

**Compendium of Medicaid Managed Care Contracting
Strategies to Promote Health Equity
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Contents

I.	Introduction	1
II.	Medicaid Managed Care Approaches to Promoting Health Equity	2
1.	Stratification of Performance Measures by Race, Ethnicity, Language, or Other	3
2.	Performance Improvement Projects With an Equity Focus.....	4
3.	Managed Care Plan Staff and Training Requirements	5
4.	Provider Requirements to Promote Health Equity and/or Cultural Competency	6
5.	National Committee for Quality Assurance Health Equity Accreditation	7
6.	Incentives to Promote Health Equity	7
7.	Report or Plan on Health Disparities, Health Equity, or Cultural Competency.....	8
8.	Engaging Stakeholders in Health Equity Efforts.....	9
9.	Primary Care Assignment and Continuity of Care.....	10
III.	Conclusion	10
	Endnotes.....	12
	Appendix A: Medicaid Managed Care Procurement Questions Related to Health Equity	14
	Appendix B: Medicaid Managed Care Contract Language – State Examples.....	35
	Appendix C: Links to Medicaid Managed Care Source Documents.....	79

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I. Introduction

States are increasingly identifying and implementing Medicaid strategies to confront longstanding and persistent health inequities. In most states, individuals with Medicaid are enrolled in managed care, and states are using their purchasing power to promote a more equitable healthcare system. Specifically, states are adopting Medicaid managed care (MMC) strategies to identify, narrow, and eliminate health disparities and center health equity in their Medicaid programs.

This *Compendium* identifies approaches states are taking within their MMC programs to promote health equity.¹ It highlights state examples² and includes excerpts from state contracts, including model contract and procurement documents. The *Compendium* synthesizes information across select states and categorizes 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. [Appendix A](#) contains specific questions from states' 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. In addition, [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. State officials can review the language to expedite the development process of their own contracts.

This *Compendium* offers a curated list of specific examples from profiled states. It does not include all state MMC procurement questions or contract language on health disparities and health equity. 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](#).

In addition, in 2023, the Centers for Medicare & Medicaid Services (CMS) released an updated [framework](#) to advance health equity among individuals enrolled in programs administered by CMS, including Medicaid and

Box 1. Key Terms

Cultural Competence and Cultural Humility: The description of services, practices, and processes that are responsive to diverse practices, assets, needs, beliefs, and languages. 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.

Health Equity: 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.

Health Disparities: 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).

Health Inequities: Differences that are unfair and unjust without comparison to another group.

the Children’s Health Insurance Program (CHIP).³ CMS identifies five priorities within the health equity framework: 1) expanding the collection, reporting, and analysis of standardized demographic data on race, ethnicity, language, gender identity, sex, sexual orientation, and disability status; 2) assessing causes of disparities within CMS programs and addressing inequities in policies and operations; 3) building the capacity of healthcare organizations and the workforce to reduce disparities; 4) ensuring the provision of linguistically and culturally tailored services; and 5) increasing accessibility to healthcare services and coverage. Many of the approaches states are using within Medicaid managed care to promote health equity align with these CMS priorities.

II. Medicaid Managed Care Approaches to Promoting Health Equity

States operate their Medicaid programs and leverage their MMC strategies in different ways. This includes their efforts to address health inequities and improve disparate health outcomes. Some states integrate health equity into their procurement processes to signal their health equity expectations and secure commitments from managed care plans (MCPs) to implement equity-related initiatives. Through the procurement process, states can assess the experience and capacity of respondents to advance the state’s health equity goals. Some states direct MCPs to take certain actions and others permit MCPs flexibility to adopt their own strategies targeting inequities.

Most MMC documents that reference health equity, health disparities, or cultural competency include definitions of those terms and other related health equity concepts. Many of the definitions are adapted from national initiatives or organizations. Defining the concepts ensures that MCPs are clear on the state’s commitments to health equity and their expectations of MCPs. Please refer to Box 1 for key terms used throughout this toolkit.⁴ (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 MCP contracting approaches states are taking—or plan to take—and includes the states that have adopted a particular strategy.⁵ The remainder of this section describes each approach in more detail and includes state-specific examples.

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

Approach	Profiled States
1. Stratification of performance measures by race, ethnicity, language, or other	DC, DE, FL, GA, KY, LA, MI, MN, MO, NC, NE, NH, NM, OH, OK, OR, PA, RI ⁶
2. Performance improvement projects with an equity focus	CA, LA, MN, NV, OH, OK, OR, WA, WV
3. MCP staff and training requirements	CA, DC, GA, HI, KY, LA, MI, MS, NE, NH, NM, NV, OH, OK, OR, PA, RI, TX, WA, WV
4. Provider requirements to promote health equity and/or cultural competency	DC, FL, GA, KY, LA, MI, MN, MS, NC, NM, NV, NY, OK, PA, RI, TX
5. National Committee for Quality Assurance (NCQA) Health Equity Accreditation ⁷	CA, DE, GA, MI, NM, OK, PA, RI
6. Incentives to promote health equity	CA, LA, MI, MN, NC, NE, NM, NV, OR, PA
7. Report or plan on health disparities, health equity, or cultural competency	CA, DE, GA, LA, MI, MN, NH, NM, NV, NY, OK, OR, PA, RI, TX
8. Engaging stakeholders in health equity efforts	CA, GA, LA, MI, MN, MO, NC, NE, NM, OR, PA, RI
9. Primary care assignment and continuity of care	FL, MN, PA

Note: For request for proposals questions and excerpts of contracts, see the appendices.

1. Stratification of Performance Measures by Race, Ethnicity, Language, or Other

Stratification of quality measures, for example by race, ethnicity, language, disability status, or 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.)

Select examples from states that require stratification are summarized below. (See [Appendix B](#) for specific MMC contract language related to stratification of performance measures to identify disparities.)

- **California's** 2024 model contract requires MCPs to identify members not using primary care; stratify primary care utilization reports by race and ethnicity to identify health disparities that result from differences in utilization of outpatient and preventive services; and develop strategies to address differences in utilization. In reporting encounter data, MCPs are required, when possible, to provide data necessary for the Department of Health Care Services (DHCS) to stratify services by age, sex, race, ethnicity, and language spoken to inform DHCS health equity initiatives and efforts to mitigate health disparities. MCPs in **California** are also required to stratify primary care spending, including primary care spending as a percentage of total spending, by age and race/ethnicity.
- **Delaware's** 2021 request for proposals (RFP) for MMC services⁸ 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 Healthcare Effectiveness Data and Information Set (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 and language); by defined geographic regions (i.e., D.C. Ward); against prior year performance; and, where possible, against regional and national benchmarks.
- MCPs in **Florida, Georgia, Kentucky, Missouri, and Oregon** are required to report stratified performance on identified measure sets. **Florida's** 2023 MMC procurement requires MCPs to include performance on the measures on their public websites to enable individuals to compare plans. New MCPs in Florida must stratify measures including HEDIS and CMS Adult and Child Core sets by age, sex, race, ethnicity, primary language, and whether the enrollee received a Social Security Administration determination of disability for purposes of Supplemental Security Income.⁹ **Georgia's** 2023 MMC procurement requires MCPs to stratify performance and quality measure results across different populations with attention to geography, age, sex, race, ethnicity, disability status, and primary language. 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 CMS Adult and Child Core Sets of measures by several categories, including race, ethnicity, region (urban/rural), gender, and age.
- **Michigan, Minnesota, and New Mexico**¹⁰ require MCPs to report stratified results for measures for which the state has implemented a financial incentive for MCO performance.
- **Ohio** and **Oklahoma** specifically require that MCPs obtain *self-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 and disability to inform the provision of culturally and linguistically appropriate services, and to identify and reduce healthcare inequities and disparities.
- **Rhode Island MCPs** must require that their contracted Medicaid accountable entity (AE) provider organizations report data on quality measures that can be stratified based upon age, race, ethnicity, language, disability, sexual orientation, gender identity, or other characteristics as specified by the state.

Box 2 references the federal rules on managed care quality strategies related to identifying, evaluating, and reducing health disparities. In addition, for its Health Equity Accreditation, NCQA requires MCPs to stratify five HEDIS measures by race and ethnicity.

Box 2. Federal Requirements

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.¹¹

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 . . .”¹² 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 as well as 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.) In addition, states may integrate projects that promote health equity into their MMC quality improvement strategies, as described in Box 3.

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

- **California** requires that each MCP PIP include implementation of equity-focused interventions to achieve improvement in access to Quality of Care which the state defines as “the degree to which health services for Members increase the likelihood of desired health outcomes and are consistent with current professional standards of care and knowledge.”¹³
- **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 individuals 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 may 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.

Box 3. Quality Improvement Strategies

States are also using their MMC quality strategies to reinforce and/or expand upon their health equity objectives. For example, in **Georgia**, MCPs must prominently and publicly feature the description of at least one quality improvement activity addressing healthcare disparities on the webpage that describes quality improvement activities. **Michigan** implemented a Lesbian, Bisexual, Transgender, Queer/Questioning (LGBTQ+) Care Quality Improvement Project to gain further understanding of the clinical and care management landscape, particularly care coordination and provider competency, to address health disparities particular to the LGBTQ population. MCPs are required to complete a state-developed reporting template to identify and demonstrate progress on activities that address the needs of LGBTQ members, and the state will award points to MCPs for completion of the templates that factor into the state's quality withhold program. **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 implement and oversee health equity-related activities and ensure MCP compliance with contract provisions that advance the states' health equity goals. 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.

- States including **California, Ohio, and Oregon** require MCPs to identify a dedicated staff position with responsibility and accountability for promoting health equity.¹⁴ **Nebraska** and **New Hampshire** have specific requirements for MCP care managers or care coordinators on staff. **Rhode Island** chief medical officers of MCPs are required to communicate regularly with providers on health equity topics.
- **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 trend analyses on disparities, and **Nevada** requires MCP quality improvement teams to include staff with expertise in health equity.
- **Mississippi, New Mexico, Oklahoma, and Oregon** include requirements for key personnel, including staff qualifications around care management and cultural competency to address specific issues and disparities for Native American and American Indian/Alaska Native (AI/AN) populations.¹⁵
- **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 on cultural sensitivity. **Oregon** CCOs must provide and require that employees, including executives and directors, complete trainings related to cultural responsiveness, implicit bias, and utilization of healthcare interpreters. Trainings must occur during new CCO employee orientations and throughout the course of employment.
- **Mississippi** and **Texas** require MCPs to conduct member services staff training on cultural competency. On a quarterly basis, MCPs in **Mississippi** must implement training for 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.” **Texas** MCPs are required to train their member services representatives in the national standards of Culturally and Linguistically Appropriate Services (CLAS) and to employ member services and behavioral health services staff who are bilingual in English and Spanish.

- **Oregon** CCOs are required to participate face-to-face in CCO Learning Collaboratives, a program in which CCOs, state agencies, and primary care home providers share best and emerging practices. The Learning Collaborative topics may include: increasing access to Culturally and Linguistically Appropriate care; reducing health disparities; and maximizing enrollee use of primary care homes through culturally specific and targeted outreach to adults and children of racial, ethnic and language minority communities and other underserved populations.

4. Provider Requirements to Promote Health Equity and/or 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 competence, and indicate in their provider network directories those providers that have completed cultural competency or similar training and their linguistic capabilities. In addition, some states stipulate that MCPs maintain a process to ensure contracted providers are meeting CLAS standards, which are intended to advance health equity, improve quality, and help eliminate healthcare disparities.

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

- **California's** MCP readiness review requires MCPs to submit policies and procedures for ensuring providers in MCPs' networks receive training, including annual diversity, health equity, and inclusion training. In addition, MCPs must describe policies and procedures for network provider completion of continuing medical education on cultural competency/humility and implicit bias.
- MCPs in **D.C., Florida, Michigan, Minnesota, and New Mexico** 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.¹⁶ In addition, **Minnesota** MCPs must participate in state efforts to increase the pool of culturally and linguistically competent providers, including the state's planning efforts to expand the pool of such providers. **New Mexico** MCPs must indicate the provider's race and ethnicity and whether providers serve special populations, for example individuals with disabilities or LGBTQ+ individuals.
- **Georgia, New Mexico, North Carolina, Pennsylvania, and Rhode Island** require MCPs to conduct specific provider trainings to bolster their networks' abilities to serve enrollees' needs. **Georgia** requires MCPs to demonstrate that they have “a robust Cultural Competency Training Program and evaluation frameworks within the Provider Network,”¹⁷ and MCP contracts with providers must include provisions for complying with the training program. In **Pennsylvania**, MCPs must conduct provider training for primary care providers and dentists, minimally, on cultural competency, and effective engagement with members with limited English proficiency, including finding and working with interpreters. Finally, the scope of the required provider training and education program that MCPs in **Rhode Island** must implement includes anti-bias workshops.
- MCPs in **New York** must ensure the cultural competence of their provider networks 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.

5. National Committee for Quality Assurance Health Equity Accreditation

NCQA has two health plan accreditation programs specifically focused on health equity, and states are requiring their MCPs to obtain accreditation.¹⁸ 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 has phased out their Distinction in Multicultural Health Care that some states previously required of their Medicaid plans and replaced it with these health equity accreditation programs.

State approaches to NCQA Health Equity Accreditation are summarized below. There may be other states that are not profiled in this compendium that require NCQA Health Equity Accreditation.

- **California, Delaware, Georgia, Michigan, New Mexico, Oklahoma, and Rhode Island**, require Medicaid MCPs to attain NCQA Health Equity Accreditation. The states generally establish timeframes by when MCPs must meet this contractual provision (e.g., within 18 to 24 months of the contract start date).
- In **California**, MCPs must notify the state of any change in NCQA Health Equity Accreditation status within 30 days of receipt of the final NCQA report. If an MCP fails to obtain or maintain its NCQA Health Equity Accreditation status, the MCP will be subject to corrective actions which may include sanctions, liquidated damages, and termination. California also requires its MCPs to ensure that all fully delegated subcontractors have full NCQA Health Equity Accreditation no later than January 1, 2026.
- **Rhode Island's** new model contract indicates that if an MCP fails to obtain NCQA Health Equity Accreditation (or Health Equity Accreditation Plus) within 24 months of the contract start date, the state may suspend enrollment or terminate the MCP contract.

6. Incentives to Promote Health Equity

Using different strategies, states may hold MCPs accountable for performance and/or performance improvement using financial and/or non-financial incentives. States can incorporate financial incentives (and penalties) into their MCP contracts to support their health equity goals, including setting performance targets for reducing health disparities, collecting and reporting data to inform health equity strategies, and directing actions intended to reduce inequities. States may also require MCPs to develop and implement value-based payment strategies with network providers to improve quality of care and population health outcomes. States can direct the implementation of a specific value-based payment model or afford MCPs flexibility to develop their own model or strategies that center health equity.

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

- **California** requires MCPs to annually calculate, report on, and meet specified quality benchmarks and health disparity reduction targets for specific populations and measures identified by the state. California may impose financial or administrative sanctions, such as suspending automatic assignment of enrollees in an MCP, if an MCP fails to meet the requirements. In addition, California may compel MCPs to implement corrective actions and consider quality and disparity reduction performance in determining an MCP's capitation rate for the next year.
- **Louisiana, Michigan, and Minnesota** withhold a portion of their MCP capitation payment for meeting established performance achievement and performance improvement requirements relative to health equity. **Michigan** incorporates financial incentives for MCPs to complete the required reporting for the LGBTQ+ Care Quality Improvement Project described in Box 3. **Minnesota** MCPs can earn back portions of the withheld capitation for performance improvement relative to a baseline year, reduction in an identified disparity gap (e.g., performance of a race or ethnicity group relative to a reference group), and compliance with the requirement to report on health equity community engagement activities focused on addressing health disparities.

- **New Mexico's** MCPs must reinvest a specified percentage of revenue into the community, prioritizing behavioral health investments.¹⁹ Should there be additional funds available, the MCP should develop a reinvestment strategy to support population health and health equity.
- **North Carolina** permits MCPs to include expenditures on initiatives to advance health equity in its medical loss ratio and risk corridor expenses.
- **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.
- **Pennsylvania** implemented a pay-for-performance (P4P) program with the state's MCPs and requires MCPs to develop a P4P program with providers. Those two P4P programs utilize the same measures. MCPs are eligible for an additional financial incentive for improving performance for individuals who are Black as part of the MCP P4P program. MCPs are also eligible to retain a percentage of excess revenue to invest in initiatives such as health equity and community development, among others, subject to state approval. MCOs are required to participate in the state's maternity care bundled payment program, which includes equity-related components, such as stratification of the severe maternal morbidity rate by race and ethnicity and eligibility for savings achieved for meeting established performance percentiles on select measures for enrollees who are Black.

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—increase health plan attention to health equity and disparities. These health equity related plans or reports may be outside of other managed care reporting activities forcing health plans to focus on the singular topic of health equity. The reports 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).²⁰

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

- **California, Delaware, Georgia, Louisiana, Minnesota²¹, New Mexico, Pennsylvania, and Rhode Island** 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. **Georgia** MCPs must design and maintain a written Cultural Competency & Health Equity Plan that addresses the cultural, socioeconomic, racial, and regional disparities in healthcare among individuals and communities within the MCP's service area. 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. **New Mexico** MCPs are required to develop and implement a comprehensive Cultural Competency Program and Cultural Humility Plan (CHP) that must identify and address healthcare disparities and ensure equitable access to and the delivery of services to all, including individuals with limited English proficiency, diverse cultural and ethnic backgrounds, or disabilities; and regardless of gender, sexual orientation, or gender identity. MCPs must solicit and incorporate member and stakeholder feedback to the plan during an annual Member Advisory Board meeting.
- **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, Georgia, Louisiana, Minnesota, New Mexico, and Rhode Island** require community and enrollee engagement in the development of the required MCP health equity plans or population health strategies that integrate equity.
- **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.
- **Georgia** requires that MCP Cultural Competency & Health Equity Plans must include identifying community advocates and agencies that provide culturally competent services and are available to assist individuals with limited English proficiency. In addition, both **Georgia** and **Louisiana** require MCPs to engage diverse families when designing services and interventions that integrate care and address childhood adversity and trauma; and obtain ongoing input from members who have disparate outcomes.
- MCPs in **New Mexico** must identify how member and stakeholder feedback were incorporated into their CHP. **Rhode Island** MCPs must obtain input from their Member Advisory Committees on their health equity plans.
- 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.
- **Minnesota** holds MCPs financially accountable for reporting on their community engagement activities, including providing documentation of agendas, minutes, and other materials that describe how the MCPs incorporated community feedback about health equity into their population health management strategies.

- **Oregon** developed a [checklist](#) that MCPs can use to facilitate meaningful community engagement in the process of developing a required community health improvement plan.

9. Primary Care Assignment and Continuity of Care

State MMC programs generally require that individuals select a primary care provider upon enrollment with an MCP. Should individuals not identify a primary care provider within a certain period of time from enrollment, states may employ a methodology to "assign" an enrollee to a primary care provider. The methodology may consider claims history, prior relationship with a primary care provider, proximity to a provider's practice, age, and other variables. Alternatively, states may provide guidance to MCPs to identify a primary care provider for enrollees who have not selected one after a certain period. Some states are incorporating provisions in their contracts related to assignment to a primary care provider that require MCPs to ensure racial, ethnic, language, and/or cultural concordance or competence between enrollees and primary care providers. In addition, states incorporate provisions into their MCP contracts to ensure continuity of care should a provider no longer participate in an MCP's network. Those provisions ensure enrollees' care is not disrupted while trying to find another provider.

- **Florida** MCPs are required to assign a primary care provider to individuals who did not select one at the time of MCP selection and assign individuals to a provider who is linguistically and culturally competent to communicate with the enrollee or has office staff who can do so. Similarly, **Pennsylvania** MCPs must consider language and cultural compatibility between the enrollee and primary care provider.
- **Minnesota** requires MCPs to permit continuation of covered services for up to 120 days to enrollees if an enrollee is receiving culturally and linguistically appropriate healthcare services and the MCP does not have a provider with that expertise.

III. Conclusion

Consistent with the ways in which states operate their Medicaid programs, they are employing a variety of Medicaid managed care approaches to confront longstanding health inequities and persistent healthcare disparities. This *Compendium* highlights how states are signaling to MMC contractors that health equity is a priority. 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 provisions 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.

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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 The *Compendium* has been updated eight times since its original publication in June 2020. 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.

² 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.

³ Centers for Medicare & Medicaid Services. 2023. "CMS Framework for Health Equity."

<https://www.cms.gov/priorities/health-equity/minority-health/equity-programs/framework>. Accessed April 17, 2024.

⁴ The terms defined in Box 1 and primarily used throughout this *Compendium of Medicaid Managed Care Contracting Strategies to Promote Health Equity* are those adopted by State Health and Values Strategies. While both cultural competency and cultural humility 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. This *Compendium* uses cultural competency, which is the terminology used by the states profiled. For more information about these definitions, please refer to the [Health Equity Language Guide for State Officials, Talking About Anti-Racism and Health Equity: Addressing Bias](#).

⁵ The *Compendium* 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. Similarly, the MMC contract language in Appendix B does not include contract language from all states or all MMC programs identified and may summarize a state's approach in one or more of its Medicaid managed care programs.

⁶ New Mexico and Pennsylvania require stratification by race and ethnicity for specific initiatives.

⁷ In 2010, NCQA introduced the Multicultural Health Care (MHC) Distinction, which gave organizations a roadmap to identify and address healthcare 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 healthcare 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 healthcare 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.

⁸ The 2021 RFP solicited responses for contracts beginning January 1, 2023.

⁹ Florida's requirement that MCPs stratify performance by identified subpopulations and include performance on their websites will begin in calendar year 2026.

¹⁰ New Mexico has implemented Delivery System Improvement Performance Targets (DSIPT), including one with a focus on treatment for Hepatitis C. For the Hepatitis C treatment target, MCPs are required to submit a biannual report including data analysis on its population diagnosed with Hepatitis C, stratified by race and ethnicity, including the technical specifications for HEDIS. MCPs are financially accountable for performance on DSIPTs.

¹¹ § 42 CFR 438.330(b)(6) states: "'disability status' means, at a minimum, whether the individual qualified for Medicaid on the basis of a disability. States must include in this plan the State's definition of disability status and how the State will make the determination that a Medicaid enrollee meets the standard including the data source(s) that the State will use to identify disability status."

¹² § 42 CFR 438.330.

¹³ California Department of Health Care Services. 2024. "2024 Medi-Cal Managed Care Boilerplate Contract." State of California. <https://www.dhcs.ca.gov/provgovpart/Documents/2024-Managed-Care-Boilerplate-Contract.pdf>. Accessed March 20, 2024.

¹⁴ In California, MCPs must maintain a full-time chief equity officer. Ohio requires that MCPs identify a health equity director, and in Oregon, the position is a health equity administrator.

¹⁵ 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.” (See 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.) New Mexico MCPs’ key personnel must include someone “with the education and experience such that the staff person has the skills and/or knowledge necessary to work on Native American health disparity issues and Cultural Competence concerns related to Care Coordination, services, and care delivery.” (See New Mexico Health Care Authority. 2023. “Medicaid Managed Care Services Agreement Model Contract, September 28, 2023.” State of New Mexico. <https://www.hsd.state.nm.us/2022-turquoise-care-mco-rfp-procurement-library/>. Accessed February 24, 2024.) 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 work with the state’s Tribal Advisory Council to select a Tribal Liaison to “assist with Contractor’s training and education programs relating to its services and other matters relating to the specific concerns of Oregon’s Tribal communities and the coordinated care health care system” among other responsibilities. (See Oregon Health Authority. 2024. “Health Plan Services Contract.” State of Oregon. <https://www.oregon.gov/oha/HSD/OHP/CCO/2024-M-CCO-Contract-Template.pdf>. Accessed March 26, 2024.)

¹⁶ Minnesota indicates that for hospitals, MCPs should only list the languages spoken by on-site interpreter staff.

¹⁷ Georgia Department of Community Health. 2023. “Medicaid Care Management Services Model Contract.” State of Georgia. <https://ssl.doas.state.ga.us/gpr/eventDetails?eSourceNumber=41900-DCH0000133&sourceSystemType=ps>. Accessed February 12, 2024.

¹⁸ *“Health Equity Accreditation focuses on the foundation of health equity work: building an internal culture that supports the organization’s external health equity work; collecting data that help the organization create and offer language services and provider networks mindful of individuals’ cultural and linguistic needs; identifying opportunities to reduce health inequities and improve care. Health Equity Accreditation Plus is for organizations further along on their health equity journey. It focuses on collecting data on community social risk factors and patients’ social needs, to help the organization offer social resources that can have the most impact; establishing mutually beneficial partnerships that support community-based organizations; building meaningful opportunities for patient and consumer engagement; identifying opportunities to improve social need referral processes and the partnerships that make them possible.”* National Committee for Quality Assurance. 2024. “NCQA’s Health Equity Accreditation Programs.” <https://www.ncqa.org/programs/health-equity-accreditation/>. Accessed March 11, 2024.

¹⁹ For additional information about approaches that states can take to reduce racial and ethnic inequities in mental healthcare and improve mental health outcomes, see [Medicaid Managed Care Approaches to Confront Mental Health Inequities](#).

²⁰ 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 healthcare, including: the process of identifying racial and ethnic disparities among enrollees; how information is used to design targeted clinical programs to improve healthcare 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 healthcare.

²¹ In addition, in Minnesota’s Medicaid accountable care organization model, called Integrated Health Partnerships (IHP), contractors are required to design an intervention to address specific healthcare disparities observed in the IHP’s population. IHPs must submit an annual written report and evaluation of the intervention, including the impact and effectiveness of the intervention as well as IHP’s performance on equity measures defined by the IHP and agreed upon by the state. Minnesota Department of Human Services. 2024. “Integrated Health Partnerships Contract.” https://mn.gov/dhs/assets/2024-ihp-rfp-appendix-g_tcm1053-585001.pdf. Accessed March 28, 2024.

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

This Appendix contains MMC procurement questions related to health equity for profiled states with MMC procurements no earlier than 2018, including: California, Delaware, Florida, Georgia, Louisiana, Michigan, Minnesota, Mississippi, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, and Texas. Profiled states are presented in alphabetical order with a brief statement about the RFP issued followed by select equity-related questions from the state's procurement documents. The questions incorporated in this Appendix are intended to provide a sample of the types and variety of equity-related questions states are including in their procurements. Not all questions from procurements related to health equity or health disparities are incorporated here, and question formats and numbers may differ from state documents. In addition, examples of procurement questions related to addressing health-related social needs can be found in a companion document, "[Addressing Health-Related Social Needs Through Medicaid Managed Care.](#)"

See [Appendix C](#) for links to states' MMC procurement documents.

California: In February 2022, the California Department of Health Care Services (DHCS) released a MMC RFP for coverage areas where Medi-Cal offers members a choice of a commercial plan and a local initiative plan.

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 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 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.

11. 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.
12. 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.
13. 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: In December 2021, Delaware released a MMC RFP for the Diamond State Health Plan (DSHP) and Diamond State Health Plan Plus (DSHP Plus) program.

1. 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.

2. 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.

Florida: In April 2023, Florida released a competitive procurement to solicit MCP participation to provide acute and LTSS services to Medicaid members, including but not limited to those who are elderly and/or who have a physical disability.

1. Chronic Disease Management Program:
 - a. The respondent shall submit supporting documentation about each chronic disease management program identified, including at a minimum, the following information:
...Mitigation strategies used to address barriers such as **culturally appropriate** materials, new provider relationships or communication methods, new information technology solutions, new relationships with community-based organizations, etc.

Georgia: The Georgia Department of Community Health (DCH) released a MMC RFP in September 2023 seeking Care Management Organizations (CMOs) for its GA Families and GA Families 360° programs.

1. GFMS10. Describe how individuals and systems within the Supplier, Subcontractors, and Providers contracted with Supplier, will effectively provide services to people identifying across all cultures, races, ethnic backgrounds, sexes, gender expressions, sexual orientations, abilities and religions in a manner that recognizes, values, affirms and respects the worth and dignity of the individual Members and their community. Please include the following at a minimum:
 - a. A description of the current Cultural Competency and disparity reduction training and evaluation frameworks for the CMO's Member Services staff and Contract Providers, including specific examples of successes in Cultural Competency and Cultural Humility within the CMO;
 - b. A plan (timeline, benchmarks, and evaluation criteria) to build, execute, and demonstrate increasingly robust Cultural Competency, Cultural Humility, and disparity reduction training and evaluation frameworks for the CMO's Member Services staff and Contract Providers.
2. GFMS47. Discuss the Supplier's plan to offer, promote and support the use of Telehealth services throughout Georgia. Specifically, include the following at minimum:...
 - a. How the Supplier's Telehealth offerings will increase access, improve health equity, and better manage Chronic Conditions;
 - b. Strategies to provide Telehealth services to Members in rural areas, including but not limited to ensuring Members have access to the necessary technology (e.g., phone connectivity, adequate internet connectivity, remote monitoring capabilities). The response should consider a variety of access channels for Telehealth services (e.g., home access, presentation site access, and access sites at Provider locations).
3. GFMS46. Explain the Supplier's plan to develop and maintain a comprehensive Provider network to ensure it meets DCH access and availability requirements for all Covered Services. Include the following at minimum: ...
 - a. In building and maintaining the Supplier's Provider network, describe how the Supplier will ensure the ability of network Providers to provide physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid Members with physical and/or mental disabilities, as required by 42 CFR § 438.206(c)(3).
4. GFMS35. Describe the Supplier's approach to stakeholder engagement, including its plan to leverage the Member Advisory Committee, Provider Advisory Committees, the Georgia Families Monitoring and Oversight Committee, satisfaction surveys, and other ad hoc sources of feedback:
 - a. Provide overall strategy for soliciting ongoing feedback from Members, Providers, and other stakeholders including other state agencies to ensure the Supplier is responsive to a representative set of needs and feedback. Describe the Supplier's plan to gather input from populations groups with disparate health outcomes. Also include an overview of which staff will be involved in collecting and responding to feedback from Members and Providers.
 - b. Describe how the Supplier will select and engage Members and Providers on its Member and Provider Advisory Committees. Describe how the Supplier will track and respond to Member and Provider feedback from advisory committees. Provide examples from Medicaid managed care contexts and contracts where the Supplier has collaborated with Member and Provider Committees for program improvement, including any illustrative agendas and meeting minutes from other contracts....
 - c. Include an overview of how the Supplier will use information collected to improve operations, stakeholder experience, and reduce disparities. Include examples of cases in

which the Supplier has been successful at addressing the expressed needs of Members and/or Providers.

5. GFMS37. Supplier shall demonstrate how its systems, databases, and analytical capabilities will support effective program administration through reporting and insights. These capabilities shall provide actionable information aligned with the current and evolving DCH Quality Strategy. In its response, the Supplier shall use concise narratives and descriptions or images of analytical reports, tables, graphs, and other outputs that will be available to DCH to manage both population health and overall operational performance. At a minimum, the Supplier shall demonstrate capabilities to collect risk-stratified population health data and provide actionable insights and analyses in the priority areas below....
 - a. How analytical capabilities will support reducing disparities by identifying and addressing gaps in access or outcomes for particular subpopulations, such as by races/ethnicity, community, or geographies;
 - b. How the Supplier will handle any data quality issues or issues with gaps in data.

Louisiana: *The Louisiana Department of Health's Bureau of Health Services Financing (Medicaid) released a MMC RFP in June 2021.*

1. The Proposer should describe its recent experience with utilizing data regarding SDOH to improve health equity and the health status of targeted populations, including the Proposer's approach to collecting SDOH data. Include at least one example of how an issue impacted by SDOH was identified, which interventions were developed, how the impacts of the interventions were assessed, and what outcomes were achieved. The Proposer should describe how this approach may be applied to a population health and/or health equity priority(ies) named in the Model Contract.
2. 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.

Health Equity

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. 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.
3. Describe the Proposer's organizational practices related to ensuring the Proposer and its provider network provide culturally and linguistically appropriate services to enrollees.
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.
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.
6. Does the Proposer currently utilize community health workers, peer support specialists, and douglas 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.

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.
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.
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.
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:
 - i. Pregnancy: Percentage of Low Birthweight Births
 - ii. Contraceptive Care – Postpartum Women Ages 21–44 Page 32 of 55
 - iii. Child: Well-Child Visits in the First 15 Months
 - iv. Childhood Immunizations (Combo 3)
 - v. Preventive Dental Services
 - vi. Immunizations for Adolescents (Combo 2)
 - vii. Adult: Colorectal Cancer Screening
 - viii. HIV Viral Load Suppression
 - ix. Cervical Cancer Screening
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.
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.
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.
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:
 - i. Well-child visits and vaccination rates for children and adolescents.
 - ii. Preventive dental services for children and adolescents.

Network Management

1. The Proposer should demonstrate how it will ensure timely access to culturally competent primary and specialty care services, necessary to promote LDH's goals of utilizing providers who

are accepting new Medicaid patients or are regularly serving Medicaid patients in their offices or practices.

2. Specifically, the proposal should include:
 - ... Strategies to ensure that your provider network is able to meet the multi-lingual, multi-cultural and disability needs of its enrollees; and

Quality

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:
 - a. 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;
 - b. Identifying underlying reasons for variations in the provision of care to enrollees; and
 - c. Implementing improvement strategies related to analytical findings pursuant to the two (2) functions described above.

Michigan: In October 2023, the Michigan Department of Health and Human Services released an RFP to solicit MCO participation in its MMC Comprehensive Health Care Program.

1. Describe the Bidder's approach to ensuring children are receiving immunizations consistent with the Bright Futures/American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care...The response must include the Bidder's experience with and approach to monitoring and increasing access for children and youth with high rates of health disparities, particularly Black and American Indian / Alaskan Native children and anticipated results of those efforts. When citing relevant experience, the Bidder must clearly state what coverage program(s), state(s) and year(s) the experience comes from and how it will translate to a Michigan Medicaid context (e.g., total enrollees in coverage program, covered populations, covered services).
2. Describe the Bidder's experience and proposed approach for identifying and addressing racial inequities experienced by pregnant and postpartum individuals and their newborns. At a minimum, discuss the Bidder's experience and proposed approach in identifying and addressing low birth weight, preterm births, maternal mortality and other important maternal and infant outcomes. How will disparities be identified and monitored? How will Bidders leverage data to inform their strategies? How will the strategies described be sustained and adjusted in the future? When citing relevant experience, the Bidder must clearly state what coverage program(s), state(s) and year(s) the experience comes from and how it will translate to a Michigan Medicaid context (e.g., total enrollees in coverage program, covered populations, covered services).
3. Describe Bidder's approach in value-based payment arrangements.....
 - a. Describe current experience incorporating equity considerations into Bidder's VBP approach in alignment with recommendations from the HCP-LAN's Health Equity Advisory Team (HEAT). Include baseline and post-implementation performance on program measures.
 - b. Describe Bidder's proposal for incorporating HCP-LAN HEAT recommendations into Bidder's VBP approach.

Case Scenario:

4. Dalya, a 30-year-old woman, immigrated to Michigan with her partner and their one month newborn. Breastfeeding has been difficult for several reasons, including trouble with the infant not latching and that the family is experiencing food insecurity, impacting Dalya's milk supply. In

addition to feeding difficulties, neither Dalya nor the infant have been sleeping well. Dalya has been feeling exhausted and overwhelmed since the delivery, and she recently went to a clinic complaining that her heart has been racing and she feels weak and light-headed when trying to get back to her daily routine. She was told she might have postpartum depression or anxiety and was encouraged to find a counselor to follow up with, but she hasn't been able to do so yet. Dalya and her partner are sexually active and currently not using any form of birth control. Both parents speak Spanish exclusively. How will the Bidder address Dalya's and the infant's needs? Please indicate what systems the Bidder will utilize to ensure Dalya and the infant are continuously engaged in care.

Minnesota: In January 2021 and January 2022, Minnesota's Department of Human Services released competitive RFPs to solicit MCOs to provide prepaid healthcare services to eligible individuals through the Families and Children Medical Assistance and MinnesotaCare contracts. The 2022 RFP focused on 80 greater Minnesota counties (outside of the major metropolitan area of Minneapolis-St. Paul). Select questions pertaining to health equity from that RFP are incorporated below.

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 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.
5. 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)
6. 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 January 2021 Minnesota RFP for Families and Children Medical Assistance and MinnesotaCare contracts for the seven county metro area which includes Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington included bidder questions such as:

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: In November 2021, Mississippi's Division of Medicaid's (DOM) released a Medicaid and CHIP managed care procurement to solicit Coordinated Care Organization (CCO) participation in the state's Medicaid managed care program, known as MississippiCAN.

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: Nevada released a MMC RFP in March 2021.

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.

New Hampshire: In September 2023, New Hampshire's Department of Health and Human Services, Division of Medicaid Services released a managed care procurement to solicit MCO participation in the state's Medicaid managed care program, known as New Hampshire Medicaid Care Management (MCM).

1. Describe the Respondent's mechanisms in place to support its Members, including specific language assistance capabilities, services and supports, to help potential Members and Members with Limited English Proficiency (LEP), disabilities, special health care needs, and diverse cultural and ethnic backgrounds. Indicate how the Respondent will identify, monitor and address cultural and linguistic disparities among Members.

2. Describe how the Respondent will ensure cultural competency throughout the Respondent's Participating Provider network.

New Mexico: The New Mexico Human Services Department issued an RFP to solicit proposals from MCOs to provide services to members in the New Mexico Medicaid managed care program, called Turquoise Care, for contracts beginning in 2024.

1. Describe the Offeror's approach to develop, maintain, and monitor a comprehensive provider network. Include the following in the Offeror's response:
 - a. The Offeror's current understanding of network challenges in New Mexico and the Offeror's strategy to address the challenges to ensure network adequacy.
 - b. The Offeror's network development approach to ensure timely access to:
 - i. Behavioral Health providers, including higher levels of care (e.g., inpatient and residential services) and community-based, trauma-informed services to reduce unnecessary utilization of emergency room services, inpatient services, and out-of-home/out-of-state placements;
 - ii. Specialty providers; and
 - iii. Providers on and off reservation with cultural and linguistic competency to deliver services to Native American members.
 - c. The Offeror's approach to eliminating barriers for members who need an accommodation or adaptation to access and participate in services.
 - d. The Offeror's approach to monitoring to ensure network adequacy, including provider capacity.
 - e. The Offeror's approach to monitoring to ensure appointment availability standards are met.
2. Describe the Offeror's strategies to collaborate and invest to increase Members' equitable access to high quality primary care, improve the quality of primary care services, and expand the primary care network. Offeror's response must include the anticipated measurable impact to overall health care delivery to Members.
3. Describe the Offeror's strategies for outreaching and engaging Members in Care Coordination, including:
 - a. Members who are pregnant or post-partum;
 - b. Members with behavioral health conditions;
 - c. Members who are elderly or disabled and in need of LTSS;
 - d. Members who are justice-involved;
 - e. Members who are Native American;
 - f. Members with significant intellectual and developmental disabilities;
 - g. Members who are homeless, precariously housed, and/or transient;
 - h. Members in out-of-home or out-of-state placements;
 - i. Members who do not speak English (e.g., Native American languages, Spanish) or have other communication needs (e.g., TTY, augmentative communication devices);
 - j. Members who are difficult to contact or choose not to engage;
 - k. Adolescents transitioning to adulthood; and
 - l. Members residing in rural and/or frontier areas of New Mexico.

Case scenarios

4. Alejandra is a forty-one (41)-year-old Latina woman who is pregnant with her second child and lives near Las Cruces. She is a first generation immigrant originally from Mexico who moved to the United States with her parents when she was seven (7) years old. Alejandra speaks limited English. Her first child is ten (10) years old and though there were no major complications at birth, she was born underweight and spent several days in NICU following her birth. She is ten (10)-

weeks pregnant, has not yet found an OBGYN, and indicates that she prefers to use a midwife. Her health history indicates that she has been treated for high blood pressure for the last thirteen (13) months; however, a review of her claims shows she has not filled her blood pressure medication consistently and has missed at least five thirty (30)-day fills in the last thirteen (13) months. She has a good relationship with her Primary Care Provider (PCP) but has missed appointments several times over the last eighteen (18) months.

Lenore, a care coordinator outreaches to Alejandra and learns that Alejandra has been struggling financially since she lost her full-time job due to COVID-19. She found a part-time job that pays much less that allows her to work from home, but she is at risk of losing her apartment, as she has not been able to pay her rent for six (6) months. She does not own a car and has frequently been unable to pick up her blood pressure medications or make it to her doctor appointments. A brief assessment demonstrates significant food insecurities for Alejandra and her family over the last year. Her husband works in construction and has had very little work over the last year. Alejandra shares with Lenore that she is overwhelmed, cries frequently, and feels very stressed most days.

- a. Describe the Offeror's approach to meeting the Member's needs based on the information provided in the scenario and how the Offeror will coordinate the care of this Member; and
 - b. Describe the Offeror's experience with identifying and reducing health disparities in pregnant and postpartum Medicaid members. Include a description of the disparities identified, populations, strategies for addressing the disparities, any measurable improvement, whether the improvement has been sustained, and how the Offeror will apply the lessons learned to address health disparities to improve health outcomes for Members in New Mexico.
5. Mitena is a thirty-two (32) year old, Native American, single mother of three who lives in Santa Fe and calls the Offeror's member services line to ask for help for her thirteen (13)-year-old daughter, Tallulah. Tallulah has increasingly withdrawn from her family and friends over the course of the past two months. Mitena reports that Tallulah has periodically had cuts on her arms, which Tallulah blamed on the cat. Mitena also reported that Tallulah seems like she has lost a significant amount of weight in a relatively short period of time. Tallulah just came home from school, complaining to her mother that she hated school and her friends, and locked herself in her room. When Mitena tried to talk to Tallulah, Tallulah told her mother that she doesn't want to live. As a single mother of three (3) without the use of a car, Mitena cannot bring her oldest daughter, Tallulah, to the emergency room without calling an ambulance. Mitena wants to make sure calling an ambulance is the right thing to do.
- a. Describe how the Offeror will assist the Tallulah and her mother to respond to the Tallulah's immediate and ongoing needs.
6. Dee is a sixty-seven (67)-year-old African American female, diagnosed with type 2 diabetes on insulin, obesity, hyperlipidemia, and hypertension. Dee is Medicare and Medicaid eligible and enrolled in the Offeror's D-SNP. The Offeror has made several attempts to engage Dee into care coordination, but she has refused. Dee has had a long time relationship with her PCP. In addition to medications, Dee's PCP has recommended dietary changes and exercise. Dee enjoys having big family gatherings with "treats and sweets" and has expressed no interest in changing her lifestyle.

Dee has had three emergency room visits in the last twelve (12) months precipitated by "chest pain" that Dee thought might be a heart attack. The emergency room found no evidence of heart attack, but each time referred her back to her PCP. Dee's PCP contacted the Offeror's care coordination unit. The PCP reported that Dee was seen that day because she had been feeling nauseous and "just off." Dee reported that she was experiencing brain fog, periodic muscle

cramps, and general malaise. The PCP also shared that during his examination, he noticed edema in the member's feet and ankles. The PCP states that he is concerned about potential Diabetic Kidney Disease and has ordered additional testing to confirm. The PCP believes that the member needs care coordination and is requesting care coordination on her behalf from the Offeror.

- a. Describe how the Offeror will respond to the PCP, and how the Offeror will address Dee's immediate and ongoing care coordination and health care needs.

North Carolina: North Carolina's Department of Health and Human Services, Division of Health Benefits released a Prepaid Health Plan (PHP) Services RFP in August 2018.

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.
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. 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...
3. 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.

4. 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.
5. 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:

- i. Care Management;
- ii. Motivational Interviewing;
- iii. Housing Quality;
- iv. Social Determinants of Health;
- v. Community Engagement; and
- vi. Language Accessibility.

6. Case Scenario

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:

- i. Network Adequacy;

- ii. Provider Contracting;
- iii. Provider Support;
- iv. Cultural Competency; and
- v. Community Engagement.

Ohio: Ohio’s Department of Medicaid released a MMC RFA in 2020.

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: The Oklahoma Health Care Authority released a MMC RFP in 2022.

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)

Oregon: In 2019, the Oregon Health Care Authority released a competitive Request for Application (RFA) to solicit Coordinated Care Organizations’ (CCO) participation to provide healthcare services to Medicaid members. Attachment 10 of the RFA on Social Determinants of Health and Equity included bidder questions such as:

1. Please briefly describe the Applicant’s current organizational capacity to develop, administer, and monitor completion of training material to organizational staff and contractors, including whether the Applicant currently requires its Providers or Subcontractors to complete training topics on health and Health Equity.
2. Please describe Applicant’s capacity to collect and analyze Race Ethnicity Language and Disability data.
3. Please provide a general description of the Applicant’s organizational practices, related to the provision of culturally and linguistically appropriate services. Include description of data collection procedures and how data informs the provision of such services, if applicable.
4. Please describe the strategies used to recruit, retain, and promote at all levels, diverse personnel and leadership that are representative of the demographic characteristics of the Service Area.
5. Please describe how Applicant will ensure the provision of linguistically appropriate services to Members, including the use of bilingual personnel, qualified and certified interpreter services, translation of notices in languages other than English, including the use of alternate formats. Applicant should describe how services can be accessed by the Member, staff, and Provider, and how Applicant intends to measure and/or evaluate the quality of language services.
6. Please describe how Applicant will ensure Members with disabilities will have access to auxiliary aids and services at no cost as required in 42 CFR 438.10, 42 CFR part 92, and Section 1557 of the Affordable Care Act. Response should include a description of how Applicant plans to monitor access for Members with disabilities with all contracted providers.

Pennsylvania: In 2019, Pennsylvania’s Department of Human Services released a competitive RFA to solicit MCO participation in the Physical HealthChoices program across five regions and all counties of the Commonwealth.

1. Describe the management techniques, policies, procedures and initiatives you have implemented and will implement to promote health care equity (i.e., reductions in disparity in treatment and outcomes among disparate races and ethnic groups). Please provide the results and any lessons learned about these efforts. Describe the strategy to be used for the HealthChoices PH Program. (Limit to six pages)
2. Describe the process and initiatives to actively identify and outreach to members with special needs who would benefit from assistance from the Special Needs Unit. Include how this outreach will address the unique cultural and ethnic populations that exist in the Zone(s). (Limit to four pages)

Rhode Island: The Rhode Island Executive Office of Health and Human Services (EOHHS) issued an RFP in December 2023 to solicit proposals from contractors to provide MMC services to Rhode Island Medicaid enrollees. Contracts awarded as part of this procurement will take effect July 1, 2025.

1. The Bidder should provide a description of the Bidder’s plan for promoting workforce diversity, equity, and inclusion at all levels with its organization. The response should include the organizational goals and benchmarks that the Bidder has set to become a more inclusive and diverse organization and/or the steps the Bidder has or will take to address structural racism, unconscious and implicit bias within its organization. The response also should describe how the Bidder will evaluate current organizational efforts, human resources practices, track progress and continue to improve the organizational structure, policies, and processes to support workforce diversity, inclusivity, and equity.
2. The Bidder should describe the Bidder's strategies to reduce disparities in access/utilization of services. The description should include:
 - a. Initiatives the Bidder will provide to help improve the experiences for communities that experience barriers and disparities in health care outcomes.
 - b. How the Bidder's organization establishes and maintains processes that are culturally responsive and that support the integration and coordination of a Member’s primary care, behavioral health, and LTSS.
3. The Bidder should describe the Bidder's experience, innovative strategies, and comprehensive approach to providing prevention and health promotion services, with emphasis on populations for whom standard outreach and engagement strategies may be less effective.
4. The Bidder should provide a summary of the Bidder's process for engaging and communicating with Members upon enrollment to include how Member communications will be conducted before and after July 1, 2025, including, but not limited to, the Bidder’s Member portal, welcome letters, ID cards, provider directory and member handbook, Primary Care Provider selection, Accountable Entity education and, if indicated, transitions of care. The summary should describe the Bidder’s strategies to communicate with Members who are difficult to reach or may experience unique access challenges, including:
 - a. Members who speak languages other than English as their primary language;
 - b. Members who are deaf, blind, or visually impaired; and
 - c. Members who are from various cultures, Black Indigenous, People of Color (BIPOC), or LGBTQ+.
5. The Bidder should describe how the Bidder solicits and/or receives member feedback regarding member satisfaction, communications, service delivery, quality improvement, provider networks, and health plan operations, including how the feedback is used to improve your organization’s operations. The response should describe Bidder’s approach to assure feedback from diverse

- member groups and how Bidder will use this feedback to assess how structural racism impacts member's experiences and improve health outcomes for the RI Medicaid population.
6. The Bidder should describe the Bidder's approach to Member health education and health literacy. The response must include:
 - a. Demonstrated or planned strategies for conducting activities that promote and increase health literacy to members that speak languages other than English or have indicated a preference for communications in another non-English language; for persons who are deaf, blind, hard of hearing or visually impaired; and for those with limited reading comprehension;
 - b. Identification of the health education activities that are relevant given the populations covered, to include, BIPOC and LGBTQ+ populations;
 - c. Processes for evaluation of the effectiveness of education strategies implemented and how Bidder uses the information learned to make changes to its member engagement approach; and
 - d. The means of communication that will be employed to connect with members, including the use of internet, smart phone-based applications and other technologies to educate members regarding care pathways for their individual medical issues.
 7. Describe the Bidder's approach to, and experience with, improving population health for Medicaid populations including how principles of a population health approach will inform and guide its managed care program in Rhode Island. Examples of past strategies used, including outcomes data, should be included where possible. The Bidder should describe its population health management strategy, program structure, population health assessment, health activities, health experience, role in local initiatives, quality of care and delivery. The response should include at a minimum:
 - a. Sources and types of data and information collected and used by the Bidder to inform your organization's population health strategies and initiatives, including the collection and utilization of data regarding SDOH;
 - b. The criteria and thresholds for risk stratification and how risk stratification informs your organization's population health strategies;
 - c. Member outreach and engagement strategies;
 - d. Collaboration, coordination, and data sharing with other entities, including community-based organizations, that impact population health;
 - e. Implementation of a bi-directional data exchange between EOHHS and the Bidder;
 - f. Utilization of the InterRAI Home Care Assessment, performed by EOHHS, to facilitate care for LTSS-eligible Members; and
 - g. How the Bidder evaluates the impact of its population health strategies on health outcomes to inform the development of and updates to the Bidder's health equity strategy and quality plans as required in the Model Contract.
 8. The Bidder should describe the Bidder's experience and successes in identifying, addressing, and mitigating racial and ethnic disparities within a Medicaid population. Include the metrics used to evaluate the program, the measurable improvements achieved and describe how long the improvements have been maintained.
 9. The Bidder should describe the Bidder's data collection procedures related to enrollee's race, ethnicity, language, disability status (RELD data), geography, sexual orientation and gender identity (SOGI) and how such data informs the provision of racially, culturally, and linguistically appropriate services for Members. If the Bidder does not currently collect some types of RELD, SOGI, geographic, or other data, describe how the Bidder plans to capture this data during the first two years of the Contract award.

10. The Bidder should describe the Bidder's approach to, and experience with, performing utilization management (UM) for Medicaid populations and how it will implement the UM program requirements as set forth in the Model Contract. The response should include at a minimum: ... Health disparities and ensuring equity...
11. The Bidder should provide the Bidder's approach to overall quality management and quality improvement (QM/QI) and specific strategies that will be used to advance Rhode Island's Medicaid Managed Care Quality Strategy across all programs and populations, including physical health, behavioral health, and LTSS as set forth in the Model Contract. The response should include: ... Description of how the Bidder will stratify quality results for RELD and SOGI.
12. The Bidder should provide a table that identifies its performance on quality indicators for population(s) similar to those of Rhode Island. The response should include, at a minimum, three (3) years of data for the following six (6) HEDIS measures for each State in which the Bidder serves. The data should include the numerator, denominator, and performance percentile for each measure. The Bidder should also include i) a description of activities that generated improvement in measures, ii) actions taken for those measures with a decline or no improvement in performance, and iii) data analysis to identify and actions taken to address disparities for subsets of the population within a measure. In each case the Bidder should include how the Bidder used data and data analysis to inform those actions/initiatives, and how the Bidder will implement those strategies in Rhode Island.
13. The Bidder must provide a detailed plan and timeline for obtaining NCQA Health Equity Accreditation (or Health Equity Accreditation Plus) and LTSS Distinction within twenty-four (24) months of execution of this Agreement. If the Bidder does not currently have these Accreditations/Distinctions in Rhode Island, the Bidder should provide a specific timeline outlining the Bidder's plan to achieve this in Rhode Island.
14. The Bidder should describe how the Bidder will incentivize and utilize alternative payment methods to address health disparities and the social determinant needs of Members, improve health equity in access to and delivery of health care services, and improve adult and child health outcomes. Address the following items in the response:...
 - a. Provide examples of the types of APM arrangements, types of Providers that participated in APM arrangements, actual or anticipated number of members served under APM arrangements and indicate whether the examples are planned or implemented.
 - b. How the Bidder assesses an AE or Provider's capacity and ability to contract under an APM arrangement and evaluates whether the AE or Provider is able to progress along the LAN framework;
 - c. How the Bidder shares quality, utilization, cost, and outcomes data with AEs and Providers participating in these arrangements, supports AEs and Providers to be successful under these reimbursement arrangements, and implements strategies to reduce AE and Provider administrative burden; and
 - d. How the Bidder evaluates the success of the APM arrangement, including the types of performance metrics and the evaluation process.
15. The Bidder shall provide a summary of how the Bidder establishes and maintains a robust geographically and culturally diverse provider network to assure a complete continuum of behavioral health, physical health, LTSS, and preventive services to deliver the full array of In-Plan Services as outlined in the Model Contract that assures timely access. The response should include:
 - a. A summary of the Bidder's knowledge of the current RI provider landscape and understanding of any particular issues related to network development in this state.
 - b. Individual letters of intent (LOIs) from Rhode Island Medicaid providers, showing those providers who intend to join Bidder's network, including behavioral health providers,

- primary care providers, acute care providers, LTSS providers, any gaps in the current network (LOIs may be non-binding);
- c. Geographic access maps showing the service locations of providers who have submitted LOIs or who are contracted (noted separately); and
 - d. A description of the Bidder intends to develop a sufficient Provider Network, including a timeframe with targeted goals, that will address identified gaps and that specifically addresses the needs of the following populations:
 - i. Individuals with mental health and/or substance abuse issues;
 - ii. Children and adolescents, including those who are involved with the Rhode Island Department of Children, Youth and Families;
 - iii. People who need assistance with activities of daily living;
 - iv. Persons with a comorbid physical, mental health, and substance use conditions; and
 - v. Individuals who are racially and ethnically diverse.
16. The Bidder should describe how the Bidder is working to diversify its provider network to meet the cultural and linguistic needs and preferences of the organization’s members, including how the Bidder will ensure its provider networks are reflective of the RI communities. The response should include at a minimum, an example of how the Bidder identifies the cultural, linguistic and diversity gaps in their provider network, the outreach and incentives used to formalize agreements with these providers and the process and data used by the plan to conduct ongoing evaluation of provider network diversity.
17. The Bidder should describe the Bidder’s proposed approach to offering, promoting, and supporting the appropriate and effective use of telehealth services to increase access and health equity for Rhode Island Medicaid members. The response should assume a post-pandemic environment where access would be balanced with appropriate utilization management and timely access to office-based care that meets the time, distance and availability standards included in the Model Contract.

Texas: In 2022, the Texas Health and Human Services Commission (HHSC) released its STAR and CHIP Managed Care Services RFP for managed acute care services to Medicaid and CHIP enrollees.

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 – State Examples

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, Language, or Other

State	Contract language
California	<p>Contractor must maintain policies and procedures that meet the following Basic Population Health Management (PHM) requirements, at a minimum:</p> <ul style="list-style-type: none"> Review Member utilization reports to identify Members not using Primary Care; stratify such reports, at minimum, by race and ethnicity to identify Health Disparities that result from differences in utilization of outpatient and preventive services; and develop strategies to address differences in utilization... <p>...After implementation of Community Supports, Contractor must submit the following data and reports to DHCS to support DHCS oversight of Community Supports:</p> <p>1) Encounter Data Encounter Data, when possible, must include data necessary for DHCS to stratify services by age, sex, race, ethnicity, and language spoken to inform Health Equity initiatives and efforts to mitigate Health Disparities undertaken by DHCS.</p>
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>
D.C.	<p>The Contractor’s CQI Plan shall include the use of health information exchange and other tools to access clinical and Enrollee Encounter Data. These tools should include the capacity for, but not limit to the following: ... Reducing racial, socioeconomic and ethnic disparities in health care utilization and in health outcomes. Comparing health care utilization data for Enrollees by Enrollee subgroups, such as, race/ethnicity, language, and by DC Ward against prior year performance, and, where possible, against regional and national benchmarks...</p>
Florida	<p>Beginning with the Performance Measures Report that is due to the Agency no later than July 1, 2026, covering the measurement period of calendar year 2025, the MCP shall report on all contractually required performance measures statewide, stratified by: age, sex, race, ethnicity, primary language, and whether the enrollee received a Social Security Administration determination of disability for purposes of Supplemental Security Income. The MCP shall continue to report</p>

State	Contract language
	all measures by region...The Agency may require that the MCP submit performance measures stratified by other factors such as rural/urban and others, with at least 60 days' notice.
Georgia	<p>Stratification: A process by which clinicians, Providers, and other entities report measures by different groups of Members (e.g., male, female, African American, white or combination of groups) to find potential differences in care (e.g., examining a measure of how many Members received routine mammography by how many African American women received the recommended care).</p> <p>18.5 Performance Measures 18.5.2 Reporting of Performance and Quality Measures shall include stratification of performance measure results across different populations with attention to geography, age, sex, race, ethnicity, disability status, and primary language.</p> <p>18.3 Contractor's Quality Strategy</p> <p>18.3.1 The Contractor must submit a written Quality strategy plan for assessing and improving the Quality of care and Health Care services which meets the requirements of 42 CFR 438.330 to DCH for review and obtain DCH's approval at least sixty (60) Calendar days before the Operational Start Date and at least 90 days prior to implementing any changes.</p> <p>18.3.1.17 Ensuring that Contractor makes comparisons across Quality and performance data to identify disparities that should be addressed as a part of Contractor's Quality planning.</p> <p>18.3.1.18 Evaluating the effectiveness of interventions to reduce healthcare disparities.</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,</p>

State	Contract language
	<p>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> <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 must...Stratify 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: 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 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>
New Hampshire	<p>4.13.5 Quality and Administrative Reporting Deliverables 4.13.5.2.2 NCQA Medicaid Accreditation measures, including race and ethnicity stratification, which shall be generated without NCQA Allowable Adjustments and validated by submission to NCQA.</p>

State	Contract language
New Mexico	Delivery System Improvement Performance Target: Hepatitis C Treatment: The CONTRACTOR shall submit a biannual report including data analysis on its population diagnosed with Hepatitis C, stratified by race and ethnicity, including the technical specifications for HEDIS. The biannual reports are due to HCA ninety (90) Calendar Days after the end of each six-month period. HCA will provide the CONTRACTOR with annual targets for percents of Members with Hepatitis C, as defined by a positive Hepatitis C Virus Ribonucleic Acid (HCV RNA) test within the calendar year. The annual target percent will be identified by HCA following six months of baseline data and shared with the CONTRACTOR. Hepatitis C Diagnosis is defined as a positive HCV RNA test within the past two calendar years (e.g., if the DS IPT CY is 2025, diagnosis is defined as a positive HCV RNA test within CY24 or CY25). Treatment is defined as being “successful” when a resulting negative viral load follows a positive HCV RNA test by at least three months. The data source is the Synchrony HIE, including claims data with corresponding labs, and will be collected by HCA. For purposes of this DS IPT, the CONTRACTOR shall treat an annual percent of Members with Hepatitis C, meeting the annual target as set by HCA.
North Carolina	Quality Management and Quality Improvement Disparities Reporting and Tracking The PHP shall report measures against a set of stratification criteria that may include, but is not limited to: race and ethnicity, geography, eligibility category, and age and gender where appropriate and feasible for many of the Quality Measures. The PHP shall address inequalities as determined by the Department during review of the PHP’s performance against disparity measures.
Ohio	Population Health Improvement Strategies c. Health Equity i. The MCO must participate in and support ODM's efforts to reduce health disparities, address social risk factors, and achieve health equity. The MCO's health equity efforts must include the following: 1. Identifying disparities in health care access, service provision, satisfaction, and outcomes. This includes: 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	1.11.7 Addressing Health Disparities ...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.
Rhode Island	16.2. Quality Measurement 16.2.1. The Contractor is responsible for: 16.2.1.1. Collecting and reporting data to EOHHS on select quality measures as identified by EOHHS that can be stratified based upon Members’ age, race, ethnicity, language, disability, sexual orientation, gender identity, or other

State	Contract language
	characteristics as specified by EOHHS and by attributed AE, if applicable. EOHHS reserves the right to provide additional guidance on how and what data the Contractor shall collect to track information regarding Health Equity; and 16.2.1.2. Requiring that when AEs and Providers report data on quality measures that such data captures information and can be stratified based upon Members' age, race, ethnicity, language, disability, sexual orientation, gender identity, or other characteristics as specified by EOHHS.

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

State	Contract language
California	Each PIP must include the following: a) Measurement of performance using objective quality indicators; b) Implementation of equity-focused interventions to achieve improvement in access to Quality of Care... ¹
Minnesota	7.8 ANNUAL QUALITY PROGRAM UPDATE. 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 description of at least one quality improvement activity addressing health care disparities.
Nevada	7.9.5. Performance Improvement Projects (PIPs) 7.9.5.5. The Contractor must participate in one (1) statewide PIP focusing on reduction in African American maternal and infant morbidity and mortality as defined by the State. 7.9.5.6. The Contractor must select an additional two (2) projects from the list below, to serve as the Contractor's required PIPs in accordance with 42 CFR 438.330(a)(2) and 42 CFR 438.358:... 7.9.5.6.4. SDOH and health equity.
Ohio	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.
Oklahoma	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.
Oregon	6. Performance Improvement Projects

¹ Quality of Care means the degree to which health services for Members increase the likelihood of desired health outcomes and are consistent with current professional standards of care and knowledge. Source: California Department of Health Care Services Exhibit A Scope of Work 2024 Managed Care Boilerplate Contract.

State	Contract language
	...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.
Washington	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.
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.

State	Contract language
	<p>B. Develop and implement policies and procedures aimed at improving Health Equity and reducing Health Disparities;</p> <p>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;</p> <p>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;</p> <p>E. Develop targeted interventions designed to eliminate Health Inequities;</p> <p>F. Develop quantifiable metrics that can track and evaluate the results of the targeted interventions designed to eliminate Health Inequities;</p> <p>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> <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 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> <p>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</p>

State	Contract language
	<p>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.</p>
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> <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>
Florida	<p>The MCP shall have procedures to address changes in the MCP network that negatively affect the ability of enrollees to access services, including access to a culturally diverse provider network...</p> <p>The MCP shall include in its printed provider directory the following information:</p> <ul style="list-style-type: none"> • The provider’s cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider’s office, and whether the provider has completed cultural competence training.
Georgia	<p>Health Equity Director (FTE: 1.0)...</p> <p>Responsible for promoting fairness and inclusivity in healthcare. Health equity director leads effort to reduce disparities among diverse members, creating</p>

State	Contract language
	<p>strategies to address social factors (e.g., addressing social determinants of health) and ensure equitable healthcare delivery. Accountable for the development and implementation of the Health Equity Plan and any other health equity related organizational initiatives. The Health Equity Director shall serve as the single point of contact responsible and accountable for all matters related to health equity within the Contractor’s organization and Provider Network to support the effectiveness and efforts of the Contractor’s Health Equity Plan. The HE Director 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 Director 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 and Chief Analytics 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, and other 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>Bachelor’s degree At least five (5) years of experience leading health equity initiatives. In-depth knowledge of health disparities and community engagement strategies incorporated into the tailoring of intervention strategies.</p>
Hawaii	<p>Data Analytics Officer:</p> <p>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</p>

State	Contract language
	<p>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>
<p>Louisiana</p>	<p>Part 2: Contractor Responsibilities 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 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;

State	Contract language
	<ul style="list-style-type: none"> • 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. Personnel, Organizational Structure, and Governing Body</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. The program must include additional facets of diversity, equity, and inclusion in addition to implicit bias.</p> <ul style="list-style-type: none"> 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. 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.
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,</p>

State	Contract language
	<p>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</p> <p>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.</p> <p>7.9.4.13. Adequate Resources</p> <p>The IQAP must have sufficient material resources and staff with the necessary education, experience, or training to effectively carry out its specified activities...</p> <p>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:...</p> <p>7.9.4.13.2.4. Health equity;</p>
New Mexico	<p>3.3.3 The CONTRACTOR’s Key Personnel</p> <p>3.3.3.18 A full-time staff person dedicated to this Agreement who shall oversee and be responsible for all Cultural Competency activities;</p> <p>3.3.3.19 A full-time staff person dedicated to this Agreement who shall oversee and be responsible for Health Equity activities;</p> <p>3.3.3.20 A full-time staff person dedicated to this Agreement with the education and experience such that the staff person has the skills and/or knowledge necessary to work on Native American health disparity issues and Cultural Competence concerns related to Care Coordination, services, and care delivery;</p> <p>3.3.3.21 A minimum of four (4) full-time staff persons to work directly with I/T/Us² and a minimum of two (2) full-time staff persons to work directly with I/T/Us for billing and Claims issues. These staff persons must proactively outreach I/T/Us to inform I/T/Us about available Covered Services and other benefits (i.e., In Lieu of Services and Value Added Services) available to Native American Members, and offer training and technical assistance for billing and Claims. At least one (1) of these staff persons must be proficient in at least one (1) New Mexican Native American/pueblo language;</p> <p>3.3.3.22 A full-time staff person dedicated to this Agreement who shall oversee Member services including, among others: (i) the Member services call center; and (ii) the CONTRACTOR’s Health Literacy and Health Education efforts;...</p>
Oklahoma	<p>1.4.6.2 Key Staff</p> <p>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</p>

² Indian Health Service, Tribal health Providers and Urban Indian Providers

State	Contract language
	<p>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.</p> <p>1.11.7 Addressing Health Disparities ...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 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 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> <p>Governing Board and Governance Structure</p> <p>3. Tribal Liaison a. ORS 414.581 established a Tribal Advisory Council. The Tribal Advisory Council is responsible for, among other matters, serving as a channel of communication between Contractor, other CCOs, and Indian Tribes in Oregon regarding the health of Tribal communities. In order to facilitate communication between the Tribal communities and Contractor, the Tribal Advisory Council or particular members of the TAC will work with Contractor to select a Tribal Liaison. b. The Tribal Liaison shall be an employee or a Subcontractor of Contractor. Contractor’s Tribal Liaison shall have the following responsibilities:</p>

State	Contract language
	<p>(1) Actively participate in the development of the Community Health Assessment as set forth in Ex. K of this Contract;</p> <p>(2) Actively participate in the development and drafting of the Community Health Improvement Plan as set forth in Ex. K of this Contract:</p> <p>(3) Facilitate the resolution of any issues that arise between Contractor and a Provider of Indian health services within Contractor’s Service Area;</p> <p>(4) Serve as the primary point of contact for communicating regularly with the Tribal Advisory Council about matters affecting both Contractor and the Tribal communities within the State; and</p> <p>(5) Assist with Contractor’s training and education programs relating to its services and other matters relating to the specific concerns of Oregon’s Tribal communities and the coordinated care health care system.</p> <p>c. OHA will provide Guidance Documents and technical assistance to assist Contractor and the Tribal Liaison with meeting their respective responsibilities. The Guidance Documents will include, without limitation, a sample job description for the Tribal Liaison which will include the minimum responsibilities, in addition to those set forth above in Para. a of this Sec. 3, Ex. B, Part 1 of this Contract, of such employee or Subcontractor.</p>
<p>Rhode Island</p>	<p>1.6. Contractor’s Key Personnel</p> <p>1.6.2. As stated in the Contractor’s proposal, the Contractor shall designate Key Personnel who will be assigned to the Agreement. For the purposes of this requirement, Key Personnel include:...</p> <p>1.6.2.11. Chief Diversity, Equity, and Inclusion Officer (CDEIO); Chief Health Equity Officer; Privacy Official</p> <p>1.7.3. For the basis of this Agreement, Executive Management Functions and Executive Leadership will consist of the following locally-based FTEs:...</p> <p>1.7.3.11. Chief Diversity, Equity, and Inclusion Officer (CDEIO); and,</p> <p>1.7.3.12. Health Equity Officer (HEO).</p> <p>1.7.14.6. The CMO is responsible for development, implementation, and oversight of:...</p> <p>k) Diversity and Health Equity initiatives.</p> <p>1.7.14.7. The CMO shall serve as a liaison between the Contractor and its Providers and communicate regularly with Providers, addressing areas of clinical relevance including but not limited to:...</p> <p>c) Health Equity, promotion, and disease management programs</p> <p>1.7.19. Chief Diversity, Equity, and Inclusion Officer</p> <p>1.7.19.1. The Chief Diversity, Equity and Inclusion Officer (CDEIO) is responsible for the promotion of a diversity and inclusion throughout the Contractor’s organizational management and ensuring compliance with the training and development of staff and Network Providers under this Agreement.</p> <p>1.7.19.2. The CDEIO shall have a master’s degree in social work, Public Administration, Health Care Administration, Human Resources, or a related field. They shall have at least five (5) years of experience in diversity and inclusion roles,</p>

State	Contract language
	<p>preferably within healthcare setting and experience in developing and implementing diversity, equity, inclusion, and inclusion strategies.</p> <p>1.7.19.3. The CDEIO shall have a deep understanding of Federal and State Laws regarding equal employment opportunity, affirmative action, and civil rights. Knowledge about Medicaid policies would be beneficial. Proficiency in analyzing data related to diversity and inclusion, and ability to generate actionable insights from the same.</p> <p>1.7.19.4. The CDEIO shall have relevant certifications related to diversity and inclusion such as the Certified Diversity Professional (CDP) or the Certified Diversity Executive (CDE). These certifications are required by Year 2 of the Agreement.</p> <p>1.7.19.5. The CDEIO shall be an exceptional leader for change management and ability to lead diversity initiatives across the Contractor’s organization and a deep commitment to promoting diversity, equity, and inclusion in previous roles and provide evidence-based outcomes to EOHHHS on work during the term of this Agreement.</p> <p>1.7.19.6. The CDEIO shall report to the CEO and is responsible for managing and overseeing the Contractor’s efforts to:</p> <ul style="list-style-type: none"> a) Create a diverse and inclusive workforce. b) Identify and address potential discrimination or biases in the workforce. c) Ensure compliance with yearly workforce trainings, such as anti-bias, anti- racist, sexual harassment, and health inequities training. d) Launch initiatives to change culture. e) Create a supportive environment for all Members of the organization. f) Develop, execute, and monitor compliance with a comprehensive, organization-wide Strategic Health Equity, Diversity, and Inclusion Plan, including management of AEs involved in developing and overseeing plan. <p>1.7.19.7. The Chief DEI Officer shall serve as a leader in the organization and has primary responsibility for:</p> <ul style="list-style-type: none"> a) Submitting the Health, Equity, Diversity, and Inclusion Plan to EOHHHS during Readiness Review, then annual reports describing Plan activities and outcomes. b) Developing training programs for staff. c) Reviewing and assessing the impact and effectiveness of diversity and inclusion programs. <p>1.7.20. Health Equity Officer</p> <p>1.7.20.1. The Health Equity Officer (HEO) shall serve as the single-point of contact responsible and accountable for all matters related to health equity within the Contractor’s organization and provider network to support the effectiveness and efforts of the Contractor’s Health Equity Plan.</p> <p>1.7.20.2. The HEO shall have at least eight (8) years of relevant community experience in organizing or supporting at-risk and vulnerable populations and shall have a deep knowledge of cultural competency and historical traumas within the United States healthcare delivery system and challenges serving Medicaid Members.</p> <p>1.7.20.3. The HEO have strong leadership skills and knowledge about the local and underserved populations in Rhode Island.</p>

State	Contract language
	<p>1.7.20.4. The Contractor may hire or designate an existing employee to serve as the HEO.</p> <p>1.7.20.5. The HEO shall be a high-level employee (i.e., Reporting to any of the Executive within this Section), but may have more than one area of responsibility and job title.</p> <p>1.7.20.6. The roles and responsibilities of the HEO are to:</p> <ul style="list-style-type: none"> a) Oversee the Contractor’s strategic design, implementation, and evaluation of health equity efforts in the context of the Contractor’s population health initiatives. b) Inform decision-making around best payer practices related to disparity reductions, including the provision of health equity, social determinants of health, and health related social needs and research to leadership and programmatic areas; c) 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 Members with disparate outcomes are incorporated into the tailoring of intervention strategies; d) Collaborate with the CTO to ensure that Contractor collects and meaningfully uses race, ethnicity, disability and geographic data to identify disparities; e) Coordinate and collaborate with Members, Providers, local and State government, community-based organizations, EOHHS, and other EOHHS Contractors to impact health disparities at a population level; f) Ensure that efforts addressed at improving health equity, reducing disparities, and improving cultural competency are designed collaboratively and that lessons learned are incorporated into future decision-making. <p>1.16. Staff Training, Licensure, and Meeting Attendance</p> <p>1.16.5. The Contractor shall ensure that all staff members having contact with Members or Providers receive initial and ongoing training on health equity, HSRN, SDOH, beyond Culturally and Linguistically Appropriate Services (CLAS) requirements and with regard to the appropriate identification of handing of quality of care concern.</p> <p>13.3. Health Risk Assessment</p> <p>13.3.4. The Contractor’s data system shall have sufficient IT infrastructure and data analytics capacity to support EOHHS’ vision and goals for quality improvement, measurement, and evaluation, including the capability to:</p> <ul style="list-style-type: none"> 13.3.4.1. Identify service access, utilization, health outcomes, intervention effectiveness, social risk factors, and survey (e.g., CAHPS) results by Member characteristics including race, ethnicity and language, disability, and by attributed AE; and 13.3.4.2. Employ advanced analytic methods such as hot spotting and predictive analytics and modeling to improve the identification of Members and Member communities disproportionately impacted by or at risk for poor health outcomes and social risk factors. 13.3.4.3. Support the monitoring and comparison of process and outcome measures over time to inform disparity reduction efforts.

State	Contract language
<p>Texas</p>	<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 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 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: 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;</p>
<p>Washington</p>	<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</p>

State	Contract language
	<p>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, 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</p>

State	Contract language
	Tribes and Non-Tribal IHCPs applicable to the Contractor’s Regional Service Area(s).
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 Health Equity and/or Cultural Competency

State	Contract language
Georgia	<p>12.1.4 In addition to complying with all applicable regulatory requirements, the Contractor’s Provider Contracts shall:</p> <p>12.1.4.22 Require that Providers comply with the Contractor’s Cultural Competency & Health Equity Plan...</p>
Kentucky	<p>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...</p>
Louisiana	<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> <p>2.6. Health Equity Plan requirements</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"> • 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	<p>Appendix 16. Provider Directory Listing Requirements</p> <p>“Whether the provider has completed cultural competency training” (required for PCPs and specialists, optional for other provider types listed in Directory).</p>
Minnesota	<p>3.10.6 Provider Directory.</p> <p>The MCO must make available:</p> <p>3.10.6.1 A Provider Directory that lists the contracted Providers within the MCO’s network, including Primary Care Providers, physicians including specialists and subspecialists, hospitals, pharmacies, behavioral health providers, and LTSS</p>

State	Contract language
	<p>provider as appropriate. The Directory must include Network Provider names, group affiliation, locations, telephone numbers, web sites as appropriate, and other requirements as specified in the Provider Directory Guidelines technical specifications posted on the STATE's managed care web site. [42 CFR §438.10(h)(1)]</p> <p>3.10.6.2 The directory shall indicate the Network Provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the Provider or a skilled medical interpreter at the Provider's office, and whether the provider has completed cultural competence training. For hospitals, the MCO should list only the languages spoken by on-site interpreter staff.</p>
Mississippi	<p>Initial training (for provider) - 5. The importance of ensuring health equity, addressing implicit bias, and maintaining cultural competency in the delivery of services;</p>
Nevada	<p>7.5.3.3. Cultural Competency Education and Training</p> <p>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 Hampshire	<p>4.7. Access</p> <p>4.7.1. Participating Provider Network</p> <p>4.7.1.2 The MCO shall develop and maintain a statewide Participating Provider network that adequately meets all covered medical, mental health, Serious Mental Illness, Serious Emotional Disturbance, Substance Use Disorder and psychosocial needs of the covered population in a manner that provides for coordination and collaboration among multiple Providers and disciplines and Equal Access to services. In developing its Participating Provider network, the MCO shall consider and address the following factors to ensure network adequacy for each Member:</p> <p>4.7.1.2.6 The linguistic capability of Providers to communicate with Members in non-English languages, including oral and American Sign Language.</p>
New Mexico	<p>4.11 Provider Services</p> <p>4.11.5.5 The CONTRACTOR's training program shall include the methods the CONTRACTOR will use to ensure that Providers of all types receive education and training about delivering culturally and linguistically appropriate services to Members. The CONTRACTOR shall ensure this education and training is provided on an ongoing basis, but not less than annually.</p> <p>4.11.5.5.1 The CONTRACTOR shall include an annual calendar of Provider training that fully describes the training topics and delivery modalities in the CONTRACTOR's CHP and/or shared with HCA.</p> <p>4.11.5.5.2 The CONTRACTOR shall regularly evaluate the training needs of the Providers and update the training programs, when appropriate.</p> <p>4.11.5.5.3 Training must go beyond race/ethnicity to include health disparities and health care needs of priority populations.</p> <p>4.15.5 Provider Directory</p>

State	Contract language
	<p>4.15.5.1 The CONTRACTOR shall develop and maintain a general Provider directory, which must include the following for all Contract Providers: complete name and any group affiliation; specialty, as appropriate; all locations; telephone numbers; office hours; non-English languages spoken (including American Sign Language) and if the languages are spoken by the Provider or a skilled medical interpreter; identification of Contract Providers accepting new patients (closed or open panels); weekend and after-hours availability; website URL, as appropriate; whether the Provider's office/facility has accommodations for Members with physical disabilities, including offices, exam room(s), and equipment; whether the Provider has completed Cultural Competence training; any special populations served (e.g., individuals with disabilities or LGBTQ+); the Provider's race and/or ethnicity; and a photograph of the Provider; and hospital listings, including locations of emergency settings and Post-Stabilization Services, with the name, location, and telephone number of each facility/setting.</p>
New York	<p>15. ACCESS REQUIREMENTS 15.10 Cultural and Linguistic Competence</p> <p>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> <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 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, ii. VBP/APM Strategy, iii. Care Management Policy, iv. Provider Support Plan, v. Provider Training Plans, vi. Opioid Misuse Prevention Program, and</p>

State	Contract language
	<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> <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	1.12.2 Cultural Competency

State	Contract language
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.
Pennsylvania	R. Provider Services 2. Provider Education At a minimum, the PH-MCO must conduct the Provider training for PCPs and dentists, as appropriate, and include the following areas:... c. Sensitivity training on diverse and Special Needs populations such as persons who are deaf or hard of hearing: how to obtain sign language interpreters and how to work effectively with sign language interpreters. d. Cultural Competency, including: the right of Members with LEP to engage in effective communication in their language; how to obtain interpreters, and; how to work effectively with interpreters. e. Treating Special Needs populations, including the right to treatment for individuals with disabilities.
Rhode Island	18.27. Provider Training 18.27.1. The Contractor shall have an ongoing Provider education and training program that at a minimum, addresses the following topics:... 18.27.1.8. The Contractor’s Health Equity Plan. 18.27.1.9. Cultural Competency, and the unique needs of Medicaid Members. 18.27.1.12. Anti-bias workshops as outlined in Section 13.3, “Health Risk Assessment.”
Texas	The MCO must establish ongoing Provider training that includes the following topics: 2. Medical Home Services Model... 7. Cultural Competency Training based on federal and State requirements;

5. NCQA Health Equity Accreditation

State	Contract language
California	A. Contractor must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by no later than January 1, 2026. Contractor must maintain full NCQA HPA and Health Equity Accreditation throughout the term of this Contract and submit every three years NCQA HPA and Health Equity Accreditation results. Contractor must also complete additional NCQA accreditation programs as directed by DHCS. B. In accordance with W&I section 14184.203, Contractor must also ensure that all its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors have full NCQA HPA and Health Equity Accreditation by no later than January 1, 2026. Contractor must also ensure all its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors maintain full NCQA HPA and Health Equity Accreditation throughout the term of this Contract. Contractor must ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors also complete additional NCQA accreditation programs as directed by DHCS.

State	Contract language
	<p>C. Contractor must provide DHCS with the following components of Contractor’s, Fully Delegated Subcontractor’s, and Downstream Fully Delegated Subcontractor’s NCQA HPA and Health Equity Accreditation status and reviews within 30 calendar days of the receipt of the completed report from NCQA: 1) Accreditation status; 2) Survey type; 3) Results of the review; 4) HEDIS and CAHPS summary level data; 5) Recommended actions or improvements; 6) Corrective Action plans and summaries of findings; and 7) Expiration date of the accreditation.</p> <p>D. Contractor must notify DHCS of the date of its NCQA site visit within 15 calendar days of confirmation of the site visit by NCQA. Contractor must make available all written materials submitted to NCQA available to DHCS and allow DHCS representative(s) to participate in the NCQA audit activities, including but not limited to, the NCQA site visit.</p> <p>E. Contractor must notify DHCS of any change in NCQA HPA and Health Equity Accreditation status within 30 calendar days of receipt of the final NCQA report. In addition to complying with the Corrective Actions imposed by NCQA, Contractor must also comply with any additional Corrective Actions imposed by DHCS to address a change in Contractor’s accreditation status.</p> <p>F. If Contractor fails to obtain or maintain its HPA or Health Equity Accreditation status within the timeframe described above and anytime thereafter, Contractor will be subject to Corrective Actions by DHCS, including but not limited to, the actions set forth in Exhibit E, Subsections 1.1.16 (Termination), 1.1.19 (Sanctions), and 1.1.20 (Liquidated Damages).</p> <p>G. Contractor must have policies and procedures in place to oversee the HPA and Health Equity Accreditation status of its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors throughout the term of this Contract. Contractor must have policies and procedures in place to subject its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors to Corrective Actions if Contractor’s Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor fails to maintain its HPA and Health Equity Accreditation status, including, but not limited to, termination of Subcontractor Agreements or Downstream Subcontractor Agreements with Fully Delegated Subcontractors or Downstream Fully Delegated Subcontractors, sanctions, and damages.</p>
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>

State	Contract language
	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.
Georgia	3.6 ...By 18 months after Operational Start Date, the Contractor must achieve NCQA Health Equity Plus Accreditation Status.
New Mexico	3 CONTRACTOR's Administrative Requirements 3.1 Requirements Prior to Operation The CONTRACTOR shall, within eighteen (18) months of Go-Live, obtain NCQA Distinction in Multicultural Health Care/Health Equity Accreditation and Long-Term Services and Supports (LTSS) Distinction in the State of New Mexico. (The NCQA Distinction in Multicultural Health Care is scheduled to change to transition to NCQA "Health Equity Accreditation" and "Health Equity Accreditation Plus" for surveys after July 2022.) The CONTRACTOR shall provide HCA the current and each reoccurring NCQA accreditation and distinction award letter from NCQA to HCA within thirty (30) Calendar Days of receipt.
Oklahoma	1.4.2 Accreditation ...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.
Rhode Island	5.5. Certification of Licensure and Accreditation 5.5.4. Ensuring access to high quality and cost-effective services to all Rhode Islanders is paramount; therefore, the Contractor shall obtain NCQA Health Equity Accreditation (or Health Equity Accreditation Plus) and LTSS Distinction within twenty-four (24) months of execution of this Agreement. If not yet accredited for Rhode Island Medicaid, Contractor must nonetheless follow all NCQA standards. 5.5.5. Achievement of provisional accreditation status shall require a corrective action plan within thirty (30) Calendar Days of receipt of the Final Report from the NCQA and may result in termination of the Agreement. 5.5.6. Failure to obtain NCQA Health Plan Accreditation within twelve (12) months and Health Equity Accreditation (or Health Equity Accreditation Plus) and LTSS Distinction within twenty-four (24) months of execution of the Agreement may result in suspension of enrollment or termination of this Agreement.

6. Incentives to Promote Health Equity

State	Contract language
California	2.2.6 Quality Improvement and Health Equity Transformation Program Policies and Procedures Contractor must develop, implement, maintain, and periodically update its QIHETP policies and procedures that include, at a minimum, the following: G. The policies and procedures designed to identify, evaluate, and reduce Health Disparities, by performing the following: 1) Analyzing data to identify differences in Quality of Care and utilization, as well as the underlying reasons for variations in the provision of care to its Members;

State	Contract language
	<p>2) Developing equity-focused interventions to address the underlying factors of identified Health Disparities, including SDOH; and</p> <p>3) Meeting disparity reduction targets for specific populations and/or measures as identified by DHCS</p> <p>Exhibit A, Attachment III, Subsection 2.2.9.A (Quality Performance Measures</p> <p>b. On an annual basis, Contractor must track and report on a set of Quality Performance Measures and Health Equity measures identified by DHCS in accordance with all of the following requirements:...</p> <p>4) Contractor must meet Health Disparity reduction targets for specific populations and measures as identified by DHCS.</p> <p>5) In accordance with 42 CFR section 438.700 et seq., W&I section 14197.7, and Exhibit E of this Contract, DHCS may impose financial sanctions, administrative sanctions, and/or Corrective Actions on Contractor for failure to meet required MPLs³ as detailed in APL 23-012. DHCS may require Contractor to make changes to its executive personnel if Contractor has persistent and pervasive poor performance as evidenced by multiple performance measures consistently below the MPL over multiple years. DHCS may also limit Contractor’s Service Area expansion or suspend Member Enrollment based on Contractor’s persistent and pervasive poor performance on Quality Performance Measures. In addition to sanctions and Corrective Actions, 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 Contractor in advance of each applicable Rating Period, within the determination of Capitation Payment rates for that Rating Period.</p> <p>A.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.</p>
Louisiana	<p>4.4.1 MCO Performance Withhold Amount.</p> <p>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...

³ Minimum Performance Level (MPL)

State	Contract language
	<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>
<p>Minnesota</p>	<p>4.11.3 Health Equity Stakeholder/Community Engagement.</p> <p>4.11.3.1 The MCO will include as part of its Population Health Management Strategy described in section 7.3, a process for engaging and obtaining input to advance health equity from communities in the enrolled population groups who experience disparate outcomes. The MCO will participate in community-led initiatives or other efforts that capture and address stakeholder feedback around health inequities in access to and quality of care.</p> <p>4.11.3.2 The specific engagement activities and the results of the feedback will be provided to the STATE in the form of a Health Equity Addendum to the Population Health Management Report. The report documentation will include agendas, minutes, and other artifacts that demonstrate the capture and connection of the activity to health equity concerns of community participants.</p> <p>4.11.3.3 The MCO must develop and execute plans to use the information to respond to issues raised, and document the results in the annual Population Health Management report, due July 31 of the Contract Year. Reporting health equity community engagement activities focused on addressing health disparities shall be worth twelve (12) points.</p> <p>4.11.5 Administrative and Access/Clinical Performance Targets for PMAP and MinnesotaCare.</p> <p>Detailed descriptions of each withhold measure are provided in the most recent version of the STATE document titled “2024 Managed Care Withhold Technical Specifications.” These specifications are posted on the DHS Partners and Providers, Managed Care Organizations web site at www.dhs.state.mn.us/dhs16_139763.</p> <ul style="list-style-type: none"> • The rates calculated will be MCO-specific for the total MCO enrolled population. • The STATE shall provide MCO-specific baseline values stratified by race and ethnicity groups to the MCO for the measures to which stratified race and ethnicity apply. • The STATE will calculate quality measures using administrative claims. • Each measure’s overall rate (for all subpopulations) for 2024 shall be assessed against MCO’s baseline rate from Contract Year 2022. • Each measure stratified by race and ethnicity groups (Asian/Pacific Islander, Black, Hispanic, Native American, and non-Hispanic White) shall be assessed against a baseline disparity gap with the state average rate for all MCOs. • For each disparity gap that improves, the MCO shall be awarded points. • For each disparity gap that worsens, the MCO shall lose points. • If no disparity gap exists for the reference year of 2022, then the performance goals are a five percent (5%, percentage point) improvement for the MCO’s rate for each of the stratified race and ethnicity groups for each measure and/or sub measures. • Partial scoring for measures. A portion of the withhold points will be awarded

State	Contract language
	<p>commensurate with the achieved improvement. The percentage of improvement will be calculated to the first decimal. The number of points will be awarded based on the percentage of improvement achieved.</p> <ul style="list-style-type: none"> • Calculation of the MCO’s score. The total points earned by the MCO for each measure will consist of the sum of the point calculations for the resulting change in each healthcare disparity gap between the reference group (state average rate for all MCOs) and each race and ethnicity group as observed from the baseline to performance time periods. <p>The MCO’s total earned points shall be summed and divided by the total points available (that is, a score of the percentage of points earned versus points available) for the performance period.</p> <ul style="list-style-type: none"> • Points for Sub-measures. For each of the measures which have two (2) sub-measures half of the total points will be awarded to each sub-measure. This affects the following measures: <ul style="list-style-type: none"> • Well Child Visits in the First 30 Months of Life; • Prenatal and Postpartum Care; • Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment; • Follow-Up After Hospitalization for Mental Illness (7-day and 30-day).
Nebraska	<p>7. Value-based contracting</p> <p>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.</p>
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: ...</p>

State	Contract language
	<p>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 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</p>

State	Contract language
	<p>the sum of:... 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
California	<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
Delaware	<p>3.14.24 Cultural Competence and Health Equity</p> <p>3.14.24.3 The Contractor shall encourage and foster Cultural Competency and Health Equity through the implementation of a Cultural Competence and Health</p>

State	Contract language
	<p>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.</p> <p>3.14.24.4 The Cultural Competence and Health Equity Plan shall, at a minimum, address the following:</p> <ul style="list-style-type: none"> 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; 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; The Contractor’s strategies and methods for recruiting staff and contracting with providers with backgrounds representatives of the members served; and 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>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>
Georgia	<p>7.8.1. The Contractor shall have a comprehensive written Cultural Competency & Health Equity Plan describing how the Contractor will ensure that Covered Services are provided in a culturally competent manner to all Members, including those with Limited-English Proficiency, hearing impairment, a speech or language disorder, physical disabilities, developmental disabilities, differential abilities, or diverse cultural and ethnic backgrounds. The Cultural Competency & Health Equity Plan must describe how the Providers, individuals and systems within the Contractor’s Plan will effectively provide Covered Services to people of all</p>

State	Contract language
	<p>cultures, races, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of the individual Members, and protects and preserves the dignity of each.</p> <p>7.8.2 To enhance workforce diversity and sustainability in its Provider Network and to endeavor toward increasingly more equitable Health Care delivery approaches and outcomes, the Contractor’s Cultural Competency & Health Equity Plan must include:</p> <p>7.8.2.1 Building, executing, and demonstrating a robust Cultural Competency Training Program and evaluation frameworks within the Provider Network.</p> <p>7.8.2.2 Planning for Interpretation Services and Translation Services for written materials, consistent with Section 7.10 to meet the needs of Members whose primary language is not English, using qualified medical interpreters (both sign and spoken languages), and make available easily understood Member oriented materials, including the posting of signage in the languages of the commonly encountered group and/or groups represented in the service area;</p> <p>7.8.2.3 Identifying community advocates and agencies that could assist Limited English-Proficiency and/or that provide other Culturally Competent services, which include methods of outreach and referral;</p> <p>7.8.2.4 Incorporating Cultural Competence into Utilization Management, Quality improvement, and planning for the course of treatment;</p> <p>7.8.2.5 Identifying and employing resources and interventions for high-risk health Conditions found in certain cultural groups;</p> <p>7.8.2.6 Recruiting and training a diverse staff and leadership that are representative of the demographic characteristics of the State.</p> <p>7.8.3 The Contractor shall submit its Cultural Competency & Health Equity Plan to DCH during Readiness Review and as updated annually thereafter. Contractor’s Cultural Competency & Health Equity Plan must be 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>7.8.4 The Contractor may distribute a summary of the Cultural Competency & Health Equity Plan to the In-Network Providers if the summary includes information on how the Provider may access the full Cultural Competency & Health Equity Plan on the Contractor’s website. This summary shall also detail how the Provider can request a hard copy and any updates thereto from the Contractor at no charge to the Provider.</p> <p>7.8.5 The Contractor’s Cultural Competency & Health Equity Plan must engage a variety of Members and populations in the development of its health equity approach. Overall strategies and specific activities to achieve each measurable objective must include, but are not limited to:</p> <p>7.8.5.1 Engaging diverse families when designing services and interventions that integrate care and address childhood adversity and trauma; and</p> <p>7.8.5.2 Obtaining ongoing input from Members who have disparate outcomes to incorporate the perspective of the Member.</p>
Louisiana	<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</p>

State	Contract language
	<p>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; ○ 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; ○ 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;

State	Contract language
	<ul style="list-style-type: none"> ○ 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 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>
Minnesota	<p>7.3 POPULATION HEALTH MANAGEMENT (PHM). The MCO shall create and report annually to the STATE a Population Health Management Strategy or any amendment to the original PHM strategy by July 31 of the Contract Year, including structure and processes to maintain and improve health care quality, and measures in place to evaluate MCO’s performance on its process outcomes (for example, clinical care, or Enrollee experience of care). The MCO must inform the STATE within thirty (30) days if the MCO makes a modification to its PHM Strategy, consistent with section 3.11.4, Service Delivery Plan.</p> <p>7.3.1 The MCO’s PHM Strategy shall be consistent with current NCQA “Standards and Guidelines for the Accreditation of Health Plans” pursuant to the current Standards for Population Health Management (PHM). At a minimum, the comprehensive PHM Strategy shall describe: (1) Measurable goals and populations targeted for each of the four areas of focus; (2) Programs and services offered to members for each area of focus; (3) At least one activity that is not direct member intervention (an activity may apply to more than one areas of focus); (4) How member programs are coordinated across potential settings, Providers, and levels of care to minimize the confusion for Enrollees being contacted from multiple sources (coordination activities may apply across the continuum of care and to other organization initiatives); (5) How Enrollees are informed about available PHM programs and services (for example, by interactive contact and/or distribution of materials); and (6) How the MCO promotes health equity (strategy that describes the MCO’s commitment to improving health equity and the actions the MCO takes to promote equity in management of Enrollee care).</p> <p>7.3.2 The PHM Strategy shall include the following areas of focus: (1) Keeping Enrollees healthy, (2) Managing Enrollees with emerging risk, (3) Patient safety or outcomes across settings, (4) Managing multiple chronic illnesses, and (5) Improvements in health equity across disparate populations (see section 4.11.3 above).</p>
Nevada	<p>7.5.3.2. Cultural Competency Plan 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>

State	Contract language
	<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>
New Hampshire	<p>4.4 Member Services</p> <p>4.4.8. Cultural and Accessibility Considerations</p> <p>...</p> <p>4.4.8.3 Cultural Competency Plan</p> <p>4.4.8.3.1 In accordance with 42 CFR 438.206, the MCO shall have a comprehensive written Cultural Competency Plan describing how it will ensure that services are provided in a culturally and linguistically competent manner to all Members, including those with LEP, using qualified staff, interpreters, and translators in accordance with Exhibit O: Quality and Oversight Reporting Requirements.</p> <p>4.4.8.3.2. The Cultural Competency Plan shall describe how the Participating Providers, and systems within the MCO will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the each Member and protects and preserves a Member’s dignity.</p> <p>4.4.8.3.3 The MCO shall work with the Department Office of Health Equity to address cultural and linguistic considerations.</p>
New Mexico	<p>3.5.1 Cultural Competency Program and Cultural Humility Plan (CHP)</p> <p>3.5.1.1 The CONTRACTOR shall develop and implement a comprehensive Cultural Competency program that aligns with National Culturally and Linguistically Appropriate Services (CLAS) Standards, is described in a written CHP, and is formally evaluated and updated at least annually.</p> <p>3.5.1.2 The CONTRACTOR’s CHP must identify and address health care disparities and ensure equitable access to and the delivery of services to all Members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, or disabilities; and regardless of gender, sexual orientation, or gender identity.</p> <p>3.5.1.3 The CHP must identify the goals and objectives of the CONTRACTOR’s Cultural Competency program and align with the goals and objectives described in the CONTRACTOR’s Population Health Management plan and HCA’s Quality Strategy.</p> <p>3.5.1.3.1 The CONTRACTOR shall evaluate its CHP annually to determine its effectiveness and identify opportunities for improvement.</p> <p>3.5.1.3.2 The CONTRACTOR shall, as part of the evaluation of its CHP, evaluate the effectiveness and outcomes of cultural competency training provided and include evaluation results in its annual CHP.</p> <p>3.5.1.4 The CONTRACTOR must submit the CHP and, starting in contract year two (2), the annual evaluation to HCA annually by April 30 of each Contract Year.</p> <p>3.5.1.5 The CHP shall demonstrate how the CONTRACTOR will recruit and retain a diverse staff to meet the cultural needs of its membership and include cultural competence as part of job descriptions.</p>

State	Contract language
	<p>3.5.1.6 Member and stakeholder feedback must be key components of the CHP development with clear indications of how Member and other stakeholder feedback was collected and incorporated into the CHP.</p> <p>3.5.1.6.1 The CONTRACTOR shall attend the Native American Advisory Board meetings (NAAB).</p> <p>3.5.1.6.2 The CHP shall provide evidence of how Members are selected for participation on the Member Advisory Board (see Section 4.12.3.2 in this Agreement) and how diversity of representation is achieved each year.</p> <p>3.5.1.6.3 The CONTRACTOR shall share its CHP at one (1) of the annual statewide Member Advisory Board meetings for purposes of soliciting Member and stakeholder feedback, which shall be incorporated into the annual evaluation and update.</p> <p>3.5.1.6.4 The CHP must describe how Members are supported to participate in the Member Advisory Board meetings, including but not limited to: access to materials ahead of time, child care, translation services, virtual attendance options, technology assistance, literacy support, and other accommodations that ensure member representatives are able to meaningfully participate.</p> <p>3.5.1.7 The CHP shall describe how the CONTRACTOR will assess the cultural and linguistic needs of its Members and identify health disparities so that the CHP accurately represents and addresses the cultural and linguist needs of its Members and the CONTRACTOR’s strategies to mitigate health disparities. The CONTRACTOR must also describe how the CONTRACTOR will continuously monitor for changes in the cultural and linguistic needs of its Members and/or health disparities and adjust its CHP to meet the evolving needs of its membership.</p> <p>3.5.1.8 The CHP shall describe how the CONTRACTOR will use the CHP to shape and inform the CONTRACTOR’s Network Development and Management plan and activities to ensure adequate access and availability of services that are delivered in a culturally competent, linguistically appropriate, and equitable manner. This must include how the CONTRACTOR will retain an accounting of annual required provider trainings on cultural competency.</p> <p>3.5.1.9 The CHP shall describe how the CONTRACTOR will monitor and evaluate its Member-facing operational areas to ensure staff are providing culturally competent, linguistically appropriate, and equitable care for Members.</p> <p>3.5.2 The CONTRACTOR shall conduct initial and annual organizational self-assessments of culturally and linguistically competent-related activities and shall integrate cultural and linguistic competence-related measures into its internal audits, performance improvement programs, Member Satisfaction Surveys, and outcomes-based evaluations.</p> <p>3.5.3 The report of the CONTRACTOR’s evaluation of its CHP shall be used to inform the CONTRACTOR’s Population Health Management and Quality Assurance program. Report findings shall be part of a continuing quality improvement cycle with goals developed to address any findings where the CONTRACTOR can improve in Cultural Competency, linguistic competency, and Health Equity.</p> <p>3.5.4 The CHP must outline how the evaluation findings are leveraged by the CONTRACTOR to improve services and how the findings are used to update the</p>

State	Contract language
	CONTRACTOR’s annual Population Health Management plan, QM/QI evaluation, and QM/QI program description.
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> <ol style="list-style-type: none"> a. Identify organizations and advocates that could work with LEP communities and individuals in a culturally competent way; 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</p> <p>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:</p> <ol style="list-style-type: none"> (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.
Texas	2.6.18.1 Cultural Competency Plan Exhibit H (RFP SOW)

State	Contract language
	<p>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:</p> <ol style="list-style-type: none"> 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>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-

State	Contract language
	<p>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> <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 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 hard-to-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</p>

State	Contract language
	outcomes; Carved Out Services; Coordination of Care; Health Equity; and Accessibility of Services
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; • 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>
Minnesota	<p>4.11.3 Health Equity Stakeholder/Community Engagement.</p> <p>4.11.3.1 The MCO will include as part of its Population Health Management Strategy described in section 7.3, a process for engaging and obtaining input to advance health equity from communities in the enrolled population groups who experience disparate outcomes. The MCO will participate in community-led initiatives or other efforts that capture and address stakeholder feedback around health inequities in access to and quality of care.</p> <p>4.11.3.2 The specific engagement activities and the results of the feedback will be provided to the STATE in the form of a Health Equity Addendum to the Population Health Management Report. The report documentation will include agendas, minutes, and other artifacts that demonstrate the capture and connection of the activity to health equity concerns of community participants.</p> <p>4.11.3.3 The MCO must develop and execute plans to use the information to respond to issues raised, and document the results in the annual Population Health Management report, due July 31 of the Contract Year. Reporting health</p>

State	Contract language
	equity community engagement activities focused on addressing health disparities shall be worth twelve (12) points.
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> <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>

State	Contract language
	<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>
New Mexico	<p>4.12.3.2.2 The Member Advisory Board shall consist of members representing all populations served by the CONTRACTOR, family members and Providers. The CONTRACTOR shall have a diversity of representation of its Members in terms of race, ethnicity, gender, other cultural characteristics, special populations, and New Mexico’s geographic areas.</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; 5. Reporting of outcomes to County Agencies, CFACs, CBOs, and other community partners; 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 7. Information on how the PHP is addressing health disparities and incorporating health equity into their internal and external policies, and procedures
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</p>

State	Contract language
	and CHP process. The checklist is located at https://www.oregon.gov/oha/OEI/Documents/Community%20Engagement%20Strategies%20Checklist_vOHA_FINAL.pdf .
Rhode Island	<p>5.3. Behavioral Health Workgroup</p> <p>5.3.1. The Contractor shall participate in an ongoing workgroup with EOHHS, BHDDH, DCYF, health plans, AEs, Member advocates, and other stakeholders and interested parties identified by EOHHS. The purpose of the workgroup is to identify gaps, implement changes, and evaluate needs including:</p> <p>5.3.1.1. Practices and protocols to promote health equity and access to integrated and coordinated physical health, behavioral health, SUD, and SDOH services.</p> <p>22.8. Member Advisory Committee</p> <p>22.8.7. The Member Advisory Committee shall review and provide input on Member materials, including educational materials and the Contractor’s Health Equity Plan.</p>

9. Primary Care Assignment and Continuity of Care

State	Contract Language
Florida	<p>Section V. Services Administration</p> <p>D. Coverage Provisions</p> <p>1. Primary Care Provider Initiative</p> <p>f. The Managed Care Plan shall assign a PCP to those enrollees who did not choose a PCP at the time of Managed Care Plan selection. The Managed Care Plan shall take into consideration the enrollee's last PCP (if the PCP is known and available in the Managed Care Plan's network), closest PCP to the enrollee's ZIP code location, keeping children/adolescents within the same family together, enrollee’s age (adults versus children/adolescents), and PCP performance measures.</p> <p>(1) If the language and/or cultural needs of the enrollee are known to the Managed Care Plan, the Managed Care Plan shall assign the enrollee to a PCP who is or has office staff who are linguistically and culturally competent to communicate with the enrollee.</p>
Minnesota	<p>6.18.3 Provider Termination Not for Cause or Enrollee New to MCO.</p> <p>This section describes the requirements for transition of care if the Provider contract termination is not for cause; or if the Enrollee is new to the MCO and meets the following criteria. The MCO must provide, upon request, service authorization to receive services that are otherwise covered under the terms of this Contract through the Enrollee's current Provider, for up to one hundred and twenty (120) days if the Enrollee is engaged in a current course of treatment for one or more of the following conditions:</p> <p>(1)An acute condition;</p> <p>(2)A life-threatening mental or physical illness;</p> <p>(3)Pregnancy beyond the first trimester of pregnancy (see also section 6.18.3.4 below for at-risk pregnancy);</p> <p>(4)A physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or</p>

	<p>(5)A disabling or chronic condition that is in an acute phase; or</p> <p>(6)If the Enrollee is receiving culturally appropriate healthcare services (excluding NEMT services) and the MCO does not have a Network Provider with special expertise in the delivery of those culturally appropriate healthcare services within the time and distance requirements of section6.13;or</p> <p>(7)If the Enrollee does not speak English and the MCO does not have a Network Provider who can communicate with the Enrollee, either directly or through an interpreter, within the time and distance requirements of section6.13; or</p> <p>(8)If a physician, advanced practice registered nurse, or physician assistant certifies that the enrollee has an expected lifetime of 180 days or less, MCO must provide, upon request, service authorization to receive services for the rest of the Enrollee's life.</p>
<p>Pennsylvania</p>	<p>Q. Assignment of PCPs</p> <p>The PH-MCO must have written policies and procedures for Members and parents, guardians, or others acting in loco parentis for Members with Special Needs, who require assistance in the selection of a PCP. The PH-MCO must receive advance written approval by the Department regarding these policies and procedures. The PH-MCO’s submission of new or revised policies and procedures for review and approval by the Department shall not act to void any existing policies and procedures which have been prior approved by the Department. Unless otherwise required by law, the PH-MCO may continue to operate under such existing policies and procedures until such time as the Department approves the new or revised version thereof.</p> <p>The PH-MCO must ensure that the process includes, at a minimum, the following features:...</p> <p>The PH-MCO must take into consideration, language and cultural compatibility between the Member and the PCP</p>

Appendix C: Links to Medicaid Managed Care Source Documents

Below are links to state Medicaid Managed Care (MMC) documents, including Requests for Proposals (RFP), Managed Care Organization (MCO) contracts and model contracts, and other sources reviewed in this *Compendium*.

1. California: [Link](#) to 2022 Medi-Cal Managed Care Plans RFP and [Link](#) to 2024 MCP boilerplate contract.
2. Delaware: [Link](#) to 2021 Medicaid MCO RFP
3. District of Columbia: [Link](#) to 2023 Medicaid MCO Contract
4. Florida: [Link](#) to Florida's Statewide MMC procurement, called an Intent to Negotiate 010-22/23
5. Georgia: [Link](#) to 2023 MMC RFP and Model Contract
6. Hawaii: [Link](#) to 2020 MMC RFP and Model Contract
7. Kentucky: [Link](#) to 2021 Medicaid MCO contracts
8. Louisiana: [Link](#) to 2021 Medicaid MCO RFP; [Link](#) to 2023 MCO contracts
9. Michigan: [Link](#) to 2023 Medicaid Health Plan RFP and Model Contract (Click on "Guest Access" on the left and then in "Keyword Search" enter "Comprehensive Health" to access RFP and "Schedule A Statement of Work Exhibit 1")
10. Minnesota: [Link](#) to 2022 Minnesota RFP for Families and Children Medical Assistance and MinnesotaCare in 80 Greater Minnesota Counties; [Link](#) to model template for 2024 contracts with MCOs for families and children (PDF); [Link](#) to Minnesota MCO Incentive and Withhold Specifications; [Link](#) to 2024 IHP RFP Model Contract; and [Link](#) to IHP RFP Appendix E. Health Equity Measures.
11. Mississippi: [Link](#) to 2021 Medicaid Coordinated Care Request for Qualifications
12. Missouri: [Link](#) to 2021 HealthNet Managed Care Request for Proposals; [Link](#) to 2022 MMC contract
13. Nebraska: [Link](#) to 2022 MMC RFP
14. Nevada: [Link](#) to March 2021 MCO RFP; [Link](#) to 2022 MMC contracts
15. New Hampshire: [Link](#) to 2023 Medicaid Managed Care RFP and Model Contract
16. New Mexico: [Link](#) to 2023 procurement documents, including Medicaid Managed Care RFP (and amendments) and MMC Model Contract (Appendix L)
17. New York: [Link](#) to 2019 Medicaid Managed Care / Family Health Plus / HIV Special Needs Plan Model Contract
18. North Carolina: [Link](#) to Medicaid Managed Care Prepaid Health Plan and Managed Behavioral Health Care contracts
19. Ohio: [Link](#) to 2021 Medicaid Managed Care Request for Applications; [Link](#) to 2021 MMC contract
20. Ohio: [Link](#) to the 2021 OhioRise contract (Managed Behavioral Health Care)
21. Oklahoma: [Link](#) to 2022 SoonerSelect RFP; [Link](#) to 2022 SoonerSelect Children's Specialty Program RFP
22. Oregon: [Link](#) to 2024 Medicaid CCO 2.0 Contract; [Link](#) to 2024 Guidance document for Transformation and Quality Strategy
23. Pennsylvania: [Link](#) to 2023 Medicaid MCO HealthChoices Agreement including Exhibits and Non-Financial Appendices; [Link](#) to 2019 Medicaid MCO HealthChoices Physical Health Request for Application; [Link](#) to 2023 Managed Care Quality Strategy
24. Rhode Island: [Link](#) to MMC RFP and Model Contract (Solicitation RFP24003614)
25. Texas: [Link](#) to 2022 STAR and CHIP Managed Care Services RFP
26. Washington State: [Link](#) to (amended) 2024 Apple Health Integrated Medicaid MCO contract
27. West Virginia: [Link](#) to State Fiscal Year 2022 MCO Model Contract