
- j) Identify how the Contractor, its Subcontractors and Network Providers will engage and support the State’s broader Health Equity initiatives, including those involving sister agencies such as the Department of Health.

3.12.2.3. The Contractor’s Health Equity, Diversity and Inclusion Plan and strategy shall be submitted for review and approval by EOHHS during Readiness Review, annually thereafter, and upon modification.

3.12.2.4. The Contractor shall monitor progress toward implementing its Health Equity, Diversity and Inclusion Plan and strategy and shall submit quarterly reports to EOHHS that include:

- a) A narrative description of activities undertaken.
- b) Quantitative progress towards meeting the measurable targets and goals identified...

Measurement and Data Analytics

3.12 Population Health

3.12.3. Health Risk Assessment (HRA)

3.12.3.2 Data from the HRA shall be stratified by Member characteristics including race, ethnicity, language, disability and by attributed AE.

3.12.3.4. All staff, including the staff of subcontracted AEs and Providers shall participate in anti-bias workshops as part of mandatory staff training no less than annually.

3.12.3.5 The Contractor’s data system shall have sufficient IT infrastructure and data analytics capacity to support EOHHS’ vision and goals for quality improvement, measurement and evaluation, including the capability to:

- a) Identify service access, utilization, health outcomes, intervention effectiveness, social risk factors, and survey (e.g., CAHPS) results by Member characteristics including race, ethnicity and language, disability, and by attributed AE; and
- b) Employ advanced analytic methods such as hot spotting and predictive analytics and modeling to improve the identification of Members and Member communities disproportionately impacted by or at risk for poor health outcomes and social risk factors.
- c) Support the monitoring and comparison of process and outcome measures over time to inform disparity reduction efforts.

3.12.4. Quality Measurement

The Contractor is responsible for:

3.12.4.1. Collecting and reporting data to EOHHS on select quality measures as identified by EOHHS that can be stratified based upon Members’ age, race, ethnicity, language, disability, or other characteristics as specified by EOHHS and by attributed AE, if applicable.

3.12.4.2. Requiring that when AEs and Providers report data on quality measures that such data captures information and can be stratified based upon Members’ age, language, disability, or other characteristics as specified by EOHHS.

Rhode Island (continued)

Quality Improvement

3.17 Quality Assurance

3.17.1 General Requirements

3.17.1.2. The QAPI aligns with the objectives of Rhode Island’s Quality Strategy ... and any priorities identified by EOHHS, including the goals of advancing Health Equity and promoting value-based, high-quality care for all Rhode Island residents.

3.17.1.4. The Contractor shall deliver quality care that enables Members to stay healthy, prevent poor outcomes and manage chronic illnesses or disabilities. Quality care refers to... e) Mechanisms to assess the quality and appropriateness of care provided to Members at risk for health disparities due to race, ethnicity, sex, primary language and sexual orientation.

3.17.3.1. The Quality Program shall be specific to the Managed Care Program requirements, guided by the current NCQA standards and Guidelines for the Accreditation of Health Plans, and shall align with the Contractor’s Health Equity and Utilization Management strategies.

3.17.6. Performance Improvement Plans (CMS Checklist I.G.5.10-.15)

3.17.6.4. Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, high-volume services, high risk services, health care disparities, and continuity and coordination of care...

Other

3.14. Provider Networks and Requirements, Access to Care

3.14.16 Network Considerations

3.14.16.10 Ability of Network Providers to communicate with Members with Limited English Proficiency in their preferred language and provide Culturally competent care and services to all Members regardless of race, ethnicity, gender, or background.

3.14.16.111 Ability of Network Providers to support the health and wellness of people with disabilities through their disability knowledge, experience, and expertise.

3.14.27. Provider Training

3.14.27.1. The Contractor shall have an ongoing Provider education and training program that at a minimum, addresses the following topics:..

h) The Contractor’s Health Equity Plan.

i) Cultural Competency, and the unique needs of Medicaid Members.

l) Anti-bias workshops as outlined in Section 3.12.3, “Health Risk Assessment.”

3.15. Accountable Entity Program

3.15.3.3. The Contractor shall develop an AE Support Plan that shall include: c) How the Contractor shall advance Health Equity and support AEs in addressing SDOH;

3.26. Claims Processing and Management Information Systems (MIS)

3.26.2.2 Key business functions shall include:

3.26.2.6 Capturing and reporting Member data by race, ethnicity, language, and other demographic characteristics as specified by EOHHS.

3.26.22. OMB Standards for Collecting and Reporting Demographic Data

3.26.22.1. In accordance with 42 U.S.C. § 300kk, the Contractor must be able to collect and report data on race, ethnicity, sex, primary language, and disability status.

3.26.22.2. The Contractor shall develop procedures to collect this information from Members or their legally Authorized Representatives.

3.26.22.3 The Contractor shall comply with the Office of Management and Budget (OMB) standards for data collection for race and ethnicity.

Virginia

[Link](#) to Medicaid MCO contract, Medallion 4.0 Managed Care Services Agreement for July 1, 2021 – June 30, 2022; [Link](#) to the 2020 – 2022 Quality Strategy (Last reviewed December 2021)

Overview
<p><i>Medallion 4.0 is Virginia’s Medicaid program that provide acute healthcare, behavioral healthcare, and drug coverage for infants, children, pregnant women, and adults in low-income families with children. 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. Virginia’s Quality Strategy includes the state’s plan to address health disparities, which includes their strategic framework, short and long term goals for disparities reductions, and quality improvement initiatives designed to reduce health disparities by age, race, ethnicity, sex, primary language, and disability status, among additional information.</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>
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>

Washington State

[Link](#) to the 2020 Washington Apple Health Integrated Medicaid MCO contract, amended on November 1, 2021

(Last reviewed December 2021)

Overview
<p><i>Washington's Medicaid managed care program includes several requirements to address health equity. MCOs are required to participate in a Health Care Disparities 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 MCOs' Quality Assessment and Performance Improvement (QAPI) programs, utilization management programs, and through incorporation of principles from the LAN's Consumer and Patient Affinity Group regarding how to promote equity within payment models. Washington also requires MCOs to implement nine of the Culturally and Linguistically Appropriate Services standards, including to collect data to monitor and evaluate the impact of 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>7.5.14 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>7.5.14.2 Collect and examine data on ethnicity, race, and language markers as provided by HCA on all Enrollees and augmented by MCOs.</p> <p>7.5.14.3 Cooperate with the Department of Health to complete the analysis of one performance measure no later than June 30.</p> <p>7.5.14.4 Define interventions to address observed disparities.</p> <p>7.5.14.5 Implement defined interventions aimed at addressing disparities.</p> <p>7.5.14.6 Evaluate the effectiveness of interventions to reduce health care disparities.</p> <p>7.5.14.7 Provide adequate funding, resources, and staff to plan, execute, and evaluate the project.</p> <p>7.5.14.8 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)

Interventions

7. Care Coordinator Responsibilities

7.2 The Health Home Care Coordinator shall provide or oversee Health Home Services in a culturally and linguistically appropriate manner and address health disparities by:

7.2.1. Interacting directly with the enrollee and his or her family in the enrollee’s primary language and recognizing cultural differences when developing the HAP;

7.2.2. Understanding the dynamics of substance use disorder without judgment; and

7.2.3. Recognizing obstacles faced by persons with developmental disabilities and providing assistance to the enrollee and his or her caregivers in addressing the obstacles.

14.6 Care Coordination Services (CCS) General Requirements

14.6.5 The Care Coordinator shall deliver services in a culturally competent manner that addresses health disparities by interacting directly and in-person with the Enrollee and his or her family in the Enrollee’s primary language; with appropriate consideration of literacy and cultural preference.

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;

7.1.1.2.4 Service to a culturally and linguistically diverse membership, including recommendations from the Contractor’s Tribal Liaison

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

10.2.2. The Contractor shall participate in and cooperate with HCA efforts to promote the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. The Contractor will provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

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); ...

11 Utilization Management Program and Authorization of Services

11.1 UM protocols shall take into account the greater and particular needs of diverse populations, as reflected in Health Disparities, risk factors (such as ACEs for Enrollees of any age), Historical Trauma, and the need for Culturally Appropriate Care.

Washington State (continued)

Other (continued)

11.1.4. The Contractor shall have and maintain a Utilization Management Program (UMP) [which shall include:...

11.1.4.14 An explanation of how UM decision making takes into account the greater and particular needs of diverse populations, as reflected in Health Disparities, risk factors (such as ACEs for Enrollees of any age), Historical Trauma, and the need for Culturally Appropriate Care.

11.1.7 The Contractor shall have written policies for applying UMP decision-making criteria based on individual Enrollee needs such as age, comorbidities, complications and psychosocial and home environment characteristics, where applicable; the greater and particular needs of diverse populations, as reflected in Health Disparities, risk factors (such as ACEs for Enrollees of any age), Historical Trauma, and the need for Culturally Appropriate Care; and the availability of services in the local delivery system.

15.1 Special Provisions Regarding Coordination with IHCPs

15.1.1 Tribal Liaison

15.1.1.2 The Contractor will designate a staff person who is competent in understanding the cultural and legal aspects of Medicaid and IHCPs and AI/AN Enrollees.

15.1.1.2.1 The Contractor must provide for training of its Tribal Liaison, conducted by one or more IHCPs, the American Indian Health Commission for Washington State, or the DSHS Indian Policy Advisory Committee, on AI/AN health disparities and needs, the Indian health care delivery system, the government-to-government relationship between the state of Washington and the federally recognized tribes, applicable federal and state laws and regulations, applicable provisions in this Contract, and matters specific to IHCPs.

Appendix E: Principles for Patient- and Family-Centered Payment

The following principles, produced by the LAN's Consumer and Patient Affinity Group, are intended to help guide the development of new payment strategies...The principles rest on the conviction that consumers, patients, and families are essential partners in every aspect of transforming health care and improving health...

Positive impact on patient care and health should be paramount.

The central consideration in all payment design should be improving patient health outcomes, experience of care, and health equity, while also ensuring the most effective use of health care resources....

Primary care services are foundational and must be effectively coordinated with all other aspects of care.

... Effective delivery and coordination of primary care services should promote better care experience, optimal patient engagement, better health outcomes, and increased health equity.

Health equity and care for high-need populations must be improved.

New payment models should foster health equity, including access to innovative approaches to care and preventing any discrimination in care. They should collect data that allow for assessment of differential impacts and the identification and redress of disparities in health, health outcomes, care experience, access, and affordability

APPENDICES

Appendix A: Excerpt of Indiana Medicaid Managed Care RFPs

The following is an excerpt from the Indiana Office of Medicaid Policy and Planning (OMPP) Medicaid Managed Care Request for Proposals for the state's Hoosier Healthwise and Healthy Indiana Plan (HIP) Medicaid programs. 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 questions in an RFP.

Response Structure:

Please review the requirements in both Attachment I - Exhibit 1 Scope of Work (Hoosier Healthwise) and Attachment N - Exhibit 1 Scope of Work (HIP) carefully and address each section and requirement. Please describe your relevant experience and explain how you propose to perform the work in its entirety, including but not limited to the specific elements highlighted below. Where applicable, the Respondent should indicate how their proposed offering will address program goals, including:

- Ensuring all services are delivered through a health equity lens

For the Hoosier Healthwise^{xii} proposal, please describe your relevant experience. Explain how you propose to perform the work in its entirety to meet the needs of the Hoosier Healthwise members, including but not limited to the following:

Section 4.0 - Member Services

- Health equity, including how the Respondent intends to: reduce adverse health outcomes for those with limited English proficiency and diverse cultural and ethnic backgrounds; determine the root cause of inequities; develop targeted interventions and measures; and collect and analyze data to track progress in disparity reduction efforts...

Appendix B: Excerpt of Louisiana Medicaid Managed Care RFPs

The following is an excerpt from the Louisiana Department of Health (LDH) Medicaid Managed Care Organizations Request for Proposals for the state's Medicaid Managed Care program. 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 questions in an RFP.

2.6.4 Population Health [12-page limit]

2.6.4.1 The Proposer should describe its approach to, and experience with, improving population health for Medicaid populations including how principles of a population health approach will inform and guide its managed care program in Louisiana. This should include approaches to such components as:

2.6.4.1.1 Identifying baseline health outcome measures and targets for health improvement;

2.6.4.1.2 Measuring population health status and identification of sub-populations within the population;

2.6.4.1.3 Identifying key determinants of health outcomes and strategies for targeted interventions to reduce disparities;

2.6.4.1.4 How required components of this procurement and other Proposer developed initiatives are integrated, representing a comprehensive approach to population health; and

2.6.4.1.5 Other considerations the Proposer may seek to present.

2.6.4.2 The Proposer should describe what it will do to address population health in the first year of the contract, including milestones and timeframes.

2.6.4.3 The Proposer should describe its recent experience with utilizing data regarding SDOH to improve health equity and the health status of targeted populations, including the Proposer's approach to collecting SDOH data. Include at least one example of how an issue impacted by SDOH was identified, which interventions were developed, how the impacts of the interventions were assessed, and what outcomes were achieved. The Proposer should describe how this approach may be applied to a population health and/or health equity priority(ies) named in the Model Contract.

2.6.4.4 The Proposer should describe its approach to engage providers, enrollees, and families, and to contracting with community-based organizations and OPH to coordinate population health improvement strategies to increase health equity.

2.6.5 Health Equity [12-page limit]

2.6.5.1 Describe the Proposer's management techniques, policies, procedures, and initiatives it has implemented to promote health equity for enrollees and the proposed approach

to promoting health equity for its Medicaid managed care program in Louisiana.

2.6.5.2 Specifically describe strategies the Proposer uses or will use to recruit, retain, and promote at all levels, personnel and leadership who are representative of the demographic characteristics of its Medicaid managed care populations and, in particular, those persons who identify as members of communities underrepresented in the workforce to date.

2.6.5.3 Describe the Proposer's organizational practices related to ensuring the Proposer and its provider network provide culturally and linguistically appropriate services to enrollees.

2.6.5.4 Describe the Proposer's organizational capacity to develop, administer, and monitor completion of training material for its staff, contractors and network providers, including if providers or Material Subcontractors are currently required to complete training topics on health equity, beyond CLAS standards.

2.6.5.5 Describe the Proposer's demonstrated experience and capacity for engaging community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic, and racial disparities in health care that exist among Enrollees.

2.6.5.6 Does the Proposer currently utilize community health workers, peer support specialists, and douglas in any capacity in its Medicaid managed care programs? If yes, please describe how these workers are utilized and how performance of the approach is measured and evaluated.

2.6.5.7 Describe how the Proposer will engage Medicaid consumers and trusted messengers, including community health workers and/or community-based organizations, to improve access to quality care and reduce health disparities among Louisiana Medicaid enrollees. Please include specific actions, timelines, and a plan for evaluating the effectiveness of these partnerships at improving health equity.

2.6.5.8 Describe the Proposer's data collection procedures related to enrollees' race, ethnicity, language, disability status (RELD data), geography, and how such data informs the provision of culturally and linguistically appropriate services for enrollees. If some types of RELD and rural/urban data is not now collected and used for this purpose, describe how the Proposer will incorporate RELD and geographic data.

2.6.5.9 Describe the Proposer's demonstrated experience (if any) and proposed approach to utilizing RELD and rural/urban data to improve health outcomes and address disparities in health outcomes for enrollees.

2.6.5.10 Specifically, how does, or will the Proposer, stratify, analyze, and act on data regarding inequities in care for enrollees related to the following measures or comparable measures:

- 2.6.5.10.1 Pregnancy: Percentage of Low Birthweight Births
- 2.6.5.10.2 Contraceptive Care – Postpartum Women Ages 21–44 Page 32 of 55
- 2.6.5.10.3 Child: Well-Child Visits in the First 15 Months
- 2.6.5.10.4 Childhood Immunizations (Combo 3)
- 2.6.5.10.5 Preventive Dental Services
- 2.6.5.10.6 Immunizations for Adolescents (Combo 2)
- 2.6.5.10.7 Adult: Colorectal Cancer Screening
- 2.6.5.10.8 HIV Viral Load Suppression
- 2.6.5.10.9 Cervical Cancer Screening

2.6.5.11 Describe how the Proposer will leverage data analysis and community input to address inequities in outcomes experienced by pregnant and postpartum Black Enrollees and their newborns related to pregnancy, childbirth, and the postpartum period.

2.6.5.12 Describe how the Proposer will use feedback from enrollees and their family members to identify and execute program improvements. Include specific examples of experience that will enable the Proposer to be successful in this endeavor in LA, including but not limited to community engagement; home visiting programs; collaboration with community-based organizations, doulas, and/or community health workers; and provider training.

2.6.5.13 Specifically, which outcome measures does the Proposer propose to focus on to improve pregnancy and birth outcomes for Black populations enrolled in Louisiana Medicaid and what activities will the Proposer engage in to reduce disparities and improve outcomes for pregnant and postpartum Black Enrollees and their newborns during and after pregnancy? Please include specific actions and timelines.

2.6.5.14 Describe the Proposer’s relevant experience and proposed approach to engage parents and adolescents in decreasing disparities for the following types of services. For each, include specific examples of experience that will enable the Proposer to be successful in this endeavor in Louisiana to address disparities (such as by race/ethnicity, disability status, and urban/rural status) and how you will engage enrollees, their family members, and providers in designing and implementing this initiative:

- 2.6.5.14.1 Well-child visits and vaccination rates for children and adolescents.
- 2.6.5.14.2 Preventive dental services for children and adolescents.

2.6.8 Network Management [10-page limit]

2.6.8.1 The Proposer should demonstrate how it will ensure timely access to culturally competent primary and specialty care services, necessary to promote LDH’s goals of utilizing providers who are accepting new Medicaid patients or are regularly serving Medicaid patients in their offices or practices.

2.6.8.2 Specifically, the proposal should include:

2.6.8.2.1 Work plan that includes strategies and timeline to build or scale up its provider network to meet network adequacy standards by the Readiness Review;

2.6.8.2.2 Identification of network gaps (distance standards, after-hours clinic availability, closed panels, etc.);

2.6.8.2.3 Strategies that will be deployed to increase provider capacity and meet the needs of enrollees where network gaps have been identified;

2.6.8.2.4 What you consider to be the most significant challenges to developing a complete Statewide Provider network;

2.6.8.2.5 Strategies (including a description of data sources or tools utilized) for monitoring compliance with the provider network standards Attachment F, Provider Network Standards;

2.6.8.2.6 Strategies for recruitment and retention efforts, particularly in areas where network gaps exist;

2.6.8.2.7 Strategies to ensure that your provider network is able to meet the multi-lingual, multi-cultural and disability needs of its enrollees; and

2.6.8.2.8 Details regarding planned protocol for terminating network providers without cause, including how to minimize negative impact on enrollees.

2.6.11 Quality [15-page limit; clinical practice sample guidelines, NCQA rating attachment, and certificates of accreditation are exempt from section-specific and total page limits]

2.6.11.3 The Proposer should describe how the Proposer's Medicaid managed care Quality Assessment and Performance Improvement (QAPI) Program includes the following functions related to organization-wide initiatives to improve the health status of covered populations, and describe in detail at least one (1) data-driven clinical initiative that the Proposer initiated within the past twenty-four (24) months that yielded improvements in clinical care for similar populations. Functions include:

2.6.11.3.1 Analyzing gaps in delivery of services and gaps in quality of care, areas for improved management of chronic and selected acute diseases or conditions, and reduction in disparities in health outcomes;

2.6.11.3.2 Identifying underlying reasons for variations in the provision of care to enrollees; and

2.6.11.3.3 Implementing improvement strategies related to analytical findings pursuant to the two (2) functions described above.

Appendix C: Excerpt of Michigan’s FY21 MHP Contract

The following is an excerpt from the Michigan Department of Health and Human Services FY21 Medicaid Managed Care contract, which provides additional information on Michigan’s Health Equity HEDIS Measures.

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...

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... Health Equity HEDIS.

For each performance area, the following categories are identified: Measure: Goal, Minimum Standard for each measure, Data Source, and Monitoring Intervals, (annually, quarterly, monthly).

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.	Informational Only	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.	Informational Only	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.	Informational Only	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 	Informational Only	MDHHS Data Warehouse	Quarterly

Appendix D: 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 questions in an RFP.

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 E: Excerpt of Nevada Medicaid Managed Care RFPs

The following is an excerpt from the Nevada Department of Health & Human Services Medicaid Managed Care Request for Proposals for the state's Medicaid programs. The RFP in its entirety can be found [here](#). The questions related to health equity are listed below. The RFP also contains additional questions related to addressing the SDOH and community engagement strategies.

3.3.11.4. Describe the Vendor's plans to work with the community to engage Members and Providers in a culturally appropriate way, understand the unique needs and resources within the community, and collaborate to meet the needs of Members within those communities.

3.3.12.2. Describe the Vendor's experience and successes in identifying, addressing, and mitigating racial and ethnic disparities within a Medicaid population. Include the metrics used to evaluate the program, the measurable improvements achieved and describe how long the improvements have been maintained.

3.3.15.5. The State intends to implement a required performance improvement project (PIP) to address maternal and infant health disparities within the African American population. Describe how the Vendor plans to approach this PIP, including the Vendor's partnerships with key Providers and key community agencies serving this population, the model of care the Vendor proposes to support this population and improve maternal and infant health outcomes, the specific quality measures the Vendor will utilize to evaluate the performance of the PIP design, and the Vendor's reporting capability to report upon the measures selected. In addition, provide at least one example of how the Vendor has addressed maternal and infant health disparities for African Americans or other high-risk maternal health membership within a Medicaid population, the measurable improvements achieved, and how the Vendor has maintained the improvements over time.

3.3.15.9. Describe the Vendor's experience implementing and advancing Value-Based Purchasing (VBP) arrangements, as described in the Health Care Payment Learning and Action Network (LAN) alternative payment methodology framework, with Providers that incentivize Providers to address the social determinant needs of Members, improve health equity in access to and delivery of health care services, and improvements in maternal and child health outcomes. Address the following items in the response:

- a. Provide examples of the types of VBP arrangements, types of Providers that participated in VBP arrangements, actual or anticipated number of Members served under VBP arrangements, and indicate whether the examples are planned or implemented.
- b. How the Vendor assesses a Provider's capacity and ability to contract under a VBP arrangement and evaluates whether the Provider is able to progress along the LAN framework;
- c. How the Vendor shares quality, utilization, cost, and outcomes data with Providers participating in these arrangements, supports Providers to be successful under these reimbursement arrangements, and implements strategies to reduce Provider administrative burden; and
- d. How the Vendor evaluates the success of the VBP arrangement, including the types of performance metrics and the evaluation process.

Appendix F: Excerpt of Oregon's CCO Contract Exhibit K - SDOH and Equity

The following is an excerpt from the Oregon Health Administration's Exhibit K, Social Determinants of Health and Equity. Exhibit K includes directs Oregon's CCOs to address the SDOH and health equity through activities that include conducting a community health needs assessment and developing a strategy to address health equity, among additional requirements.

1. Community Advisory Council (CAC)

To ensure that the health care needs of all Members of the Community within Contractor's Service Area are being addressed... Contractor shall... establish a Community Advisory Council...

5. Contractor's Annual CAC Demographic Report

a. To understand how Contractor's CAC membership is representative of the Communities in Contractor's Service Area, Contractor shall complete and submit to OHA annually an Annual CAC Member Demographic Report. The Annual CAC Demographic Report shall include descriptions of all of the following...

(b) The entities within Contractor's Service Areas that must be engaged in the creation of the CHA must include, without limitation:

- ix. Culturally specific organizations, including Regional Health Equity Coalitions, and
- x. Representatives from populations who are experiencing health and health care disparities.

6. Community Health Assessment (CHA)

d. Contractor's shared CHA must comply, at a minimum, with all of the following requirements:

- 1. Identify the demographics of all of the Communities served within Contractor's Service Area, including race, ethnicity, languages spoken, disabilities, age, gender, sexual orientation, and other applicable identifying factors;
- 3. Identify the health disparities among all of the Communities, including those defined by race, ethnicity, languages spoken, disabilities, age, gender, sexual orientation, and other factors within Contractor's Service Area;
- 4. Determine and identify factors that contribute to health disparities...

7. Community Health Improvement Plan (CHP)

c. The CHP must describe the health priorities goals and strategies that govern the activities, services, and responsibilities that Contractor will undertake and implement in order to address the population health needs and resources of the Communities within Contractor's Service Area as documented in its CHA. The CHP must be based on all the required elements of the CHA and include, without limitation:...

6. Identify and include the findings of the CHA regarding health disparities among the diverse Communities within Contractor's Service Area... including those defined by race, ethnicity, language, disability, age, gender, sexual orientation, and other relevant factors. Based on such findings, include strategies for prioritizing the remediation the health disparities among such Communities.

8. Social Determinants of Health and Equity Spending Programs: SDOH-E Partners and SHARE Initiative

b. Supporting Health for All through Reinvestment Initiative. Contractor shall spend a portion of its previous calendar year's net income or reserves that exceed the financial requirements prescribed by OHA...on services designed to address health disparities and the SDOH-E.

10. Health Equity Plans

Contractor shall develop and implement a Health Equity Plan designed to address the cultural, socioeconomic, racial, and regional disparities in health care...

(2) In order to support the effectiveness and efforts of Contractor's Health Equity Plan, Contractor shall hire or designate an existing employee to serve as a Health Equity (HE) Administrator... The scope of the HE Administrator's responsibilities shall include, without limitation: (i) the development and implementation of Contractor's Health Equity Plan, (ii) ...participate in Health Equity Committees and other related workgroups; (iii) facilitation of the transmission of information... regarding Health Equity activities; (iv) ensuring [the delivery of] Culturally and Linguistically Appropriate services...

c. Strategies, Goals, Objectives, Activities, and Metrics – Requirements

2.... Contractor shall promptly develop and implement at least one strategy for each of the following focus areas:

b. Methods and processes (i) for the utilization of race, ethnicity, language, disability (REAL+D) data to advance Health Equity... (ii) for assessing gaps in the current demographic data systems and processes (both Contractor's and Contractor's Provider Network); (iii) identifying the challenges encountered in collecting demographic data (both Contractor's and Contractor's Provider Network), and (iv) for developing actionable plans for the collection, analysis and reporting of demographic data...

c. Providing: (i) effective, equitable, understandable, and respectful quality care and services, including, without limitation, free-of-charge Certified or Qualified Interpreters for spoken and sign languages...

d. Organizational governance systems that promote Health Equity through the delivery of CLAS;

e. Recruitment strategies and processes that result in the hiring of competent leadership and a workforce that is reflective of the REAL+D demographics of Contractor's Service Area;...

f. Training and education for Contractor's Governing Board, leadership, and workforce that provides such parties with the awareness and tools that will enable such parties to be culturally and linguistically responsive to the REAL+D demographics in Contractor's Service Area...

5. Contractor's Health Equity Plan shall be comprised of three main sections as follows:

(a) Narrative of the Health Equity Plan development process, including meaningful Community engagement...

(b) Focus areas, strategies, goals, objectives, activities, and metrics; and

(c) Organizational and Provider Network Cultural Responsiveness and Implicit Bias Training and Education Plan.

b. Narrative Health Equity Plan Development and Implementation - Requirements

The Narrative Section of Contractor's Health Equity Plan shall include a description of each of the following components: (1) Contractor's organization and organizational commitment to Health Equity;...

(2) The general population of those residing in Contractor's Service Area, Contractor's workforce demographics, and CAC demographic composition...

(3) Contractor's organizational oversight and accountability structure that serves to support the implementation of the Health Equity Plan components...

(4) How the Health Equity Plan was developed, including the meaningful involvement of its Health Equity stakeholders (e.g., Members, CAC, and other Community stakeholders)...

d. Organizational and Provider Network Cultural Responsiveness and Implicit Bias Training and Education Plan-Requirements

1. ... Contractor shall provide... Cultural Responsiveness and implicit bias continuing education...

4. Contractor shall ensure that all of its employee training offerings (and any Cultural Competence and implicit bias training Contractor may offer to its Provider Network) include...

(a) Implicit bias/addressing structural barriers and systemic structures of oppression,

(b) Language access (including the use of plain language) and use of Health Care Interpreters..., , including without limitation, the use of Certified or Qualified Health Care and American Sign Language Interpreters.

(c) The use of CLAS Standards in the provision of services,

(d) Adverse childhood experiences/trauma informed care practices that are culturally responsive and address historical trauma,

(e) Uses of REAL+D data to advance Health Equity...

e. Annual Health Equity Assessment Report

(1) Contractor shall provide OHA with an Annual Health Equity Assessment Report... an assessment of progress made with respect to the strategies, tasks, and activities for each of the focus areas identified and as set forth in Contractor's Health Equity Plan...

(2) For reporting on Contract Years two through five, Contractor's Annual Health Equity Assessment Report shall... also include an assessment of progress made with respect to the strategies, tasks, and activities for each of the focus areas... as set forth in Contractor's Health Equity Plan and Updated Health Equity Plan and other relevant information relating to:

(a) Contractor's progress on organizational capacity for Health Equity and cultural responsiveness;

(b) How Contractor has used and integrated considerations of REAL+D and CLAS in the organization and the Provider Network; and

(c) Information relating to Contractor's Cultural Responsiveness and implicit bias training activities...

Appendix G: Excerpt of Pennsylvania's Quality Strategy

Within Pennsylvania's Quality Strategy, 10% of the MCO's Pay for Performance program is based on addressing disparities for Black / African American members. MCOs are required to attain or to work toward attaining NCQA's Multicultural Health Care accreditation, and the Quality Strategy includes Pennsylvania's plan to stratify measures to identify disparities. Pennsylvania's VBP program is also designed, in part, to advance health equity.

Health Equity

In accordance with 42 CFR § 438.340, states must identify as part of their quality strategies efforts to “identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status.” As in many states, health disparities are a serious issue in Pennsylvania. A baby born in North Philadelphia has a life expectancy of just 68 years, when 5 miles to the south, the life expectancy is 88 years. As such, in 2019, DHS added a section in our Strategic Plan to promote health equity. This help set a collective vision moving forward as a department, with each program office playing a role. O

MAP has the most experience measuring and analyzing disparities. For the past several years, OMAP shared identified health disparities with the PH-MCOs, but disparities have persisted. As a result, OMAP will begin linking 10% of the 2021 MCO P4P Program payment to the African American Community specifically, starting with an incremental improvement payout for maternity and well-child measures for care rendered in 2020. In 2022 and ongoing, OMAP will evaluate disparities and if any additional measures should be added.

In addition, in 2019, OMAP added language into the agreements that required PH-MCOs to either achieve, or be working towards, the attainment of the NCQA distinction in Multicultural Health Care; OLTL added the same requirement for CHC-MCOs for 2021. This distinction recognizes MCOs that adopt best practices for collecting race, ethnicity, and language data, for providing language assistance, for cultural responsiveness, and for reduction of health disparities. Pennsylvania is home to the first MCO in the country to achieve this designation (Health Partners Plans) and six PH-MCOs have achieved this designation in total. DHS is considering expansion of this requirement across all program offices that contract with MCOs.

OMHSAS has begun to analyze HEDIS® measure data stratified by demographic characteristics, including age, race, ethnicity, gender, geographic location, and MCO. Additionally, the ICP quality measures are being stratified by these characteristics as well. The results will be shared with the primary contractors and BH-MCOs.

OLTL is assessing its available data to start measuring disparities. OLTL has identified FED assessments, claims data, and HEDIS® measures as several data sources that could be used to identify disparities, and will begin analysis in 2020.

CHIP is simultaneously also conducting preliminary analyses with its encounter data to identify possible disparities to track over time.

Bend the Healthcare Cost Curve

Value Based Payment

Value Based Payment (VBP) is a DHS initiative to transition providers to being paid for the value of the services provided, rather than simply the volume of services. VBP strategies and VBP models are critical for improving quality of care, efficiency of services and reducing cost. As each of the program offices are at different stages in the maturity of their VBP programs and vary in structure, DHS began working on a VBP alignment initiative in 2019. The guiding principles of this alignment include: ... (5) Promoting health equity.

Appendix H: Excerpt of Rhode Island's RFQ Questions

The following is an excerpt from the Rhode Island Department of Health Medicaid Managed Care Organizations 2021 Request for Qualifications for the state's Medicaid Managed Care program. The RFQ in its entirety can be found [here](#). This appendix includes RFQ questions that are focused on health equity and disparities.

Section 4. Technical Proposal

C. Technical Proposal Requirements

Responses should demonstrate the potential for innovation and increased value inherent in the managed care structure and not available in the fee-for-service (FFS) delivery system. These questions reflect State priorities and should address, where applicable, racial disparities, community collaboration, and person-centered design even if the question does not expressly state those themes.

4.4.1.2 Plan for Promoting Workforce Diversity, Equity and Inclusion

Provide a description of the Bidder's plan for promoting workforce diversity, equity and inclusion at all levels with its organization. The response should include the organizational goals and benchmarks that the Bidder has set to become a more inclusive and diverse organization and/or the steps the bidder has or will take to address structural racism, unconscious and implicit bias within its organization. The response should also describe how the Bidder will evaluate current organizational efforts, human resources practices, track progress and continue to improve the organizational structure, policies and processes to support workforce diversity, inclusivity and equity.

Population Health, Diversity, Health Equity and Inclusion (15-page limit; 150 Points)

EOHHS seeks to advance health equity through Medicaid managed care population health management strategies, which are designed to promote health equity and redress health disparities to achieve optimal health outcomes for all individuals receiving Medicaid. 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.

4.6.1 Describe the Bidder's approach to, and experience with, improving population health for Medicaid populations including how principles of a population health approach will inform and guide its managed care program in Rhode Island. The Bidder should describe its population health management strategy, program structure, population health assessment, health activities, health experience, role in local initiatives, and quality of care and delivery. The response should include at a minimum:

4.6.1.1. Sources and types of data and information collected and used by the Bidder to inform your organization's population health strategies and initiatives, including the collection and utilization of data regarding social determinants of health (SDOH);

4.6.1.3 Member outreach and engagement strategies;

4.6.1.5 How the Bidder evaluates the impact of its population health strategies on health outcomes to inform the development of and updates to the Bidder's health equity strategy and quality plans...

4.6.3 Describe how the Bidder will identify and address the social determinants of health (SDOH) needs affecting its membership in the context of the Bidder's population health management strategy. Include an example of the Bidder's recent experience and success addressing SDOH to improve health equity and population health outcomes, including your organization's approach to collecting SDOH data. Include at least one (1) example that demonstrates how the Bidder used data to identify an issue impacted by SDOH, which interventions were developed, how the impacts of the interventions were assessed, and outcomes were achieved.

4.6.5 Describe the Bidder's experience and successes in identifying, addressing, and mitigating racial and ethnic disparities within a Medicaid population. Include the metrics used to evaluate the program, the measurable improvements achieved and describe how long the improvements have been maintained.

4.6.6 Describe the Bidder's data collection procedures related to enrollee's race, ethnicity, language, disability status (RELD data), geography, and how such data informs the provision of culturally and linguistically appropriate services for members. If the Bidder does not currently collect some types of RELD and geographic data, describe how the Bidder plans to capture this data during the first two (2) years of the Contract award.

4.7 Quality and Performance Improvement (10-page limit; 150 Points)

4.7.1 Describe how the Bidder will further incentivize AEs and other providers, to address health disparities and the social determinant needs of members, improve health equity in access to and delivery of health care services, and improve adult and child health outcomes...

4.10 Provider Network/Provider Services (10-page limit; 70 Points)

4.10.4 Describe the Bidder's proposed approach to offering, promoting, and supporting the appropriate and effective use of telehealth services to increase access and health equity for Rhode Island Medicaid members. The response should assume a post-pandemic environment where access would be balanced with appropriate utilization management and timely access to office-based care that meets the time, distance and availability standards...

ⁱ Prior versions of the Compendium included contract language from Covered California. Information on Covered California was excluded from this version in order to focus on Medicaid managed care. Additional information regarding Covered California can be found here: <https://hbex.coveredca.com/stakeholders/plan-management/>.

ⁱⁱ Everette, T. D., Sathasivam, D., & Siegel, K. (2021, August 9). Health Equity Language Guide for State Officials. Health equity language guide for state officials. <https://www.shvs.org/resource/health-equity-language-guide-for-state-officials/>.

ⁱⁱⁱ 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.

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

^v See Louisiana Medicaid Managed Care Organizations (MCO) Request for Proposals (RFP) and Model Contract. Accessed at <https://wwwcfprd.doa.louisiana.gov/osp/lapac/dspBid.cfm?search=department&term=4>

^{vi} 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>.

^{vii} 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.

^{viii} <https://www.dhs.pa.gov/HealthChoices/HC-Services/Documents/HC%20Agreement%202021.pdf>

^{ix} <https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf>

^x On June 1, 2021, the California Department of Health Care Services (DHCS) released a draft Medi-Cal MCP RFP and sample MCP contract package for a January 2024 implementation. The draft RFP and model contract are not complete. Additional provisions are expected to be included in the final RFP.

^{xi} 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).

^{xii} Respondents are required to submit a separate response to the same question for the state's Healthy Indiana Plan (HIP)