

**Compendium of Medicaid Managed Care Contracting
Strategies to Promote Health Equity
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I. Introduction

The State Health and Value Strategies (SHVS) program continues to support states in their efforts promote health equity in Medicaid programs.¹ Healthcare inequities are well-documented, longstanding, and persist, and lead to disparate health outcomes. Medicaid serves a disproportionate number of people of color, people with disabilities, and individuals with low incomes, subpopulations that also experience barriers to accessing healthcare. States are increasingly leveraging their Medicaid programs to transform healthcare systems with attention to improving individual and population health outcomes. States are examining policy levers and developing strategies to identify, narrow, and eliminate health disparities and center health equity in their Medicaid programs.

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 barrier/factor.² 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, male, cis-gender, heterosexual).

This *Compendium* identifies approaches states are taking within their Medicaid managed care (MMC) programs to promote health equity. It has been updated seven times since its original publication in June 2020. The *Compendium* highlights examples from states to further illustrate how they are implementing specific approaches and includes excerpts from state contract and procurement documents.³ It synthesizes information across select states and categorizes their approaches to support cross-state learning; it does not contain recommendations on which approach(es) may be most effective for a particular state's environment or where a state may see the greatest impact.

State policymakers and Medicaid officials can use this *Compendium* to develop managed care procurements or update and operationalize key MMC contract provisions. For example, a state may adopt a procurement question like one in [Appendix A](#) to assess respondents' experience and capabilities to achieve the state's health equity goals. In addition, [Appendix B](#) contains excerpts of health disparity and health equity language states are using in their MMC contracts. State officials can review the language and incorporate provisions into their own MMC contracts to expedite the development process.

This *Compendium* does not include all state MMC procurement questions or contract language on health disparities, health equity, or cultural competency. Instead, it offers a curated list of specific examples from profiled states. In some cases, relevant MMC contract language was excluded from this *Compendium* due to length. Where publicly available, the full MMC contracts (or model contract and procurement scope of work) are accessible through the website links provided in [Appendix C](#).

The *Compendium* focuses narrowly on the specific contractual and procurement language of health equity, health disparities, and cultural competency. Many states are integrating health equity into their broader system transformation strategies, for example, through initiatives to bolster comprehensive primary care, promote integrated, whole-person care, address social risk factors, and support a sustainable and racially and ethnically representative workforce. Those efforts are beyond the scope of this *Compendium*.

For additional information about steps Medicaid agencies can take to advance their equity goals, see [Promoting Health Equity in Medicaid Managed Care: A Guide for States](#).

II. Methodology

The authors examined a select number of MMC contracts, requests for proposals (RFPs), requests for applications (RFAs), requests for quotes (RFQs), quality strategies, and strategic priorities that explicitly mentioned health disparities and/or health equity. The criteria for inclusion in this *Compendium* were MMC contracts with provisions on health disparities, health equity, and/or cultural competency. This *Compendium* is not an exhaustive review of all states' MMC program activities or contracts.

III. Medicaid Managed Care Approaches to Promoting Health Equity and Reducing Disparities

State contracting approaches for identifying and reducing health disparities and inequities vary. This reflects the different ways in which states operate their Medicaid programs and leverage their MMC strategies. Some states integrate health equity and disparities into their procurement processes to signal their expectations of managed care plans (MCPs) in promoting health equity and securing commitments from respondents to implement equity-related initiatives. The procurement process also allows states to assess the experience and capacity of respondents to advance equity goals. State contract terms and requirements also vary, with some directing MCPs to take specific action, and others creating broader parameters around health equity and permitting MCPs flexibility to adopt strategies targeting inequities.

Most MMC documents that reference health equity or health disparities include definitions of key concepts and terms, many of which were adapted from national initiatives or organizations (e.g., the Robert Wood Johnson Foundation). Establishing definitions of health equity within managed care strategies can ensure that MCPs are clear on how the state views health equity and ensure that equity-related interventions and contract provisions advance equity in a manner consistent with the state's goals and definitions. (For more information on the importance of defining health equity, see [Promoting Health Equity in Medicaid Managed Care: A Guide for States](#) and for examples of definitions, see the SHVS [Health Equity Language Guide for State Officials](#).)

Table 1 identifies how states are incorporating health equity and health disparities into their Medicaid MCP contracting strategies. The table identifies the states that have implemented, or plan to implement, a particular approach.⁴ The authors identified the most common provisions across MMC programs. Some states may have other provisions related to health equity and health disparities that are not incorporated here. The remainder of this section describes each approach in more detail with state-specific examples. In addition, the *Compendium* includes the following appendices.

- [Appendix A](#) contains specific questions states incorporated into MMC procurements. States incorporate health equity and disparities provisions into their procurements to signal that they are priorities and to solicit information from respondents about their experiences and capabilities to advance states' health equity goals.
- [Appendix B](#) contains the specific health equity and disparities language states are using in their MMC contracts. In some cases, this contract language is part of model contracts and scopes of work released with recent MMC procurements and not yet implemented.
- [Appendix C](#) Appendix C includes links to contracts and other sources referenced in this document.

Table 1: State Medicaid Managed Care Approaches to Promote Health Equity and Disparities

Approach	Profiled States
1. Stratification of quality measures by race, ethnicity, and language	DC, DE, KY, MO, OH, OK, OR
2. Performance improvement projects with an equity focus	CA, LA, MN, NV, OH, WA, WV
3. MCP staff and training requirements	CA, DC, HI, KY, LA, MI, MS, NE, NV, OH, OK, OR, TX, WA, WV
4. Provider requirements to promote equity and cultural competency	DC, KY, LA, MI, MS, NC, NV, NY, OK, TX
5. National Committee for Quality Assurance (NCQA) health equity accreditation ⁵	CA, DE, OK
6. Financial incentives to promote health equity	CA, LA, MI, MN, NC, NE, NV, OR, PA
7. Report or plan on health disparities, health equity, or cultural competency	CA, DE, LA, MI, NV, NY, OK, OR, TX
8. Engaging stakeholders in health equity efforts	CA, LA, MI, MO, NC, NE, OR

The remainder of this section elaborates on each of the above approaches and includes examples from states. For RFP questions and excerpts of contracts, see the appendices.

1. Stratification of Quality Measures by Race, Ethnicity, and Language

Stratification of quality measures by race, ethnicity, language, or other population group (e.g., disability, rurality) is among the most common approach states are taking with their MMC contractors. Stratifying measures by subpopulation is an important step to confirm or identify disparities and their magnitude, monitor trends by different subpopulations, establish targets for reducing disparities, and develop or direct targeted interventions and evaluations to support meaningful and lasting improvements. (See [How States Can Use Measurement as a Foundation for Tackling Health Disparities in Medicaid Managed Care](#) for more information.)

In addition, NCQA requires stratification by race and ethnicity of 13 Healthcare Effectiveness Data and Information Set (HEDIS) measures beginning in measurement year 2023. This is an addition of eight measures and will increase transparency into health plan performance. It will also identify where there are disparities and the magnitude of the differences by race and ethnicity to inform policymaking and targeted interventions.⁶

Select examples from states that require stratification are summarized below.

- **Delaware's** 2021 RFP for MMC services⁷ includes provisions requiring contractors to identify disparities in access, enrollee satisfaction, and outcomes, obtain member-identified race, ethnicity, disability, and other demographic data, and stratify measures, such as HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS), to determine populations at the highest risk of poor outcomes. Contractors will be required to share this information with the state.
- **The District of Columbia (D.C.)** requires contractors to compare healthcare utilization data for enrollees by subgroups, such as race/ethnicity, language, and by defined geographic regions (i.e., D.C. Ward) against prior year performance, and, where possible, against regional and national benchmarks.
- MCPs in **Kentucky** and **Missouri** are required to report stratified performance on identified measure sets. In Kentucky, MCPs must report on HEDIS effectiveness of care and access/availability of care and

compare performance on each measure by defined region, eligibility category, race, ethnicity, gender and age. Missouri MCPs must stratify the Centers for Medicare & Medicaid Services (CMS) Adult and Child Core Sets of measures by several categories, including race, ethnicity, region (urban/rural), gender and age.

- **Ohio** and **Oklahoma** specifically require that MCPs obtain *enrollee-identified* race, ethnicity and other demographic data and stratify data to identify disparities and determine the populations with the highest needs. MCPs in Oklahoma are required to implement strategies to reduce identified disparities.
- **Oregon** requires Coordinated Care Organizations (CCOs) to stratify data by race, ethnicity, and language to inform the provision of culturally and linguistically appropriate services, and to identify and reduce healthcare inequities and disparities.

Federal rules found in 42 CFR 438.340(b) stipulate that states' managed care quality strategies must describe plans for identifying, evaluating, and reducing, to the extent practicable health disparities based on age, race, ethnicity, sex, primary language, and disability status. States can use information collected from their MMC contractors to inform their quality strategies.

2. Performance Improvement Projects With an Equity Focus

MMC contractors are required to “establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees...”⁸ One component of states' comprehensive quality strategies is the performance improvement project (PIP). MMC contractors must develop and implement clinical and nonclinical PIPs. PIPs must be designed to sustain significant improvements in outcomes and satisfaction and must include performance measurement and evaluation using quality indicators, interventions to improve access and quality of care, including activities to increase and sustain improvements. Some states may require entities to implement a specific PIP focused on health equity or include an equity-focused PIP as part of a menu of options from which entities can choose. (States can also permit entities to select their own PIPs.)

Select examples of different approaches across the profiled states are summarized below.

- **California** requires MCPs to implement a health equity PIP on an identified health disparity based on, but not limited to age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider, or geographic area. California strongly encourages MCPs to focus attention on a disparity that may have been exacerbated by COVID-19 or in an area for which the MCP is not performing well on the state's quality measure set.
- **Minnesota** requires Medicaid MCPs to implement a PIP on the topic of “Healthy Start for Mothers and their Children.” The project goals include improving services provided to pregnant women and infants, with a focus on reducing health disparities. **Nevada** directs Medicaid MCPs to implement one PIP focused on reducing Black maternal and infant morbidity and mortality.
- **Nevada** and **West Virginia** include an equity-focused PIP on a menu of projects from which MCPs could select. **Nevada** includes an option for MCPs to implement a PIP focused on social determinants of health and health equity. **West Virginia** identified availability, accessibility, and cultural competency of services as a non-clinical focus area for PIP implementation.
- **Ohio's** contract signals to Medicaid MCPs that the PIPs must focus on areas that improve population health, including health equity, across the care continuum.
- **Washington** requires MCPs to participate in a statewide PIP that is designed to reduce a health disparity “identified within a performance measure.” MCPs are to collaborate with others and the Department of Health to implement this PIP.

States are also using their MMC quality strategies to reinforce and/or expand upon their health equity objectives. **Minnesota's** quality strategy includes a goal to “achieve racial equity and close disparities.” This and other stated goals guide the state’s continuous quality improvement efforts and support the state’s Department of Human Services objective to “be an anti-racist organization.” Minnesota’s quality strategy describes withhold arrangements it has implemented with MCPs to address dental health equity and supplemental questions used in adult CAHPS surveys to assess racial equity. **DC's** quality strategy reiterates that MCPs’ Quality Assessment and Performance Improvement (QAPI) Program “must include a mechanism for reducing racial, socioeconomic and ethnic disparities in health care utilization and in health outcomes.”

3. Managed Care Plan Staff and Training Requirements

Increasingly, states are incorporating contract provisions that require MCPs to create key staff positions (e.g., health equity directors) with specific qualifications and responsibilities to promote equity. States are also requiring MCPs to conduct or facilitate staff training in health equity, racial equity, cultural competency and/or implicit bias with some states focusing specific attention on staff that interact most with enrollees.

Select examples of different approaches across the profiled states are summarized below.

- **California, Hawaii, Nevada, Ohio, Oklahoma, and Oregon** establish specific personnel requirements and responsibilities of key staff to promote health equity. Medi-Cal plans in **California** must maintain a full-time chief equity officer whose responsibilities include ensuring all policy and procedures promote health equity, and implementing, monitoring, and evaluating strategies and interventions designed to identify and address root causes of health inequities. **Hawaii** requires MCPs to employ 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 for conducting disparities and trend analyses. **Nevada** stipulates that MCP quality improvement teams include staff with expertise in health equity. **Ohio** identifies specific staff responsible for advancing health equity, including a health equity director, and establishes expectations of senior leadership related to monitoring health disparities and promoting health equity. Key personnel for **Oklahoma** MCPs include a full-time tribal government liaison. The liaison is the single point of contact for the Tribal Government Relations unit of the MCP, which has responsibility for issues related to eliminating health disparities for American Indian/Alaska Native (AI/AN) populations. **Oregon** CCOs must have a health equity administrator on staff who is accountable for health equity related organizational initiatives.
- **Kentucky** requires MCPs to conduct ongoing staff training in “the areas of cultural competency, development, cultural sensitivity, and unconscious bias.” MCP policies and practices must promote among staff and within the provider network an understanding, awareness, and respect for different cultural backgrounds and must ensure provider education of cultural sensitivity.
- **Mississippi** and **Nebraska** have specific requirements for MCP care managers or care coordinators on staff. In **Mississippi**, care managers are required to receive cultural competency training, and MCPs must have at least one care manager on staff with “special training and knowledge of Care Management practices relevant to Mississippi’s Native American community.”⁹ **Nebraska** MCPs must provide training to care management staff that is to include but not be limited to health-related social needs (e.g., housing, food, interpersonal violence), health disparities, and cultural diversity. (Mississippi also requires quarterly training of MCP member services representatives that includes but is not limited to “how to interact with Members in a culturally appropriate manner, keeping in mind health equity and possible implicit bias.”)

- MCPs in **Texas** are required to train their member services representatives in the national standards of Culturally and Linguistically Appropriate Services (CLAS). MCPs must also employ member services and behavioral health services staff who are bilingual in English and Spanish.

4. Provider Requirements to Promote Equity and Cultural Competency

States require MCPs to develop a robust network of providers who can deliver services to enrollees in a culturally and linguistically competent manner, facilitate or ensure providers receive training in cultural competence¹⁰, and indicate in their provider network directories those providers that have completed cultural competency or similar training. States are leveraging their MMC contracts to require provider training to advance their health equity goals and to require MCPs to implement the CLAS standards, which are intended to advance health equity, improve quality, and help eliminate healthcare disparities and ensure their contracted providers are meeting those standards.

Select examples of different approaches across the profiled states are summarized below.

- **D.C.** and **Michigan** require MCPs to indicate specific information pertaining to provider cultural competencies and language capabilities in MCP provider directories. MCPs in **D.C.** must indicate providers' cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office in provider directories. **Michigan** MCPs must indicate completion of cultural competency training for its network of primary care providers and specialists in the provider directory.
- MCPs in **New York** must ensure the cultural competence of its provider network by requiring providers to certify, on an annual basis, completion of a state-approved cultural competence training curriculum, including training on the use of interpreters, for all provider staff who have regular and substantial contact with enrollees.
- **North Carolina** requires MCPs to include specific provisions in provider contracts that address enrollee interpretation and translation services and ensure non-discriminatory, equitable treatment of enrollees. North Carolina also requires MCPs to have a network access plan that addresses the needs of all enrollees, including those with limited English proficiency or illiteracy and historically marginalized populations.

5. National Committee for Quality Assurance Health Equity Accreditation

States are beginning to incorporate national accreditation standards into their MCP contracts by requiring MCPs to attain health equity accreditation. NCQA has two new accreditation programs specifically focused on health equity. NCQA's accreditation programs provide concrete actions and steps for health plans to develop and align organizational practices to address health inequities and improve care. NCQA is phasing out their Distinction in Multicultural Health Care that some states have required of their Medicaid plans and replacing it with these health equity accreditation programs. Some states, such as Tennessee, require MCPs to maintain the NCQA Distinction in Multicultural Health Care and upon expiration of the Distinction, obtain and maintain the NCQA Health Equity Accreditation.¹¹

The NCQA Health Equity Accreditation program establishes the foundation necessary to center equity in organizational practices with a focus on:

- Building an internal culture to support health equity work.
- Collecting and using race/ethnicity, language, gender identity and sexual orientation data.
- Promoting access and availability of language services.
- Enhancing and maintaining a culturally responsive practitioner network.

- Implementing CLAS programs.
- Analyzing data to identify disparities as well as implementing and evaluating programs to reduce inequities and improve CLAS.

The NCQA Health Equity Accreditation Plus program guides organizations in sustaining their efforts to promote health equity and working in collaboration with other organizations and partners to address inequities.

Select examples of different approaches across the profiled states are summarized below.

- Within two years from the contract start date, MCPs in **Delaware** and **Oklahoma** are required to attain NCQA's Health Equity Accreditation and maintain the status throughout the duration of the contract.
- Similarly, in California, MCPs must submit either evidence of NCQA Health Equity Accreditation or a timeline of when the MCP will complete Health Equity Accreditation. The state will require that MCPs obtain Health Equity Accreditation no later than January 1, 2026.

6. Financial Incentives to Promote Health Equity

Using different strategies, states may incorporate financial incentives into MMC contracts for MCPs to improve performance, including implementing performance-based incentives aimed at reducing disparities, improving absolute performance rates for specific population groups, or directing actions intended to reduce inequities. In addition, states may require MCPs to develop specific value-based payment strategies with network providers to improve quality of care and population health outcomes. States can require MCPs to implement a specific value-based payment strategy or model to promote health equity or require MCPs develop their own strategies that center health equity.

Select examples of different approaches across the profiled states are summarized below.

- **California** may consider MCP performance on specified equity and quality benchmarks in the determination of capitation payment rates.
- **Louisiana** and **Michigan** withhold a portion of their MCP capitation payment for meeting established performance and performance improvement requirements relative to health equity. For example, **Michigan** incorporates financial incentives in its requirement that MCPs identify and act on racial disparities to improve health equity for multiple measures. **Pennsylvania's** pay-for-performance program includes a health equity improvement performance payout for MCPs that demonstrate improvement among individuals who are Black on specified quality measures.
- **North Carolina** permits MCPs to count expenditures toward initiatives to advance health equity in its medical loss ratio and risk corridor expenses.
- MCPs in **Minnesota** selected specific quality measures for which MCPs are eligible for an adjustment to the risk corridor calculation for performance. The measures were selected based on opportunities to reduce healthcare disparities.
- **Nebraska, Nevada, and North Carolina** incorporate requirements that MCPs develop value-based payment strategies that include approaches to address health equity. **Nevada** specifically states that the strategies should incentivize providers to improve health equity in access to and delivery of healthcare services.

7. Report or Plan on Health Disparities, Health Equity, or Cultural Competency

States that require MCPs to develop specific health equity plans or reports—sometimes with planned public distribution—are signaling that it is a priority area and increases health plan attention to health equity and disparities. These health equity related plans or reports may be outside of other managed care reporting activities. This forces health plans to focus on the singular topic of health equity and can be a catalyst for health plan and state discussions to identify improvement opportunities. States may focus plans on the provision of care that represents and meets the cultural and linguistic needs of enrollees to promote health equity (i.e., cultural humility plans).¹²

Select examples of different approaches across the profiled states are summarized below.

- **California, Delaware, Louisiana, and Michigan** require MCPs to implement health equity plans that are designed to advance equity and reduce disparities. **Delaware** MCPs must identify an executive-level employee with responsibilities for executing and monitoring the plan. In **Louisiana**, MCPs must identify specific focus areas, goals within each focus area, and measurable objectives within each goal that define metrics and timelines that indicate success in their health equity plans and report annually on progress.
- **Michigan** requires MCPs to develop and implement a multi-year evidence-based, comprehensive diversity, equity, and inclusion (DEI) plan and report on the status of progress to the state.
- **Oklahoma** and **Texas** incorporate a focus on health equity in requirements that MCPs implement cultural competency and sensitivity plans. **Texas** requires MCPs to have a cultural competency plan that describes how MCPs will implement CLAS standards, provide linguistic access and disability-related access, and provide covered services to enrollees from varying cultures, races, ethnic backgrounds, and religions to ensure those characteristics do not pose barriers to gaining access to needed services.
- **Oregon** MCPs must develop health equity plans that are designed to address the cultural, socioeconomic, racial, and regional disparities in healthcare that exist among enrollees and communities within the service area.

8. Engaging Stakeholders in Health Equity Efforts

States are leveraging managed care strategies to ensure the enrollee perspective and experience are represented in health equity related activities. States are incorporating requirements to ensure MCPs are structured to listen to, understand, and reflect the priorities and experiences of enrollees they are serving. States are taking steps to direct MCPs to go beyond what is typically required of a member advisory committee to promote equity through meaningful enrollee involvement. Meaningful involvement means enrollees have substantive influence in policy development, implementation, evaluation, and improvement opportunities. (See [Transformational Community Engagement to Advance Health Equity for additional information.](#))

Select examples of different approaches across the profiled states are summarized below.

- **California** and **Louisiana** require community and enrollee engagement in the development of the required MCP health equity plans. California MCPs must describe how they will use findings and feedback from community advisory committees, enrollee listening sessions, and focus groups or surveys, and collaborate with community-based organizations to inform policies and decision-making on health equity initiatives.
- MCPs in **North Carolina** are required to implement a community engagement strategy that describes how it will collaborate with community-based organizations and local agencies, foster community

inclusion to support enrollees, address health disparities, and incorporate health equity into internal and external policies. Similarly, **Michigan** requires its MCPs to implement a community-led initiative to reduce disparities and achieve health equity. **Missouri** requires MCPs to have participatory collaborative partnerships with communities to facilitate member and community involvement in designing and implementing culturally and linguistically appropriate services.

- **California and Nebraska** contracts require MCPs to convene health equity committees with broad representation, including enrollees and community representatives. **Nebraska's** health equity committee requires MCPs to include leadership, care managers, members, community leaders, provider network managers, and a manager from the quality assurance program. MCPs must reimburse travel costs for committee members who are enrollees or their representatives.
- **Oregon** developed a [checklist](#) that MCPs can use to facilitate meaningful community engagement in the process of developing a required community health improvement plan.

IV. Conclusion

States are using different policy levers and strategies to confront longstanding health inequities and persistent healthcare disparities. States are leveraging opportunities in their MMC programs to center equity in their healthcare purchasing, delivery, and transformation strategies. This *Compendium* highlights how states are incorporating equity in their MCP procurement strategies and contract requirements to signal to contractors that health equity is a priority and support their health equity objectives. State officials can refer to this *Compendium* as they develop and operationalize equity-related contract provisions. Through contract requirements and contract terms, states can focus and sustain attention on health equity. States will need to monitor contractors for compliance with equity-related terms and consider processes to evaluate the impact of different approaches. Strategies to promote equity within MMC combined with other state-driven equity initiatives can support states' overall health equity goals.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

The Robert Wood Johnson Foundation (RWJF) is committed to improving health and health equity in the United States. In partnership with others, we are working to develop a Culture of Health rooted in equity that provides every individual with a fair and just opportunity to thrive, no matter who they are, where they live, or how much money they have.

Health is more than an absence of disease. It is a state of physical, mental, and emotional wellbeing. It reflects what takes place in our communities, where we live and work, where our children learn and play, and where we gather to worship. That is why RWJF focuses on identifying, illuminating, and addressing the barriers to health caused by structural racism and other forms of discrimination, including sexism, ableism, and prejudice based on sexual orientation.

We lean on evidence to advance health equity. We cultivate leaders who work individually and collectively across sectors to address health equity. We promote policies, practices, and systems-change to dismantle the structural barriers to wellbeing created by racism. And we work to amplify voices to shift national conversations and attitudes about health and health equity.

Through our efforts, and the efforts of others, we will continue to strive toward a Culture of Health that benefits all. It is our legacy, it is our calling, and it is our honor.

For more information, visit www.rwjf.org.

ABOUT STATE HEALTH AND VALUE STRATEGIES—PRINCETON UNIVERSITY SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies and brings together states with experts in the field. Learn more at www.shvs.org.

ABOUT BAILIT HEALTH

This *Compendium* was prepared by Erin Campbell, Mary Beth Dyer, Matt Reynolds, Christopher Romero-Gutierrez, and Erin Taylor. Bailit Health is a health policy consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies and private purchasers. For more information on Bailit Health, see www.bailit-health.com.

Endnotes

¹ Dwan Everette T., Sathasivam D., Siegel K. *Health Equity Language Guide for State Officials, Part 1: Discussing Racism*. State Health & Value Strategies. August 9, 2021. Page 5. <https://www.shvs.org/wp-content/uploads/2021/08/Talking-About-Anti-Racism-Health-Equity-1-of-3.pdf>. Accessed August 23, 2022.

² Everette, T. D., Sathasivam, D., & Siegel, K. (2021, August 9). *Health Equity Language Guide for State Officials*. <https://www.shvs.org/resource/health-equity-language-guide-for-state-officials/>.

³ In some cases, contract language may be part of model contracts and scopes of work released within Medicaid managed care procurements and not yet implemented.

⁴ This resource identifies examples of health equity and disparities approaches states are taking. It is not an exhaustive review of all MMC equity and disparities approaches for profiled states.

⁵ In 2010, NCQA introduced the Multicultural Health Care (MHC) Distinction, which gave organizations a roadmap to identify and address health care disparities for the populations they serve. The Distinction was based on the Office of Minority Health's CLAS Standards and focused on race, ethnicity and language as avenues for improving culturally and linguistically appropriate care and reducing health care disparities. In 2021, NCQA published standards and guidelines for Health Equity Accreditation, a new program that evolved and expanded the language and activities of MHC Distinction to better reflect the role of multicultural health care as an important step toward providing equitable care. In 2022, NCQA released information about Health Equity Accreditation Plus, a new program that builds on the activities of Health Equity Accreditation. Organizations can pursue Health Equity Accreditation and Health Equity Accreditation Plus simultaneously. National Committee for Quality Assurance. (2021) *Overview of Proposed Standards for a New Accreditation Program: Health Equity Accreditation Plus*. <https://www.ncqa.org/wp-content/uploads/2021/11/Overview-Memo-Health-Equity-Accreditation-Plus.pdf>. Accessed March 23, 2023.

⁶ NCQA. (2023.) *Data, Measurement and Equity*. <https://www.ncqa.org/health-equity/data-and-measurement/>. Accessed March 23, 2023.

⁷ The 2021 RFP solicited responses for contracts beginning 1/1/2023.

⁸ § 42 CFR 438.330.

⁹ Mississippi Division of Medicaid. (2022). DOM CCO Procurement – Appendix A – CCO Contract. State of Mississippi. <https://medicaid.ms.gov/coordinated-care-procurement/>. Accessed April 3, 2023.

¹⁰ Cultural competence focuses on understanding cultural differences to improve the effectiveness of care. Cultural humility approaches learning about and interacting with other cultures as a lifelong process. While both terms connote appreciation and respect for cultural differences, State Health and Value Strategies prefers the use of the term cultural humility because there is no finite set of skills for responding appropriately to all individuals. For the purposes of the *Compendium*, we have used the terminology in use by the states profiled, which is cultural competency. For more information about cultural competency as compared to cultural humility, please refer to [Health Equity Language Guide for State Officials, Talking About Anti-Racism and Health Equity: Address Bias](#).

¹¹ Division of TennCare. (2022). *Managed Care Contractors (MCCs)*. State of Tennessee. <https://www.tn.gov/tenncare/providers/managed-care-contractors.html>. Accessed March 23, 2023.

¹² Alternatively, states may require MCPs to incorporate equity in their quality improvement plans or population health strategies. For example, Hawaii requires MCPs to implement a comprehensive plan as part of its quality assurance program. The plan must describe targeted efforts to address and mitigate disparities and cultural gaps. (Hawaii also requires Medicaid MCPs to develop a separate work plan on social determinants of health. See *Addressing Health-Related Social Needs Through Medicaid Managed Care* for additional information.) MCPs in Mississippi must submit an annual "quality management work plan" as part of the broader quality program. Mississippi MCPs must include a description of how the MCP will assess and correct disparities in access to care and treatment across races, ethnic groups, geographic regions, and social determinants of health. MCPs in Nevada are required to submit an annual population health strategy in which they must describe the approach to identify and address racial and ethnic disparities in health care, including: the process of identifying racial and ethnic disparities among enrollees; how information is used to design targeted clinical programs to improve health care disparities based on race and/or ethnicity; training provided to staff related to addressing racial and ethnic disparities, diversity, and inclusion; and reporting and/or training provided to Network Providers specifically related to addressing racial and ethnic disparities in health care.

Appendix A: Medicaid Managed Care Procurement Questions Related to Health Equity

This Appendix focuses on MMC procurement questions related to Health Equity for California, Louisiana, Minnesota, Mississippi, Nevada, North Carolina, Ohio, Oklahoma, and Texas.

Profiled states are presented in alphabetical order. For each state, there is a link to MMC procurement documents (where available) and related bidder questions. The following lists of questions are numbered sequentially within each state for this Appendix but may have different numbering within the various state MMC procurement documents.

This Appendix is not a comprehensive list of all equity-related procurement questions but rather includes a variety of questions focused on advancing equity and reducing disparities. This Appendix does not include procurement questions related to addressing Health-Related Social Needs. Examples of those types of procurement questions are included in a companion document, "[Addressing Health-Related Social Needs Through Medicaid Managed Care.](#)"

California

[Link](#) to February 2022 California's Medi-Cal Commercial MCO RFP. The California RFP bidder questions related to health equity are as follows:

1. The proposer must describe their plan and approach to implement and manage the requirements described in Exhibit A, Scope of Work, Attachment III, Operations, Section 1.1.7, Chief Health Equity Officer. The response must include:
 - a. How the plan and approach will advance the DHCS priorities including, but not limited to, reducing health disparities, and
 - b. A description of proposer's experience and current investment in the role of the Chief Health Equity Officer to support plan and approach.
2. The proposer must describe their plan and approach to ensure the Medical Director fulfills all of the requirements outlined in Exhibit A, Scope of Work, Attachment III, Operations, Section 1.1.6, Medical Director. The response must include:
 - a. Detail on how the Medical Director's role is leveraged in the design and implementation of the Population Health Management Strategy and initiatives, the implementation of Quality Improvement and Health Equity activities (including reducing health disparities) and in engaging with local health departments; and
 - b. Past and current experience and investment in the role of the Medical Director and what specific qualifications in the professional experience of the Medical Director (incumbent or when recruiting), serve the specific goals of local health jurisdiction partnership, driving population health outcomes (especially for preventive care), and reducing health disparities in Medi-Cal/Medicaid populations.
3. The proposer must describe their plan and approach to implement and manage the requirements described in Exhibit A, Scope of Work, Attachment III, Operations, Section 1.1.10, Member Representation and how the plan and approach will advance the DHCS priorities including, but not limited to,
 - a. establishing and expanding local presence and engagement and reducing health disparities.
 - b. Include description of experience and current investment in Member representation in establishing public policy or similar groups to support plan and approach.
4. The proposer must describe their plan and approach to implement and manage the requirements described in Exhibit A, Scope of Work, Attachment III, Operations, Section 1.1.11, Diversity, Equity, and Inclusion Training. The response must include:

- a. How the plan and approach will advance the DHCS priorities including, but not limited to, reducing health disparities, and
 - b. A description of proposer's experience and current investment in Diversity, Equity, and Inclusion Training to support plan and approach.
5. The proposer must submit a detailed organization chart showing key staff and committees responsible for Quality Improvement (QI) and Health Equity activities, including qualifications for key quality and Health Equity positions. The organization chart and narrative must provide details on reporting relationships between quality and Health Equity staff throughout the organization. The proposer shall also describe the reporting relationships between the QI and Health Equity committee, and other committees within the proposer's organization.
6. The proposer must describe its oversight and monitoring of QI and Health Equity functions, including those that are delegated to Subcontractors or Downstream Subcontractors. Provide specific examples of oversight and monitoring activities conducted within the last three years, which demonstrate how the proposer has identified needed improvements or gaps in quality of care and/or Health Equity and instituted interventions to address those gaps. Specify any QI or Health Equity activities that are delegated and how the proposer maintains adequate oversight of these delegated activities. Provide specific examples of instances where the proposer has found gaps in the quality of care delivered by delegated entities, or disparities in care, and the steps taken with the delegated entity to address those gaps and/or disparities.
7. The proposer must describe how it will annually assess its QI and Health Equity activities, including areas of success and needed improvements in services rendered within the QI and Health Equity program, the quality review of all services rendered, the results of required performance measure reporting, and the results of efforts to reduce health disparities. Description must include but is not limited to:
 - a. Process to identify differences in quality of care and utilization of physical and behavioral health care services;
 - b. Process to develop equity focused interventions to address differences in quality of care and utilization, including addressing underlying factors such as social drivers of health;
 - c. Process to review performance measure results and address deficiencies, including results and deficiencies of all fully delegated Subcontractors.
 - d. How the proposer will ensure its QI and Health Equity Committee analyzes and evaluates the results of QI and Health Equity activities and ensures follow-up of identified performance deficiencies or gaps in care and how frequently this will occur.
 - e. How the proposer will ensure the QIHEC includes participation from a broad range of network providers, including but not limited to hospitals, clinics, county partners and physicians, as well as Members.
8. Proposer must describe how they will ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services for Members less than 21 years of age. The description should include specific strategies to identify members in need of EPSDT services, how these efforts are included in the population health management strategy, and what specific relationships the proposer leverages with Local Health Jurisdictions and Local Governmental Agencies in these efforts. The description should include any relevant data on EPSDT utilization, especially trends, any quality improvement efforts to increase EPSDT utilization and outcomes of these efforts, especially for specific subpopulations that have health disparities.
9. The proposer must describe their previous experience with areas of Marketing including, but not limited to, how the Marketing strategies align with the efforts in improving Health Equity as described in Exhibit A, Scope of Work, Attachment III, Operations, Section 4.1, Marketing.
10. The proposer must describe its experience and current investments in providing Complex Care Management (CCM) that meets the differing needs of high and rising-risk Members through both ongoing chronic care coordination, and interventions for episodic, temporary needs. The description must include

in detail the proposer's CCM care model, engagement approach, assessment and services delivered, as well as any available data on penetration (rates of eligible members, % members contacted and % enrolled) and quality and Health Equity outcomes from its CCM program.

11. The proposer must describe processes for meeting requirements and responsibilities to keep Providers informed and updated regarding Medi-Cal policies, procedures, and regulations and include the following:...
 - a. Policies regarding the content of the Provider training specifically related to inclusion (sensitivity, diversity, communication skills, and competency), special populations (e.g. Seniors and Persons with Disabilities, Members with intellectual and developmental disabilities), and Social Drivers of Health and disparity impacts.
12. The proposer must describe its experience and current engagement with Local Health Departments and Local Government Agencies in its Service Area(s) and details about how it collaborates with these partners to improve community health, specifically regarding prevention and Health Disparities. Include any regular meetings, current projects, existing MOUs or contractual arrangements (including payment), and specific results in quality or Health Disparity reduction that have occurred.
13. The proposer must describe its experience and current investments in identifying Health Disparities that result from differences in utilization of outpatient and preventive services, its strategies for addressing those differences, and the results of its efforts, including data if available.
14. If Proposer does not administer the CAHPS or other nationally recognized survey, proposer shall describe any other method it uses to measure member satisfaction, how it integrates those results into its QI and health equity program, and examples of activities undertaken as a result of the most recent results.

Delaware

Link to 2021 Medicaid Managed Care Organizations Request for Proposals for the Diamond State Health Plan (DSHP) and Diamond State Health Plan Plus (DSHP Plus) program. RFP bidder questions related to health equity are incorporated below.

Community Engagement, Health Equity, and Health-Related Social Needs (30 pages)

Describe how the bidder will work within communities to engage DSHP and DSHP Plus members, providers, community-based organizations, and other local organizations to understand the unique needs and resources within each Delaware community, and collaborate and establish partnerships to meet the immediate and long term needs of members within those communities.

Describe the strategies and resources the bidder will employ to ensure the bidder and its provider network engage DSHP and DSHP Plus members in a Culturally Competent way. Describe a recent example of an innovative approach the bidder took to promote Cultural Competency, the results achieved, and how the bidder will apply this experience to DSHP and DSHP Plus.

Describe how the bidder will identify and reduce disparities in health care access, service delivery, and health outcomes for DSHP and DSHP Plus members.

Case Scenarios (25 pages)

Céleste is a 55 year-old Haitian Creole DSHP member with limited English proficiency who was admitted to the hospital because a cat bite led to cellulitis, requiring IV antibiotics. As part of the stay, Céleste is screened for Health-Related Social Needs and is identified as living in a food insecure household. It is also

noted that she reports not having seen a primary care provider in over five years. Describe how the bidder would facilitate discharge planning and follow-up care.

Louisiana

[Link](#) to June 2021 Louisiana MMC RFP. The Louisiana RFP bidder questions related to health equity are as follows:

1. Population Health [12-page limit]

1.1 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:

- 1.1.1 Identifying baseline health outcome measures and targets for health improvement;
- 1.1.2 Measuring population health status and identification of sub-populations within the population;
- 1.1.3 Identifying key determinants of health outcomes and strategies for targeted interventions to reduce disparities;
- 1.1.4 How required components of this procurement and other Proposer developed initiatives are integrated, representing a comprehensive approach to population health; and
- 1.1.5 Other considerations the Proposer may seek to present.

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

1.3 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.

1.4 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. Health Equity [12-page limit]

2.1 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 MMC program in Louisiana.

2.2 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 MMC populations and, in particular, those persons who identify as members of communities underrepresented in the workforce to date.

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

2.4 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.

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

2.7 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.

2.8 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.

2.9 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.

2.10 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:

2.10.1 Pregnancy: Percentage of Low Birthweight Births

2.10.2 Contraceptive Care – Postpartum Women Ages 21–44 Page 32 of 55

2.10.3 Child: Well-Child Visits in the First 15 Months

2.10.4 Childhood Immunizations (Combo 3)

2.10.5 Preventive Dental Services

2.10.6 Immunizations for Adolescents (Combo 2)

2.10.7 Adult: Colorectal Cancer Screening

2.10.8 HIV Viral Load Suppression

2.10.9 Cervical Cancer Screening

2.11 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.

2.12 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.

2.13 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.

2.14 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:

2.14.1 Well-child visits and vaccination rates for children and adolescents.

2.14.2 Preventive dental services for children and adolescents.

3. Network Management [10-page limit]

3.1 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.

3.2 Specifically, the proposal should include:

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

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

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

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

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

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

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

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

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

4.1 The Proposer should describe how the Proposer's MMC 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:

4.1.1 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;

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

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

Minnesota

[Link](#) to January 2022 Minnesota RFP for Families and Children Medical Assistance and MinnesotaCare in 80 Greater Minnesota Counties (outside of the major metropolitan area of Minneapolis-St. Paul). The Minnesota RFP bidder questions related to health equity are as follows:

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...

1. What do you believe are the greatest health care challenges facing rural Minnesota and how do you propose to address them? Describe how you have engaged stakeholders to determine what those challenges are. Describe one initiative you have implemented or plan to implement to address those learnings. (4 points)
2. How are you engaged with communities served by this RFP in co-creation of policies and programs that improve health equity? What social drivers of health have you identified that are unique to these communities who experience the greatest health inequities and how are you planning to address them? (4 points)
3. What steps are you taking to ensure access to culturally-specific perinatal care through community-based providers like doulas or community health workers? How are you supporting the development of this workforce in areas where enrollees do not have access? (4 points)
4. Describe steps your organization has taken and/or will commit to taking in order to understand the housing status of your enrollees in Greater Minnesota. Please explain how you work with providers to support people who are homeless, regardless of the services they receive. (4 points)
5. How does your organization use Housing Stabilization Services to improve enrollees' overall health? Specifically describe how your organization will use Housing Stabilization services to reduce disparities and grow access to other needed services for people who have historically been underserved by Medicaid services. What efforts will be taken to grow and retain the provider base for the services and ensure adequate access in the area(s) your organization serves? (4 points)
6. Describe how your organization solicits and/or receives feedback from county staff regarding service delivery, provider networks, and health plan operations. (4 points)
 - a. Describe how that feedback is used in your organization's operations to improve outcomes for groups that experience disparities and to support county health care activities.
7. How is your organization working to ensure its provider network reflects the changing demographics of the Families and Children MA and MinnesotaCare populations in Greater Minnesota? What steps are you taking to assess the impact of discrimination in health care settings and address the health outcomes that stem from racial trauma? (4 points)
8. 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 that the providers essential to residents who experience gaps in provider access due to geographic limitations are included in your network. (4 points)

The below questions are from the January 2021 Minnesota RFP for Families and Children Medical Assistance and MinnesotaCare contracts for the seven (7) county metro area which includes Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington. The Minnesota RFP bidder questions related to health equity are as follows:

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 SDOH to improve population health and prevention. Describe your organization's work regarding community collaboration efforts, provider and other stakeholder partnerships, and data collection including SDOH 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 payment strategies to ensure access to culturally-specific care or a broader range of non-traditional medical care?

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. How do your network providers advance equity and reduce health disparities? What percentage of your network is included in the initiatives described?

Mississippi

[Link](#) to December 2021 Mississippi Medicaid Coordinated Care RFQ. *The Mississippi RFP bidder questions related to health equity are as follows:*

1. How will the Offeror address racial, ethnic, and geographic disparities in delivery of services to and outcomes for children?
2. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding behavioral health services?
3. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding perinatal and neonatal services?
4. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding Members with chronic conditions?
5. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding services for Foster Children?
6. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding dental services?
7. How will the Offeror address racial, ethnic, and geographic disparities in delivery of and outcomes regarding vision services?
8. Describe any additional practices the Offeror will use to address racial, ethnic, and geographic disparities in delivery of services.
9. Describe how the Offeror will provide education to Providers concerning cultural competency, health equity, and implicit bias, and how the Offeror will ensure that Providers apply this training.
10. Describe how the Offeror will ensure that Care Management is a tool to address health equity concerns.

11. Describe how the Offeror will integrate Social Determinants of Health, health equity evaluations, and other non-medical risk factors into the HRS and CHA.
12. In this section, the Offeror is asked to make short proposals, giving high-level details about how the Offeror would approach design and delivery of the named program elements. The Division expects the Offeror's proposals to be innovative, drawing on the Offeror's knowledge of advancements in the Medicaid industry that prioritize improved health outcomes, equity, and care; the needs of the MississippiCAN and CHIP populations; and the Offeror's creativity. The Division also expects the Offeror to demonstrate its expected commitment to its proposals by including estimated workforce needs and financial investment where prompted (and of its own volition if the Offeror's wishes to include such details in its plans).
13. How will the Offeror address Health Equity through its SDOH programs?
14. The Division is requiring consistent, deeply developed partnerships between contractors and local organizations during the next contracting cycle, especially in addressing health equity and Social Determinants of Health. The Offeror must...name four (4) potential partners.

Nevada

[Link](#) to March 2021 Nevada MMC RFP. *The Nevada RFP bidder questions related to health equity are as follows:*

1. 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.
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. 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.
4. 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:
 - 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.
 - 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;
 - 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

- How the Vendor evaluates the success of the VBP arrangement, including the types of performance metrics and the evaluation process.

North Carolina

Bidder questions related to health equity from North Carolina's August 2018 Prepaid Health Plan Services RFP are as follows:

1. The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for engaging Members prior to and after MMC launch, as outlined in *Section V.B.3. Member Engagement*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include:
 - a. Overall approach to educating and engaging Members on MMC, accessing care, and improving overall health;
 - b. Key integration points with other Departments, local DSS offices, and other local partners operating within MMC;
 - c. Methods of leveraging appropriate communication to meet the diverse needs and communication preferences of Members, including individuals with LEP and needing adaptive communication;
 - d. Commitment and process for making qualified interpreters (including sign language) available to Members and potential Members when requested, and at other times as needed in accordance with the Contract;
 - e. Description of how oral, written and sign language translation or interpreter services are certified;
 - f. Method to ensure Member language preferences and communication needs are documented in Offeror's information system;
 - g. Proposed approach to assess Member satisfaction at each point of contact (call, online and in-person), including tools, frequency and process to measure trends in Member satisfaction to support ongoing improvement to the program; and
 - h. Examples of the Offeror's Member incentive programs from other states or markets, including results and outcomes of program.

PROVIDE SUPPORTING DOCUMENTATION (not part of page count):

1. Draft Welcome Packet and Member ID card aligned with the requirements of the Contract
 2. Sample Member Handbook
 3. Sample educational materials with taglines (up to 3 samples)
 4. Sample education materials demonstrating ability to meet Contract's requirements for translation, accessibility and cultural competency (up to 3 samples)
2. The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.B.4. Marketing*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include:
 - a. Proposed marketing locations, distribution methods, and activities planned for the time period between six (6) months prior to and three (3) months after the Offeror has enrolled its first Member;
 - b. Demonstration of understanding of the diverse populations that the Offeror may serve throughout its covered Region(s) (e.g., individuals living in different geographic locations, individuals with different racial backgrounds, individuals with different literacy levels) and approach for how the Offeror will adapt its marketing materials to reach the various populations and audiences within its covered service area; and

- c. Process to ensure marketing materials are widely available throughout the Offeror's covered Region(s) to Members and potential Members, and a plan for how the Offeror intends to prevent the selective distribution of its marketing materials throughout its covered Region(s).

PROVIDE SUPPORTING DOCUMENTATION (not part of page count) to include up to five (5) samples of marketing material. Samples may include brochures, giveaways, radio/TV ads, flyers, billboards.

3. The Offeror shall describe its provider network development strategy for each Region the Offeror is submitting and offer in, including, but not limited to ensuring the development of a comprehensive network of specialty and behavioral health providers for children and adults as required in *Section V.D.1. Provider Network*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include:
 - a. Innovative approaches that will be used to develop and maintain the PHP's provider network to ensure network adequacy standards and highest quality care;
 - b. Methods for monitoring and ensuring compliance with access to care standards, including the frequency of reviewing of these standards;
 - c. Methods for ensuring all covered services are available and accessible to Members in a timely manner, including:
 - i. Offeror's plan to address the needs of all Members, including those with limited English proficiency or illiteracy, and
 - ii. Offeror's plan to ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities;
 - d. Description of how the Offeror will ensure access to care on an out-of-network basis when timely access to a Network Provider is not possible., including the Offeror's plan to educate Members on accessing out-of-network benefits;
 - e. Methods to educate providers on North Carolina's MMC program and ease the transition from Medicaid Fee-for-Service to MMC;
4. The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for performance measurement, assurance, and improvement, stated in *Section V.E. 1. Quality Management and Quality Improvement*. The Offeror shall include in its approach a description of the PHP's quality management strategy, a description of the PHP's quality management program including staffing and tools, a description of the PHP's IT infrastructure and data analytics capabilities to support quality and value, including a description of how such systems can support stratification and analysis of quality measures at a regional level, and all associated standing (permanent) and innovative QM/QA/QI programs. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The Offeror's response shall include information for the Offeror as well as all entities identified as performing a Core Medicaid Operations Function in Question #5. The response shall include:
 - a. Two state samples of multi-year (at least three years) QAPIs that demonstrate measure targets and planned interventions—as well as annual updates to the QAPI. At least one measure and one QI intervention should focus on children and one measure and one QI intervention should focus on pregnancy/maternal health. Those QAPIs should include:
 - i. IT infrastructure used to support measure analysis and quality improvement efforts;
 - ii. Measures results compared to national benchmarks; including measures that did not meet state targets;
 - iii. Evidence of measure indicators; analysis to find drivers; PDSA or other methodological approach for evaluation;

- iv. Two specific QI and two specific PIP programs. At least one PIP example should focus on children and one PIP example should focus on pregnancy/maternal health to drive improvement needed;
 - v. Associated quality improvement training plans—including methodology to target Providers; macro and micro practice interventions, methodology for sharing data and tools and any relationship to advanced payment (AP) or other incentive methods;
 - vi. Associated examples of how quality data was shared with providers. Describe utilization penetration rates among providers and outcomes of using the data and tools/applications; and
 - vii. Overall impact of the QI interventions and PIPs.
- b. Examples of at least 10 HEDIS measures stratified by geography, race/ethnicity, and gender. The Offeror shall describe the IT infrastructure and data analytic capabilities used to support the analysis, analysis of the measures, and associated QI programs implemented to address health disparities. Include measure indicators; analysis to find drivers; PDSA or other methodological approach for evaluation; interventions; planned metrics, realized metrics, and overall impact of the QI/PIP; and
 - c. Two state examples of using public health measures (i.e. BRFSS, state health statistics) and data on unmet resource needs in the development of quality improvement activities and PIPs. Include IT infrastructure, data used and data/metrics collected, collaboration strategies with State and local agencies, quality improvement interventions, and overall impact of the QI/PIP. Using NC state health statistics to then demonstrate how the Offeror might develop a similar program here and measure outcomes.
5. The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements stated in *Section V.F.1 Engagement with Federally Recognized Tribes*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include:
- a. Approach to design and implement the Tribal Engagement Strategy;
 - b. Approach to integrate with EBCI Public Health and Human Services (PHHS) offices;
 - c. Experience working with members of Federally recognized tribes in which culturally competent care is achieved, including the following metrics:
 - i. Number of beneficiaries the Offeror serves who are members of Federally recognized tribes by state; and
 - ii. Volume, type, and availability of services.
 - d. Experience and approach for working with IHCP providers, including:
 - i. Proposed training methods for Contract Liaisons
 - ii. Proposed plan to contract with IHCPs as required under the Contract.

PROVIDE SUPPORTING DOCUMENTATION to include a Draft Tribal Engagement Plan that reflects the unique needs of the North Carolina Medicaid and NC Health Choice program and tribal Members in North Carolina, including EBCI.

6. The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements stated in *Section V.F.2. Engagement with Community and County Organization*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include:
- a. Approach to design and implement Local Community Collaboration Strategy;

- b. Prior experiences supporting and working with communities and community-based organizations and implementing a similar strategy that the Department is looking to implement through the Contract;
- c. Considerations for magnitude of the state/number of county and community based services while remaining cost effective; and
- d. Approach to reducing burden on agencies/partners.

PROVIDE SUPPORTING DOCUMENTATION (not part of page count):

1. Offeror's draft Community and County Engagement Plan that demonstrates an understanding of the North Carolina Medicaid and NC Health Choice program, the state's geographic and cultural diversity and the different types of community of agencies engaged with Members.

7. Use Case Scenario 2.

Francisco, age 15, has moderate persistent asthma. He sees a primary care doctor regularly. However, this year, he had several emergency department visits and one hospitalization related to his asthma. Francisco uses his limited Spanish skills to interpret medical information for his mother, Lenita, who speaks limited English. Being a teenager, Francisco does not always understand what the doctor is saying. As a result, he relies on TV for information. Francisco has recently stopped using his asthma control medicine after seeing several TV commercials for asthma medication with long lists of side effects, some life threatening.

Francisco's father, whom he adores, lives outside the U.S. and Francisco is depressed and anxious about the separation. Francisco and Lenita's apartment is full of mold and pests, but Lenita, who is undocumented, is fearful that complaining to the landlord might lead to an eviction or involvement of immigration authorities. Francisco and Lenita live in a violent neighborhood, but Francisco is worried that if he reports gang activity and threats to the police, his mother will also be deported. The emotional and physical stress has caused Francisco's schoolwork to suffer.

The Offeror must describe how it would address Francisco's situation. At minimum, the Offeror shall address the following programs and services in its response:

- a. Care Management;
- b. Motivational Interviewing;
- c. Housing Quality;
- d. Social Determinants of Health;
- e. Community Engagement; and
- f. Language Accessibility.

8. Use Case Scenario 7.

Dr. Charles Xavier is a licensed clinician who provides a diverse range of services to his local community in rural North Carolina. He is an integral member of this community with large Hispanic and elderly populations, and he speaks both English and Spanish. Dr. Xavier had a medical malpractice issue five (5) years ago and has since undergone training and made improvements to his practice to remediate this issue and future issues.

The Offeror must describe how it would assess the quality of Dr. Xavier's practice. At minimum, the Offeror shall address the following in its response:

- a. Network Adequacy;

- b. Provider Contracting;
- c. Provider Support;
- d. Cultural Competency; and
- e. Community Engagement.

Ohio

[Link](#) to September 2020 Ohio MMC RFA. The Ohio RFP bidder questions related to health equity are as follows:

1. Describe the Applicant’s proposed approach to offering, promoting, and supporting the appropriate and effective use of telehealth services to increase access and health equity for Ohio Medicaid members. In your response assume a post-pandemic environment where access would be balanced with appropriate utilization management.

Oklahoma

[Link](#) to December 2022 Oklahoma Health Care Authority RFP. The Oklahoma RFP bidder questions related to health equity are as follows:

1. Tribal Government Liaison: Describe your relevant experience and proposed approach for undertaking an outreach strategy for AI/AN Enrollees and how you will use the Tribal Government Liaison position to support AI/AN Enrollees and Indian Health Care Providers (IHCPs) in accordance with the requirements outlined in Contract Section 1.17.1: “Tribal Government Liaison.” Also include the process for identification and resolution of barriers that are unique to service delivery on and off Tribal lands. (Page Limit: Three (3) pages)
2. Health Outcomes: Describe how your organization uses rural/urban and other available data to improve health outcomes and address disparities in health outcomes for Enrollees in rural communities. (Page Limit: Two (2) pages)
3. Health Equity: Describe your organization’s plan to improve health equity across the State of Oklahoma. In your response, include specific racial and ethnic minority populations and health disparities that present the biggest potential areas of improvement. (Page Limit: two pages)

Texas

[Link](#) to the December 2022 STAR and CHIP Managed Care Services RFP. The Texas RFP bidder questions related to health equity are as follows:

1. Scenario: Ms. Myat is a 24-year-old woman who is seeking care for her 2 ½ year-old son, Arkar. She has become concerned that he doesn’t seem to be talking as much as other children his age. Of note, Ms. Myat, her husband, and their son Arkar are Karenni and emigrated from Myanmar about 2 years ago seeking asylum. Ms. Myat has limited English proficiency and her preferred language is Karenni. After discussing her concern with a fellow parent, it was suggested that Ms. Myat set up an appointment with Arkar’s pediatrician so Arkar can be evaluated. Arkar’s last visit to the pediatrician was over a year ago when he last received immunizations. Ms. Myat was directed to call the number on the back of Arkar’s Medicaid identification card. Upon calling, Ms. Myat had difficulty understanding the instructions. She then sought the assistance of a representative from the local advocacy organization. Please describe Respondent’s approach to address this scenario. At a minimum, the response should:
 - a. Describe how the Respondent will address the communication barrier for a Member with limited English proficiency;
 - b. Describe how the Respondent will address a Member’s need for a developmental assessment in a culturally sensitive manner; and
 - c. Describe how the Respondent will identify additional health promotion opportunities and provide health education activities.

2. Describe the Respondent's approach to developing, contracting, and managing a robust, qualified, and culturally competent Provider Network. The response should describe the Respondent's strategies to collaborate and evaluate Provider satisfaction, processes for Provider contracting and credentialing, and incentive programs or other mechanisms to promote Provider participation.

Appendix B: Medicaid Managed Care Contract Language

The tables in this appendix are organized according to the approaches described in the *Compendium* and include excerpts from state contracts. States are listed in the first column of each table and listed in alphabetical order.

1. Stratification of Quality Measures by Race, Ethnicity, and Language

State	Contract language
Delaware	<p>The Contractor shall participate in and support the State’s efforts to reduce health disparities and achieve Health Equity for members. The Contractor’s efforts must include identifying disparities in health care access, service provision satisfaction and outcomes. This includes obtaining data on member demographics (e.g., member-identified race, ethnicity, disability, gender identity, sexual orientation, geography, and preferred language) and stratifying measures (e.g., claims, HEDIS, CAHPS, and health risk assessment data) to determine populations at highest risk of poor outcomes and sharing data on member demographics, measures, and populations identified at highest risk of poor outcomes with the State.</p>
Kentucky	<p>The Contractor shall report activities to address the performance measures in the QAPI Plan quarterly and shall submit an annual report after collection of performance data. The Contractor shall make comparisons across data for each measure by the Medicaid geographic regions, eligibility category, race ethnicity, gender and age to the extent such information has been provided by the Department to Contractor. The Contractor shall incorporate consideration of social determinants of health into the process for analyzing data to support population health management. Reported information may be used to determine disparities in health care. The Contractor shall submit a plan to the Department for initiatives and activities the Contractor will implement to address identified disparities.</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>
Louisiana	<p>Section 2.6 Health Equity; 2.6.3 Transparency of MCO Performance on LDH Incentive-based Measures:</p> <p>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.</p> <p>For CY2023, Attachment H: Quality Performance Measures requires specific quality measures to be stratified by race/ethnicity and rural/urban status:</p>

State	Contract language
	<ul style="list-style-type: none"> • Pregnancy: Percentage of Low Birthweight Births, Contraceptive Care – Postpartum Women Ages 21–44 • Child: Well Child Visits in the First 30 Months of Life, Childhood Immunizations (Combo 3), Immunizations for Adolescents (Combo 2) • Adult: Colorectal Cancer Screening, HIV Viral Load Suppression, Cervical Cancer Screening • 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 (within 30 days). <p>The Contractor’s Health Equity Plan mustStratify Contractor results on certain quality measures to identify/address disparities.</p> <p>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.</p>
Missouri	<p>2.23.11 Quality Assessment and Improvement Evaluation Reports:</p> <p>2.23.12 Adult and Child Core Sets Reporting – The health plan shall submit a report on Adult and Child Core Sets that reflect results stratified by several categories: gender, age group (as defined in each measure’s specifications), race, ethnicity, and region (urban/rural). The Adult and Child Core Sets Reports shall be submitted in the format and frequency specified by the state agency at the Adult and Child Core Sets Report located and periodically updated on the state agency Managed Care Program website under Reporting Schedules and Templates.</p>
Nebraska	<p>Quality Performance Measurement and Evaluation</p> <p>b. The MCO must use QI activities and initiatives to improve population health outcomes, including the creation of new processes and procedures through iterative testing and evaluation that, at a minimum, incorporates insights from data, research, members, and providers. The MCO must use QI activities and initiatives to identify disparities in health care access, service provision, satisfaction, and outcomes. This includes obtaining data on member demographics and social determinants, stratifying MCO data (e.g., claims, Healthcare Effectiveness Data, information set [HEDIS], CAHPS, health risk assessment, member-identified race, ethnicity, geography, language, and SDOH) to determine populations with the highest needs.</p>
North Carolina	<p>Quality Management and Quality Improvement</p> <p>j. Disparities Reporting and Tracking</p> <p>i. 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.</p>

State	Contract language
	<ul style="list-style-type: none"> iii. The PHP shall address inequalities as determined by the Department during review of the PHP’s performance against disparity measures.
Ohio	<p>Population Health Improvement Strategies</p> <ul style="list-style-type: none"> c. Health Equity <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 1. Identifying disparities in health care access, service provision, satisfaction, and outcomes. This includes: Obtaining data on member demographics and social determinants; and 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.
Oklahoma	<p>1.11.7 Addressing Health Disparities</p> <p>...To further advance OHCA’s efforts to achieve health equity, the Contractor shall collect and use Enrollee-identified race, ethnicity, language, and Social Determinants of Health data to identify and reduce disparities in health care access, services, and outcomes. This includes, where possible, stratifying HEDIS® and CAHPS®, and Health Risk Assessment results by race, ethnicity, or other relevant demographics, and implementing a strategy to reduce identified disparities.</p>

2. Performance Improvement Projects (PIPs) With an Equity Focus

State	Contract language
Louisiana	<p>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.</p>
Minnesota	<p>7.8 ANNUAL QUALITY PROGRAM UPDATE.</p> <p>7.8.1 The MCO shall submit, on or before May 1st of the Contract Year, a web site link to a public web page associated with the MCO describing quality improvement activities that have resulted in measurable, meaningful and sustained improved health care outcomes for the contracted populations. The MCO will describe the quality strategies, including quantitative evidence of improvements, lessons learned, and how the quality improvement outcomes will influence future activities. The web page must prominently feature the</p>

State	Contract language
	description of at least one quality improvement activity addressing health care disparities.
Nevada	<p>7.9.5. Performance Improvement Projects (PIPs)</p> <p>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.</p> <p>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:...</p> <p>7.9.5.6.4. SDOH and health equity.</p>
Ohio	<p>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.</p>
Oklahoma	<p>1.11.3 Quality Assessment and Performance Improvement (QAPI) Program The Contractor shall review, evaluate, and report outcome data to the OHCA at least quarterly for performance improvement, recommendations, and interventions. The Contractor shall include QAPI activities to improve health care disparities identified through data collection.</p>
Oregon	<p>6. Performance Improvement Projects</p> <p>...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.</p>
Washington	<p>The Contractor shall have an ongoing program of performance improvement projects (PIPs) that focus on clinical and non-clinical areas in alignment with CMS’ EQR Protocols. PIPs identified by the Contractor are subject to review and approval of HCA including, but not limited to area of focus, design and implementation, and evaluation methodologies. The Contractor shall conduct the following PIPs:....One statewide PIP, called the MCO Collaborative Health Equity PIP, conducted in partnership with peer MCOs and DOH, and designed to reduce a health disparity identified within a performance measure.</p>
West Virginia	<p>(3) The activity must be primarily designed to:</p> <ul style="list-style-type: none"> a) Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among MCO specified populations. Examples include the direct interaction of the MCO (including those services delegated by Contract for which the MCO retains ultimate responsibility under this Contract), providers and the enrollee or the enrollee's representative (for example, face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes, including activities such as: <ul style="list-style-type: none"> i. Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives including through the use of the medical homes model as defined in section 3502 of the ACA. ii. Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine. iii. Quality reporting and documentation of care in non-electronic format. iv. Health information technology to support these activities. v. Accreditation fees directly related to quality of care activities.

3. Managed Care Plan Staff and Training Requirements

State	Contract language
California	<p>Contractor must maintain a fulltime chief health equity officer... The chief health equity officer responsibilities must include, but should not be limited to, the following:</p> <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> a. Marketing strategy; b. Medical and other health services policies; c. Member and provider outreach; d. Community Advisory Committee (CAC); e. Quality Improvement activities, including delivery system reforms; f. Grievance and Appeals; and g. 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, Downstream Subcontractors, Network Providers, and entities included, but not limited to local community-based organizations (CBOs), local health department, behavioral health and social services, child welfare systems and Members in Health Equity efforts and initiatives; D. Implement strategies designed to identify and address root causes of Health Inequities, which include but is not limited to systemic racism, Social Drivers of Health, and infrastructure barriers; 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, Downstream Subcontractor, and Network Provider staff receive mandatory diversity, equity and inclusion training (sensitivity, diversity, communication skills, and cultural competency training) as specified in Exhibit A, Attachment III,...annually. This includes...: 1) reviewing training materials to ensure the materials are up-to-date with current standards of practice; and 2) maintaining records of training completion. <p>1.1.11 Diversity, Equity and Inclusion Training: Contractor must 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</p> <p>4.1.1, Subsection A, Training and Certification of Marketing Representatives: ...Marketing strategies must align with Contractor’s efforts in improving Health Equity.</p> <p>5.1.2, Subsection C, Member Services Staff: Contractor shall ensure its Member Services staff are educated on assisting Members with disabilities, chronic</p>

State	Contract language
	<p>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.</p> <p>5.2.11, Subsection C, Diversity, Equity, and Inclusion Training: Contractor must provide annual sensitivity, diversity, cultural competency and Health Equity training for its employees and contracted staff. Training must consider structural and institutional racism and Health Inequities and their impact on Members, staff, Network Providers, Subcontractors, and Downstream Subcontractors...The training must include the following requirements:</p> <ol style="list-style-type: none"> 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 Health Inequities and identified cultural groups in Contractor’s Service Area which includes: the groups’ beliefs about illness and health; need for gender affirming care; methods of interacting with Providers and the health care structure; traditional home remedies that may impact what the Provider recommends to treat patient; and language and literacy needs.
D.C.	<p>C.5.7 Language Access and Cultural Competence</p> <p>C.5.7.1.1.3 Foster in its staff behaviors that effectively address interpersonal communication styles that respect beneficiaries’ cultural backgrounds.</p> <p>C.5.7.1.2 The Contractor shall ensure that its policies and procedures incorporate any laws, regulations, and guidance about Cultural Competence and language access issued by the Government of the District and the U.S. Department of Health and Human Services.</p> <p>C.5.7.1.4 The Contractor shall conduct Cultural Competence trainings annually for all staff, Network Providers and subcontractors. Such trainings shall address at a minimum:</p> <p>C.5.7.1.4.1 Enhanced awareness of Cultural Competency imperatives and issues related to improving access and quality of care for Enrollees;</p> <p>C.5.7.1.4.2 The Contractor’s policies and procedures on Cultural Competence;</p> <p>C.5.7.1.4.3 Requirements of Title VI of the Civil Rights Act of 1964 and the implementing regulations;</p> <p>C.5.7.1.4.4 Requirements of the D.C. Language Access Act of 2004 and the implementing regulations; and</p> <p>C.5.7.1.4.5 The Contractor’s policies and procedures on language access, including how staff can access language assistive services on behalf of Enrollees with limited English proficiency</p>

State	Contract language
	<p>C.5.7.1.4.3 Cultural Competency trainings shall also provide a forum for staff and providers to reflect on their own cultures and values and how they relate to delivery of services to those with differing beliefs and practices.</p>
Hawaii	<p>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.</p>
Kentucky	<p>Appropriate foreign language and/or oral interpreters shall be provided by the Contractor and available free of charge and as necessary to ensure availability of effective communication regarding treatment, medical history, or health education and otherwise comply with 42 C.F.R. 438.10(d). Enrollee written materials shall be provided and printed in English, Spanish, and each Prevalent Non-English Language. Oral interpretation shall be provided for all non-English languages. The Contractor staff shall be able to respond to the special communication needs of the disabled, blind, deaf, and aged, and effectively interpersonally relate with economically and ethnically diverse populations. The Contractor shall provide ongoing training to its staff and Providers on matters related to meeting the needs of economically disadvantaged and culturally diverse individuals.</p> <p>The Contractor shall participate in the Department’s effort to promote the delivery of 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. The Contractor shall address the special health care needs of its Enrollees needing culturally sensitive services. The Contractor shall conduct ongoing training of staff in the areas of cultural competency development, cultural sensitivity, and unconscious bias. The Contractor shall incorporate in policies, administration and service practice the values of the following: recognizing the Enrollee’s beliefs; addressing cultural differences in a competent manner; fostering in staff and Providers attitudes and interpersonal communication styles which respect Enrollee’s cultural background. The Contractor shall communicate such policies to Subcontractors and include requirements in Subcontracts to ensure Subcontractor implementation of such policies.</p>
Louisiana	<p>Part 2: Contractor Responsibilities</p> <p>2.2 Administration and Contract Management - Staffing Requirements (key personnel)</p> <p>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</p>

State	Contract language
	<p>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:</p> <ul style="list-style-type: none"> • 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. <p>2.2.2.7 Staff Training, Licensure, and Meeting Attendance</p> <p>... 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.</p>
Michigan	<p>Section 2.1.1 Personnel A.</p> <p>3. Contractor must implement an evidence-based, comprehensive diversity, equity, and inclusion (DEI) assessment and training program for the organization. The program must assess all organizational personnel, policies, and practices. Contractor must conduct at least one implicit bias training workshop as part of their DEI program, attended by all personnel by the end of FY 22. The program must include additional facets of diversity, equity, and inclusion in addition to implicit bias.</p> <p>a. Contractor must utilize the DEI assessment and training program for the organization to develop and implement a multi-year plan for integrating diversity, equity, and inclusion into organizational policies and practices.</p>

State	Contract language
	<p>b. Contractor must provide status reports on the progress of their assessment activities, including but not limited to assessment findings, training(s) conducted, evaluation results of the training, and recommended next steps based on assessment findings and training evaluation results annually as part of the Compliance Review. Reports of next steps must include estimated timelines, perceived challenges/barriers, and mitigation strategies for these perceived challenges/barriers.</p>
Mississippi	<p>Customer Care - The Contractor’s Member services call center staff must receive trainings at least quarterly. Trainings must include education about Medicaid, MississippiCAN, and CHIP; appropriate instances for transferring a MississippiCAN or CHIP Member to a Care Manager, the Behavioral Health/Substance Abuse line, or the Nurse Advice line; customer service, including but not limited to how to interact with Members in a culturally appropriate manner, keeping in mind health equity and possible implicit bias. Staff must receive updates about continued Medicaid changes and requirements, including “Late Breaking News” articles; Provider Bulletins; State Plan Amendments, CHIP State Health Plan Amendments, and Administrative Code Filings; Provider Billing Handbook; and MississippiCAN and CHIP updates. The Contractor will submit quarterly reports detailing the trainings conducted, topics covered, and the number and positions of staff completing the trainings.</p> <p>Care Managers - Care Managers must additionally receive Cultural Competency training. Additionally, the Contractor must hire at least one Care Manager with special training and knowledge of Care Management practices relevant to Mississippi’s Native American community</p>
Nevada	<p>7.5.3.3. Cultural Competency Education and Training 7.5.3.3.1. The training program must include the methods the Contractor will use to ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery to Members of all cultures. The Contractor must regularly assesses the training needs of the staff and update the training programs, when appropriate. 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;</p>
Oklahoma	<p>1.4.6.2 Key Staff Quality Director who shall be responsible for the operation of the Contractor’s Quality Assessment and Performance Improvement (QAPI) program in accordance with the requirements of Section 1.11: “Quality” of this Contract. The Quality will be responsible for developing and managing the Contractor’s portfolio of improvement projects and will work collaboratively with all Contractor’s and OHCA to improve population health outcomes, including addressing health equity and Social Determinants of Health. 1.11.7 Addressing Health Disparities</p>

State	Contract language
	<p>...The Contractor shall maintain health equity representatives who are actively involved in improvement initiatives to reduce disparities by obtaining input from Enrollees and from Providers of direct services which are intended to reduce adverse health outcomes among Enrollees, determining the root cause of inequities, developing targeted interventions and measures, and collecting and analyzing data to track progress in disparity reduction efforts.</p> <p>1.17.1 Tribal Government Liaison</p> <p>As a part of Key Staff, the Contractor shall employ a full-time Tribal Government Liaison (as described in Section 1.4.6.2: “Key Staff”) to conduct outreach to the AI/AN community and to serve as a resource for Enrollees and Providers with questions or issues. The Tribal Government Liaison will develop policy and lead Tribal consultation with Tribal governments and Tribal health care Providers in Oklahoma. The Contractor shall develop and submit a Tribal outreach plan to OHCA during Readiness Review for review and approval. The Tribal Government Liaison will also be responsible for communicating with and advising Contractor’s Key Staff on topics regarding issues and concerns raised by IHCPs and AI/AN Enrollees including but not limited to, reimbursement, claims payments, access to care, and Enrollment, etc. The Tribal Government Liaison will also coordinate cultural competency training for Contractor’s staff.</p>
Oregon	<p>Exhibit K – Social Determinants of Health and Equity</p> <p>10. Health Equity Plan</p> <p>Contractor shall employ a Health Equity Administrator (HEA) who is accountable for the development and implementation of the Health Equity Pan and any other health equity related organizational initiatives. Contractor must ensure the designated HEA meets the following characteristics: (a) must be a director level employee; (b) must have budgetary authority; (c) must demonstrate knowledge and expertise in health equity; and (d) must be able lead health equity organizational efforts and to allocate the necessary time and organizational resources. Contractor shall document any changes in its HEA’s roles and responsibilities or areas of accountability or both and promptly notify OHA, via Administrative Notice, of any such changes.</p>
Texas	<p>Service Coordination staff must complete a minimum of 16 hours of service coordination training every two years, unless otherwise specified. MCOs must administer the training, which must include information related to the population served, including but not limited to: h. Cultural Competency based on CLAS;</p> <p>Member Services</p> <p>The MCO must ensure that Member-facing hotlines meet Cultural Competency requirements, described further in Section 2.6.18.1, and that Member-facing hotlines staff appropriately handle calls from callers who speak Prevalent Languages in the SA(s) the MCO serves, including Spanish; calls from individuals who are deaf or hard-of-hearing, or have limited communication skills; and calls from Members with an Intellectual or Developmental Disabilities (IDD).</p> <p>To meet the Cultural Competency requirements, the MCO must employ Member Services and BH services staff who are bilingual in English and Spanish, must provide oral interpretation services to all Member-facing hotline callers free of charge, and must secure the services of other contractors as necessary to meet</p>

State	Contract language
	<p>these requirements. The MCO must ensure all Member-facing call center staff treat callers with dignity and respect the callers' needs for privacy.</p> <p>The MCO must ensure all Member Hotline staff are:.... ... Able to converse with Members with IDD, with responses free of cultural bias; ... Trained regarding the federal and State Cultural Competency standards in accordance with Section 2.6.18.1, including arranging for interpreter services;</p> <p>In addition, the Nurse Hotline staff must be Trained regarding Cultural Competency.</p> <p>The BH Services Hotline must meet Cultural Competency requirements, described further in Section 2.6.18.1, and provide Linguistic Access to all Members, including the interpretive services required for effective communication.</p> <p>The MCO must properly train NEMT Services call center staff on NEMT Services policies, including the following: .. cultural competency.</p> <p>The MCO's website must comply with HHSC's Marketing policies and procedures, as set forth in the Chapter 4 of Exhibit B. The website's content must include for providers:</p> <ol style="list-style-type: none"> 1. Training program schedules and topics, and directions for Provider enrollment in training, including continuing education credits for training on issues related to the Members; 4. Information on Cultural Competency and how to provide culturally sensitive care;
Washington	<p>The Care Coordinator shall provide or oversee interventions that address the physical health, social, economic, behavioral health, functional impairment, cultural, and environmental factors affecting health and health care choices. The Care Coordinator shall deliver services in a culturally appropriate 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.</p> <p>The Care Coordinator shall deliver services in a culturally appropriate 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.</p> <p>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. No later than September 30 of each year,</p>

State	Contract language
	<p>the Contractor will provide written documentation of efforts to obtain this training.</p> <p>Health Home Care Coordinators complete the following training modules through State-sponsored classroom training or using State-developed training materials published on the DSHS website within six (6) months of hire. 3.4.1. Outreach and Engagement Strategies; 3.4.2. Navigating the LTSS System; 3.4.3. Cultural and Disability Considerations; 3.4.4. Assessment Screening Tools; and 3.4.5. Coaching and Engaging Clients with Mental Health Needs.</p> <p>The Health Home Care Coordinator shall provide or oversee interventions that address the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors affecting enrollee’s health and health care choices available to Health Home enrollees 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;</p> <p>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.</p> <p>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.</p> <p>The Contractor’s staff, including Tribal Liaison, shall receive annual training applicable to the AI/AN communities in the RSAs contracted, including cultural humility, IHCPs and services available, and the Protocols for Coordination with Tribes and Non-Tribal IHCPs applicable to the Contractor’s Regional Service Area(s).</p>
West Virginia	<p>The MCO staff (including care management and enrollee services staff) and contracted providers shall receive training in the following areas:</p> <ul style="list-style-type: none"> • Specific training on care coordination job functions with an annual refresher training on motivational interviewing; • Bi-annual training on cultural competency and implicit bias; • Annual training on customer service; and • Additional training relative to SDoH case management that the MCO deems necessary.

4. Provider Requirements to Promote Equity and Cultural Competency

State	Contract language
Kentucky	The Contractor shall ensure that Provider education includes: Cultural sensitivity; Integrated healthcare, addressing Social Determinants of Health, and population health management initiatives; The Contractor’s QAPI program, the EQRO, and the Provider’s role in impacting quality and healthcare outcomes, including ongoing education about QAPI program findings and interpretation of data when deemed necessary by the Contractor or Department;
Louisiana	<p>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.</p> <p>2.6. Health Equity Plan requirements Overall strategies and specific activities to achieve each measurable objective must include, but are not limited to:...</p> <ul style="list-style-type: none"> • 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;
Michigan	Appendix 16. Provider Directory Listing Requirements “Whether the provider has completed cultural competency training” (required for PCPs and specialists, optional for other provider types listed in Directory). Also see “n. Other” section below related to LGBTQ+ Care Quality template and required provider training.
Mississippi	Initial training (for provider) - 5. The importance of ensuring health equity, addressing implicit bias, and maintaining cultural competency in the delivery of services;
Nevada	<p>7.5.3.3. Cultural Competency Education and Training 7.5.3.3.3. The education program must include methods the Contractor will use for Providers and other Subcontractors with direct Member contact. The education program must be designed to make Providers and Subcontractors aware of the importance of providing services in a culturally competent manner. The Contractor must make sufficient efforts to train Providers and Subcontractors or assist Providers and Subcontractors in receiving training on how to provide culturally competent services.</p>
New York	<p>15. ACCESS REQUIREMENTS 15.10 Cultural and Linguistic Competence a) The Contractor shall promote and ensure the delivery of services in a culturally competent manner to all Enrollees, including but not limited to those with limited English proficiency and diverse cultural and ethnic backgrounds as well as Enrollees with diverse sexual orientations, gender identities and member of diverse faith communities. For the purpose of this Agreement, cultural competence means having the capacity to function effectively within the context of the cultural beliefs, behaviors, and needs presented by Enrollees and their communities across all levels of the Contractor’s organization.</p>

State	Contract language
	<p>b) In order to comply with this section, the Contractor shall:</p> <p>i. Maintain an inclusive, culturally competent provider network, as provided in Section 21 of this Agreement, including culturally competent network of Behavioral Health Providers, individual behavioral health practitioners, community-based providers and peer-delivered services;...</p> <p>c) The Contractor shall ensure the cultural competence of its provider network by requiring Participating Providers to certify, on an annual basis, completion of State-approved cultural competence training curriculum, including training on the use of interpreters, for all Participating Providers’ staff who have regular and substantial contact with Enrollees. The State will provide cultural competence training materials to the Contractor and providers upon request.</p>
North Carolina	<p>V.G. Program Operations</p> <p>4. PHP Policies</p> <p>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:</p> <p>i. Network Access Plan,</p> <p>ii. VBP/APM Strategy,</p> <p>iii. Care Management Policy,</p> <p>iv. Provider Support Plan,</p> <p>v. Provider Training Plans,</p> <p>vi. Opioid Misuse Prevention Program, and</p> <p>vii. Local Community Collaboration Plan.</p> <p>V.D. Providers</p> <p>1. Provider Network</p> <p>c. Furnishing of Services (42 C.F.R. § 438.206(c))</p> <p>vi. The PHP shall promote the delivery of services by Network providers in a Culturally and Linguistically Competent manner to all Members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, deafness and who are deaf or hard of hearing, and regardless of gender, sexual orientation, or gender identity. 1.The PHP shall assist providers with meeting these requirements, including educating providers on the availability of the Cultural and Linguistic Competency resources, accessing the resource, and responsibility in providing access to interpreter services and having sufficient interpreter capacity.</p> <p>3. Provider Relations and Engagement</p> <p>c. Provider Education and Training</p> <p>v. The PHP shall develop a Provider Training Plan that outlines training topics and dates. The PHP Provider Training Plan shall reference and acknowledge the broader role the PHP has in supporting Department initiatives. Training must include: ... 6. How the PHP is addressing health disparities and incorporating health equity into their internal and external policies, and procedures.</p> <p>d. Provider Manual</p>

State	Contract language
	<p>iv. The PHP shall develop, maintain, and distribute a Provider Manual that offers information and education to providers about the PHP and Medicaid Managed Care. At a minimum, the Provider Manual must cover the following subject matter: ... 8.Network requirements, including nondiscrimination, Cultural and Linguistic Competency expectations, on-call coverage, credentialing, re-credentialing, access requirements, no reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability; ... 12.Cultural and Linguistic Competency and accessibility requirements;</p> <p>V.D. Providers</p> <p>1. Provider Network</p> <p>c. Furnishing of Services (42 C.F.R. § 438.206(c))</p> <p>vi. The PHP shall promote the delivery of services by Network providers in a Culturally and Linguistically Competent manner to all Members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, deafness and who are deaf or hard of hearing, and regardless of gender, sexual orientation, or gender identity. 1.The PHP shall assist providers with meeting these requirements, including educating providers on the availability of the Cultural and Linguistic Competency resources, accessing the resource, and responsibility in providing access to interpreter services and having sufficient interpreter capacity.</p>
Oklahoma	<p>1.12.2 Cultural Competency</p> <p>....i. Provide annual training to Participating Providers and Enrollee-facing staff (e.g., Enrollee Services and Care Managers (if applicable) to ensure the delivery of culturally and linguistically appropriate care.</p>
Texas	<p>The MCO must establish ongoing Provider training that includes the following topics:</p> <p>2. Medical Home Services Model...</p> <p>7. Cultural Competency Training based on federal and State requirements;</p>

5. NCQA Health Equity Accreditation

State	Contract language
Delaware	<p>3.13.9 NCQA Health Equity Accreditation</p> <p>3.13.9.1 The Contractor must earn NCQA’s Health Equity Accreditation in the State of Delaware within two years from the Start Date of Operations and maintain Health Equity Accreditation throughout the term of the Contract.</p> <p>3.13.9.2 The Contractor shall provide the State information regarding the Contractor’s progress in achieving Health Equity Accreditation upon the State’s request.</p> <p>3.13.9.3 The Contractor shall provide the State with evidence of the Contractor’s Health Equity Accreditation, including the results of the Contractor’s most recent NCQA review.</p> <p>3.13.9.4 The Contractor shall authorize NCQA to provide the State a copy of the most recent Health Equity Accreditation review for the Contractor.</p>
Oklahoma	<p>1.4.2 Accreditation</p>

State	Contract language
	...The Contractor must earn National Committee for Quality Assurance’s (NCQA’s) Health Equity Accreditation in the State of Oklahoma within two (2) years from the Operations Start Date and maintain Health Equity Accreditation throughout the term of the Contract. The Contractor shall provide the State with evidence of the Contractor’s Health Equity Accreditation, including the results of the Contractor’s most recent NCQA review. The Contractor shall authorize NCQA to provide the State a copy of the most recent Health Equity Accreditation review for the Contractor.

6. Financial Incentives to Promote Health Equity

State	Contract language
California	1.5 Determination and Redetermination of Capitation 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.
Louisiana	<p>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...</p> <ul style="list-style-type: none"> • 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... <p>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.</p>
Minnesota	7.13 RISK CORRIDORS QUALITY INCENTIVE MEASURES FOR 2021 MCO shall be eligible for an adjustment to the risk corridor calculation in section 4.4.2.7 if quality measurement scores below are met or exceeded. The measures have been selected to address and improve healthcare disparity gaps among MCO enrollees.
Nebraska	7. Value-based contracting By the end of the first year of the contract and annually thereafter, the MCO must submit to MLTC for its review and approval its plan for implementing value-based purchasing (VBP) agreements. MCO’s shall include in their VBP plans strategies for localizing care management, addressing SDOH gaps, and addressing health equity for the Medicaid population. MCO’s must include plans for VBP for Medical and Behavioral health services and providers. MLTC reserves the right to establish benchmarks for the percentage of covered lives and paid dollars included in VBP arrangements.

State	Contract language
Nevada	<p>7.7. Payment to Providers</p> <p>7.7.6. Value Based Purchasing</p> <p>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.</p>
North Carolina	<p>V.E. Quality and Value</p> <p>2. Value-Based Payments (VBP)</p> <p>e. To ensure the PHP’s response aligns with the Department’s strategy and goals, the PHP shall develop a PHP VBP Strategy for Contract Years 1-3, in alignment with the Department’s short- and long-term goals to shift from a fee for service system to VBP.</p> <p>v. The VBP Strategy shall contain the following elements: 1.A narrative description addressing: ... vi. The PHP’s approach to address health disparities and incorporate health equity into their internal and external policies, and procedure</p> <p>V.I. Financial Requirements</p> <p>2. Medical Loss Ratio</p> <p>b. 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:</p> <p>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.</p> <p>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 CBOs that provide meals, transportation or other essential services.</p> <p>c. The following requirements apply to both the CMS-defined MLR and the Department-defined MLR:</p> <p>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.</p> <p>d. If the PHP’s Department-defined MLR is less than the minimum MLR threshold, the PHP shall do one of the following...</p> <p>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;</p> <p>iv. Allocate a portion of the total obligation to a mix of Department-approved contributions to health-related resources and/or Department-approved</p>

State	Contract language
	<p>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.</p> <p>4. Risk Corridor</p> <p>a. A risk corridor arrangement between the PHP and the Department will apply to share in gains and losses of the PHP as defined in this section. The Risk Corridor payments to and recoupments from the PHP will be based on a comparison of the PHP's reported Risk Corridor Services Ratio ("Reported Serves Ratio") for the Risk Corridor Measurement Period as defined in this section, to the Target Services Ratio consistent with capitation rate setting and set forth in the Standard Plan Rate Book ("Target Services Ratio").</p> <p>...</p> <p>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:...</p> <p>f) Contributions to community-based health-related resources and initiatives that advance Health Equity, subject to Department review and approval...</p> <p>...</p> <p>ix. Terms of the Risk Corridor a) If the Reported Services Ratio is less than the Target Services Ratio minus 3%, the PHP shall pay the Department 50% of the Reported Services Ratio denominator multiplied by the difference between the Target Services Ratio minus 3% and the Reported Services Ratio. b) If the Reported Services Ratio is greater than the Target Services Ratio plus 3%, the Department shall pay the PHP 50% of the Reported Services Ratio denominator multiplied by the difference of the Reported Services Ratio and the Target Services Ratio plus 3%.</p>
Pennsylvania	<p>Health Equity: The PH-MCO is eligible for a Health Equity Improvement Performance payout for Controlling High Blood Pressure, Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%), Prenatal Care in the First Trimester, Postpartum Care and Well-Child Visits in the First 15 Months for their African American population. The PH-MCO's Maximum Program Payout amount is equivalent to 10% of the sum of the amounts defined in Section II. below divided by five (5) unique quality indicators.</p> <p>Scale 2 (See Section I. B. 2.) applies to improvement performance for the Health Equity quality measures Controlling High Blood Pressure, Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%), Prenatal Care in the First Trimester, Postpartum Care and Well-Child Visits in the First 15 Months.</p>

7. Report or Plan on Health Disparities, Health Equity, or Cultural Competency

State	Contract language
<p>California</p>	<p>2.2.7 Quality Improvement and Health Equity Annual Plan: ...Develop a QI and Health Equity plan annually for submission to DHCS that includes the following:</p> <ul style="list-style-type: none"> • A comprehensive assessment of the QI and Health Equity activities undertaken • Planned equity-focused interventions to address identified patterns of over- or underutilization of physical and behavioral health care services; • A description of Contractor’s commitment to Member and/or family focused care through Member and community engagement such as review of CAC findings, Member listening sessions, focus groups or surveys, and collaboration with local community organizations; and how Contractor utilizes this information ...to inform Contractor policies and decision-making; • To the extent that Contractor delegates its QI and Health Equity activities..., Contractor’s QI and Health Equity annual plan must include evaluation and findings specific to the Fully Delegated Subcontractor’s and Downstream Fully Delegated Subcontractor’s performance
<p>Delaware</p>	<p>3.14.24 Cultural Competence and Health Equity 3.14.24.3 The Contractor shall encourage and foster Cultural Competency and Health Equity through the implementation of a Cultural Competence and Health Equity Plan. The plan shall address how the Contractor intends to better meet the needs of members to advance Health Equity and reduce Health Care Disparities. The Contractor shall appoint an individual executive employee responsible for executing and monitoring the plan who reports directly to the Compliance Officer. 3.14.24.4 The Cultural Competence and Health Equity Plan shall, at a minimum, address the following: A description of how data is collected that identifies member demographics (race, ethnicity, etc.) and how this data is used to assess Cultural Competency and Health Equity needs and areas for improvement; The ongoing strategy and methods to engage local organizations to develop or provide Cultural Competency training to Contractor staff, providers, and Subcontractors/Downstream Entities and collaborate on initiatives to increase and measure the effectiveness of Culturally Competent service delivery; A summary of the Contractor’s policies and procedures for Cultural Competence, including how it tracks and addresses Grievances and non-member concerns related to the Cultural Competence of providers, staff and Subcontractors/Downstream Entities; Actions to train Contractor staff, providers, and Subcontractors/Downstream Entities on Cultural Competency, including the content and frequency of the training; The available resources for language assistance for individuals with Limited English Proficiency and auxiliary aids for individuals with disabilities, including how the Contractor monitors providers for language and accessibility for individuals with disabilities, and how new technologies to improve accessibility are assessed and implemented;</p>

State	Contract language
	<p>Goals to improve Cultural Competence and Health Equity, how these goals are developed and assessed, including the indicators used as benchmarks toward achieving these goals;</p> <p>The Contractor’s strategies and methods for recruiting staff and contracting with providers with backgrounds representatives of the members served; and</p> <p>The involvement of Executive Management, members, providers, and community stakeholders in the development and ongoing operation of the Cultural Competence and Health Equity Plan.</p> <p>3.14.24.5 The Contractor shall ensure that its Cultural Competence and Health Equity Plan is reviewed at least quarterly by the Compliance Committee and updated at least annually.</p> <p>3.14.24.6 The Contractor shall submit its annual Cultural Competence and Health Equity Plan to the State for review. (See Section 3.21.13, Member Services Reports.)</p>
<p>Louisiana</p>	<p>2.6 Health Equity</p> <p>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.</p> <p>The Contractor’s Health Equity Plan shall be composed of three main sections, as follows:</p> <ul style="list-style-type: none"> • 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. • Overall strategies and specific activities to achieve each measurable objective must include, but are not limited to: <ul style="list-style-type: none"> ○ 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; ○ Engaging diverse families when designing services and interventions that integrate care and address childhood adversity and trauma; ○ Obtaining ongoing input from Enrollees who have disparate outcomes to incorporate the perspective of the Enrollee; ○ 2.6.1 The Contractor’s Health Equity Plan shall be composed of three main sections, as follows: <ul style="list-style-type: none"> ○ Narrative of the Health Equity Plan development process, including meaningful community engagement;

State	Contract language
	<ul style="list-style-type: none"> ○ 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. ○ Overall strategies and specific activities to achieve each measurable objective must include, but are not limited to: ○ 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; ○ Engaging diverse families when designing services and interventions that integrate care and address childhood adversity and trauma; ○ Obtaining ongoing input from Enrollees who have disparate outcomes to incorporate the perspective of the Enrollee; ○ 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; ○ Plan to conduct cultural responsiveness and implicit bias training within the Contractor’s organization and among Network Providers. <p>2.6.2 Health Equity Plan Timeline</p> <p>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.</p>
Nevada	<p>7.5.3.2. Cultural Competency Plan</p> <p>7.5.3.2.1. The Contractor must have a comprehensive cultural competency program, which is described in a written plan. The Cultural Competency Plan (CCP) must describe how care and services will be delivered in a culturally competent manner.</p> <p>---</p> <p>7.5.3.2.5. The Contractor must demonstrate how it plans to recruit and retain staff who can meet the cultural needs of the Contractor’s membership and cultural competence must be included as part of job descriptions.</p> <p>7.5.3.2.6. The CCP must include a process to obtain Member and stakeholder feedback that will be used to improve the cultural competency program and cultural support provided by clinical and member services programs.</p>
Oklahoma	<p>1.12.2 Cultural Competency</p> <p>...The Contractor shall develop and submit a cultural competency and sensitivity plan to OHCA during Readiness Review. The plan shall include guidelines for evaluating health equity and monitoring disparities in membership and service quality, especially with regard to minority groups. Elements of this plan shall address how the Contractor will:</p> <p>a. Identify organizations and advocates that could work with LEP communities and individuals in a culturally competent way;</p>

State	Contract language
	<ul style="list-style-type: none"> b. Incorporate cultural competence into the Contractor’s medical, behavioral health, and Care Management programs, including outreach and referral methods; c. Recruit and train culturally diverse staff that will be able to operate fluently with all Enrollee communities throughout the State; d. Ensure Enrollee assessments inquire about language preference; e. Conduct self-assessments of cultural and linguistic competence before services commence and with annual frequency thereafter; f. Ensure cultural competence outcomes through internal audits and performance improvement targets; g. Develop a set of cultural competency standards designed to help all parts of the Care Management process deliver culturally sensitive care; h. Identify and develop intervention strategies for high-risk health conditions found in certain cultural groups; and i. Provide annual training to Participating Providers and Enrollee-facing staff (e.g., Enrollee Services and Care Managers (if applicable) to ensure the delivery of culturally and linguistically appropriate care.
Oregon	<p>10. Health Equity Plan Contractor shall develop and implement a Health Equity Plan designed to address the cultural, socioeconomic, racial, and regional disparities in health care that exist among Contractor’s Members and the Communities within Contractor’s Service Area.</p> <p>(3) Contractor shall provide OHA with an annual update to its Health Equity Plan, which was originally submitted in Contract Year one (2020), no later than June 30 of each Contract Year using the template provided by OHA on the CCO Contract Forms Website. Contractor shall provide OHA with its Health Equity Plan update, via Administrative Notice, for review and approval....</p> <p>(5) Contractor’s Health Equity Plan update shall be comprised of two main sections as follows: (a) Focus areas, strategies, goals, objectives, activities, metrics updates, and progress report; and (b) Organizational and Provider Network Cultural Responsiveness and Implicit Bias Training and Education Plan.</p>
Texas	<p>2.6.18.1 Cultural Competency Plan Exhibit H (RFP SOW) The MCO must have a comprehensive written Cultural Competency plan describing how the MCO will ensure culturally competent Services and provide Linguistic Access and Disability-related Access. The plan must be developed in adherence to the federal and State Cultural Competency standards in the format as required by HHSC as described in Chapter 16 of Exhibit B.</p> <p>The Cultural Competency plan must adhere to the following: 1. Title VI, 42 U.S.C. § 2000d et seq., Civil Rights Act guidelines; 2. The Americans with Disabilities Act; 3. 28 C.F.R. § 36.303 and 42 C.F.R. § 438.206(c)(2); and 4. 1 Tex. Admin. Code pt. 15, ch. 353, subch. E, § 353.411.</p>

State	Contract language
	<p>The MCO’s Cultural Competency Plan must include how the MCO will provide Linguistic Access and Disability-related Access, including appropriate hotline access and sign language interpretation services during Provider appointments. The Plan must also describe how the MCO effectively provides Covered Services to Members from varying cultures, races, ethnic backgrounds, and religions to ensure those characteristics do not pose barriers to gaining access to needed services. This includes providing interpreter services as necessary during appointments with Providers to ensure effective communication.</p> <p>Additionally, the Cultural Competency plan must detail how the MCO will implement each component of the federal and State standards and how its implementation of these standards impact implementation of the principal standard from the U.S. Department of Health & Human Services’ National Culturally and Linguistically Appropriate Services (CLAS) Standards: “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.”</p> <p>The Cultural Competency plan must describe how the individuals and systems within the MCO organization will effectively provide Services to people of all cultures, races, ethnic backgrounds, languages, communications needs, Disabilities, and religions, in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each. The plan must be made available to the MCO’s Providers.....</p>

8. Engaging Stakeholders in Health Equity Efforts

State	Contract language
California	<p>2.2.3 Quality Improvement and Health Equity Committee (QIHEC): Contractor shall implement and maintain a QIHEC designated and overseen by its Governing Board. Contractor’s medical director ...must head QIHEC in collaboration with Contractor’s Chief Health Equity officer.</p> <ul style="list-style-type: none"> Contractor must ensure that a broad range of Network Providers, including but not limited to hospitals, clinics, county partners, physicians, Subcontractors, ..., Network Providers, and Members, actively participate in the QIHEC or in any sub-committee that reports to the QIHEC. The Subcontractors..., and Network Providers that are part of QIHEC must be representative of the composition of the Contractor’s Provider Network and include, at a minimum, Network Providers who provide health care services to Members affected by Health Disparities, LEP Members, CSHCN, Seniors SPDs and persons with chronic conditions... <p>Exhibit A, Attachment III – 4.3 Population Health Management and Coordination of Care R.0104 Submit policies and procedures for engaging stakeholders as part of Contractor’s PNA, Population Health Management Strategy (PHMS), and</p>

State	Contract language
	<p>development process for new initiatives including, LHDs, LEAs, LGAs and all other stakeholders.</p> <p>5.2.11, Subsection E, Community Advisory Committee: 1) Contractor must have a diverse CAC...comprised primarily of Contractor’s Members, as part of the Contractor’s implementation and maintenance of Member and community engagement with stakeholders, community advocates, traditional and Safety-Net Providers, and Members. The CAC Selection Committee must ensure CAC membership reflects the general Medi-Cal population in Contractor’s Service Area, including representatives from IHS Providers, and adolescents and/or parents and/or caregivers of children, including foster youth, as appropriate and be modified as the population changes to ensure that Contractor’s community is represented and engaged. The CAC Selection Committee must make good faith efforts to include representatives from diverse and hardto-reach populations on the CAC, with a specific emphasis on persons who are representative of or serving populations that experience Health Disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities...</p> <p>The CAC shall carry out the duties which include identifying and advocating for preventive care practices to be utilized by the Contractor; 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 must provide and make recommendations to Contractor regarding cultural appropriateness of communications, partnerships, and services; The CAC must review PNA findings and have a process to discuss improvement opportunities with an emphasis on Health Equity and SDOH.</p> <p>Contractor must allow its CAC to provide input on selecting targeted health education, cultural and linguistic, and QI strategies; Contractor must provide sufficient resources for the CAC to support required CAC activities, including supporting,,, engagement strategies such as consumer listening sessions, focus groups, and/or surveys; The CAC must provide input and advice, including... Culturally appropriate service or program design; Priorities for health education and outreach program; Member satisfaction survey results; Findings of the PNA; Plan marketing materials and campaigns; Communication of needs for Network development and assessment; Community resources and information; Population Health Management; Quality; Health Delivery Systems Reforms to improve health outcomes; Carved Out Services; Coordination of Care; Health Equity; and Accessibility of Services</p>
Louisiana	<p>The Contractor’s Health Equity Plan must ... Engage a variety of Enrollees/populations in the Contractor’s health equity approach.</p> <p>Overall strategies and specific activities to achieve each measurable objective must include, but are not limited to:...</p> <ul style="list-style-type: none"> • Engaging diverse families when designing services and interventions that integrate care and address childhood adversity and trauma;

State	Contract language
	<ul style="list-style-type: none"> • Obtaining ongoing input from Enrollees who have disparate outcomes to incorporate the perspective of the Enrollee;
Michigan	<p>2. Community Collaboration Project “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. Contractors may propose the development of their own community collaboration initiative to improve population health if such initiatives do not exist in a particular region. All community collaboration projects are subject to MDHHS approval prior to implementation.”</p> <p>3. Services Provided by Community-based Organizations. “Contractor must, to the extent applicable, support the design and implementation of Community Health Worker (CHW) interventions delivered by community-based organizations which address Social Determinants of Health and promote prevention and health education, and are tailored to the needs of community members in terms of cultural and linguistic competency and shared community residency and life experience.”</p> <p>g. Contractor must ensure CHWs are trained in all privacy laws and HIPAA provisions, and have successfully completed training in the following core competencies in order to serve Enrollees in the community....</p> <p>v. Communication skills and cultural responsiveness</p>
Nebraska	<p>Health Equity Committee: A diversity, equity and inclusion committee is a task force of diverse staff members who are responsible for helping bring about the cultural, and possibly ethical, changes necessary for MCO business.</p> <p>a) The MCO must participate in the MLTC’s efforts to reduce health disparities, address social risk factors, and achieve health equity.</p> <p>b) The MCO must identify disparities in health care access and availability, service provision, member satisfaction, and outcomes. These activities include obtaining data on race, ethnicity, geography, language, and Social Determinants of Health (SDOH) using assessments such as HRS and HRA to determine population with the highest needs.</p> <p>c) The MCO must ensure the delivery of services in a culturally competent and effective manner to all members by promoting cultural competency at all levels of the MCO and with network providers, including promoting awareness of implicit biases and how they impact policy and processes.</p> <p>d) The MCO must engage caregivers and families when designing services and interventions that integrate care and address childhood adversity and trauma.</p> <p>e) The MCO must obtain ongoing input from members within population streams who have disparate outcomes to:</p> <p>i. Create strategies for reducing health disparities that incorporate the perspective of the member; and</p>

State	Contract language
	<p>ii. Define metrics, timelines, and milestones that indicate success; and establish credibility and accountability through active member involvement and feedback.</p> <p>f) The MCO must collaborate and partner with members, other Nebraska-contracted managed care entities, network providers, and internal staff to test, refine, and share successful strategies for reducing disparities.</p> <p>...</p> <p>Health Equity Committee: The Health Equity Committee must identify areas of disparity and collaborate with members, providers, and communities to develop policy and care strategies that proactively promote the elimination of health disparities.</p> <p>...</p> <p>The MCO must describe how the MCO meets the requirements for addressing health disparities in the annual QAPI Program evaluation as part of its QAPI submission.</p> <p>l) The Health Equity Committee must include MCO leadership, care managers, members representing the geographic, cultural, and racial diversity of the MCO’s membership, community leaders, provider network manager, and the QAPI Program manager.</p> <p>m) The Health Equity Committee must meet a minimum of quarterly, and the MCO must keep written minutes of the meetings. The MCO must pay travel costs for committee members who are members or their representatives.</p> <p>n) MLTC must be copied on all correspondence to the committee, including agendas and committee minutes.</p> <p>Note: All committees that report to the Quality Assurance and Performance Improvement Committee (QAPIC) must have a representative from the health equity committee.</p>
North Carolina	<p>2. Engagement with Community and County Organizations</p> <p>...</p> <p>e. The PHP shall develop and implement a Local Community Collaboration and Engagement Strategy that supports continued engagement with County Agencies, CFACs and CBOs and build partnerships at the local level to improve the health of their members. As long as the Local Community Collaboration and Engagement Strategy clearly states that it applies to Medicaid Direct, the Local Community Collaboration and Engagement Strategy may apply to other PHP operations, including, without limitation, the BH I/DD Tailored Plan contract.</p> <p>i. The Local Community Collaboration and Engagement Strategy shall address how the PHP will work to reduce potential local barriers to health such as program eligibility, enrollment continuity, member engagement, unmet resource needs (e.g., transportation, food insecurity, housing) and local continuums of care. The strategy shall include:</p> <ol style="list-style-type: none"> 1. An approach to understand the unique needs of the counties and communities the PHP serves; 2. Methods of collaborative outreach and engagement with county agencies, CBOs, and other community partners; 3. Measures of successful engagement and collaboration; 4. Measures to foster community inclusion supporting PHP members;

State	Contract language
	<p>5. Reporting of outcomes to County Agencies, CFACs, CBOs, and other community partners;</p> <p>6. Contracting status with each provider identified in each local area crisis services plan and other key crisis providers identified by the Department within their regions; and</p> <p>7. Information on how the PHP is addressing health disparities and incorporating health equity into their internal and external policies, and procedures</p>
Oregon	<p>Exhibit K – Social Determinants of Health and Equity</p> <p>7. Community Health Improvement Plan</p> <p>b. The development and drafting of the CHP must be transparent and public. Therefore, Contractor shall meaningfully and systematically engage and collaborate with representatives of local government, local Tribal Organizations, community partners and stakeholders, and critical populations to create its CHP, which must include local public health authorities, local mental health authorities, Hospitals, Indian Health Care Providers, Tribal Liaison, and other CCOs, and federally recognized Tribes when such parties share Contractor’s Service Area.</p> <p>(1) Contractor may utilize the OHA Office of Equity & Inclusion’s community engagement checklist to support meaningful engagement throughout the CHA and CHP process. The checklist is located at https://www.oregon.gov/oha/OEI/Documents/Community%20Engagement%20Strategies%20Checklist_vOHA_FINAL.pdf.</p>

Appendix C: Links to Medicaid Managed Care Procurement Documents and Other Sources

Below are links to state MMC documents and other sources reviewed in this *Compendium*.

1. California: [Link](#) to 2022 Medi-Cal Managed Care Plans Request for Proposals
2. Delaware: [Link](#) to 2021 Medicaid Managed Care Organizations Request for Proposals
3. District of Columbia: The current DC Medicaid MCO RFP or contract is not posted publicly; [Link](#) to the 2020 Quality Strategy
4. Hawaii: [Link](#) to 2020 Medicaid Managed Care Request for Proposals
5. Kentucky: [Link](#) to 2021 Medicaid MCO contracts
6. Louisiana: [Link](#) to 2021 Medicaid Managed Care Organizations Request for Proposals; [Link](#) to 2023 Managed Care Organization Contracts
7. Michigan: [Link](#) to Medicaid Health Plan contract amended 2022
8. Minnesota: [Link](#) to 2022 Minnesota RFP for Families and Children Medical Assistance and MinnesotaCare in 80 Greater Minnesota Counties; [Link](#) to 2023 Model Contract with MCOs for families and children; [Link](#) to Minnesota Quality Strategy
9. Mississippi: [Link](#) to 2021 Medicaid Coordinated Care Request for Qualifications
10. Missouri: [Link](#) to 2021 HealthNet Managed Care Request for Proposals; [Link](#) to 2022 Managed Care Contract
11. Nebraska: [Link](#) to 2022 Medicaid Managed Care Request for Proposals
12. New York: [Link](#) to 2019 Medicaid Managed Care / Family Health Plus / HIV Special Needs Plan Model Contract
13. Nevada: [Link](#) to March 2021 MCO Request for Proposals; [Link](#) to 2022 Managed Care Contracts
14. North Carolina (Medicaid Managed Care): [Link](#) to Medicaid Managed Care Prepaid Health Plan and Managed Behavioral Health Care contracts
15. Ohio (Medicaid Managed Care): [Link](#) to 2021 Medicaid Managed Care Request for Applications; [Link](#) to 2021 Medicaid Managed Care Contract
16. Ohio (Managed Behavioral Health Care): [Link](#) to the 2021 OhioRise Contract
17. Oklahoma: [Link](#) to 2022 SoonerSelect Request for Proposals; [Link](#) to SoonerSelect Children’s Specialty Program Request for Proposals
18. Oregon: [Link](#) to 2023 Medicaid CCO 2.0 Contract; [Link](#) to 2022 Guidance document for Transformation and Quality Strategy
19. Pennsylvania: [Link](#) to 2022 Medicaid MCO contract; [Link](#) to 2020 Quality Strategy
20. Texas: [Link](#) to 2022 STAR and CHIP Managed Care Services Request for Proposals
21. Washington State: [Link](#) to (amended) 2020 Apple Health Integrated Medicaid MCO contract
22. West Virginia: [Link](#) to State Fiscal Year 2022 Managed Care Organization Model Contract